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Disabled People and Development

Lorna Jean Edmonds

**Poverty Reduction and Social Development Division
Regional and Sustainable Development Department
Asian Development Bank**

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About the author. Dr. Lorna Jean Edmonds is the Director, Research Services, Queen's University in Kingston, Ontario, Canada. Dr. Edmonds has extensive international experience as an educator, researcher, policy adviser, and project leader in the field of community-based rehabilitation (CBR) and including disabled people in development. She has coordinated continuing education, undergraduate and graduate programs, and published and lectured in CBR and international program management at Queen's University and internationally.

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FOREWORD

There are some 600 million people with disabilities worldwide, or 10% of the world population, with 400 million of them estimated to live in the Asia and Pacific region. Taking into consideration the impact on families, the lives and livelihood of more than 800 million people, or about 25% of the population, are affected. Many of the disabled remain invisible. People with disabilities are poor because they are denied access and opportunities most basic to human development—education, income, and self-esteem. However, people with disabilities have the capacity to become productive citizens and contribute to national development. Given their large numbers, the short-term costs of educating and integrating persons with disabilities will be surpassed by the long-term savings to families and society. Countries enjoy productivity gains and economic returns when disabled people are allowed to develop their skills and intellectual and physical potential, and engage in economic activities.

To assist the Asian Development Bank (ADB) and its developing member countries (DMCs) in incorporating disability issues in poverty reduction strategies and programs, a regional technical assistance (RETA 5956 on Identifying Disability Issues Related to Poverty Reduction) was approved and cofinanced by the Government of Finland. The purpose of this project was to promote understanding of and build capacity to address the needs of people with disabilities in ADB operations and in the DMCs. The technical assistance involved a series of participatory local and national workshops leading to the preparation of four country studies—in Cambodia, India, Philippines, and Sri Lanka. Reports of the country studies were presented at a regional conference on disability and development held at ADB in October 2002.

Disabled People and Development is one of the major outputs of the technical assistance. It describes the evolution of the global response to disability as well as the concepts and tools for addressing disability issues. The publication is accompanied by the *Disability Brief*, which focuses on disability issues in development for ADB operational staff as well as their government counterparts in ADB projects. Full texts of the four disability country reports are available on the ADB website at www.adb.org/SocialProtection/disability.asp.

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All the team members would like to acknowledge the participation and contributions of Henry Enns in the project, particularly his role in the completion of the regional participatory workshops. Henry Enns is remembered as one of the world’s remarkable leaders in the disability movement.

The final editing of the document was done by a team of RSDD-RSPR staff headed by Michiel Van der Auwera, Social Protection Specialist, under the guidance of Shireen Lateef, Officer-in-Charge, RSDD-RSPR.

ABBREVIATIONS

ADB	–	Asian Development Bank
ADD	–	Action on Disability and Development (United Kingdom)
APCD	–	Asia-Pacific Development Center on Disability
APD	–	Association of People with Disabilities (India)
BMF	–	Biwako Millennium Framework
BPA	–	Blind People's Association (India)
BPKS	–	Bangladeshi Protibandhi Kallyan Somity
CAILC	–	Canadian Association of Independent Living Centres
CBR	–	community-based rehabilitation
CIDA	–	Canadian International Development Agency
CSP	–	country strategy and program
CT	–	Cambodia Trust
DFID	–	Department for International Development
DMC	–	developing member country
DPI	–	Disabled Peoples' International
DPO	–	disabled people's organization
EFC	–	Employers Federation of Ceylon (Sri Lanka)
ESCAP	–	Economic and Social Commission for Asia and the Pacific (United Nations)
ICACBR	–	International Centre for the Advancement of Community Based Rehabilitation
ICF	–	International Classification of Functioning, Disability and Health
IL	–	independent living
ILO	–	International Labour Organization
KIPA	–	knowledge, inclusion, participation, access
NCD	–	national council on disability
NGO	–	nongovernment organization
PRS	–	poverty reduction strategy
PRSP	–	poverty reduction strategy paper
STAC	–	stimulation and therapeutic activity center (Philippines)
UN	–	United Nations
UNESCO	–	United Nations Educational, Scientific and Cultural Organization
UNICEF	–	United Nations Children's Fund
USAID	–	United States Agency for International Development
WHO	–	World Health Organization
WB	–	World Bank

NOTE

In this report, “\$” refers to US dollars.

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I. INTRODUCTION

1. Disability is increasingly on the development agenda. Its role in development needs to be fully understood and the issues addressed as a core dimension of our collective efforts. Another essential dimension is to make education programs accessible for personnel working in this field in the Asian Development Bank (ADB), its developing member countries (DMCs), United Nations agencies, and local and international nongovernment organizations (NGOs). The education programs need to focus specifically on increasing the capacity of these countries and organizations to include the needs of people with disabilities in all aspects of development policy and programs. They need to demonstrate how to apply a strategic and results-based approach to reducing poverty among people with disabilities, their families, and communities.

A. Definition of Disability

2. Unquestionably, defining disability is one of the major challenges, both practically and politically, when making the connection between disability and development. Consensus on a definition, however, would enhance evaluation and research. A common working definition would also facilitate communication and education and provide people with disabilities, their representative organizations, related groups, and development practitioners with a framework for profiling, measuring, replicating, and advancing disability policies into sound programming and sustainable development. Arriving at such a definition, however, is no easy task.

3. Disability is about people and their social relationships, and as such it is about the life of people with disabilities and their interaction with the community and the environment. Further, those defined as people with disabilities do not necessarily view themselves that way (McColl and Bickenbach 1998). People have the right to be called what they choose (WHO 2001). As a result, there is no single accepted definition of disability. There has been significant progress, however, in terms of the evolution of the basic philosophical foundations that characterize our global response to disability and how disability is defined and classified. Disabled Peoples' International (DPI) currently promotes the International Classification of Functioning, Disability and Health (ICF), which defines disability as '*an outcome of the interaction between a person with an impairment and the environmental and attitudinal barriers that he/she faces*'.¹

4. Disability for the purpose of development includes physical, intellectual mental health, sensory, or other types of impairments that limit one or more of the major life activities and put individuals and their family at risk of being in poverty. This risk of poverty for a disabled person is related to barriers to knowledge and participation, such as (1) discrimination and abuse because of gender, age, language, color, race, culture, disability, disease (e.g., HIV/AIDS), status, and geography; (2) lack of access to education, health care, transportation, communication, housing, employment, religious institutions, marriage, and child raising; and (3) other restrictions and limitations in their community. As with gender issues, the goal is to remove these barriers.

¹ <http://www.dpi.org/en/resources/topics/topics-definition-disability.htm>

5. Disabled people's organizations (DPOs) are NGOs that are established, governed, and managed by people with disabilities. They represent the voice and interests of people with disabilities at the international and local community level with a commitment to the overall development of all. There are two types of DPOs: those organizations formed to represent all types of disabilities, such as DPI; and those that focus on one type of disability, such as the World Blind Union. DPOs function to

(i) facilitate people with disability in discovering, formulating and defining the problem of powerlessness, (ii) provide the setting in which alternative explanations regarding the causes and dynamics of powerlessness are generated, (iii) facilitate the decision-making process with respect to the identification and removal of obstacles to learning, growth and participation, (iv) facilitate the implementation of individual as well as group action decisions, and (v) enable individuals to monitor or get feedback on the results of their own actions and the reactions from other parts of the social system. Gadacz 1994, p. 156.

6. Only through the participation of DPOs is it possible to identify the needs of people with disabilities and effectively plan, implement, and evaluate poverty reduction strategies.

B. Terminology: Words Matter

7. Terminology is an important and often sensitive issue in the field of disability and development. Accordingly, knowing the definition of and using the right terms are very important. In everyday language, the preferred terms are *disabled person*, *people with disability*, and *people with disabilities*. UN organizations make reference to *persons with disabilities*, another common and acceptable term.² The term *impairment* should be used sparingly and only under exceptional circumstances. The following represent the most accepted definitions currently promoted by Greater London Action on Disability (GLAD), a disability NGO in the United Kingdom, for inclusion in the draft Disabled People' Rights and Freedoms Bill.³

- (i) **Disability:** the outcome of the interaction between a person with an impairment or health condition and the negative barriers of the environment (including attitudes and beliefs, etc.).
- (ii) **Disabled person/people:** a person or people (group of individuals) with an impairment or health condition who encounters disability or is perceived to be disabled.
- (iii) **Impairment:** a characteristic and condition of an individual's body or mind, which unsupported has limited, does limit or will limit that individual's personal or social functioning in comparison with someone who has not got that characteristic or condition. Impairment relates to a physical, intellectual, mental or sensory condition; as such it is largely an individual issue. Accordingly, disability is the way(s) in which people with impairments are excluded or discriminated against; as such, it is largely a social and development issue. People with impairments are people with

² <http://www.unescap.org/esid/psis/disability/decade/terminology.htm>

³ <http://www.glad.org.uk/Pages/rightsnow.htm>

specific conditions; people with disabilities are people with impairments who are excluded or discriminated against due to environmental factors.

- (iv) **Environmental factors:** factors that make up the physical, social, and attitudinal environment in which people live and conduct their lives

8. The reality is that everybody has an impairment—it only becomes disabling when it interacts with the environment. For instance, a person in the United Kingdom with poor vision (an impairment) would receive glasses and not be considered or feel himself/herself to be a disabled person. However, a person in rural Africa with the same poor vision would not have access to ophthalmic care, would probably not do well at school, and would become a disabled person due to his or her impairment interacting with the environment.

C. Purpose

9. This document aims to provide a consolidated set of guidelines to identify and address the issues affecting people with disabilities in poverty reduction strategies. These will assist people in the identification, design, preparation, and implementation of projects.

10. The main contribution of this document is that it provides the information and analytical tools for identifying the extent to which disability is a development issue; and for analyzing, identifying, and addressing the needs of people with disabilities within development. The tools include a disability checklist, consisting of a set of key questions for investigation; suggestions for including disability in programming; resources agencies and literature to access for more knowledge on disability issues; strategies for implementation; and case studies.

11. These tools are provided to address the needs of people with disabilities credibly and effectively and in a participatory way in the process of analysis and design. The checklist questions are aimed at determining the key issues requiring attention to ensure an inclusive approach in project analysis leading to design and programming. Strategies are proposed for promoting the inclusion of disability in development, through sector-wide and sector-specific programming and disability-specific projects. The case studies are examples to illustrate current practice in disability and development. Access to these tools and resources will enhance the capacity of those working on disability to address the needs of people with disabilities both within sectors and in cross-cutting issues.

12. This document also provides opportunities to reshape the attitudes of key people and institutions toward disability. In this way, users can truly assist people with disabilities and their families to step out of the vicious and overwhelming poverty cycle. For example, application of the tools described herein can improve the chances for children with disabilities to make friends, learn, be children, and grow up to be productive and responsible adults. Each question and strategy proposed in the document has been carefully selected to help practitioners to enable disabled children to go to school, take a bus, and some day go to work and reach their potential as citizens of their communities. This can only be achieved by changing the attitudes of society toward people with disabilities and their families, and by establishing responsive and effective programs by, with, and for people with disabilities.

D. Structure of the Report

13. Many of the tools used to investigate poverty are essentially the same as those required to analyze the needs of people with disabilities and should be applied. The key is to ask about disability when investigating each of these components. One—and very important—contribution of this document is to assist analysts to ask about disability during country programming and while preparing and implementing projects.

14. Priority should be given to streamlining the information collection process in a way that ensures that questions and answers can be structured to link directly to poverty outcomes and indicators and areas for strategic action without duplication of effort.

15. Accordingly, this document has been structured to provide analysts with:

- (i) the rationale for including the needs of people with disabilities in development programming and poverty reduction strategies;
- (ii) a structure for guiding the data collection, analysis, design, and programming of mainstreaming disability and disability-specific projects; and
- (iii) resources for enhancing the capacity of analysts and other decision makers to address the needs of people with disabilities effectively and credibly.

16. The KIPA—knowledge, inclusion, participation, and access—“clear direction” framework forms the core structure of the document. It is described in detail in Chapter 3. The framework is used for integrating the needs of people with disabilities into national poverty reduction strategies. The KIPA acronym represents the four main outcomes guiding the integration of the needs of people with disabilities into development. The cycle includes analysis and identification, design and implementation, and monitoring and evaluation. This document provides the structure to streamline the project cycle to ensure that the investigative and implementation processes lead directly to project design and the achievement of poverty reduction goals. The main tools presented—checklist, strategies, case studies, and suggestions for including disability in development—are all structured on the KIPA framework.

17. An overview of where disability can be included in the project cycle is provided. It examines the areas where an inquiry about the needs of people with disabilities is warranted; indicates how to obtain the needed information throughout the country programming and project design process; and provides the analyst with information as to where and when the needs of people with disabilities should be considered, as well as a checklist and strategies applied.

18. A disability checklist is included to provide analysts with questions to investigate the needs of people with disabilities more fully and effectively, particularly information related to statistical data profiles, household characteristics, the causes of poverty, and the responses to poverty.

19. Finally, strategic options are given that provide a more detailed and convincing description of the priorities and alternatives for addressing poverty within the population of people with disabilities and their families.

II. BACKGROUND ON DISABILITY

A. The Imperative for Targeting Disability in Country Strategies

1. Addressing Disability will Contribute to Poverty Reduction

20. Most people involved in development have not been directly associated with people with disabilities or their issues. Accordingly, they may not appreciate the extent to which people with disabilities and their families are excluded, impoverished, and marginalized within a vicious poverty-disability cycle (DFID 2000).

It is a two-way relationship — disability adds to the risk of poverty, and conditions of poverty increase the risk of disability. Elwan 1999.

21. The “invisibility and isolation” of people with disabilities are caused by stigma, discrimination, myths, misconceptions, and ignorance. Only by a thorough analysis of this experience from research, evaluation, and input from people with disabilities can society build a sound understanding and development strategy (Elwan 1999). However, the reality is that little research and development programming has been conducted. The needs and issues of people with disabilities are not being addressed. They are ignored. Current literature, however, highlights a correlation between the extent to which the issues affecting people with disabilities are addressed and an ability to meet poverty reduction goals (Elwan 1999; Miles 1999, Johnsson and Wiman 2001). Possibly, the circumstances of people with disabilities are significantly impeding poverty reduction strategies by virtue of not being targeted as a distinct population and priority development challenge. Research and evaluation on the links between poverty and disability are urgently needed. The lack of statistical data on this link further illustrates marginalization of people with disabilities (ILO 2002).

22. Experience and research in developed countries, such as Australia, Canada, Sweden, United Kingdom, and United States (US), have demonstrated a positive correlation between growth and development and targeted social change by, with, and for people with disabilities (HRDC 2002). Social change strategies have included the establishment of disability rights and DPOs, access to the built environment, inclusive private and public sector policies, and participation and capacity building of people with disabilities, their families, and the organizations that represent them.

23. There is no expectation of capacity in developing countries to apply the full extent of disability standards experienced in more developed societies. There is, however, significant evidence that these countries still have many options. Research conducted by Ninomiya (1999) in six Asian countries provided key insights into the essential role of self-help organizations of people with disabilities in effecting change and promoting positive attitudes toward disability. The research reported that DPOs were effective in poverty reduction and decision making at national and local government levels. However, DPOs require support for including more women and people from rural communities in decision making, strengthening management capacity, and accessing current information on disability and development trends and best practice. Given the opportunity, they could advance the disability development process by providing people with disabilities and their communities with the opportunity to participate and be engaged

as leaders in the development process. Although some countries in the region are making advances, this opportunity has yet to be offered to the majority of communities in the region.

2. Current Reality: Lack of disability programming

24. One of the reasons for the lack of disability programming may be lack of appreciation of the role and impact that this distinct vulnerable population—people with disabilities and their families—has on advancing the development process. The Millennium Development Goals (MDGs), which represent key policy directions for targeting income, poverty reduction, health, environment, and other sectors, make no reference to the needs of people with disabilities. Is there awareness of the United Nations Standard Rules for the Equalization of Opportunity of Disabled Persons⁴ and the responsibility for countries and UN agencies to apply these standards?

25. To date, the reality is that neither sector-wide nor sector-specific programs are reaching people with disabilities and their families to the extent required. This includes humanitarian aid programs and policies and initiatives specific to gender, children, adolescents, youth, and aging and minority groups. Most disability programs are relegated to NGO-based activities. They are small scale and are not included in national and international poverty reduction strategies (Miles 1999). Involvement in disability programming by country partners and the development agencies that support them has been negligible.

26. However, there is recent evidence, albeit inconsistent and incremental, that disability is on the development agenda and that future programming may increase. Major development agencies are demonstrating efforts to raise the profile and importance of addressing the needs of people with disabilities in development planning and programming. They include ADB, the World Bank, Japan International Cooperation Agency (JICA), Finnish International Development Agency (FINNIDA), United States Agency for International Development (USAID), Norwegian Agency for Development Cooperation (NORAD), and the Canadian International Development Agency (CIDA). The United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), International Labour Organization (ILO), World Health Organization (WHO), and United Nations Educational, Scientific and Cultural Organization (UNESCO) are four key multilateral international organizations in the region partnering with DPOs to advance disability policy making and programming.

27. There are good reasons for ADB and other development agencies to sharpen their focus on disability. They need to deepen their investigation of the physical, environmental, and social causes of disability as major contributing factors to poverty. The 1997 Asian economic and financial crisis revealed that the poor were more severely affected than others. A large proportion of the region's population does not have the capacity to withstand economic instability and volatility (ADB 2001a). A significant subpopulation among those classified as "poor" are people with disabilities and their families.

⁴ <http://www.un.org/esa/socdev/enable/dissreoo.htm>

3. Current Reality: Disability is Increasing

28. The statistics and country profiles on the causes of disability and the health and well-being of people with disabilities throughout the region are also grim. It is estimated that people with disabilities represent 10% of the population. The World Bank estimates that in countries emerging from conflict, as much as 25% of the population are clinically depressed. In Asia alone, it is estimated that there are at least 400 million people with disabilities. Not only people with disabilities but also their families and communities are affected by disability. According to United Nations estimates, at least 25% of any population are directly or indirectly affected by the presence of disability (UN Department for Policy Coordination and Sustainable Development 1982). Considering the impact on the families and communities, this could represent a vulnerable population of more than 1 billion people. People with disabilities are identified as “the poorest of the poor....More than 1.3 billion people world wide struggle to exist on less than \$1 a day and the disabled in their countries live at the bottom of the pile” (Wolfensohn 2002). Poverty and disability are interrelated. Poor people are more likely to have a disability because of the conditions in which they live. Disability is likely to make people poorer because of limited opportunities and discrimination (Peat 1998). Therefore, people with disabilities and their families are clearly a major cohort of this very vulnerable population.

29. The number of people with disabilities is expected to increase. The reasons are complex and multifaceted and largely due to health, demographic, and development factors. These include poor nutrition (including vitamin A deficiency), the aging population, increase in violence and conflicts, land mines and unexploded ordinance, HIV/AIDS, measles and polio, traffic and occupational accidents, disaster, and substance abuse. Increased commercialization of the health sector is also a factor, as is the inaccessibility of services to address such basic needs as prenatal and primary health care, rehabilitation, education, access to clean water and sanitation, and employment and income security. Finally, reductions in infant and maternal mortality rates are leading to survival of more people with disabilities.

30. It is estimated that by 2025 there will be more than 800 million older people in the world. Two thirds of these older people will be living in developing countries, and a majority of them will be women (WHO 1998). It is estimated that disabled women and girls represent up to 20% of the world's female population (Hans and Patri 2003). Women are more likely to be caregivers to people with disabilities. Disabled women, particularly those from poor rural villages, lead an existence of extreme subservience, with very little control over their lives and face discrimination and abuse not only because of gender but also due to their disability (Hans and Patri 2003). Disability is an important concern of the women's rights movement in the same way that gender is an important concern of the disability movement.

31. Aging is linked to an increase in prevalence of disability and greater dependence on others. A 1994 study of disability prevalence in Australia, Botswana, People's Republic of China (PRC), and Mauritius showed that the frequency of disability increases approximately 3–5 fold between the ages of 30–44 and 60–64. Blindness and visual impairment are major causes of disability in older people, particularly in developing countries. It is estimated that over 25 million older people are blind today and that their number will double by 2025 (WHO 1998). Five mental disorders were among

10 leading causes of disability in the world in the 1990s, measured by years lived with disability (Murray and Lopez 1996).

4. Disability Programming is Effective

32. Most causes of disability are preventable. At least 50% of the causes of disability in Asia and Africa are preventable (DFID 2000). Also, people with complex needs because of severe impairments are more likely to die, so there is a higher ratio of disabled adults and children with mild to moderate disabilities. Further, children constitute a larger percentage of the disabled population in developing societies than in developed societies (Miles 1999).

33. One third of people with disabilities are children and two thirds of them have preventable disabilities (Peat 1997). One child in 10 is born with or acquires a disability because of preventable diseases, congenital causes, malnutrition, micronutrient deficiencies, accidents and injuries, armed conflicts, or land mines (CIDA 2001). In the last decade of the 20th century, 2 million children were killed in wars and more than 5 million were disabled (CIDA 2000).

34. When persons becomes disabled, their needs are sometimes manageable. The quality of life and participation of people with disabilities improve with proper knowledge and skills on how to live independently. This can be done by increasing their technical skills through education and professional development, and functional independence through clinical treatment, health and rehabilitation, access to community public and private sector resources and services, and support to manage and participate in family and community decision making (Edmonds 2002b; HRDC 2002). The problem is that these resources and skills remain largely inaccessible. Less than 2% of people with disabilities have access to rehabilitation and less than 5% have access to education (Elwan 1999; Miles 1999). United Nations 1998 data show that at least 350 million people with disabilities live in areas where the services they need are not available (UN 1998). As a result, society is deprived of access to the talents and skills and contribution of this very large population of people with disabilities. It is time to correct this situation and act on an inclusive disability and development agenda for action.

The international community can no longer afford to overlook the immense resources that women with disabilities offer. Disabled women have knowledge, skills and expertise, and with access to appropriate resources can provide leadership and make important contributions to our own lives and our communities, regions, countries and the world. It is time to bring the perspective of women with disabilities and to include them in international efforts to achieve economic justice, human rights and a peaceful world. Hans and Patri 2003, p. 175.

5. Priority: Mainstreaming Disability in Poverty Reduction Strategies

35. Development is about reducing social discrimination and bringing excluded people, such as disabled women and children, into the mainstream of society so that they can attend school, go to work, bear children, raise a family, access health and rehabilitation, be members of political parties, go to the theater and religious institutions, get on buses, answer the phone, and access the Internet—like all other citizens. It is not

only rights that are wanted, nor is it simply access to “social and medical” services. People with disabilities and their families want and deserve what other members of their community have—their rightful place as citizens. They too want and deserve to step out of the poverty-disability cycle that they so often face in their struggle for basic survival, notwithstanding their desire to be socially and economically responsible.

36. Some strategists argue that the issues affecting people with disabilities are already “mainstreamed” because they are included within the category of “vulnerable population” or in gender- and child-specific programming. However, disability advocates and other professionals in development appreciate that simply mainstreaming disability into existing sector programs is not enough. Experience has clearly demonstrated that disabled people continue to be excluded from society, are largely an invisible and silent population, and consequently lack capacity to cope, communicate, and contribute. Gender programming is one blatant example where the needs of disabled women have not been addressed (Hans and Patri 2003). It is not sufficient to simply include people with disabilities in the broad category of “vulnerable persons” and assume they will benefit from mainstreamed programming. They are no more “homogenous” a population than are women and men, children, the elderly, and refugees. Just as “gender and development” and “child rights” strategies specifically target the issues unique to these groups, people with disabilities too have distinct needs.

...if they ignore the difference - or bury it in a general or common legislative - they may avoid fuelling stereotypes but at the cost of ignoring the differences that actually exist....one of the main motivations for a disability specific convention is precisely to accelerate the mainstreaming of disability... Quinn and Degener 2002.

37. The needs of people with disabilities and their families must be identified and addressed in a manner consistent with and reflective of their dynamic qualities, capacities, vulnerabilities, and expectations. Community-based, integrated, accessible, and participatory principles and strategies for development, building on local capacity, need to replace the inadequacy of past exclusionary and specialized institution-based, paternalistic services (Coleridge 1993; Peat 1997; Elwan 1999; Edmonds 2002b; Wiman, Helander, and Westland 2002). Strategic and results-oriented programming must be introduced and managed to address the issues affecting people with disabilities. This requires mainstreaming the issues affecting people with disabilities in both sector-wide and specific programming. For example, one can only imagine the significant and visible cost-benefit to society if the reconstruction of postconflict Bosnia-Herzegovina and post-Hurricane Mitch Honduras had ensured that accessibility of the built environment had been addressed (ICACBR 2001; Stienstra et al. 2002). These are lost opportunities.

38. A two-pronged approach of mainstreaming and disability-specific projects is essential for development initiatives to have the desired impact on poverty reduction. Mainstreaming disability through a targeted and results-oriented strategy addresses the needs of people with disabilities as a unique constituency. It ensures that people with disabilities have the same access to basic and essential services and infrastructure as others. Their issues are then incorporated into all relevant sectors and policies, such as gender, resettlement, and labor.

39. Disability-specific projects with DPOs are essential to address the distinct needs and qualities of people with disabilities. For example, technical assistance for people with disabilities and their employers to enhance capacity of the former to participate in economic opportunities will increase their self-confidence and the willingness of employers and other employees to include people with disabilities as members of their team. Employer-oriented policies, such as subsidies, quotas, anti-discrimination laws, tax incentives, and education about supported work programs, are other strategies for achieving inclusion.

6. Women and Children with Disabilities

40. Significant attention must be paid to addressing the needs of women with disabilities in program and project design. Women with disabilities face a triple disadvantage as “women, as disabled, and as women with disabilities.”

The disability-alone categorization was therefore insufficient to understand their (women with disabilities) problems. This is proved by the fact that disabled women are nearly invisible elements, not only in the general disability movement but more so in the women's movement.
 (Hans and Patri 2003, p. 14)

41. Both the disability and gender movements have excluded the “face” of disabled women in their discourse and development. Accordingly, the combination of disability and gender creates additional disadvantages and barriers to the inclusion of women with disabilities in development. Even women often silence the voices of women with disabilities, and their needs are not recognized within gender policies. Attitudes toward women with disabilities and the expectation of their roles in society in many cases significantly limit their lifestyle choices, including family, motherhood, education, employment, and health care; and influence the way disabled women perceive themselves and are perceived by others. In the Asia and Pacific region, disabled women face some of the greatest struggles because of cultural and social structures that restrict women's mobility, freedom of speech, and basic human rights. Disabled women, particularly those in rural communities, often have no or very limited freedom or independence. It cannot be overstated how necessary it is to pay significant attention to addressing the needs of disabled women.⁵

42. Children with disabilities are another group that requires a significant focus to ensure prevention, early intervention, timely rehabilitation, access to education, recreation, and social integration leading to their full inclusion in society as children and then later as adults. Disabled children require adequate support and opportunities for appropriate responses and assistance, including integration into mainstream society. This will consequently lessen the burden of disability. The Convention on the Rights of the Child is an essential guiding framework; it specifies children's rights to protection from all forms of economic and sexual exploitation, violence, armed conflict, and discrimination based on disability, gender, religion, or ethnicity.⁶ It is unjust for disabled children to be excluded from growing up with other children in the normal course of life.

⁵ <http://www.dawncanada.net/national.htm>

⁶ <http://www.unicef.org/crc/convention.htm>

43. Disability must be mainstreamed in gender and child rights programming in the same way that child rights and gender must be integrated into disability programming.

B. Models of Disability and How They Shape the Global Response

44. Several models of disability have been conceptualized to help describe and understand disability and development. It is important to be familiar with these models because they provide a perspective on the rationale for the policies and programs developed for, with, and by people with disabilities. There are four main models: charity, medical, social, and citizenship.

1. Charity Model

45. The charity model was the principal paradigm up to World War II and is the philanthropic and charitable approach to disability that provided medical treatment, community aid, and safekeeping for those described as being “less fortunate” and “defective.” This model portrays disability as a personal tragedy with people with disabilities being objects of pity and referred to as “crippled,” “crazy” or “idiot.” A common fund-raising strategy for disability projects was to portray people with disabilities as those who needed “help,” “care,” and “protection” from people without disability. This entrenched society’s view of people with disabilities as dependent. In addition, people with disabilities were sometimes portrayed as being dangerous and weird, creating fear and unease toward them. This led to the belief that some people with disabilities needed to be hidden from society or institutionalized for the “good and protection of society.” It also promoted the perception that people with disabilities do not have the capacity to become equal members of society or the capacity to contribute economically and socially to their community’s development. Therefore, many people with disabilities were institutionalized “for their own good” (Barnes and Mercer 2003).

46. In a more positive light, charitable organizations were viewed as providing services at a time when no one else cared or were not able to participate. For example, in the latter part of the 19th century and early part of the 20th century, religious institutions primarily supported the needy and destitute because no social protection system existed to offer support for vulnerable people. Many of these still function today in developed and developing countries to meet basic needs of the very vulnerable. Charitable services can also be described as being humanitarian during emergency situations in which the first priority for people in such need is security, care, attention, and support. Basic survival rather than empowerment is the priority in this context. However, for people with disabilities—like other members of society—the need for charitable support should be the exception, not the rule. To date, this is not the situation in the region, where the charity model remains one of the main paradigms.

2. Medical Model

47. The medical model emerged after World War II as a result of significant progress and advancement in the health sciences, technology, and pharmaceutical industry. This created unprecedented improvements in the capacity of society to prevent the causes of impairment and improve the functional independence of people with impairments. There was tremendous growth in the western world leading to the institutionalization and financing of medical and social welfare services to a scale and magnitude not witnessed

before. However, this came with a price—the medicalization of disability. The services were provided within a paradigm that perceived people with impairments (“disabilities”) as “sick.” While these people had the right to receive rehabilitation and medical services, it was the professionals who had the responsibility to decide what was best for the sick (CAILC 1992; Gadacz 1994). Empowerment of people with disabilities was limited to achieving functional independence through rehabilitation. This allowed professionals in general and medicine in particular to control the lives of people with disabilities.

48. The medical approach to the management of the issues affecting people with disabilities results in disability being viewed primarily as an “impairment”—a problem of the individual. “Disability” then, is an impairment or disease to be prevented and/or treated. Accordingly, people with disabilities would be institutionalized or isolated from the community and professionals, mostly within the medical and rehabilitation system, would direct. Input by people with disabilities or their family members would not normally be viewed as a necessary step in the planning and decision-making process. The expectation to support people with disabilities beyond the medical/rehabilitation system was not a priority of policy makers.

49. This approach creates a passive and isolationist relationship between the “patient” and the “professional” within a philosophy of a “helping” system. It emphasizes the “sick” role and medicalization of disability, and perpetuates dependency on the system. Empowerment is valued only in terms of the extent to which people with disabilities can perform activities of daily living related to functional independence. Little responsibility is placed on the role of the environment, including the attitudes of society toward an impairment or handicap. Critics of the medical model focused on its inherent narrowness, limitations, and its concept of the individual “experience” of impairment as being too simplistic. Medical model programs that are institutionally based are also very costly. This is particularly relevant when, in many instances, the vast majority of the needs of people with disabilities living in institutions or hospitalized could be more cost-effectively provided through alternative community-based programs.

3. Social Model

50. The social model marked the 1970s and 1980s. It emerged as a result of a political movement led by people with disabilities to destabilize and deconstruct the medical model of disability. It was a response to the medicalization of disability and its profound negative effects on the self-identity of many people with disabilities, and the negative attitudes created as a result of the charity and medical models. The aim was to create positive attitudes about people with disabilities by people with disabilities, their families, and especially society as a whole. This was to be achieved by creating a better understanding of the rights of people with disabilities and the imperative to overcome the economic, social, and environmental barriers that affect the ability of people with disabilities to participate and engage in community life like other citizens. Terminology mattered, leading to the identification of “people with disability” and “people/persons with disabilities” as the most appropriate terms. The emergence of the social model made room for considering issues of abuse, negligence, isolation, and marginalization in the lives of disabled women, children, and men by shifting the focus away from the disabling condition as presented in the medical and charity models to the environment as a disabling element. This is particularly relevant for disabled women in the region, many of

whom live in patriarchal societies that promote dependence on men and family at the expense of basic human rights for women (Hans and Patri 2003).

51. The disability movement started in North America and Europe in the 1970s, largely led by Viet Nam War veterans and young human rights activists with disabilities. Key milestones in the sociopolitical reform of the conceptualization of disability around the world were the establishment of independent living centers and advocacy-focused DPOs in many western countries. It later expanded to Africa, Latin America, and Asia in the 1980s. As a result, many DPOs were established in the region and have become national advocacy leaders and service providers.

52. The establishment of DPI in 1980 and its receipt of Economic and Social Council (ECOSOC) consultative status in the United Nations in 1983 marked the internationalization of the disability consumer movement. Further, it recognized the efforts of organizations over the previous 15 years to raise the profile of the imperative to address the needs of people with disabilities as a worldwide development priority. The disability movement created a consumer-led and community-development approach to governing programs and services. This, in effect, represented all sectors of society.

53. The social model locates disability outside the individual and places it in an oppressive and disabling environment. It focuses on the community, society, and the role of government in discriminating against and excluding people with impairments, rather than on the individual and his or her "own" impairment, as expressed in the medical model. Advocates of the social model convincingly argued that the problem to be addressed is neither biological nor medical and that it is not the individual but the social context that is disabling. The problems are the prevailing social norms, environmental barriers, and negative attitudes constructed and held by the nondisabled members of society. This restricts the ability of people with impairments to become integral members of society and equal citizens of their communities. Advocacy, information sharing, peer support, networking, and skills and services development are the prime areas of activity and services offered by the independent living (IL) movement and DPOs (CAILC 1992; Driedger 1989; Gadacz 1994). Participation in decision making and human rights were central to the definition of empowerment of people with disabilities.

54. Historically, DPOs have advocated strongly and successfully for the equal rights of people with disabilities in North America and Western Europe (Driedger 1989). By the 1980s, people with disabilities were active, participating, and visible members of these societies. National, local, and institutional policies have changed, forcing these societies to be more inclusive, accessible, and accepting of people with disabilities. The outcome has been a marked shift in the scope and type of services, including rehabilitation and disability services, employment, education, and transportation. It also resulted in increased opportunities for independent living and integration through improved access to community resources and activities. Attitudes within these countries have been changing. Australia, Canada, European Union, and US are examples. People with disabilities are becoming integral members of the social, cultural, and economic dynamics of society. For example, a recent investigation of the economic status of people with disabilities in the countries noted above found that between 37% (Canada) and 49% (US) of the population of people with disabilities are employed (HRDC 2002). A key success factor has been mainstreaming disability, leading to specific legislation

guiding public and private sector development policies in which people with disabilities played leadership roles. There are lessons to be learned from such experience in the development and implementation of effective strategies in this region.

55. The influence of the social model on policy making and programming has spread to developing countries, including several in the region. However, progress in terms of visible social change at the individual, family, and community levels has been disappointing in many cases. Although there are isolated examples of programs that embrace the social model, the charity and medical models dominate the community agenda on disability programming. Further, unlike in countries with developed disability programming, the DPOs and many of the stakeholders involved in disability programming in this region have not only limited resources but also weak management and leadership capacity to effect social change.

56. The social model clearly articulates the power of and necessity for consumer participation in decision making to facilitate good and sound governance through inclusion of people with disabilities in policy making. However, particularly in North America and among international and UN agency disability programming, this led to the pendulum of control over policymaking regarding the needs of people with disabilities swinging from professional to consumer domination. A weakness is that the process creates conflict and a lack of collaboration and cooperation among disability groups and the other stakeholders (DeJong 1993). To an extent, this conflict is also visible in some countries within the region. Another weakness in the social model is that women with disabilities are not included in gender policies and disability programming or in key institutions and decision making. For example, only in 2003, more than 30 years after the disability movement was initiated, did a disabled woman become the chairperson of DPI. Other people with disabilities underrepresented include children and youth, indigenous populations, and people with mental health problems and intellectual disabilities. A further criticism of the social model of disability is the dichotomy of the “body” and “society,” which makes an assumption that impairment itself is a given, but does not influence the social experiences of people with disabilities (Crow 1996; Goodley 2001).

57. The strategy advocated by DPOs within the concept of the social model significantly diminished the role of the institution and professionals while community development and independent living programs were advocated as more appropriate bases for development. Consequently, this model tended to ignore those situations whereby people with disabilities needed access to professional and institutional services. As a result, institutions and professionals in this and other developing regions were largely isolated from external support for capacity building from international agencies.

4. Citizenship Model

58. The period of the 1990s to the present represents a further reconceptualization of disability and development into the citizenship model (CAILC 1993). Research on the introduction of community-based rehabilitation (CBR) into the mainstream of the health system in Bosnia-Herzegovina (Edmonds 2002b) and an extensive review of the literature shaped the construction of the framework of the citizenship model. It identified the need to bridge the dichotomy of the medical and social models by using an integrated development approach (WHO 2001). The key is that all stakeholders have the

opportunity to contribute to and benefit from the reform of disability policies, education, and service at the community and institutional levels.

59. The research reported that people with disabilities desire access to a continuum of services offered by various stakeholders from the institution to the community level. These represent core strategies for poverty reduction and integration. Stepping out of the poverty cycle will only be achieved when public and private sector institutions, community programs, and all sectors mainstream disability. Collectively, they must create common knowledge, capacity, and understanding; break down barriers; and promote equality toward an inclusive society. Collectively, they must reach the most vulnerable, particularly women and children and those in rural and isolated settings.

60. Research also demonstrated that people with disabilities are not greatly concerned about whether or not leaders are disabled persons or members of another stakeholder group. Rather they want the main consideration for leadership, advocacy, and decision making to be the capacity to manage and influence social change in a way that improves their ability and that of their stakeholders to participate and be empowered.

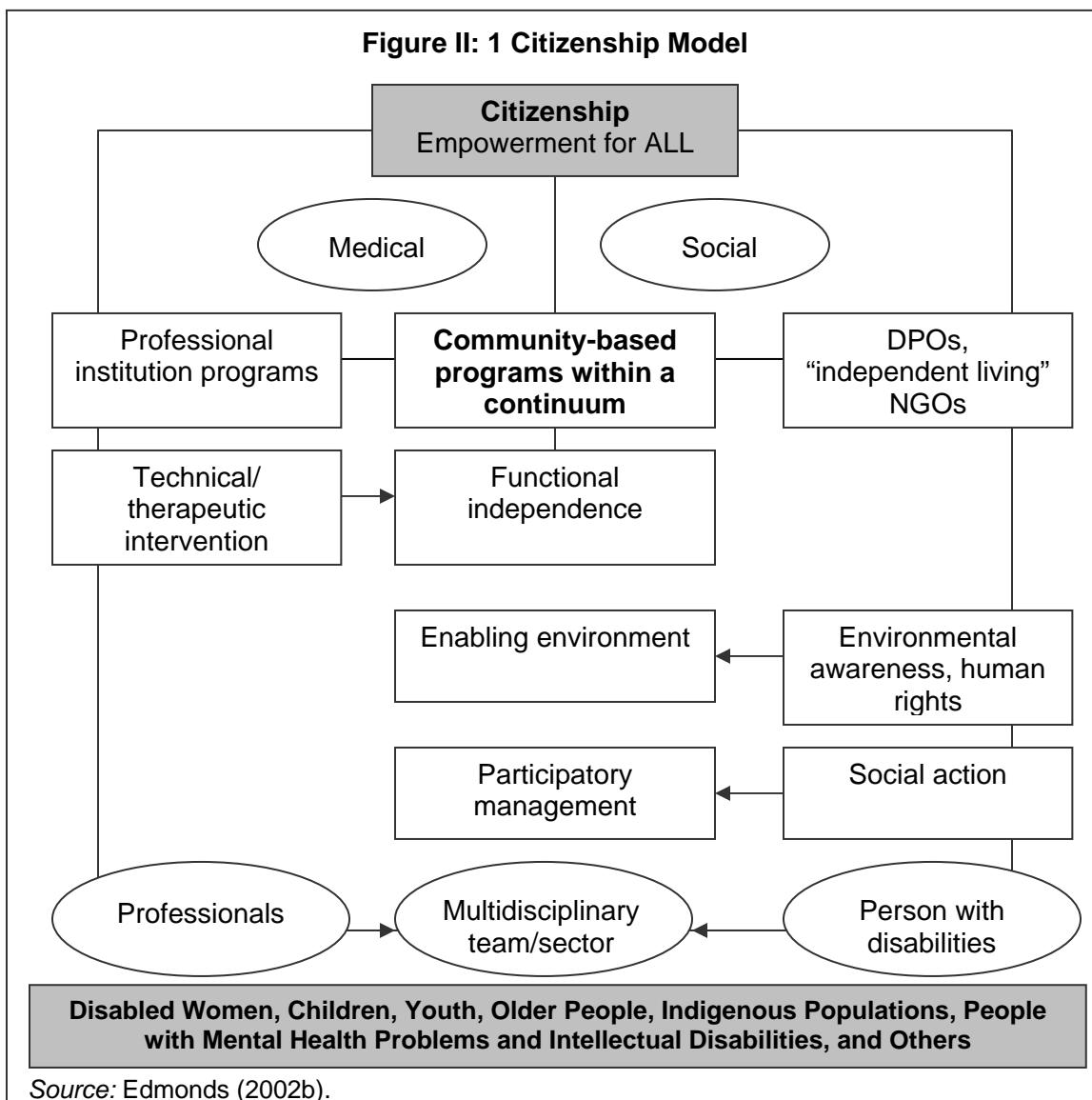
61. In this model, however, empowerment has a much broader definition and scope than in the medical and social models. People with disabilities who participated in the research stated that empowerment (and thus citizenship) for them meant participation in decision making, changes to the environment, and human rights legislation. Of equal importance was a degree of control over, as well as access to, the skills, knowledge, and support systems that facilitate functional independence. It was also the capacity to manage in a way that was empowering for all (Edmonds 2002b).

62. Accordingly, the citizenship model represents an international development paradigm in which people with disabilities deserve and aspire to have the same opportunities as other citizens of their community. This model aims to conceptualize a development framework that focuses on building an inclusive civil and rights-based society that is committed to diversity, equality, and participation of all. This is achieved by recognizing the diversity and uniqueness of people with disabilities, particularly women, children, and the aging population. They must be granted equal opportunities for achieving full economic potential and realizing their human rights. Figure II.1 provides a conceptual framework of this model.

63. The citizenship model aims to overcome the shortcomings of the social, medical, and charity models and build on their strengths. It aims to capture the individual and social response to disability in terms of people's capacities and restrictions in a positive and constructive way that contributes to the inclusion and integration of all members of society. A priority is also to focus on the issues related to people with disabilities who are underrepresented within the global movement, such as women, youth, children, indigenous peoples, and those with "invisible" disabilities, such as people with mental health problems and intellectual disabilities. Such people are often the poorest members of society.

64. The model also identifies a role for programs that are not solely institutionally or DPO/independent living (IL) defined. These are defined as "community-based" programs. Their role is to respond to the need for services that combine elements of the

knowledge, skills, and resources of the institutional and DPO/IL programs by tapping into and building on their existing strengths and capacities of the community. Likewise, DPOs and institutional programs must function as a part of a continuum within the community and incorporate the best practice⁷ models (skills, knowledge, and management of services) appropriate to the needs of the community they serve.



65. The core thrust toward poverty reduction in the citizenship model is that empowerment is achieved when all people with disabilities and the people who support them, such as family groups and parents, attain the following:

⁷ Best practice is a term used to describe an intervention that has met a set of criteria. Some of the commonly used criteria are: grounded in theory, proven effective, collaborative approach, responds to the needs of audience, high reach for cost, necessary support available (Health Communication Unit 2001).

- (i) reach their potential to possess the knowledge and skills for
 - technical and functional independence and self-advocacy,
 - critical analysis and awareness of the environment for policy development,
 - management of knowledge/resources involving multistakeholder and participatory strategies for social action;
- (ii) access a continuum of programs and services of their choice that are culturally, socially, and economically appropriate; and
- (iii) achieve results through an integrated and coordinated decision-making approach to planning, programming, and evaluating programs and services through a process of multistakeholder participation that is empowering for all.

66. One implication of the citizenship model is that all stakeholders must be educated and involved to create an environment of power sharing and capacity for partnership. Society must be changed to embrace the full range of these empowering activities for the needs of people with disabilities. It requires a balanced combination of measures for the equalization of opportunities, rehabilitation, management, and prevention through access to the full range of options available to all members of their communities. It requires building the capacity of all agencies and support systems in communities to understand the needs of people with disabilities and the strategies for their integration. This is the challenge for the region.

Application of the Citizenship Model to the Asia-Pacific Region

67. There are many barriers to overcome in the region before disability services and programs are mainstreamed across all sectors and full citizenship of people with disabilities is achieved. In many communities, basic survival overwhelms people with disabilities and their communities; the medical and charity models are the prevailing paradigms. Accordingly, to progress toward “citizenship,” ESCAP and the Asia-Pacific Development Center on Disability (APCD) have adopted a set of strategic targets. These are presented in ESCAP’s Biwako Millennium Framework (BMF) for Action Toward an Inclusive Barrier-free and Right’s based Society for Persons with Disabilities in Asia and the Pacific.⁸

68. The BMF document was developed to support the new Asian and Pacific Decade of Disabled Persons 2003–2012. It emphasizes that the highest strategic priority for the region is to strengthen the leadership capacity of DPOs and related family and parents’ associations, with a particular focus on the inclusion of women with disabilities. This requires access to knowledge and skills in (i) self-help and technical interventions, such as employment and education; (ii) critical awareness skills to promote an enabling environment (barrier free and human rights); and (iii) management capacity for leadership and social action. The evidence suggests that the quality of life of people with disabilities and of the broader community improves when people with disabilities themselves participate in policy making. The role of DPOs is to voice their concerns and

⁸ <http://www.unescap.org/esid/psis/disability/bmf/bmf.html>

advise the community and policy makers regarding best-practice strategies for making communities barrier free, with services that are accessible, of high quality, and empowering.

69. The BMF contains seven priority areas for action:

- Early detection, early intervention, and education.
- Poverty reduction through capacity building, social security, and sustainable livelihood programs.
- Access to built environments and public transport.
- Access to information and communications and relevant technologies.
- Training and employment, including self-employment.
- Self-help organizations of persons with disabilities and related family and parents' associations.
- Women with disabilities.

Details are available in the BMF website (refer to footnote 8).

70. The imperative is to shift the region from dominance of institutional medical and charity model programs to that of independent living and community-based rehabilitation approaches for addressing the current and pressing challenges for achieving citizenship.

71. This model of inclusion and integration (Figure II.2) has been designed by organizations of and for people with disabilities through the Asia-Pacific Development Center on Disability (APCD), one of the key agencies involved in the education process.⁹ Its mission is “to empower people with disabilities and those empowered to promote a barrier-free society in which four barriers—environmental physical barrier, information barrier, government and system barrier, and human attitudinal barrier—have been identified”. This framework is core to moving the organizations, agencies, and policies in the region toward the citizenship model of disability.

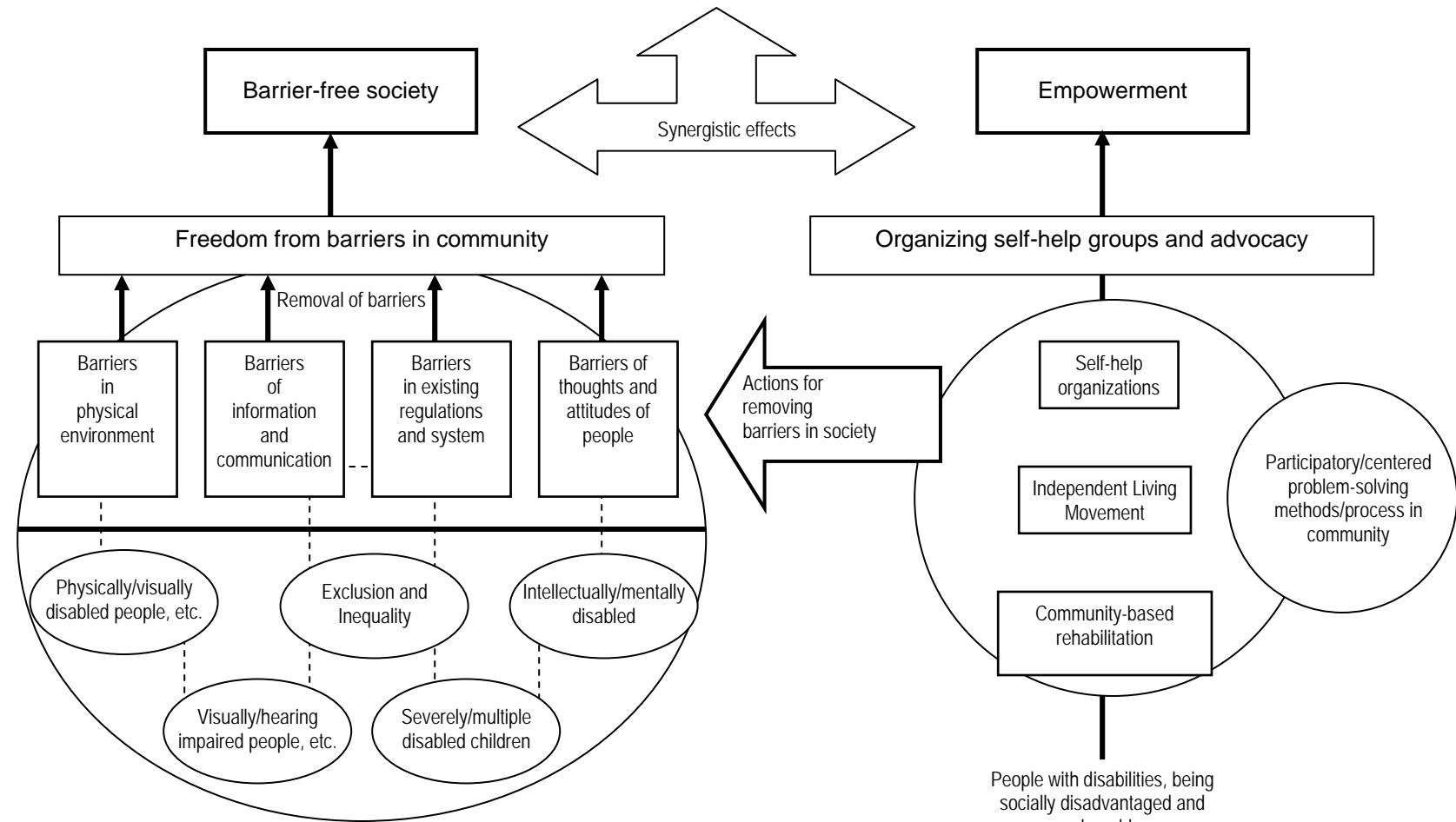
C. Classification of Disability

72. Central to disability reform is the development of a universally acceptable classification system to facilitate planning, decision making, and evaluation that describes the capacities and restrictions from the individual to the macro policy level. The challenge is to collect information that profiles the complexity of disability in a manageable way—which is highly situational and context specific. This is no easy task because what would be a barrier in one community is not necessarily a barrier in another. For example, roads that are paved and on flat terrain are not barriers for school children who require a wheelchair for mobility. When this is the case, wheelchairs function effectively. However, wheelchairs are of little value to children with mobility challenges who want to go to school in communities where the roads are rocky, sandy, and on hilly terrain.

⁹ <http://www.apcdproject.org>

Figure II.2: APCD Social Model

Full Participation and Equality of People with Disabilities in Society



APCD = Asia-Pacific Development Center on Disability
Source: <http://www.apcdproject.or/about/index.html>

73. Further, a danger of classification systems is that they may shape citizens' expectations and perceptions of people with disabilities. Great sensitivity needs to be taken when considering approaches to classification systems.

74. Various attempts have been made to classify disability. Each approach developed reflects one of the models of disability and is a good example of the way a prevailing model of disability influenced the global response to disability planning and programming (McColl and Bickenbach 1998). It is important to note that people with disabilities have been very critical of these classification systems, which do not yet truly represent their realities.

75. The current development paradigm promotes citizenship through a rights-based and inclusive model. Recognizing that people with disabilities have complex and distinct health, environmental, and social requirements, a necessary condition for development is a support system that is culturally and regionally diverse. In this model, the priority is to profile the full spectrum of people with disabilities. It aims to capture the disability category, the functional limitations, and barriers to access and participation in a quantifiable and descriptive manner.

76. The International Classification of Functioning, Disability, and Health (ICF), published by WHO in 2001, reflects some of the core ideas of the citizenship model.

ICF is based on an integration of these two opposing models. In order to capture the integration of the various perspectives....ICF attempts to achieve synthesis, in order to provide a coherent view of different perspectives of health from a biological, individual and social perspective.
(WHO 2001, p. 20)

77. The purpose of this classification system is to standardize the language and provide a unified framework for description and quantification of disability. A central tenet has been to combine the need by health services and development agencies for information on health and functioning (as it relates to the medical model) to the need to describe the magnitude of disability in terms of how the environment is a positive or limiting factor (social model). This new version of ICF is available online.¹⁰

78. ICF defines disability as an umbrella term for impairment, activity limitations, and participation restriction. It is viewed as a complex collection of culturally and context-specific conditions, many but not all of which are created by the social environment (WHO 2001). This places disability in its wider societal context, which in turn becomes responsible for environmental, attitudinal, and ideological modifications. These are viewed as necessary to ensure full participation of people in all aspects of life with disabilities. However, although a step forward from the previous classification system, it is argued that the ICF fails to identify disability as a social process or set of social relationships. The ICF continues to be viewed by some as an extension of the medical model that defines individuals rather than social processes as "the problem."

79. ICF is a tool that can be used to describe and compare the health of populations in an international context. The new classification aims to promote a universal

¹⁰ <http://www3.who.int/icf/icftemplate.cfm>

orientation, neutral terminology, and recognition of the importance of environmental factors. In addition it aims to address the role of impairment in the lives of people with disabilities by providing a comprehensive framework for understanding health, functioning, and disability. It recognizes and quantifies the reality that disability and functioning are outcomes of complex, dynamic, and multidirectional interactions between health conditions and contextual factors. The IFC also promotes the need for a continuum of services and support systems to be accessible to all citizens with disabilities and their communities. Within this continuum, users “theoretically” can make the appropriate choices according to their needs, local context, and resource capacities, and development practitioners can collect information to reflect the needs and patterns of usage and their impact. This, however, will depend in the first instance on the extent to which services are accessible, a situation not yet a reality for the majority of people with disabilities in the region.

80. The ICF offers development practitioners information that describes the factors affecting the ability of people with disabilities to step out of the disability-poverty cycle. These factors are related to environmental and sociocultural barriers and disadvantages preventing people with disabilities from accessing resources and participating in activities and initiatives that would make them and their families visible, productive, and integral members of the community. Of crucial importance is the investigation and analysis of the factors that restrict accessibility due to physical and attitudinal barriers to go to school, to go to work, to help out in the home, and to enable family members to participate in these endeavors. What is also needed is an appreciation of what kinds of social services and support systems, such as appropriate technology, knowledge, and skills are available and required to help people with disabilities and their families to lead an independent and productive family life.

D. International Action on Disability

1. United Nations and the UN Standard Rules

81. The UN, through the Division for Social Policy and Development, Programme on Disabled Persons,¹¹ promotes, monitors, and evaluates the implementation of the World Programme of Action and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities. It also prepares publications and information on the issues affecting people with disabilities; promotes national, regional, and international programs and activities; provides support to governments and NGOs; and gives substantial support to technical cooperation projects and activities.

82. In addition to this work, the UN through its agencies, in particular WHO, ILO, and UNESCO, has played a major role in shaping disability policies and programs internationally. In addition, regional organizations, such as ESCAP, have played a leadership role in promoting disability rights and introducing the issues affecting people with disabilities to their member countries. The UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities, adopted by the UN General Assembly in 1993, have been instrumental in shaping the international development agenda and guiding countries in their reform process.¹²

¹¹ <http://www.un.org/esa/socdev/enable>

¹² <http://www.un.org/esa/socdev/enable/dissre00.htm>

83. Although the UN standard rules are not legally binding, they serve as a basis for policy making and technical and economic cooperation. They represent a moral and political commitment of governments of member states to ensure equal opportunities for all their citizens. The rules reflect the social model of disability and use the rights-based approach. The last section of the UN standard rules identifies a special rapporteur to monitor implementation of the rules by the member states.

84. The UN standard rules recognize the need to address both individual needs, such as rehabilitation or helping devices, and societal barriers to equal participation. The term *equalization of opportunities* refers to "...the process through which the various systems of society and the environment, such as services, activities, information and documentation, are made available to all, particularly to persons with disabilities" (UN 1993). People with disabilities are equal members of society and have the right to live in their communities and use ordinary social, health, education, and employment services. As people with disabilities realize their rights, they should also assume the same responsibilities as other members of society according to their ability.

85. In 2001, the UN General Assembly established an ad hoc committee to consider proposals for a comprehensive convention that will promote and protect rights and dignity of people with disabilities based on the achievements of the holistic approach in the areas of social development, human rights, and nondiscrimination. At the first meeting of the ad hoc committee in 2002, discussions were initiated on the need for an international convention stressing the importance of NGO participation in the process.¹³ Further meetings mandated by the General Assembly are now underway to advance this process.

2. UN Economic and Social Commission for Asia and the Pacific

86. ESCAP¹⁴ assists governments of member states and self-help organizations to create inclusive, barrier-free, rights-based societies for persons with different disabilities. It supports governments in the region to promote the participation of people with disabilities in the development process. ESCAP, with a full-time disability advisor supporting its role, is a valuable resource to ADB. The support is provided through operational activities, encouragement of networking and collaborative action, identification of examples of good practice, and advisory services on the implementation of the Agenda for Action for the Asian and Pacific Decade of Disabled Persons (1993–2002).

87. The governments of the Asian and Pacific region created the Asian and Pacific Decade of Disabled Persons in order to improve the quality of life of these persons. This initiative promoted the inclusion of people with disabilities in society and in all mainstream development programs. During the decade, ESCAP produced guidelines for Promotion of Non-Handicapping Physical Environments for Disabled Persons.¹⁵

¹³ <http://www.un.org/esa/socdev/enable/rights/adhocom.htm>

¹⁴ <http://www.unescap.org/sps/disability.htm>

¹⁵ http://www.unescap.org/esid/psis/disability/decade/publications/pnedp/index_pdf.asp

88. The Asian and Pacific Decade of Disabled Persons was extended for another decade (2003–2012) in order to achieve full participation and equality of people with disabilities in the region.

89. ESCAP member countries adopted the BMF with its seven priority policy areas. The BMF also encourages governments to support and contribute to the work of the UN ad hoc committee.

3. International Labour Organization

90. ILO¹⁶ promotes social justice and internationally recognized human and labor rights. The ILO Disability Programme promotes decent work for women and men with disabilities and helps people with disabilities to participate fully in labor markets. Working from the Infocus Programme on Skills, Knowledge, and Employability, the Disability Programme involves the following main activities: improving knowledge on disability-related matters concerning training and employment, advocacy, guidance and policy advice to governments, workers, and employers' organizations; and technical advisory services and cooperative activities.

91. The ILO approach is based on the principles of equal opportunity, equal treatment, nondiscrimination, and mainstreaming. These principles are underlined in ILO Convention 159 concerning Vocational Rehabilitation and Employment (Disabled Persons), 1983, its accompanying Vocational Rehabilitation and Employment (Disabled Persons) Recommendation, 1983 (No. 168), and other ILO conventions concerning equality of opportunity.

92. ILO works on promotion of the economic empowerment of people with disabilities through international labor standards, policy development, research, publications, and technical cooperation projects. Since its adoption in 1983, 73 ILO member states have ratified ILO Convention 159. This Convention requires member states to adopt national vocational rehabilitation and employment policies that are based on the principles of equal opportunity and equal treatment, with an emphasis on mainstreaming when appropriate and on community participation. The ILO Code of Practice on Managing Disability in the Workplace, adopted in 2001, reinforces the importance of removing the barriers to recruitment, promotion, job retention, and return to work that people with disabilities face. It also advocates addressing the issues affecting people with disabilities within the framework of labor markets rather than social protection policies. The code promotes the business case for employing people with disabilities, human rights of people with disabilities, and the economic empowerment that contributes toward independent living and sustainable livelihoods.¹⁷

93. The ILO Disability Programme in Asia and the Pacific reflects the general nature of the ILO mission internationally. The primary goals of this program are the development of positive attitudes and actions regarding training and employment of people with disabilities, and increasing knowledge about vocational rehabilitation and development of skills.

¹⁶ <http://www.ilo.org/public/english/region/asro/bangkok/ability/index.htm>

¹⁷ <http://www.ilo.org/public/english/employment/skills/disability/index.htm>

4. World Health Organization

94. The WHO disability and rehabilitation program supports member states in the development of policies and programs that enhance the quality of life and equality of opportunities for all people with disabilities. In addition to its work on the ICF, described earlier, WHO focuses on CBR as a strategy for integration of rehabilitation services into primary health care. The major objective of CBR is to enable people with disabilities to maximize their physical and mental abilities, to access regular services and opportunities, and to achieve full social integration within their communities and societies. This objective uses the broader concept of rehabilitation, which includes equalization of opportunities and community integration.

95. WHO's Disability and Rehabilitation Team¹⁸ supports member states in developing appropriate services and ensuring community participation, in particular in developing and low-income countries. It also promotes intersectoral collaboration through its own work with UN agencies and international NGOs. It also monitors responses of governments of member states to the implementation of UN standard rules on medical care, rehabilitation, support services, and personnel training.

5. United Nations Development Programme

96. UNDP¹⁹ is the UN's global development network, advocating change and connecting countries to knowledge, experience, and resources to help people build a better life. UNDP is active in 166 countries, working with them on their own solutions to global and national development challenges. UNDP's network links and coordinates global and national efforts to achieve the MDGs, including the overarching goal of cutting poverty in half by 2015. UNDP sponsors development interventions with a focus on addressing the challenges of democratic governance, poverty reduction, crisis prevention and recovery, energy and environment, information and communications technology, and HIV/AIDS. People with disabilities are identified as target beneficiaries for these six focal areas.

97. One area in which people with disabilities are profiled within UNDP is land mine victim assistance²⁰ as a core component of the UNDP mine action program. The International Committee of the Red Cross estimates that on average at least 24,000 people are killed or injured by land mines every year around the world. Within the UN, WHO is responsible for the development of appropriate standards and methodologies for victim assistance, and for promoting capacity building in this area. Other UN entities, including UNDP and the United Nations Children's Fund (UNICEF), also support victim assistance activities. All agencies work closely with partner organizations outside the UN system, such as NGOs and universities. UNDP, however, coordinates support at the country level for many of the programs run by these bodies. The UNDP website provides valuable information and links to resources related to land mine victim assistance including contact information for organizations involved, information on standards and guidelines, and other documents related to victim assistance.

¹⁸ <http://www.who.int/ncd/disability/index.htm>

¹⁹ www.undp.org

²⁰ www.undp.org/bcpr/mineaction/victims.htm

6. United Nations Educational, Scientific and Cultural Organization

98. In the area of disability, UNESCO focuses on the promotion of inclusive education for all children, which requires schools to accommodate all children regardless of their physical, intellectual, emotional, social, linguistic, or other abilities. Inclusive education is the most effective way of combating discriminatory attitudes and promoting an inclusive society for all. It is applied to all education initiatives, from early childhood education, primary education, and vocational education to adult education, teachers' training, and curriculum development, as well as in other areas related to culture and social development.²¹

7. Disability Consumer Groups

99. DPI is a disability rights organization with members in 168 countries. It was conceived in Winnipeg, Canada, in 1981 during the International Year of Disabled Persons and formally established in Singapore in 1982. It has had a major influence in changing the lives of people with disabilities around the world by influencing policies in many countries within the UN and its agencies.²²

100. The World Blind Union,²³ World Federation of the Deaf,²⁴ Inclusion International,²⁵ Rehabilitation International,²⁶ World-Federation of the Deaf-Blind,²⁷ and World Network of Users and Survivors of Psychiatry²⁸ are other key international disability NGOs actively engaged in the disability movement. Many of these organizations have country-based partners or affiliated DPOs that work to advance the rights of people with disabilities and the development of policies and programs according to their needs and the communities' capacities for development. These organizations tend to be under-resourced but do make a valuable contribution at the international, national, and community levels. Also they are excellent resources for information on the issues affecting people with disabilities and have a network of people with disabilities.

101. In many countries, there are well-established, national and community-based DPOs. They actively engage in policy dialogue with communities, national government, donors, and multilateral agencies, banks, other NGOs, and implementing agencies. *Bangladeshi Protibandhi Kallyan Somity* (BPKS)²⁹ is one of the pioneer national resources in the region with a "people with disabilities self-initiatives to development" approach. This program is internationally recognized for its success in replicating a network of disability-led community programs throughout the country that are contributing to the increased economic independence and empowerment of many thousands of people with disabilities and their families. An example of their work is given in Appendix 7.

²¹ http://portal.unesco.org/education/en/ev.php-URL_ID=7939&URL_DO=DO_TOPIC&URL_SECTION=201.html

²² <http://www.dpi.org>

²³ <http://umc.once.es/>

²⁴ <http://www.wfdeaf.org/>

²⁵ <http://www.inclusion-international.org/>

²⁶ <http://www.rehab-international.org/aboutri/about.html>

²⁷ <http://www.wfdeaf.org/>

²⁸ www.wnusp.org

²⁹ bpkcs@citechco.net

102. There are also regional disability-led programs, such as the APCD. APCD is an international governmental organization committed to poverty alleviation through human resource development training in a variety of disability-related priorities, such as independent living, community-based rehabilitation, capacity building of DPOs, human rights, and information and communication technologies.³⁰ In 2003, APCD organized an international workshop on Web-based Networking to provide training for 24 delegates from 11 countries in collaboration with ESCAP. Participants were from Bangladesh, Cambodia, PRC, Fiji Islands, India, Indonesia, Japan, Lao People's Democratic Republic (Lao PDR), Philippines, Thailand, and Viet Nam. The purpose of this workshop was to create APCD web masters in order to exchange information on disabilities, especially at the grassroots level. APCD is aiming to have 100 information focal points by 2008.

8. World Bank

103. The World Bank (WB) is adding staff to support the Office of Disability and Development. A team is spearheading the development of WB policies, the coordination of WB disability and related programs, and research on the core issues affecting people with disabilities. To stimulate greater activity on disability issues, the WB has been working with each of its six regions to develop cross-sectoral working groups to develop work plans for addressing the needs of people with disabilities and to facilitate coordination. In addition, research is being conducted to examine the link between disability and HIV/AIDS and its impact on the population of people with disabilities. A Gender Fund award has recently been established in South Asia to examine disabled women's reproductive health internationally and with a specific focus on Asia. Although relatively new within the WB, this group is led by a dynamic and experienced leader who was instrumental in advancing the human rights of people with disabilities in North America and then internationally. The group is in the process of defining its particular niche within the World Bank and its international partners. Establishment of this group is a step forward to profiling disability as a priority development issue for not only agencies like the WB but also for all multilateral, bilateral, and nongovernment development agencies.³¹

104. The broader strategy of the WB Disability and Development team is building partnerships with other development agencies to increase inclusion of disability issues in development and to avoid duplication of efforts. WB has hosted international conferences where experiences on disability and inclusive development were shared. The last conference was convened in December 2004, titled: "*Disability and Inclusive Development: Sharing, Learning and Building alliances*". The disability team is also partnering with other international organizations in data-gathering efforts in order to improve the quality of the information on disabled people.

105. The other relevant agenda of the WB is the development of country-specific poverty reduction strategy papers (PRSPs). There are currently 49 interim PRSPs and 40 full PRSPs, including those for many countries in Asia (e.g., Cambodia, Central Asian republics, Lao PDR, Mongolia, Pakistan, Sri Lanka, and Viet Nam).³² Since 2001, ADB

³⁰ <http://www.apcdproject.org>

³¹ www.worldbank.org/disability.

³² www.worldbank.org/poverty/strategies

and the WB have agreed to promote increased collaboration and coordination of initiatives in the development and use of these PRSPs. Donors are using the PRSPs as their guide for coordinating and supporting priority development initiatives through donor assistance, for monitoring, and to reduce duplication of poverty analyses. Collaboration is increasing in analytical work and advice to governments. Joint assessments of poverty, joint financial sector assessments, and joint surveys are examples. Viet Nam is seen as a pilot and model of cooperation so far. However, few of these PRSPs identify or make reference to the needs of people with disabilities. It is not known if people with disabilities are represented on any of the PRSP working committees or involved in any stages of the PRSP development and analytical process. A priority is to sensitize those involved in the development of the PRSPs to analyze and identify the needs of people with disabilities, with the involvement of people with disabilities in this process.

III. KIPA “CLEAR DIRECTION” FRAMEWORK: INTEGRATING DISABILITY INTO POVERTY REDUCTION AND DEVELOPMENT STRATEGIES

106. This chapter presents the tools for reviewing the policies and programs that governments, NGOs, and other development partners implement to reduce poverty for people with disabilities and their families.

107. The focus is on defining the key components of a disability strategy that will contribute to poverty reduction. The achievement of the citizenship model for people with disabilities is synonymous with these goals. It also clearly shows the need for good governance, social development, and pro-poor sustainable economic growth as core dimensions of citizenship.

108. A strategic framework for tracking disability in development toward poverty reduction has been created (Figure III.1). This framework defines four outcomes and a set of strategies within each outcome that are required to reduce poverty and advance growth and development in the achievement of citizenship of people with disabilities. The four outcomes are knowledge, inclusion, participation and access (or KIPA).

109. Development practitioners must have the tools that allow them to maintain a focused, clear, and strategic direction. These tools are to be applied to secure the resources required for the advancement of disability policies and programs that reduce poverty and stem the widening gap between the rich and the poor.

110. The four outcomes of the KIPA framework were derived from two recent studies in which the needs of people with disabilities and the current status of disability programming were reviewed. One was research that evaluated the mainstreaming of community-based rehabilitation in the postconflict reconstruction of the national rehabilitation system in Bosnia-Herzegovina (Edmonds 2002b). The other was a baseline assessment of inclusion of disability in World Bank activities (Stienstra et al. 2002³³). The KIPA framework was then applied in the analysis of four country studies in the region carried out by ADB (Cambodia, India, Philippines, and Sri Lanka), which examined the issues of integrating disability into poverty reduction strategies.³⁴

A. Integrated Approach to KIPA: A Clear Direction

111. The poverty cycle facing the majority of people with disabilities in the region can only be truly overcome when the barriers to their inclusion and integration are addressed in an integrated way in which their needs are specifically targeted.

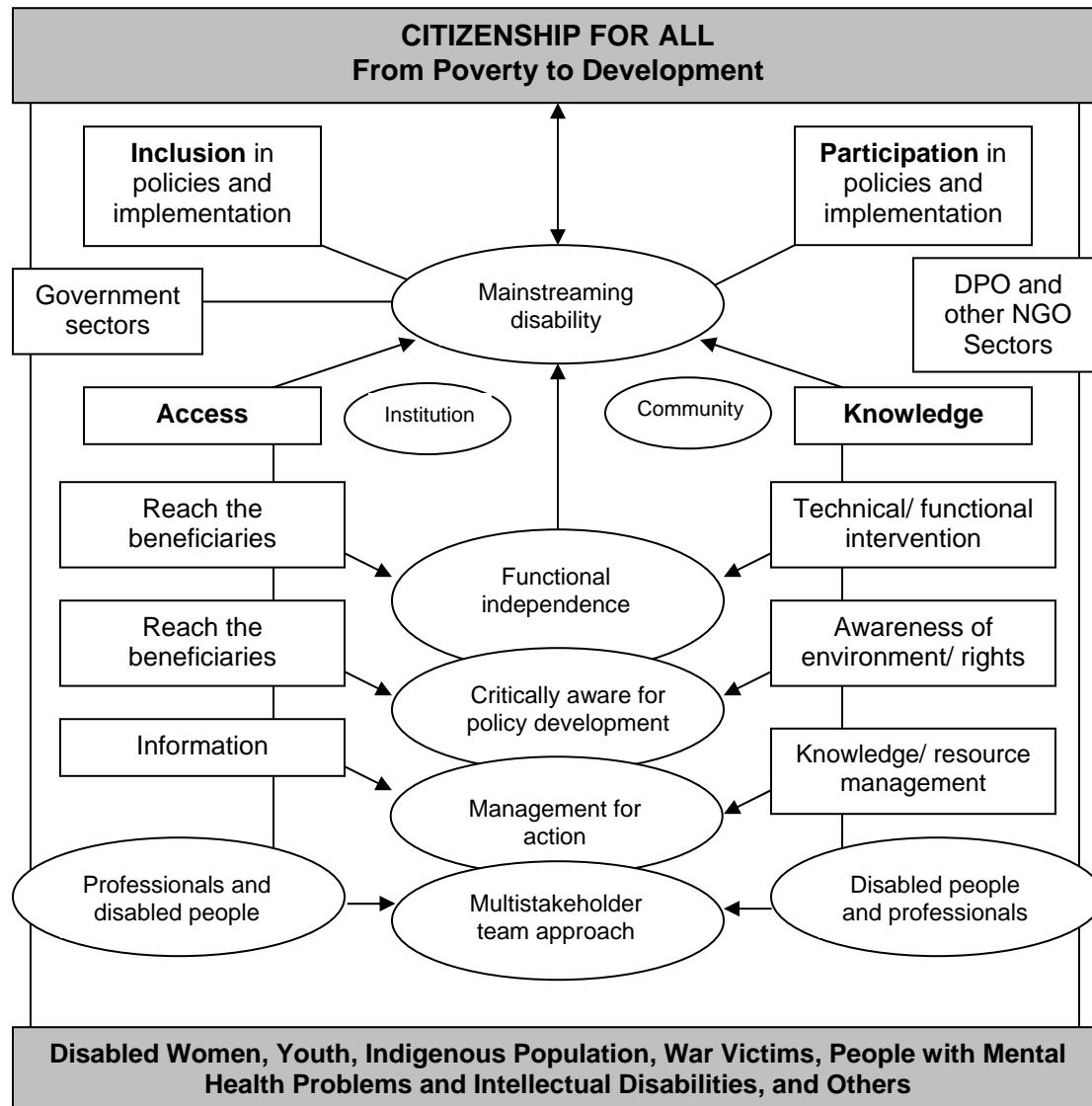
112. For example, how will increased knowledge reduce the poverty of disabled women and men? Knowledge on farming techniques and adaptive solutions for farming will help them identify their potential route out of poverty. But what about other obstacles, including lack of land or animals? Are there economic incentives to give them the chance to start a farm? Often there are negative cultural attitudes toward the suitability of people with disabilities to work (e.g., in many instances farm employers will not even consider women for work at all, let alone disabled women). Public awareness and

³³ www.worldbank.org/disability

³⁴ www.adb.org/Documents/Events/2002/Disability_Development/ortiz_edmonds.pdf

education of employers and the community are required to increase their understanding and create positive attitudes toward the inclusion of people with disabilities in economic activities. Also, these people need to build and maintain their self confidence, which is very difficult if there are no disabled people's groups for networking and peer support. DPOs or services and programs specifically for women need to be established and made accessible to women farmers so that others can gain from their experience and replicate it in other communities. Research is needed toward a better understanding of best practice, and policies implemented to sustain and replicate the process.

Figure III.1: “KIPA” Clear Direction Strategic Framework



Source: Edmonds (2002a).

113. These components need to be addressed in a comprehensive and integrated manner through coordinated development efforts among donors, government, and the public and private sector agencies responsible for implementing and supporting programs. Each outcome—knowledge, inclusion, participation, and access—is an

essential ingredient to reducing poverty. To be truly effective and sustained, however, the agencies and decision makers involved must approach the management of the development process and results in a structured way that addresses all four outcomes in a deliberate, tangible, and measurable way.

114. An integrated approach to development is essential for sustaining the reform process. Programs and projects need to link the empowering services and actions in the community (e.g., service delivery, education of community personnel, research, and evaluation) to the development of policies/legislation and the development of education curricula for the preparation of future professionals and other workers. This is required to sustain the development process. Strategies for KIPA must be mutually beneficial, complementary, and synergistic.

115. A description of the four KIPA areas follows.

1. Knowledge

116. People with disabilities deserve quality of life through knowledge that builds capacity. Knowledge includes access to information through education, training, and research. It represents the most essential dimension of KIPA. Knowledge enables people with disabilities and other stakeholders to participate and influence the quality and standards of the other three KIPA areas. An application of knowledge in India is shown in Box III.1.

Box III.1: Knowledge: Intel Corporation's Partnership with India's National Institute for the Blind

India's National Association for the Blind (NAB) was established in 1952. Since then 19 state and 65 district branches have started. NAB assists visually impaired people to lead a full life with education, training, and employment opportunities.

Intel Corporation is working with NAB to determine the role that technology can play in training visually challenged people effectively. Intel provides new software that helps the NAB (Delhi Branch) technology laboratory keep pace with rapidly changing technologies and hardware. The training modules are packaged in such a way that they can be replicated in other branches and similar institutions.

Source: Katyal 2002.

117. The key components of knowledge are capacity for

- (i) technical and functional interventions for independence,
- (ii) critical analysis and awareness of the environment for policy development,
- (iii) management of knowledge/resources and multisectoral team, and
- (iv) coordination for social action in which participation is a central tenet.

118. Technical interventions include attending primary school, university, and vocational education; functional interventions show how to manage activities of daily living through rehabilitation and other support services and building self-confidence through peer counseling.

119. Critical analysis and awareness influence policy development by increased understanding of the factors that contribute to a barrier-free environment, including community access, positive attitudes toward disability, and human rights.

120. People with disabilities and other stakeholders need to develop the capacity for social action—through the development of skills and experience in participatory management of knowledge and resources—and for the coordination of intersectoral and multistakeholder approaches to development.

121. To ensure quality, minimum standards for education and training of personnel and for scope of practice in the provision of services for these four components of knowledge are required. Standards need to be established for all levels of service delivery provided by government, private sector, and international agencies; and participating development agencies should be registered, regulated, and accredited. Knowledge provides the foundation for ensuring quality and advancing the development of the other three areas of action.

2. Inclusion

122. People with disabilities must be integrated. Inclusion identifies the issues affecting people with disabilities that need to be taken into account in the design, implementation, evaluation, and coordination of strategies, policies, programs, and projects. Box III.2 illustrates the World Bank's positive approach to inclusion.

Box III.2: Inclusion: World Bank Appoints Judith Heumann as Disability Adviser

In 2002, Judith Heumann was appointed as the World Bank's first-ever Adviser, Disability and Development in the Human Development Network. She will lead the World Bank's disability work, highlight its importance, and include it in the Bank discussions with client countries and in its country-based analytical work, as well as provide support for improving policies, programs, and projects that allow people with disabilities to live and work in the economic and social mainstream of their communities. Heumann, who had polio in 1949 and uses a motorized wheelchair, has worked extensively with governments and NGOs since the 1970s to contribute to the development of human rights legislation and policies benefiting disabled children and adults and to the worldwide development of the self-help and independent living movement. From 1993 to 2001, she served as Assistant Secretary of the Office of Special Education and Rehabilitation Services at the Department of Education, supervising a program that served almost 6 million disabled children and adults nationwide.

For information on the World Bank's work in the area of disability, visit:
<http://www.worldbank.org/disability>

123. The key aspects of inclusion are that

- (i) work on issues vital to people with disabilities is supported and included through policies and programs that dedicate financial resources through lending and budget allocations by banking, development, government, and nongovernment agencies;
- (ii) finance, personnel, and material resources are committed to the issues affecting people with disabilities and the hiring of people with disabilities in support, technical, and professional roles;
- (iii) organizations and their personnel are knowledgeable;
- (iv) there is accountability among decision makers and program implementers with the mandate to advance the issues affecting people with disabilities as a poverty reduction and growth strategy in their area(s) of development; and
- (v) a coordination mechanism is established for identifying disability needs, for services delivery, and for monitoring/evaluation.

3. Participation

124. People with disabilities and their organizations must have a voice. An excellent example is shown in Box III.3.

Box III.3: Participation: Election Monitoring in Bangladesh

During national elections in Bangladesh, Action on Disability and Development (ADD) deployed 300 observers with disabilities to work in 8 constituencies throughout the country. The observers with disabilities showed tremendous enthusiasm in election observations. Their presence was identified by distinctive outfits—cream colored T-shirts, beige caps, brown and blue shoulder bag—all prominently displayed with the words: "People with Disability's Observation of National Election, 2001." This effort was funded under a grant from the Swedish International Development Agency.

The program had three components. First, a series of workshops and media coverage was organized to raise awareness of people with disabilities' right to vote. Drama, music, adverts, press conferences and articles, T-shirts, and television features were all used to heighten awareness in these voter education activities. Second, extensive discussions were held with electoral officials to ensure access to the electoral process, e.g., securing permission for blind people to be accompanied in the booth by an assistant of their choice. And third, people with disabilities were trained as election monitors to work alongside others involved in the process. The program also helped promote citizen participation in a more general sense, strengthening democracy in countries where it remains fragile.

Source: Hossain (2001).

125. Participation guarantees that

- (i) people with disabilities and their respective organizations are represented in decisions that affect their lives and their communities;
- (ii) strategies to promote effective participation are established as core dimensions of the decision-making process of development organizations and policy-making strategies;
- (iii) people with disabilities and DPOs are hired to provide expertise in development planning, programming, and evaluating, and in the training

- of personnel within organizations to be inclusive in their approach to addressing the needs of people with disabilities; and
- (iv) all representatives of people with disabilities, including beneficiaries, are included in the decision-making and consultation process at all levels of policy, program, and project development.

126. Input of people with disabilities and the organizations that represent them is an essential prerequisite for sustainable and effective development. People with disabilities and their families have an insight about their issues, needs, and capacities to which no other group can contribute. Their participation not only enhances the quality of decision making and the development of strategies for implementation but it also engages them (as stakeholders) in processes from which they have a lot to gain (or lose). Participation in and ownership of the process and results enhance the chances of sustainable and quality development.

127. Participation does not necessarily ensure quality decision making. Who participates and the extent to which they expect and have the capacity to participate determine the value of the participatory process. Effective participation is a skill to be learned and experienced (hence the imperative for knowledge on participation). Further, DPOs are key contributors to the information development and decision-making process. They, however, do not necessarily represent the voice of the majority of people with disabilities—the beneficiaries. For example, in the area of gender it is has been clearly stated that disabled women's issues have not been effectively included and addressed by DPOs that have traditionally been led by disabled men (Hans and Patri 2003). Mechanisms need to be developed that reach out and engage the actual recipients of the strategies planned or implemented and include them in decision-making. DPOs, other stakeholders involved in disability, government, and development agencies must develop effective relationships to identify the agencies that represent the voices and needs of people with disabilities and have the capacities to effect change.

4. Access

128. People with disabilities need to be visible. An illustration of problems in access in Viet Nam is given in Box III.4.

129. Key aspects of access include ensuring that

- (i) services and programs developed by, for, and with people with disabilities reach the maximum number of beneficiaries in rural and urban communities;
- (ii) a barrier-free environment is achieved through positive attitudes toward disability and an accessible communication and built environment; and
- (iii) relevant, appropriate, and universally standardized information is collected and disseminated.

Box III.4: Access: Economic Opportunities

In Viet Nam, a woman named Nguyen Bich Hang, who had polio as a child, did well in school but when she applied to attend a university, a physician noted on her health certificate that she had a "crooked backbone, paralyzed legs and curved arm," which would make her ineligible for admission. Luckily for her, a second doctor gave her the required health clearance. Later, she graduated among the top students in her class, but could not find employment. Her entrepreneurial spirit prevailed, though, and she became a translator of French publications.

Another individual with polio, Nguyen Anh Dung, encountered the same health restrictions to university admissions. He decided to become an electrician and found employment with the Giang Vo Electronic Company. He still wants a university education, though, so has entered the evening program at the University of Technology.

These two people have been more successful than most individuals with disabilities in Viet Nam. Of the estimated 3.5 million people there who have disabilities, the vast majority are either underemployed...or completely unemployed.

Source: Schriner 2002.

130. Removing barriers and creating opportunities to access all services and resources within a community are essential for people with disabilities. Access requires that people with disabilities and other stakeholders are informed and aware of the issues and able to make decisions based on the best available information. It requires that services and resources reach the most vulnerable in rural and urban communities, and reach all people with disabilities, irrespective of age, sex, ethnicity, religion, geography, language, and disability. It requires that the built environment and systems of communication are barrier free and follow universal design and accommodation measures.

B. Applying the KIPA “Clear Direction” Framework to Poverty Analysis in Country Programming

131. Tools are required to reveal the gaps in coverage of existing programs and to provide strategies for mainstreaming the needs of people with disabilities across sectors and for designing disability-specific projects. The KIPA “clear direction” framework can be applied to each step in the development process from identification to implementation and monitoring. The first priority is to develop a disability checklist (itemized in the next chapter) to identify the key needs of people with disabilities, and the issues and circumstances at all levels that will facilitate or inhibit their inclusion. Access to this information will lead to the identification of the key poverty reduction strategies required by government, civil society, the private sector, and development agencies to address the needs of people with disabilities.

132. Box III.5 provides some key areas of focus when conducting an assessment of the perceptions and realities of the disability/poverty environment. It represents a summary of the disability checklist in terms of information gathering regarding the needs of people with disabilities in a country participating in a study. It is not an exhaustive list but is useful to start the review process and provide a snapshot of the current situation. Of importance is to expect that most government departments and implementing agencies (with the exception of those directly involved in disability) cannot complete the

questionnaire. Few have a good understanding of the needs of people with disabilities. It truly is an isolated and invisible community. This in itself is valuable information.

Box III.5: Areas for Investigating Disability in Country Planning

Knowledge to build capacity

- Determine the awareness of agency personnel of disability issues as a factor contributing to poverty and disability-specific strategies for poverty reduction.
- Find out the capacity of disabled persons and their families to participate in society as professionals and nonprofessionals.
- Find out if disability issues/awareness are taught in the education system generally and in professional disciplines where disability is a significant factor (e.g., health professionals, teachers, engineers, architects).
- Investigate the attitudes of departments and agencies (public, civil society, and private) toward disability.
- Determine the capacity for managing the mainstreaming of disability across sectors.
- Identify gaps in participatory approaches to the development, implementation, research, and evaluation of disability issues.

Inclusion to ensure integration

- Review the disability implications of laws and regulations.
- Assess the status of people with disabilities and attitudes of the agency and community toward disabled persons and the extent to which the agency/community is affected by sociocultural norms that segregate and discriminate against disabled persons.
- Review the disability implications of poverty reduction strategies (current and proposed) on disabled persons, assess whether there are positive or negative implications, and explore ways to mitigate negative impacts.
- Explore the different priorities for disabled persons across age, sex, geography (urban-rural), religion, and disability.
- Determine the extent to which disabilities issues are mainstreamed across sectors.

Participation to ensure a voice

- Review how people with disabilities are consulted for information and advice on the planning and implementation of poverty reduction strategies.
- Determine how beneficiaries are consulted (e.g., through research, public surveys, interviews, or focus-group meetings).
- Determine what formal structures exist whereby persons with disabilities are involved.

Access to increase visibility

- Determine the broad socioeconomic factors contributing to or hindering access by people with disabilities and their families, and participation in poverty reduction strategies and society in general.
- Determine how and what information is collected and disseminated to the agencies and the public about disability for decision making and public awareness.
- Assess the accessibility of the built environment for people with disabilities (physical, sensory, and intellectual).
- Investigate the extent to which programs are reaching disabled persons; for example, find out the proportion of disabled persons employed* by government and its public services sectors.
- Find out who provides employment* for disabled persons and in what capacity.

*Note: The term *employed* can be interchanged for different sectors (attending school at all levels, receiving health services, rehabilitation services, etc.).

133. The challenge is to find out the realities of disability and not just the perceptions. Negative and harmful perceptions of disability are believed to be the major cause of disability not being included in poverty reduction strategies. The list of perceptions in Box III.6 is a reminder of the real and problematic factors that need to be assessed in the poverty analysis process.

Box III.6: "Real" Perceptions in a Society

- Disability is a punishment to families for wrong doings in this life.
- Disability is a punishment to an individual for wrong doings in a previous life.
- Disability is an illness that can only be addressed through medical care.
- Mainstreamed poverty reduction activities, such as health and education, already automatically address persons' empowerment.
- People with disabilities and their families are a minority and need not be targeted in poverty reduction strategies as a distinct population.
- Making society barrier free in "poor" countries is an unrealistic option.
- Rehabilitation of people with disabilities is the highest priority.
- People with disabilities are not able to be educated and employed.
- People with disabilities are lazy and want to be cared for.
- Inclusive policies for disabled persons in the school and employment sectors are not cost effective.
- People with disabilities should be taken care of rather than expected to contribute to their community's development.

IV. INCLUDING DISABILITY IN DEVELOPMENT

134. To date, the needs of people with disabilities are rarely addressed within the majority of development initiatives implemented worldwide. The needs of disabled people could become a more important component in operations when they are included in the initial analysis for country programming.

135. When the needs of people with disabilities are identified early in the operational cycle, project activities with a disability dimension will be considered for implementation in country programming. This can only be achieved when program analysts have the capacity to work with partner countries to identify the realities of disability and the impact of disability on poverty and poverty reduction strategies. Analysts need to look at the work that is already being done through a "disability lens" to see how it affects people with disabilities and how strategies can be introduced or modified to be more inclusive. Access to reliable information and other resources is essential. Capacity to understand and address issues that relate to people with disabilities must be built in order to appreciate that programming is justified and must be included in country strategic plans. Addressing the needs of people with disabilities requires that an inclusive approach be taken at all stages of the operational cycle.

A. Disability in Country Planning

136. The purpose of the poverty analysis is to identify systemic causes of and structural solutions to poverty in its many manifestations. This information will be used in policy dialogues, strategy formulation, and project identification and preparation, to optimize the poverty reduction impact. The results of the poverty analysis are used to make strategic choices in the formulation of country planning.

137. The poverty analysis should include a poverty profile, an analysis of responses to poverty to date, a well-defined framework that links constraints to poverty reduction to possible interventions, an assessment of the national poverty reduction strategy, and recommended priority poverty reduction interventions. The three major steps in the poverty analysis process are

- (i) a poverty profile that summarizes the manifestations and causes of poverty,
- (ii) the responses of stakeholders and implementing agencies to poverty analysis to date, and
- (iii) the review and presentation of a set of options or alternative approaches for continued poverty reduction.

1. Poverty Profile

138. A poverty profile represents a comprehensive overview of the manifestations and causes of poverty through the collection of

- (i) statistical data on macroeconomic indicators, social indicators, and geographical and environmental characteristics;
- (ii) information about household characteristics related to physical well-being/survival, access to resources, knowledge and empowerment, and

- (iii) inclusion in decision making, using gender-disaggregated data when possible;
 - (iv) a risk and vulnerability profile to assist in understanding the dynamics of poverty, including major risks (life cycle, economic, environmental, social/governance), incidence of risk by population group (age, income, gender, regions), and coverage gaps and priorities to be addressed;
 - (v) a summary labor market assessment, including employment and labor-related data and the country's labor-absorbing development pattern; and an assessment of causes of poverty related to such areas as the economy, the historical patterns that perpetuate dependence, and societal patterns that discriminate—causes of poverty in relation to vulnerable groups that are excluded from the mainstream on purpose or by choice because of traditional lifestyles and patterns, governance, institutional factors, and natural and human-made disasters.

139. In relation to creating a disability-poverty analysis, the key is simply to ask about disability in reference to the tools, such as national census, household surveys, and other surveys that the analysts are currently using for the collection of information in the above-mentioned areas. However, there are little research and verifiable data in the region.

140. Research and data are necessary to demonstrate the magnitude of the problem and the challenges within a country to address the needs of vulnerable populations, and to develop a policy and the measures to monitor and evaluate its implementation.

141. The ADB country studies conducted on Cambodia, India, Philippines, and Sri Lanka are valuable sources of information on some of the current challenges and recommendations for integrating disability into poverty reduction strategies.³⁵ In addition, the Japan International Cooperation Agency has conducted a country profile on disability for 23 countries in the world.³⁶

142. The ICF is a tool for collecting standardized disability information for decision-making and is readily accessible on the Internet. Countries could use the ICF within their census studies and for small-scale investigative purposes. There are also experts trained to assist agencies to apply this tool to their data collection systems. There are other tools, such as the participation and activity limitation survey (PALS), to collect data on disability systematically. PALS was developed by Statistics Canada (2002) and may have valuable information for the development of research questions applicable to the region. Another resource is the Washington City Group on Disability Statistics. This group is currently guiding the development of general disability measures suitable for use in census, sample-based national surveys, or other statistical formats, which will provide basic information on disability throughout the world. The ICF is being used in the development of these measures.³⁷

143. A key component of the country poverty analysis is the risk and vulnerability profile. The main types of risks are in four areas:

³⁵ The four reports are available on the ADB website at adb.org/SocialProtection/disability.asp.

³⁶ The four reports are available on the ADB website at [adb.org](http://www.adb.org). Available: <http://www.jica.go.jp/english/global/dis/index.html>

www.cdc.gov/nchs/about/otheract/citygroup/objectives.htm

- (i) **Life cycle:** hunger, illness/injury/disease, disability, old age.
- (ii) **Economic:** end of source of livelihood (e.g., crop failure, cattle disease), unemployment, changes in prices of basic needs, economic crises.
- (iii) **Environmental:** drought, floods/rains, earthquakes, landslides.
- (iv) **Social governance:** extortion, corruption, crime, domestic violence, social discrimination.

144. All four areas clearly affect people with disabilities and their families. The life cycle is one obvious area where disability is identified as part of the risks associated with life, living, and the aging process. More important, however, is the extent to which people with disabilities are at risk and vulnerable to the volatility of society's economy, environment, and social governance. Of note is that most causes of disability in the region are preventable (DFID 2000). Further, many of the disabled population are children with mild to moderate disabilities; children with less significant disabilities are frequently not identified. Their needs can be effectively managed through access and inclusive interventions. Unless addressed, the needs of people with disabilities exacerbate these "risk and vulnerability profile" problems in the vicious poverty-disability cycle. They inhibit society's ability to recover from such vulnerability and the instability created.

145. The risk and vulnerability profile examines the incidence of risks by population group. Quantified information on people with disabilities in the list of affected populations is necessary.

2. Partner and Stakeholder Consultations, Forums, and Policy Dialogue

146. Throughout the country poverty analysis process, consultations and forums are conducted to seek input and advice from stakeholders regarding all steps undertaken in the country poverty analysis process. The consultations should first determine if disability is a factor to be considered as a part of the policy dialogue related to the country planning.

147. People with disabilities, DPOs, and other disability stakeholders should be included in this consultation process. It may also be important for a focus-group meeting to target the needs of people with disabilities specifically as a part of this consultative process throughout the country.

148. It may be useful to find a champion in the government to help lead the process and guide the work of the poverty analysis team. The country studies in Cambodia, India, Philippines, and Sri Lanka revealed individuals in senior positions of government committed to advancing disability policies and programs who would be interested in championing the cause. Most governments have a national disability council (NDC) or equivalent. Identifying the contact person of the NDC when ADB is about to embark on a country poverty analysis would be an excellent starting point.

149. The NDC may also be a valuable group to contact to identify local consultants from NGOs of people with disabilities and other stakeholders who could participate in the

analytical team. Finding that no such council or structure exists is also a very important indicator for further investigation.

150. Other groups that could be consulted in the country studies or act as a resource include DPOs, international and local NGOs, ESCAP, and offices of UN agencies involved in disability. These agencies provide a continuum of services implemented by, for, and with people with disabilities. Disability programs are being carried out, on a small scale, across most sectors in almost all countries within the region. Appendix 2 gives a list of useful contacts and resources agencies grouped according to specialty and Appendix 3 provides additional websites and literature sources.

151. In many countries, the analytical capacity of people with disabilities and others with experience in the disability field is high. There may, however, be a need in some instances for capacity building to strengthen the consulting skills of people with disabilities and other stakeholders.

152. Following are suggestions for engaging people with disabilities in the consultation process.

- (i) Review the need to include a disabled person or disability specialist as part of the team. Sample terms of reference for hiring such a specialist are given in Appendix 4.
- (ii) Invite DPOs and other disability stakeholders to participate in consultation workshops and focus-group meetings.
- (iii) Find out who manages the organizations serving the needs of people with disabilities and the extent to which people with disabilities are involved in decision making.
- (iv) Seek the input of beneficiaries in the review process by consulting them directly through survey, interview, and/or focus-group meeting.
- (v) If consultation meetings are planned, make sure to consult people with disabilities and their chosen advocates and supporters. If segregation of people with disabilities is the norm then consider meeting them separately.
- (vi) It is important to be sensitive to the fact that not all people with disabilities (including children, youth, and spouses) want their families involved. Further, some people with disabilities, such as persons with profound development disabilities and very low-functioning autistic people, cannot speak for themselves in a policy context. Their voices need to be heard. Partnering with advocacy groups is one key way for overcoming this challenge.
- (vii) In meetings, seating arrangements and the use of sign language interpreters (accessible sight lines), braille, and other forms of communication need to be considered so that people with disabilities are integrated and can hear and see the other participants. Suggestions on how to communicate with people with different disabilities are provided in Appendix 5.
- (viii) When consulting disabled persons, appropriate methods need to be considered to ensure full participation (i.e., focus-group sessions, community dialogues, enabling environment accessible to disabled persons, etc.).

3. Disability Checklist

153. The disability checklist in Table IV.1 is an analytical tool for assessing pro-poor strategies and uncovering policies and initiatives that disadvantage the poor. The checklist is a series of key closed and open-ended questions whose answers increase understanding of the needs of people with disabilities as a contributing factor to poverty. The checklist uses the KIPA “clear direction” framework and is organized according to the four KIPA areas—knowledge, inclusion, participation, and access.

154. The use of the disability checklist or the UN standard rules when the KIPA framework is applied will help to identify how pro-poor strategies impact on people with disabilities living in poverty, their families, and affected communities. The procedure identifies the KIPA poverty reduction category (e.g., knowledge) in which the country or participating agency is strong or weak, and where country and development agency resources have been earmarked and used. This aids the analyst in determining the effectiveness of current approaches. It helps in prioritizing where ADB and the partner country need to concentrate efforts for eradicating poverty and proposing strategies and alternative mechanisms for this purpose.

155. The primary applications of the checklist are to identify the need for including people with disabilities in the CSP and to identify the extent to which their needs should be included in the planning of the country program or project. The checklist can also be modified and used as a template for developing surveys to be distributed for response by agencies, for conducting individual interviews, and/or for focus-group meetings. It can also be used to identify priority areas for focusing research and evaluation, including the development of questions; and as a tool for the design, implementation, and evaluation of projects that have a disability dimension or disability-specific focus. Further suggestions on the use of the KIPA framework in national strategies are contained in Appendix 6.

Table IV.1: The Disability Checklist: Integration of Disability-Relevant Programs, Projects, and Activities

General open-ended questions
<p>Does the planned activity contain one or more of the following elements:</p> <ul style="list-style-type: none"> • design and construction of the built environment (such as public buildings and housing); • development of infrastructure, including transport systems, telecommunications, water, and sanitation; • development of small-scale industries and enterprises; • urban/rural community development; • development of health care, social services systems, and facilities; • human resource development including preschool, and primary, secondary, higher, and adult education, and vocational training; • public education campaigns; • income generation, with special emphasis on improving the situation of the most vulnerable, including women; • development of policy; education of policy, program, and project personnel? <p>Have people with disabilities been targeted in the planned activity? If so, please specify.</p>
Knowledge to build capacity
<p>Data collection:</p> <ul style="list-style-type: none"> • Has an analysis of the needs of people with disabilities been conducted as a part of the collection of background data of the proposed/existing program? • Is the information collected a reliable assessment of disability relevance of the undertaking and its components? • Have the sensitivity toward the needs of people with disabilities and the possible negative developments in the project been studied? <p>Critical awareness:</p> <ul style="list-style-type: none"> • Is information available and shared that increases people's awareness and understanding of how to facilitate independence of people with disabilities? • Does the information include knowledge and skills of those who provide services for and by people with disabilities? • Does the information include guidelines on how to make the built and communication environment fully accessible? • Does this information include knowledge of the policies and legislation that contribute to or discriminate against people with disabilities and the process for changing policies? • Are there programs available for organizations of people with disabilities and other stakeholder groups to enhance their capacity to understand, influence, and participate in policy development? • Do personnel receive education and training on the needs of people with disabilities and how to introduce and implement inclusive disability programming, including barrier-free design?
Inclusion to ensure integration
<p>Policy and strategies:</p> <ul style="list-style-type: none"> • Is there legislation that governs the rights of people with disabilities and promotes equal opportunity and human rights? • Are the UN standard rules for the Equalization of Opportunities for Persons with Disabilities applied in policy making and programming? • Do policy documents integrate the perspective of people with disabilities? • Are the needs of people with disabilities included in current poverty reduction strategies?

<p>Does your gender and development strategy include disabled women in policy issues and programming? Please specify the sector(s) and program(s).</p> <ul style="list-style-type: none"> • Are the strategies for addressing the needs of these people focused on their abilities? • Are there organizations, structures, and systems in place for policy making and monitoring of disability issues and initiatives, such as <ul style="list-style-type: none"> (i) a national coordinating body: a national disability council or equivalent? (ii) a person in the organization responsible for providing disability information, advice, and monitoring? If so, does she/he have a disability? • Is disability programming reflected in budgets and programs? <p>Implementation:</p> <ul style="list-style-type: none"> • Are there disability-specific or disability-relevant projects/activities? • What is the size of the respective programs (number of disabled persons covered) and what is the quality of the programming? • What are the challenges in the implementation of policies focusing on promoting equal opportunity for people with disabilities in your sector/organization?
Participation to ensure a voice
<p>Consultation:</p> <ul style="list-style-type: none"> • Have all relevant stakeholders been involved in planning, implementation, and monitoring, in particular people with disabilities and their advocates, such as DPOs, whose cooperation is needed for the inclusion of disability concerns? • Is there a formal process for consulting DPOs, people with disabilities, their families, and other stakeholder groups involved in addressing the needs of people with disabilities? <p>Decision making:</p> <ul style="list-style-type: none"> • Is there a mechanism for formally involving people with disabilities in decision making: <ul style="list-style-type: none"> (i) planning of CSP and regional or community goal setting and project initiatives, (ii) project design, and (iii) monitoring and evaluation of project implementation? • Do you know of agencies that have people with disabilities as the leaders and directors? • Do you know of any political or government representatives who have a disability?
Access to increase visibility
<p>Information:</p> <ul style="list-style-type: none"> • Is the information on disability rights and services available to people with disabilities, their families, and DPOs? • Are data on disability collected in the census or national surveys? Do the data correspond to the real situation, or is the disability prevalence underreported? <ul style="list-style-type: none"> (i) Can you provide data on the number of people with disabilities who access your services/project? (ii) Is this information accessible to all people with different types of sensory, mobility, or mental disabilities? (iii) Are people with disabilities served by your program? (iv) Does your program target all people with disabilities or a specific group? (v) Are programs reaching disabled women and children? (vi) Are programs reaching people with disabilities in rural communities? <p>Accessibility:</p> <ul style="list-style-type: none"> • Is your office/building/community accessible, including homes, other buildings (hospitals, schools, courts, libraries, shops, and social and health services buildings), public transport, and other means of communication, streets, and outdoor environment? • Are accessibility aspects for all people with disabilities (physical, intellectual, mental health, and sensory) considered? • Do you have an action plan to make the physical environment accessible?

B. Disability in Project Design and Implementation

156. In DMCs where disability is identified as a prominent development issue, project interventions on disability can be initiated.

157. Throughout the project design process the KIPA “clear direction” framework can be effectively applied as a guide for investigation, reporting, priority setting, and project design, as shown in Box IV.1. It can also be used as the template for developing the baseline measurement indicators for monitoring and evaluation of a project during its implementation phase. However, it is imperative in project design that clear indicators for development and results that ensure sustainability and replicability are established.

Box IV.1: Suggestions for Including Disability in Project Design

Knowledge

- Ensure that partnerships involve the establishment of clear expectations and division of roles and responsibilities in which the capacity of all stakeholders is enhanced.
- Establish mutual respect and understanding among the partners, leading to the creation of a new culture reflective of the partners’ combined contributions.
- Select international implementing agencies that have the capacity to address the full spectrum of program requirements—needs assessment, planning, implementation, and monitoring—in all sectors, including education, service, policy, and research.
- Ensure capacity and commitment to participatory management and coordination

Inclusion

- Promote an integrated approach to project design in which activities include all components of social change, such as policy development, education, service delivery, public awareness, and reconstruction.

Participation

- Involve disabled persons and organizations that expect to participate and cultivate participation through capacity building of other people with disabilities and organizations over the life of the project.
- Ensure that people with disabilities are involved in any project steering committee

Access

- Build on existing physical and human resources to implement projects cost effectively (i.e., locate employment training center for disabled persons in the university or local software company, train primary health care providers on early detection, prevention, and assessment of disability).

158. Because resources are scarce, needs are great, and countries have limited capacity, projects should be

- (i) *empowering*, so that people with disabilities and their communities have the confidence, capacity, and opportunity to make choices related to their participation in decision making; addressing individual, community, and national issues; and providing directions for economic, social, and political development;

- (ii) *sustainable*, to ensure that people with disabilities and their communities have the absorptive capacity to continue the development process beyond the life of the project or program and to withstand economic and political instability and volatility; and
- (iii) *replicable*, to ensure that knowledge and experience gained from a project or program methodology, design, and implementation can be repeated so that the majority of people with disabilities and their communities can access and benefit from the momentum and capital/human investment of the social change strategies implemented.

V. INCLUDING DISABILITY IN RELEVANT SECTORS

159. This section provides suggestions on addressing in various sectors of development. Case studies are presented to provide good examples of activities undertaken by ADB to advance and integrated disability issues and policies into the development agenda. Additional case studies of projects executed by other development agencies and NGO can be found in Appendix 7.

160. A number of sectors are particularly favorable for integrating the needs of disabled people. Box V.1 presents the components of various sectors in which people with disabilities are presently disadvantaged.

Box V.1: Sectors with Prominent Disability Issues^a

Education	Employment
<ul style="list-style-type: none">• Primary• Secondary• Tertiary/university• Technical education• Inclusive education	<ul style="list-style-type: none">• Private and public sector targeted employment opportunities• Small business development and microenterprise initiatives• Vocational rehabilitation programs• Supported work
Health and Social security	Infrastructure
<ul style="list-style-type: none">• Prevention and public health• Mainstreaming in primary health care• Hospitals and rehabilitation centers• Disability insurance• Disability benefits	<ul style="list-style-type: none">• Architectural design• Physical infrastructure development• Social infrastructure• Water and sanitation
Community services	Postconflict/Postdisaster Rehabilitation and Reconciliation
<ul style="list-style-type: none">• Independent living• Community-based rehabilitation• NGOs	<ul style="list-style-type: none">• Health centers• NGOs• Community-based rehabilitation

^a These sectors are not parallel to ADB sectoral classification.

A. Education

1. Critical Issues

161. Available evidence suggests that less than 10% of children and youth with disabilities have access to any form of education. This compares with an enrollment rate of 70% for nondisabled children and youth in primary education in Asia and the Pacific.

162. The exclusion of children and youth with disabilities from education results in their exclusion from opportunities for further development, diminishing their access to vocational training, employment, income generation and business development. Failure to access education and training prevents the achievement of economic and social independence and increases vulnerability to poverty.

163. Inclusive education, with access to education in the regular local neighborhood or community school, provides the best opportunity for the majority of children and youth with disabilities to receive an education, including those in rural areas. In some instances, special education may be the most appropriate form of education for some children with disabilities. The education of all children, including children with disabilities,

assists in breaking down barriers and negative attitudes and facilitates social integration and cohesion in communities. The involvement of parents and the local community further strengthens this process.

2. KIPA Disability Checklist for Education Projects

164. Knowledge

- (i) Reshape social attitudes to understand the need for disabled children to go to school.
- (ii) Introduce curricula that are disability sensitive and relevant to current trends in vocational, physical, and psychosocial rehabilitation services.
- (iii) Develop formal and nonformal education for disabled children and adults.
- (iv) Include disability in the formal and continuing education of school teachers, architects, health personnel, business personnel, etc.
- (v) Educate teachers and parents about working with children's disabilities.
- (vi) Offer disability, independent-living, and CBR programs in social, political, and health sciences, and in architecture and business in universities and continuing education institutes.
- (vii) Enable opportunities for them to become teachers.

165. Inclusion

- (i) Implement a public awareness and action-oriented, inclusive education plan to increase their enrollment in schools.
- (ii) Eliminate barriers to admission and create incentives for enrollment in vocational and professional education courses.
- (iii) Prohibit discrimination with regard to attendance at all education levels .
- (iv) Establish quota systems in the school system.
- (v) Establish policies requiring governments and international education organizations to include them in day care and education programs.

166. Participation

- (i) Involve them, their family members, DPOs, etc., in school activities.
- (ii) Increase their participation and that of their parents in the management of education programs through participatory approaches.

167. Access

- (i) Establish the necessary support to enable them to access schools, universities, etc. (accessible toilets, ramps, stipends, and funds), with equal emphasis on girls and women.
- (ii) Schools and parents should make it possible for disabled children to attend and graduate from school at all levels.
- (iii) School programs should be designed to meet disability-specific needs, including accessibility, flexible hours, and needs of working parents.
- (iv) Create financial incentives for renovations to make schools more accessible.

Box V.2: ADB Secondary Education Support Project in Nepal

Considerable progress in secondary education has been made in the past two decades. Enrollment has increased dramatically but still remains low, especially for girls and for the most poor and disadvantaged, including students with physical disabilities.

The project aims to improve the quality of public secondary education by improving access, particularly for educationally disadvantaged groups and girls, by improving the learning environment in schools through improved facilities, provision of residential accommodation for women and girls in remote areas, and scholarships for girls and students from disadvantaged groups, including students with disabilities.

Source: ADB. 2002. *Project Loan Secondary Education Support Project (NEP-34022)*. Manila.

B. Health

1. Critical Issues

168. The main causes of disability are malnutrition and unsanitary living conditions, together with poor perinatal care. Other causes are related to communicable and noncommunicable diseases. All these causes can be easily reduced through preventive medical interventions and awareness-raising campaigns.

169. As a result of the aging population, the number of persons with disabilities is increasing. The epidemic of noncommunicable diseases has resulted in a continuing rise in the number of persons with chronic diseases and disabilities. Injuries are also on the rise due to increasing violence, conflict, and traffic accidents. Persons with disabilities are living longer in all societies. The consequence of this trend has been a greater demand for rehabilitation services.

2. KIPA Disability Checklist for Health Projects

170. Knowledge

- (i) Develop curricula for mainstreaming disability in the education of existing health professional and nonprofessional workers, especially in disability prevention, identification, assessment, and referral.
- (ii) Educate people with disabilities and their families in health and physical and psychosocial rehabilitation to become village community workers, health educators, nurses, therapists, physicians, etc.
- (iii) Educate health personnel in management and participation strategies to promote multidisciplinary teams and coordination of programs among health, rehabilitation, and community-related activities.
- (iv) Establish quality standards for nonprofessional and professional services and personnel.
- (v) Provide continuing education for rehabilitation personnel on international approaches to rehabilitation.
- (vi) Educate people with disabilities and their parents on health and rehabilitation to improve their quality of life and functional independence.

171. Inclusion

- (i) Develop outreach and home-based programs by rehabilitation centers
- (ii) Decentralize rehabilitation services through the establishment of CBR centers or programs within the network of primary health care.
- (iii) Encourage participatory community-based health and CBR programs.

172. Participation

- (i) Increase involvement of NGOs and people with disabilities and their families in the management of health and rehabilitation programs through participatory approaches.
- (ii) Ensure consumer leadership in the design and delivery of health and rehabilitation services.

173. Access

- (i) Prioritize, in vulnerable communities, areas for prevention and ways to eradicate the problem (e.g., vitamin A deficiency causing blindness).
- (ii) Provide the necessary support to enable them to access health rehabilitation, transportation, and other essential services (toilets, ramps, stipends, discounts, and funds).

Box V.3: ADB Reproductive Health Project in Pakistan

Pakistan's rapid population growth has negated the impact of development, and poverty has worsened during the last decade. However, there is a clear evidence that the transition to lower fertility has begun, and that there is potential for accelerating this transition. The Government plans a transition from separate family planning and maternal and child health services to the integrated reproductive health approach. It gives priority to expanding reproductive health to the poor in the least-developed and underserved districts.

The project aims to improve the reproductive health status of families, reduce maternal and infant mortality, and reduce population growth. It seeks to integrate family planning and maternal and child health to improve the acceptability, efficiency, and impact of the services, and to make these services accessible to those in need. It is estimated that the project will prevent 11,000 maternal deaths and prevent 150,000 obstetric disabilities. Thus, the project has a strong preventive impact on disability.

Source: ADB. 2001. Project for Reproductive Health Project (PAK-30210). Manila.

C. Community Services

1. Critical issues

174. In the Asia and Pacific region, it is estimated that of 400 million persons with disabilities, more than 40% are living in poverty. They have been prevented from accessing such entitlements as health, food, education, employment, and other social services, and from participating in community decision-making processes.

175. The establishment of community-based services would help access to social services. The approach is particularly appropriate for the prevention of causes of disability, early identification and intervention of children with disabilities, reaching out to persons with disabilities in rural areas, raising awareness, and advocacy for the inclusion of persons with disabilities in all activities in the community, including social, cultural and religious activities. Education, training, and employment needs could also be met.

2. KIPA Disability Checklist for Community-Based Projects

176. Knowledge

- (i) Carry out capacity building of DPOs and other stakeholder groups to lead, manage, and participate in poverty reduction strategies and projects.
- (ii) Educate DPOs and other community services in small business development, writing proposals to donors, and other financing strategies.
- (iii) Educate people with disabilities, DPOs, and other NGOs in independent living and CBR, especially on how to organize and run advocacy groups.
- (iv) Educate employers and DPOs on the range of accommodation that can increase the employability of people with disabilities.

177. Inclusion

- (i) Finance DPOs and small businesses for disabled persons and families.
- (ii) Expand the number and scope of independent-living and CBR programs with a particular focus on rural communities and increasing the number of programs by people with disabilities.
- (iii) Improve opportunities for subsidies and supported work environments.
- (iv) DPOs should assist rural people with disabilities in self-help initiatives and to collaborate in rural development with NGOs and government.
- (v) Require international NGOs in all sectors to include people with disabilities in their activities.
- (vi) Allocate resources in NGO projects for public awareness, inclusive policies and programs, and participation of disabled persons in decision making.

178. Participation

- (i) Include people with disabilities in the management and governance of community development activities.
- (ii) Encourage participatory community-based disability services.
- (iii) Establish local disability councils to coordinate community services and integrate people with disabilities into the community.
- (iv) Conduct evaluations and other forms of information collection that directly involve beneficiaries in the process from design to implementation and dissemination of results.

179. Access

- (i) Require that the built environment is accessible for all community services, such as health, banking, shopping, and transport.

- (ii) Collect information on the access needs of people with disabilities.
- (iii) Make independent living, CBR, and NGO advocacy services, as well as centers for the performing arts, accessible to people with disabilities.

Box V.4: ADB Social Security Sector Development Program in Mongolia

From 1921 to 1990, Mongolia achieved high levels of human development with no recorded poverty. Since 1990, the economy has contracted sharply due to the withdrawal of assistance from the former Soviet Union. The collapse of the state budget led to drastic cuts in subsidies and welfare programs. The Government made steps to change the social welfare system from provision of universal access to targeted interventions. Despite these efforts, the social welfare system has had limited success in reducing poverty.

One aim of the project, in line with government policy, is to develop community-based delivery mechanisms for social welfare services to mobilize additional resources for social security and improve access to, choice of, and quality of such services. The project is supporting a shift away from large, centralized institutions to smaller, and more sustainable community-based facilities, which are being developed through pilot-testing small-scale projects and implemented at community level by government agencies, NGOs, individuals, or groups. Such facilities will promote inclusion of people with disabilities through their integration into the community

Lessons from the project will support the development of a national strategy for community-based social welfare service delivery and refinement of procedures for contracting out services to the private sector and identifying of the most successful practices.

Source: ADB. 2001. Loan Projects and Technical Assistance Grant for the Social Security Sector Development Program (MON-33335). Manila.

D. Employment

1. Critical issues

180. Employment is a key factor in the empowerment and inclusion of people with disabilities. They remain disproportionately undereducated, untrained, unemployed, underemployed, and poor—especially women, youth, and those in rural areas.

181. Persons with disabilities have unique differences and abilities. They require the same education, vocational training, employment, and business opportunities as others. Some may require specialized support services, assistive devices or job modifications, but these are all small investments compared to lifetimes of productivity and contribution.

2. KIPA Disability Checklist for Employment Projects

182. Knowledge

- (i) Train private sector management personnel to increase their understanding of the needs of people with disabilities and to promote the inclusion of people with disabilities in the workforce.

- (ii) Establish standards for accrediting organizations that provide services to increase the functional capacity of disabled persons (e.g., vocational rehabilitation), and expand income-generation projects to include them.
- (iii) Create a database of employers and vocational rehabilitation programs that employ and educate people with disabilities and their families.
- (iv) Conduct awareness-building workshops for employers to become familiar with the skills, knowledge, and talents of people with disabilities.
- (v) Conduct job fairs to introduce employers to the skills of people with disabilities and provide the latter with potential employment opportunities.

183. Inclusion

- (i) Create incentives for employers to hire people with disabilities.
- (ii) Develop innovative ways to enable people with disabilities to be employed without losing social benefits if they cannot function at equal capacity to earn a living consistent with the employment expectations.
- (iii) Establish proactive employment policies and incentives for the private and public sector to recruit people with disabilities and to offer them supportive working environments.
- (iv) Applications/ advertisements for employment should state specifically that the agency is an equal opportunity employer of people with disabilities.
- (v) Development agencies should implement pilot programs for employing people with disabilities to demonstrate the value of their inclusion.
- (vi) Employers' federations and other related agencies should hire a job placement officer for people with disabilities.

Box V.5: ADB Grant for Expanding Employment Opportunities in Mongolia

During the communist era, government policy stressed the segregation of disabled persons. "Sheltered" employment facilities for people with disabilities and separate education and training services were provided. In the postcommunist period, this undesirable system has proven unsustainable. New policies and programs are needed that draw on the resources of government, nongovernment organizations, employer's representatives, and aid agencies to promote the sustainable and viable employment of disabled persons.

This project is developing new community-based approaches to expand access to employment opportunities for about 4,000 poor disabled persons or about 12% of the total, by upgrading their knowledge and skills; supporting their business development; integrating them into the workforce and providing selective support for sheltered employment; and raising public awareness on their potential to participate productively in the workforce.

By expanding employment opportunities for disabled persons, resources for social assistance benefits to disabled persons and their households can be concentrated more on those unable to work, thereby improving their incomes. By emphasizing and demonstrating the potential of disabled persons to contribute as full-fledged members of the labor force, the project should make a sustainable and substantial contribution to poverty reduction in the country.

Source: ADB. 2002. Grant Assistance for Expanding Employment Opportunities for Poor Disabled Persons (MON-35179). Manila.

184. Participation

- (i) People with disabilities and their organizations should participate in and lead the design and implementation of microenterprise and vocational and supportive training to ensure that such programs are relevant, appropriate, and lead to secure employment.
- (ii) Establish a steering committee on employment opportunities.

185. Access

- (i) Buildings should be made accessible and offices ergonomically designed according to the needs of people with disabilities.
- (ii) Establish an employment database for people with disabilities.
- (iii) Make private sector employment and labor force participation accessible.

E. Infrastructure

1. Critical Issues

186. Inaccessibility to the built environment, including public transport, is still the major barrier for people with disabilities to active participation in social and economic activities. Some governments recognize disabled persons' basic right to equal access to build environments. The application of universal/inclusive design has emerged as a result of the struggle of persons with disabilities for accessible physical environments.

187. Universal/inclusive design approaches provide safer environments for all by reducing the rate of accidents. Physical barriers are known to prevent full participation and reduce the economic and social output of persons with disabilities. Investments in the removal and prevention of architectural and design barriers are increasingly being justified on economic grounds.

188. ADB could contribute actively to the development of a barrier-free environment by including universal/inclusive design aspects in its interventions with an infrastructure component. Research has shown that providing full access facilities from the outset has additional costs of approximately 1%. Further action is needed to develop guidelines on universal/inclusive design.

2. KIPA Disability Checklist for Infrastructure Projects or Projects with an Infrastructure component

189. Knowledge

- (i) Develop disability accessibility curricula for urban planners, engineers, and architects to increase their understanding of accessibility standards.

190. Inclusion

- (i) Development agencies and their implementing partners should ensure that people with disabilities are included in programming (e.g., schools

operated by UNICEF and other agencies should include people with disabilities in refugee settlements in their school programs).

- (ii) Reconstruction work should meet international accessibility standards, particularly where physical infrastructure has been largely destroyed.

191. Participation

- (i) Actively involve DPOs in discussions and decision making about urban and rural planning, design of buildings, roads, communication systems, and water and sanitation initiatives.
- (ii) Require people with disabilities to be represented on community governing councils, including those of resettlements for displaced persons and refugee camps, so that their needs are addressed.

192. Access

- (i) Make facilities in all built-environment projects accessible, including communications, buildings, transportation, and water and sanitation.
- (ii) Make social infrastructure accessible, such as community institutions and recreational and religious activities.
- (iii) Make public water and toilet facilities accessible.
- (iv) Make transportation and other essential services accessible by lowering or waiving the fees.

Box V.6: ADB Loan for Second Education Development Project in Mongolia

Education was one of Mongolia's principal achievements in the communist era. The decline of the state economy in the 1990s impacted negatively on the education system, particularly in the early transition years and especially in rural areas.

One aim of this project is to improve access to services (kindergartens and schools), including for children with disabilities. During rural school rehabilitation, facilities will be adapted for students with physical disabilities. The project is also exploring ways to promote inclusion of children with disabilities into the mainstream education system through information and communications technology.

Source: Based on a paper by Santosh K. Rungta, General Secretary, National Federation of the Blind, New Delhi.

F. Postconflict/Postdisaster Rehabilitation and Reconciliation

1. Critical Issues

193. Conflicts and disasters are often linked with post-traumatic stress disorder and other psychosocial diseases. The traumatic impact is much higher than the physical impact, affecting not only persons with disabilities, but everyone, especially widows, children, the displaced, and refugees. Mental health problems caused by the trauma of conflicts and disasters linger and must be solved if the victims are to return to good health. Failure to do so can leave the society vulnerable to a return to violence and inhibit efforts to rebuild social capital and social and economic development.

2. KIPA Disability Checklist for Projects in Postconflict Reconstruction, Rehabilitation, and Reconciliation

194. Knowledge

- (i) Establish programming standards for physical and psychosocial rehabilitation.
- (ii) Ensure that NGOs and public services are accredited and registered to receive support for program implementation.
- (iii) Mainstream the training of personnel in counseling for post-traumatic stress disorder, prosthetics, and orthotics, and physical and occupational therapy.
- (iv) Focus training programs on functional independence, building self-confidence, coping skills, and participation in the community.
- (v) Increase the capacity for coordination among donors, governments, and NGOs.

195. Inclusion

- (i) Postconflict development should contain the full spectrum of services, including income generation, rehabilitation, education, and accessibility of the built and communications environment and arts and culture.
- (ii) Social insurance and disability benefit policies should be inclusive, not only for war injured, war veterans, and land mine victims.
- (iii) Programming should focus on an integrated, multidisciplinary, multisectoral, community-based participatory system.
- (iv) Reconstruction programs should include a focus on arts and culture, in which psychosocial rehabilitation is achieved through participation in integrated arts programming.
- (v)
- (vi) Playgrounds should be accessible for children and mothers to socialize. Peer support programs organized and led by people with disabilities are required.

196. Participation

- (i) Increase representation of all people with disabilities in planning and implementation of postconflict reconstruction initiatives.
- (ii) Increase representation of people with disabilities from rural communities in activities related to reconstruction.

197. Access

- (i) War-damaged communities should be reconstructed according to international accessibility standards.
- (ii) Resettlement programs and reconstruction should include not only accessible new homes but also funds for returning displaced persons to renovate their previous homes.
- (iii) Ensure that project (including pension program) beneficiaries include all people with disabilities and do not discriminate by disability category.

- (iv) Collect information on land mine victims and war injured to establish a sound understanding of the impact of the conflict on communities.

Box V. 7: Psychosocial Health in Conflict-affected Areas in Sri Lanka

After 20 years of conflict in Sri Lanka and repeated efforts to resolve it and achieve lasting peace, a ceasefire agreement was signed in February 2002. During the conflict, more than 60,000 people were killed and over 1 million were displaced and live in difficult circumstances. There is a sharp increase in psychosocial disorders in the country. Most notably, suicide and drug abuse have become more prevalent.

This project will pilot-test an approach to help people with mental health problems, their families, and communities by providing services like counseling, awareness creation, medical services, training of staff, and institutional development. Service delivery will rely wherever possible on NGOs. The approach involves (i) community participation, (ii) working with people with psychosocial health problems as "agents" for change, rather than "victims," (iii) effective services for adults and children, (iv) public-private partnership, and (v) service delivery that includes establishing links with economic opportunities.

Source: ADB. 2004. Advisory Technical Assistance for Psycho-Social Health in the Conflict Affected Areas (SRI-38129). Manila.

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THE STANDARD RULES ON THE EQUALIZATION OF OPPORTUNITIES FOR PERSONS WITH DISABILITIES

(Adopted by the United Nations General Assembly, forty-eighth session, resolution 48/96, annex, of 20 December 1993, <http://www.un.org/esa/socdev/enable/dissre00.htm>)

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IV. Monitoring Mechanism

INTERNATIONAL DISABILITY-RELATED AGENCIES AND RESOURCE WEBSITES

Organization	Location	Telephone / Fax no.	E-mail	Website
ACCESS				
UN Special Rapporteur on Disability	Stockholm Sweden	T:46-8 405 1768 F:46-8 611 8003	un-spec.rapp@telia.com	
WorldEnable - Internet Accessibility Initiative			info@visionoffice.com	http://www.worldenable.net/
ADVOCACY				
Australian Council for Rehabilitation of the Disabled (ACROD)	Curtin ACT Australia	T: (02) 6283 3200; (02) 6282 4333 F: (02) 6281 3488	acrodnat@acrod.org.au	http://www.acrod.org.au
Cambodian Disabled People's Organization	Phnom Penh Cambodia	T: 855 23 215 509 F: 855 23 362 232	cdpo@camnet.com.kh	No website
Careers Australia	Deakin ACT Australia	T: (02) 6282 7886 F: (02) 6282 7885	caa@carersaustralia.com.au	
Community Friend Program	Melbourne Australia	T: 03 9488 1203	cfp@mcm.org.au	http://home.vicnet.net.au/~friend/
Council of Canadians with Disabilities	Winnipeg Canada	Voice/TTY: 204-947-0303	ccd@ccdonline.ca	www.ccdonline.ca
Disability Australia	Richmond Australia	T: 613 94294210 F: 6139201 9598	frankhb@connexus.net.au	
Disabled People's Association Singapore	Singapore	T: 65 6899-1220 F: 65 6899-1232	dpa@dpa.org.sg	http://www.dpa.org.sg
Disabled Peoples' International (DPI) Asia Pacific	Tokyo Japan	T: 81-426-45-2216 F: 81-426-45-2210	HumanCare@nifty.com; yukin@din.or.jp	
Queensland Advocacy Incorporated	Brisbane Australia	T: 07 3236 1122 F: 07 3236 1590	qai@uq.net.au	
BLIND				
Association for the Blind of Western Australia	Victoria Park Australia	T: 08 9311 8202 F: 08 9361 8696	mailbox@abwa.asn.au	http://www.abwa.asn.au
Christoffel Blindenmission International (CBMI) / Christian Blind Mission e. V.	Zurich Switzerland Bensheim Germany	T: 41 1 202 21 24 F: 41 1 201 20 55 T: 49 6251 131 0 F: 496251 131 165	cbmizurich@cbmi.org overseas@cbmi.org	www.cbmi.org
Royal Blind Society	Burwood Australia	T: (02) 9334 3333 F: (02) 9747 5993	clientliaison@rbs.org.au	http://www.rbs.org.au/
Royal New Zealand Foundation for the Blind	Auckland New Zealand	T: 0800 24 33 33	pdaye@rnzfb.org.nz	http://www.rnzfb.org.nz
Singapore Association for the Visually Handicapped	Singapore	T: 65 6251-4331 F: 65 6253-7191	labelle@savh.org.sg	http://www.savh.org.sg/
Thailand Association of the Blind	Bangkok Thailand	T: 66-2 246-2287 F: 66-2-8895308	mbuntan@.tab.or.th	http://www.tab.or.th
World Blind Union	Singapore	T: 65-6286-4555 F: 65-6286-4554	adaptive@singnet.com.sg	http://umc.once.es/
COMMUNITY-BASED REHABILITATION				
Actionaid India	Karnataka, India	T: 91 08 558 6682	niti lab@actionaidindia.org	http://www.actionaidindia.org
International Centre for the Advancement of Community Based Rehabilitation	Kingston Canada	T: 613-533-6000 ext 77883; 613-533-6881 F: 613-533-6882	icacbr@post.queensu.ca	http://meds.queensu.ca/icacbr/
NORFIL Foundation, Inc.	Quezon City Philippines	T: 632-372-3577 F: 632-373-2169	norfil@philonline.com.ph	http://www.trabaho.com/html/customized_ad/norfil4.html

Organization	Location	Telephone / Fax no.	E-mail	Website
CHILDREN				
Indonesian Society for the Care of Disabled Children	Jakarta Indonesia	T: 62-21-725-4357 F: 62-21-724-7366		
Liliane Stitching Fonds	Vlijmen The Netherlands	T: 31 4108-19029 F: 31 4108-17354	voorlichting@lilianefonds.nl	www.lilianefonds.org
Tui Amanaki Centre (OTA)	Nuku'alofa, Tonga	T: 676-29180 F: 676-23613	ota@kalianet.to	
United Nations Children's Fund (UNICEF)	New York USA	T: 212-326-7000 F: 212-887-7465	info@unicef.org	http://www.unicef.org/programme/cprotection/index.html
DEAF				
Gallaudet University's Center for Global Education	Washington, DC USA	T: 202 651-6050 TTY: (202) 651-6050 F: 202 651-6038	global.education@gallaudet.edu	www.gallaudet.edu
Global Deaf Connection	Minneapolis USA	T/TTY: (612) 724-8565 F: 612 729-3839	DeafConnection@visi.com	http://www.deafconnection.org/
Pakistan Association for the Deaf	Karachi Pakistan	T: 0092 021 4387150 F: 0092 021 4387140	dossas@cyber.net.pk	http://www.pad.sdnpk.org/
Singapore School for the Deaf	Singapore	T: 065 6473 3822	admin@ssd.edu.sg	http://www.ssd.edu.sg
Tui Amanaki Centre (OTA)	Nuku'alofa Tonga	T: 676-29180 F: 676-23613	ota@kalianet.to	
Victorian Deaf Society	Melbourne Australia	T: 03 9657 8111 F: 03 9650 6843	info@vicdeaf.com.au	http://www.vicdeaf.com.au
World Federation of the Deaf	Tokyo Japan	T: 81-3-3268-8847 F: 81-3-3267-3445	info@jfd.or.jp	
DEVELOPMENT AGENCIES				
Canadian International Development Agency	Hull Canada	T: 819 997-5006 Toll free: 1-800-230-6349 F: 819 953-6088	info@acdi-cida.gc.ca	http://www.acdi-cida.gc.ca/index-e.htm
Department for International Development (DFID)	London United Kingdom	T: 0845 300 4100 T (Outside UK): 44 (0) 1355 84 3132 F: 44 (0) 1355 84 3632	enquiry@dfid.gov.uk	http://www.dfid.gov.uk/
Finnish International Development Agency	Helsinki Finland	T: 358 (0)134 161		
Japan International Cooperation Agency	Tokyo Japan	T: 81-3-5352-5311/5312/5313/5314 F: 81-3-5352-5490	Miyahara.Chiie@jica.go.jp	http://www.jica.go.jp/english/index.html http://www.jica.go.jp/english/global/dis/index.html
Swedish International Development Cooperation Agency	Stockholm Sweden	T: 46-8-698 50 00 F: 46-8-20 88 64	info@sida.se	http://www.sida.se/Sida/jsp/Crosslink.jsp?d=160&a=4123
The United States Agency for International Development	Washington, DC USA	T: 202-712-4810 F: 202-216-3524	See website for contact information	http://www.usaid.gov/about/disability/

Organization	Location	Telephone / Fax no.	E-mail	Website
DEVELOPMENT BANKS				
Asian Development Bank	Manila Philippines	T: 632 632 4444 F: 632 636 2444	information@adb.org	http://www.adb.org/
The World Bank Group - Including Persons with Disabilities	Washington, DC USA	T: 202-473-1112 F: 202-522-6138	disabilitygroup@worldbank.org	http://www.worldbank.org/disability
DIABETES				
International Diabetes Federation	Brussels Belgium	T: 32 2-5371889 F: 32 2-5371981	info@idf.org	www.idf.org
DISABILITY – ADVOCACY AND PROGRAMS IN Asia and Pacific Region				
Bangladesh Protibandhi Kallyan Somity	Dhaka Bangladesh	T: 880-2-8615502 F: 880-2-9663615	bpks@citechco.net	
Bangladeshi Protibandhi Foundation	Dhaka Bangladesh	T: 9351625	bpf@bangla.net	
Callan Services for Disabled Persons	Sepik Papua New Guinea	T: 675 856.1910 F: 675 856.2924	calser3wk@global.net.pg	www.callanservices.org
Centre for Disability in Development	Dhaka Bangladesh	T/F: 880-2-7711467	cdd@banqla.net	
Disabled People's Association Singapore	Singapore	T: 65 6899-1220 F: 65 6899-1232	dpa@dpa.org.sg	http://www.dpa.org.sg
Disability Organizations Joint Front	Mount Lavinia Sri Lanka	T: 941 855188	cryils@dialogsl.net	
Disability Resource Centre Malaysia	Kuala Lumpur Malaysia	T: 006-03-91324996		
NORFIL Foundation, Inc.	Quezon City Philippines	T: 632-372-3577 F: 632-373-2169	norf@philonline.com.ph	http://www.trabaho.com/html/customized_ad/norfil4.html
The United Nations Disability Program/ Disabled Person's Unit	New York USA	T: 212 963-1996		http://www.un.org/esa/socdev/enable/
DISABILITY- ADVOCACY AND PROGRAMS INTERNATIONAL				
Action on Disability and Development (ADD)	Somerset United Kingdom	T: 44 01373 473064 F: 44 01373 52075	add@add.org.uk	http://www.add.org.uk/index_main.html
Canadian Centre on Disability Studies	Winnipeg Manitoba Canada	T: 204 287-8411 F: 204 284-5343 TTY: 204 475-6223	ccds@disabilitystudies.ca	http://www.disabilitystudies.ca/
DPI	Winnipeg Manitoba Canada	T: 204 287-8010 F: 204 783-6270	info@dpi.org	http://www.dpi.org/en/start.htm
Handicap International	Lyon France; Bangkok Thailand	T: 33 4 78 69 7979 F: 33 4 78 69 7994 T: 662-381-8861-2	Handicap-international@infonie.fr	http://www.handicap-international.org/english/contact.html
Inter-American Institute on Disability	Rockville USA	T: 301 309-9469 F: 301 309-9486	iid@iidisability.org	
International Centre for the Advancement of Community Based Rehabilitation	Kingston Canada	T: 613-533-6000 ext 77883; 613-533-6881 F: 613-533-6882	icacbr@post.queensu.ca	http://meds.queensu.ca/icacbr/
International Disability and Development Consortium	Surrey United Kingdom	T: 44 0 1252 821 429 F: 44 0 1252 821 428	administrator@iddc.org.uk	www.iddc.org.uk/dis_dev/topics.shtml
Mobility International USA	Eugene USA	T: 541 343-1284 F: 541 343-6812	info@miusa.org	www.miusa.org

Organization	Location	Telephone / Fax no.	E-mail	Website
World Institute on Disability	Oakland USA	T: 510 763-4100 TTY: 510 208-9496 F: 510 763-4109	interwid@wid.org	www.wid.org
World Vision Foundation of Thailand	Bangkok Thailand	T: 02 381-8863-5 F: 02 711-4100-1; 02 381-2034	info@worldvision.or.th	http://www.worldvision.or.th/index_e.html
DISABLED WOMEN				
The Global Fund for Women	San Francisco USA	T: 415 202-7640 F: 415 202-8604	americas@globalfundforwomen.orgamerica s	http://www.globalfundforwo men.org/3grant/criteria-guidelines.html
Disabled Women's Network (DAWN)	Ottawa Canada	T: 613-235-4242 F: 513-235-3881	kathy@dawncanada.net	http://www.dawncanada.net/national.htm
Mobility International USA	Eugene USA	T: 541 343-1284 F: 541 343-6812	info@miusa.org	www.miusa.org
EDUCATION				
Asia and Pacific Development Centre on Disability Project	Bangkok Thailand	T: 662-247-2619 F: 662-247-2375	info@apcdproject.org	http://www.apcdproject.org
Community-based Rehabilitation Development and Training Centre	Solo Indonesia	T: 62-271-780075; 780829 F: 62-271-780976	cbr@indo.net.id	http://www.dinf.ne.jp/doc/japanese/twg/eng/contact/cbr.html
UN Educational, Scientific and Cultural Organization (UNESCO): Special Needs Education	Paris France	T: 331 45 68 11 95 F: 331 45 68 56 26/7		http://www.unesco.org/
EMPLOYMENT AND LABOR				
GLADNET	Calgary AB Canada	T: 403.228.2227 F: 403.228.2207	info@gladnet.org	
International Labour Organization (ILO)	Geneva Switzerland	T: 41.22.799.6111 F: 41.22.798.8685	ilo@ilo.org	http://www.ilo.org/public/english/employment/skills/disability/
ILO	Bangkok Thailand	T: 662.288.2273, 288.1720 F: 662.288.1023, 288.3062	Bangkok@ilo.org	http://www.ilo.org/public/english/region/asro/bangkok/
ILO Ability Asia	Bangkok Thailand	T: 662.288.1792	abilityasia@ilo.org	http://www.ilo.org/public/english/region/asro/bangkok/ability/index.htm
GOVERNMENT				
Japan International Cooperation Agency	Tokyo Japan	T: 81-3-5352-5311/5312/5313/5314 F: 81-3-5352-5490		http://www.jica.go.jp/english/index.html http://www.jica.go.jp/english/global/dis/index.html
National Council for the Welfare of Disabled Persons	Quezon City Philippines	T: 929-8879; 920-1503 F: 929-8879	mal@ncwdp.gov.ph	http://www.ncwdp.gov.ph/
National Council on Disability	Washington, DC USA	T: 202 272-2004 F: 202 272-2022	mquigley@ncd.gov	http://www.ncd.gov/
National Secretariat for Persons with Disabilities	Battaramulla Sri Lanka	T: 0094 1 877124 F: 0094 1 883525	mssecslnet.lk	
Social Welfare Department (Hong Kong, China)	Hong Kong China	T: 2892 5151 F: 2838 0757	dsw@swd.gov.hk	http://www.info.gov.hk/swd/html_eng/index.html
HEALTH				
World Health Organization Disability & Rehabilitation	Geneva Switzerland	T: 41 22 791 2111 F: 41 22 791 0746	See website for contact information	http://www.who.int/en/ http://www.who.int/ncd/disability/index.htm

Organization	Location	Telephone / Fax no.	E-mail	Website
INDEPENDENT LIVING				
CAILC	Ottawa Canada	T: 613 563-2581 F: 613 563-3861 TTY: 613 563-4215	cailc@magma.ca	http://www.cailc.ca/
INTELLECTUAL/MENTAL HEALTH PROBLEMS				
Action for Autism	New Delhi India	T: 91-11-641-6469, F: 91-11-641-6470	autism@vsnl.com	http://www.autism-india.org
Actionaid India	Karnataka India	T: 91 08 558 6682	nitilab@actionaidindia.org	http://www.actionaidindia.org
Association for Stimulating Know How (Ask)	New Delhi India	T: 91 11 6313925, 6317655 F: 91-11-631-3925	askindia@ndf.vsnl.net.in	http://askindia.org/
Department of Family and Community Services-Disability Programs	Canberra Australia	T: 1800 260 402	internet@facis.gov.au	http://www.facs.gov.au/internet/facsiinternet.nsf/disabilities/nav.htm
Disability Action Council	Phnom PenhCambodia	T:855-23 215341, 218797 F:855-23 214 722	dac@bigpond.com.kh	http://www.dac.org.kh/
Canadian Association for Community Living	Toronto Canada	T: 416 661-9611 F:416 661-5701 TTY:416 661-2023	info@cacl.ca	http://www.cacl.ca/
DAWN Canada	Ottawa Canada	T: 613-235-4242 F: 513-235-3881	kathy@dawncanada.net	http://www.dawncanada.net/national.htm
Inclusion International	London Great Britain	T: 44-20-76 96 69 04 F:44-20-76 96 55 89	info@inclusion-international.org	http://www.inclusion-international.org/index.htm
Mental Disability Rights International	Washington, DC USA	T: 202 296-0800 F: 202 728-3053	mdri@mdri.org	www.mdri.org
New Life Psychiatric Rehabilitation Association of Hong Kong	Hong Kong China	T: 852-2332-4343 F: 852-2770-9345	dw@nlpra.org.hk	http://www.nlpra.org.hk/text/eng.htm
Pathway Centres for Rehabilitation & Education of the Mentally Retarded	Chennai India	T: 91-44-49 28 366 F: 91-44-49 28 949	pathway@pathwayindia.org	http://www.pathwayindia.org
UDAAN For The Disabled	New Delhi India	T: 91-11-51631140	arun@udaan.org	http://www.udaan.org
World Network of Users and Survivors of Psychiatry	Odense C Denmark	T: 45 6619-4511	admin@wnusp.org	www.wnusp.org
LAND MINES				
Landmine Survivors Network	Washington, DC USA	T: 202 464-0007 F: 202 464-0011	lsn@landminesurvivors.org	www.landminesurvivors.org
REHABILITATION AND APPROPRIATE TECHNOLOGY				
Australian Rehabilitation & Assistive Technology Association	Glenorie Australia		tonyharman@bigfoot.com	http://www.arata.org.au
Callan Services for Disabled Persons	Sepik Papua New Guinea	T: 675 856.1910 F: 675 856.2924	calser3wk@global.net.pg	www.callanservices.org

Organization	Location	Telephone / Fax no.	E-mail	Website
Centre for the Rehabilitation of the Paralysed	Dhaka Bangladesh	T: 088 02 7710464-5 F: 088 02 7710069	crp@bangla.net	http://www.crp-bangladesh.com/
China Rehabilitation and Research Center	Beijing PRC	T: 86-10-67563322-5101	xiongbaiqing@sina.com	
Cooperative Orthotic and Prosthetic Enterprise	Lao PDR	T: 856-21-218427 F: 856-21-218427	cope@laotel.com	
Handicap International	Lyon France Bangkok Thailand	T: 33 4 78 69 7979 F: 33 4 78 69 7994 T: 662-381-8861-2	Handicap-international@infonie.fr	http://www.handicap-international.org/english/contact.html
Korean Society for Rehabilitation of Persons with Disabilities	Seoul Republic of Korea	T: 82-2-2636-3414 F: 82-2-2636-3422	rikorea@hanmail.net ksrd@blue.nownuri.net	http://www.dinf.ne.jp/doc/japanese/twg/eng/contact/ksrpd.html
National Rehabilitation Center for the Disabled	Saitama Prefecture Japan	T: 042-995-3100 F: 042-995-3102	kikakuka@rehab.go.jp	http://www.rehab.go.jp/English
Nevedac Prosthetic Centre	Chandigarh India	T: 91-172-370133, 382559 F: 91-172-642042	See website for contact information	http://www.medireh.com/
Rehabilitation Alliance	Hong Kong China	F: 852-2788-7709	scnQai@citvu.edu.hk	
Rehabilitation International	Tokyo Japan	T: 813-5273-0601 F: 813-5273-1523	matsuir@hokusei.ac.jp	http://www.rehab-international.org/aboutri/about.html
Sri Lanka Foundation for the Rehabilitation of the Disabled	Colombo Sri Lanka	T/F: 689287	cyrils@dialogsl.net	
RESEARCH				
Center for International Rehabilitation Research Information and Exchange	Buffalo USA	T: 716 829-3141 ext. 149 F: 716 829-3217	ub-cirrie@buffalo.edu	www.cirrie.buffalo.edu
The Washington City Group on Disability Statistics	Hyattsville USA	T: 301 458-4636	See website for contact information	http://www.cdc.gov/nchs/citygroup.htm
SENSORY				
The Institute of Speech and Hearing	Bangalore India	T/F: 91 - 80 - 5460405 / 5470037 / 5468470	ishblr@indiainfo.com	http://www.speecheart.org
UNITED NATIONS				
United Nations (UN)	Geneva Switzerland	T: 4122 917-9000 F: 4122 917 9022	inquiries@un.org	http://www.un.org/english/
UN Special Rapporteur on Disability	Stockholm Sweden	T: 46-8 405 1768 F: 46-8 611 8003	un-spec.rapp@telia.com	http://www.disability-rapporteur.org/
UN and Persons with Disabilities	New York USA	F: 212-963-0111	inquiries@un.org	http://www.un.org/esa/socdev/enable
UN Ad Hoc Committee comprehensive & integral international convention to promote & protect rights & dignity of person with disabilities	New York USA	F: 212-963-0111	inquiries@un.org	http://www.un.org/esa/socdev/enable/rights/adhocom.htm
UN Basic Facts				http://www.un.org/aboutun/basicfacts/index.html

Organization	Location	Telephone / Fax no.	E-mail	Website
UN Department for Policy Coordination & Sustainable Development. World Programme of Action Concerning Disabled	New York USA	F: ++-212-963-0111	inquiries@un.org	http://www.un.org/esa/socdev/enable/diswpa00.htm
The UN Disability Program/ Disabled Person's Unit	New York USA	T: 212 963-1996		
UN Economic and Social Commission for Asia and the Pacific	Bangkok Thailand	T: 66 02 288-1492 F: 66 02 288-1030	akiyama@un.org	www.unescap.org

CAILC = Canadian Association of Independent Living Centres; GLADNET = Globally Applied Disability Research and Information Network on Employment and Training.

ADDITIONAL WEBSITES AND RELATED RESOURCES

Asian Development Bank Regional Workshop on Disability and Development Manila 2002**Draft Recommendations**

http://www.adb.org/Documents/Events/2002/Disability_Development/ortiz_edmonds.pdf

Asian and Pacific Decade of Disabled Persons 1993–2003

<http://www.unescap.org/decade/publications/z15009gl/z1500901.htm>

Community-based Rehabilitation links

www.cbrresources.org/#anchor490954

Comparative Study of Employment Policies For Disabled Persons in Selected Countries

Neil Lunt & Patricia Thornton, University of York, Social Policy Research Unit, York

<http://gladnet.org/infobase/employment/Policies/conclus.htm>

Disability and Self-Directed Employment: Business Development Models

Neufeldt, Aldred H., and Alison Albright, Eds. (1998). Ontario: Captus Press.

Disability Information and Resources

<http://www.makoa.org/>

Disability Services - Terminology

www.uncwil.edu/stuaff/SDS/disterm.html

Disability Weblinks

www.disabilityweblinks.ca/pls/dwl/dl.home

Disability World

<http://www.disabilityworld.org/>

The Center for Universal Design

http://www.design.ncsu.edu/cud/univ_design/ud_pubs.htm

Universal Design: General Concepts, Universal Design Principles and Guidelines

http://trace.wisc.edu/world/gen_ud.html

SAMPLE TERMS OF REFERENCE FOR A SOCIAL DEVELOPMENT SPECIALIST WITH EXPERTISE IN DISABILITY

1. Under the guidance of Asian Development Bank (ADB) staff and in consultation with the senior officials of the line ministries and state governments concerned, the consultant will

- (i) be responsible for conducting the study at the national and state levels;
- (ii) prepare an overall work plan for the study;
- (iii) identify, in consultation with ADB, suitable state-level agencies (state and nongovernment) and stakeholders for state-level consultations in the country/countries and develop a state-level study outline;
- (iv) visit the participating country/countries for state-level consultation and field study/assessment, and
- (v) prepare a report that consolidates all the work.

2. More specifically, the consultant will be responsible for the following:

A. Review of literature and secondary data

- (i) Review publications (research papers, reports, statistical data, etc.) on disability internationally and specific to the participating country/region;
- (ii) examine disability gaps/disparities and their trends in demography, education attainment, health standards, and economic/political and social participation, etc., which will to the extent possible, be disaggregated by state, rural-urban; and socioeconomic group (e.g., income levels) and analyze their causes;
- (iii) examine social, legal, gender, and cultural factors that affect the roles of people with disabilities; and
- (iv) look into the plurality of needs of people with disabilities in different regions and different religious groups, ethnic groups, and communities within states that have a high incidence of poverty.

B. Analysis of policies and institutions

- (i) Examine macroeconomic government policies and other policies (including policies on disability, women, and children) and analyze their implications for people with disabilities, in particular, the impact of macroeconomic and sectoral policies on people with disabilities; correlation between disability, inequality, and poverty; correlation between disability and gender; and institutional issues;
- (ii) examine institutional settings, roles, and mandates of government and nongovernment agencies responsible for the implementation of the relevant policies and assess the capacity and effectiveness of these institutions;
- (iii) look into the implementation systems established for the delivery of programs at the state, district, and subdistrict level, and suggest appropriate strategies for improving the system;

- (iv) explore to what extent different grassroots-level initiatives created through self-help groups and voluntary organizations can be integrated for delivery of programs; and
- (v) based on the analysis, identify the critical areas that require interventions.

C. Assistance to people with disabilities

- (i) Collect information on the programs, projects, or other activities of disabled people by government institutions, donors, nongovernment organizations, and private sector; and
- (ii) assess the impact of these activities and compile a list of lessons learned.

D. Assessment of ADB operations

- (i) Examine ADB operations in participating country/countries and assess the extent to which disability policies for promoting an enabling environment have been implemented and their impact at the macroeconomic, policy, sector, and project levels; and
- (ii) identify key issues, constraints, and opportunities for ADB to incorporate disability issues into its operations, in particular, in the scope of its poverty reduction goal.

E. Identification of priority needs of people with disabilities for ADB

- (i) Study the findings of ADB's participatory poverty analysis and identify the linkages between disability and poverty;
- (ii) identify major areas of concern regarding disability considerations for the country/countries in general and for ADB assistance in particular, with specific attention to policy support, capacity building, and state-level operations; and
- (iii) draft an ADB disability strategy based on the analysis, stipulating the overall goal, approach, strategic areas of assistance, and implementation mechanisms and procedures.

F. Preparation of country study report on people with disabilities

On the basis of the above, prepare a country paper on disability for the participating country/countries as outlined.

G. Reporting

The consultant is responsible for preparing regular progress reports and a final report at the end of the study.

SUGGESTIONS FOR COMMUNICATING WITH PEOPLE WITH DISABILITIES¹

1. It is important to recognize that people with disabilities may require special accommodation to ensure their full participation. However, these should be enabling only, and not serve to create a bridge between people with disabilities and other stakeholders. The things that draw people together, such as shared concern for their communities, understanding of local context, and desire for change should always be emphasized over those things that make people different from one another. Following are some concrete suggestions on how to communicate in a mutually effective way with people with disabilities in general and more specifically with people with intellectual disabilities or a mental health problem and sighted people. The suggestions for sighted people are provided to show how "differences" can influence our perceptions of others and how important it is to be natural, proactive, and inclusive in all aspects of interaction with people with disabilities.

2. Guidelines to bear in mind when talking about people with disabilities:

- (i) Do not focus on the disability unless it is crucial to a story; avoid tear-jerking human interest stories about incurable diseases, congenital impairments, or severe injury;
- (ii) do not portray successful people with disabilities as superhuman;
- (iii) do not sensationalize disability;
- (iv) emphasize abilities, not limitations;
- (v) avoid "tragic but brave" stereotypes—in fact, avoid stereotypes altogether;
- (vi) show people with disabilities as active participants in society; portraying people with disabilities interacting with people without disability in social situations and work environments helps break down barriers and opens lines of communication; and
- (vii) label jars not people.

3. Meeting people with disabilities:

- (i) Speak directly to the person who has a disability, not through any companion who may be present;
- (ii) if you offer help, wait until the offer is accepted, then listen to or ask for instructions; don't be offended if the offer of assistance is turned down; and
- (iii) consider the needs of people with disabilities when planning meetings or events.

4. Meeting people who have a hearing or speaking impairment:

- (i) Do not begin a conversation with a hearing-impaired person until he/she has noticed you and is prepared for it;

¹ Source: ESCAP terminology for disabled persons
(<http://www.unescap.org/esid/hds/decade/terminology.htm>)

- (ii) if a sign language or speech interpreter is present, speak to the person you are meeting rather than to the interpreter;
 - (iii) when you are speaking to a hearing-impaired person, do not shout or exaggerate your lip movements; speak slowly and clearly and do not cover your mouth;
 - (iv) if the person you are speaking to is lip-reading, make sure you are facing the light; look directly at the person and speak at your normal volume;
 - (v) give your whole attention to a person with speech impairment; do not correct or speak for the person; wait quietly while the person talks and resist the temptation to finish sentences;
 - (vi) where possible, ask questions that require short answers; and
 - (vii) do not pretend to understand if you do not; repeat what you understand and ask again.
5. Meeting people who have a mobility impairment:
- (i) When talking for longer than a few minutes to a person using a wheelchair, place yourself at that person's eye level so that he or she will not get a stiff neck from looking up for a prolonged period;
 - (ii) never lean against or push a person's wheelchair; always ask whether assistance is required or not;
 - (iii) never pat someone using a wheelchair on the head;
 - (iv) when arranging to meet a person who uses a wheelchair, always give the person prior notice so that time is allowed for the arrangement of transportation; and
 - (v) when deciding where to meet make sure that there is a ramped or step-free entrance, an elevator (if necessary) and, of course, accessible toilet facilities.
6. Meeting people who have a visual impairment:
- (i) Identify yourself clearly, and introduce anyone else who is present; try to indicate where they are placed in the room;
 - (ii) when offering a handshake, say something like "Shall we shake hands?";
 - (iii) when help is needed in an unfamiliar place, say, "Let me offer you an arm"; this will enable you to guide rather than propel or lead the person;
 - (iv) when you come to a step, say whether it is a step up or a step down;
 - (v) when offering a seat, place the person's hand on the back or arm of the chair;
 - (vi) when talking in a group that includes people with visual impairments, remember to say the name of the person to whom you are speaking; and
 - (vii) do not leave someone talking to an empty space; tell that person when you wish to end a conversation or to move away.
7. Meeting people with intellectual disabilities or a mental health problem:²

Simplify communication. How does one talk to someone who has a cognitive disability (previously referred to as mental retardation)? There are no hard and fast rules to use.

² Source: The Arc, an advocacy group (<http://thearc.org>)

The communication techniques below may be helpful and can even be used to improve communication with people who have similar disabilities, such as traumatic brain injuries, learning disabilities, and Alzheimer's disease.

8. Remember to

- (i) speak directly to the person;
- (ii) keep sentences short;
- (iii) use simple language; speak slowly and clearly;
- (iv) ask for concrete descriptions, colors, clothing, etc;
- (v) break complicated series of instructions or information into smaller parts; and
- (vi) whenever possible, use pictures, symbols, and actions to help convey meaning.

9. Be patient, by

- (i) taking time giving or asking for information;
- (ii) avoiding confusing questions about reasons for behavior;
- (iii) repeating questions more than once or asking a question in a different way;
- (iv) using firm and calm persistence if the person doesn't comply or acts aggressive;
- (v) not asking questions in a way to solicit a certain answer when questioning someone with a cognitive disability; don't ask leading questions; and
- (vi) phrase questions to avoid "yes" or "no" answers; ask open-ended questions (e.g., "Tell me what happened?").

10. Keep in mind

- (i) not to assume that someone with a cognitive disability is totally incapable of understanding or communicating;
- (ii) to treat adults as adults; don't treat adults who have a cognitive disability as children;
- (iii) when communicating with someone who has a cognitive disability, give him or her the same respect you would give any other person; and
- (iv) when speaking to an individual, use the phrase "person with a disability;" most people who have a cognitive disability do not like being called "retarded" or even have the word "retardation" used in reference to their disability.

11. Suggestions for meeting sighted people:³

What to do when you meet sighted person? People who use their eyes to receive information about the world are called sighted people or "people who are sighted." Legal "sight" means any visual acuity greater than 20/200 in the better eye without correction or an angle of vision wider than 20 degrees. Sighted people enjoy rich full lives, working,

³ Source: ESCAP terminology for disabled persons.

playing, and raising families. They run businesses, hold public office, and teach your children.

12. How do sighted people get around? People who are sighted may walk or ride public transportation, but most choose to travel long distances by operating their own motor vehicles. They have gone through many hours of training to learn the "rules of the road" in order to further their independence. Once that road to freedom has been mastered, sighted people earn a legal classification and a "Driver's License" that allows them to operate a private vehicle safely and independently.

13. The following discusses how to assist a sighted person.

- (i) Sighted people are accustomed to viewing the world in visual terms. This means that in many situations, they will not be able to communicate orally and may resort to pointing or other gesturing. Subtle facial expressions may also be used to convey feelings in social situations. Calmly alert the sighted person to his surroundings by speaking slowly, in a normal tone of voice. Questions directed at the sighted person help focus attention back on the verbal rather than visual communication.
- (ii) At times, sighted people may require help finding things, especially when operating a motor vehicle. Your advance knowledge of routes and landmarks, particularly bumps in the road, turns, and traffic lights, will assist the "driver" in finding the way quickly and easily. Your knowledge of building layouts can also assist the sighted person in navigating complex shopping malls and offices. Sighted people tend to be very proud and will not ask directly for assistance. Be gentle yet firm.

14. How do sighted people use computers? The person who is sighted relies exclusively on visual information. His or her attention span fades quickly when reading long texts. Computer information is presented in a "graphical user interface." Because coordination of hands and eyes is often a problem for sighted people, the computer mouse, a handy device that slides along the desktop, saves confusing keystrokes. With one button, the sighted person can move around his or her computer screen quickly and easily. People who are sighted are not accustomed to synthetic speech and may have great difficulty understanding even the clearest synthesizer. Be patient and prepared to explain many times how your computer equipment works.

15. How do sighted people read? Sighted people read through a system called "print." This is a series of images drawn in a two-dimensional plain. People who are sighted generally have a poorly developed sense of touch. Braille is completely foreign to the sighted person and he or she will take longer to learn the code and be severely limited by his or her existing visual senses. Sighted people cannot function well in low lighting conditions and are generally completely helpless in total darkness. Their homes are usually very brightly lit at great expense, as are businesses that cater to the sighted consumer.

16. How can I support a sighted person? People who are sighted do not want your charity. They want to live, work, and play along with you. The best thing you can do to support sighted people in your community is to open yourself to their world. These citizens are vital contributing members to society. Take a sighted person to lunch today!

ADDRESSING DISABILITY IN NATIONAL STRATEGIES, USING THE KIPA “CLEAR DIRECTION” FRAMEWORK

1. Disability in Poverty Reduction Strategies

1. The following suggestions illustrate how the KIPA “clear direction” framework can be used for including disability in the poverty reduction process.

2. Knowledge

- (i) Educate and train people with disabilities as providers at all levels of the sector delivery system (education, health, rehabilitation, architecture, engineering, etc).
- (ii) Provide continuing education programs for marginally qualified disabled persons and their families to equip them for entry into vocational, professional schools, higher education, and employment.
- (iii) Educate decision makers to the needs of people with disabilities, with equal emphasis on women and children, through access to continuing education on the citizenship approach to disability, including how to engage people with disabilities in the decision-making process (a requirement of all management personnel).
- (iv) Establish minimum standards, accreditation, and registration of agencies to implement quality programs that promote continuity and consistency of personnel and knowledge.

3. Inclusion

- (i) Ensure that disability programs are mainstreamed in all sectors as a core dimension of country programming and project implementation and not relegated to health and social welfare departments.
- (ii) Implement an affirmative action plan to bring more disabled persons into project and public sector management, boards, and community organizations.
- (iii) Incorporate nontraditional programming, such as recreational, cultural, and arts programs, into mainstream programs and projects as core sector development priorities.
- (iv) Ensure that insurance and benefits programs are inclusive of all people with disabilities, particularly in areas of postconflict reconstruction where there is a tendency to support war veterans, war injured, and land mine victims to a greater extent than other people with disabilities whose needs are just as great.
- (v) Decentralize administration and management decision making to involve staff and beneficiaries.
- (vi) Allocate financial resources in mainstreamed projects to address disability issues effectively and responsibly.
- (vii) Establish role models and peer counselors to support the efforts of people with disabilities to be integrated into sector activities, such as employment and education opportunities.

4. Participation

- (i) Include people with disabilities as agents of change and not just as beneficiaries.
- (ii) Engage people with disabilities as active planning participants with responsibilities as providers and promoters of project activities and to share responsibility for the success of initiatives.
- (iii) Build partnerships with disabled persons' organizations and other community organizations.

5. Access

- (i) Establish clear definitions/classification of disability that aid the collection of statistics on disability through national census and specific surveys for planning, decision making, and evaluation.
- (ii) Create opportunities for people with disabilities to access and share experiences with other disabled persons.
- (iii) Change attitudes toward disability by using information that promotes positive images of people with disabilities, directed at channels that are accessible, such as community centers, religious groups, trade unions, public institutions, nongovernment organizations (NGOs), and other natural groups.
- (iv) Ensure that programs guarantee an accessible physical, social, and communication environment.

2. Disability in National and Community Promotion of Citizenship

6. Knowledge

- (i) Establish standards and accreditation of organizations involved in disability and development to create a standard of quality among delivery agencies.
- (ii) Conduct education of personnel on inclusive disability policies and management of the needs of people with disabilities in mainstreaming and disability-specific programs.
- (iii) Establish a database of public and private sector industries and services involved in capacity building and community development of people with disabilities and stakeholders who provide services.
- (iv) Educate people with disabilities, in particular women with disabilities, on how to participate effectively in the various governing and decision-making structures and processes within government and community services.
- (v) Conduct research and analysis on best-practice approaches to disability and development.

7. Inclusion

- (i) Apply and monitor United Nations (UN) Standard Rules for the Equalization of Opportunities for Disabled Persons in national policies and programming.

- (ii) Implement the Economic and Social Commission for Asia and the Pacific (ESCAP) agenda for the second Asian and Pacific Decade of Disabled Persons, 2003–2012.
- (iii) Implement the paradigm shift from a charity-based approach to a rights-based and inclusive approach, especially the right to development.
- (iv) Establish policy review panels with national coordination committees on disability, with representation of people with diverse disabilities to review relevant policies and their implementation.
- (v) Integrate the needs of people with disabilities into government line structures for policy development and decision making (governing councils and management/staff positions).
- (vi) Mainstream disability in line ministries by establishing disability focus groups to raise awareness, share knowledge, and leverage interest and ownership for introducing and monitoring disability in their sectors and projects; disability is not just an issue for the ministries of welfare and social affairs.
- (vii) Provide government budgetary allocations to all ministries for disability-specific initiatives.
- (viii) Establish disability policies in country and sector-specific programs to facilitate participation and access to the economy, social sector, and private sector, and related financial/budget support systems.
- (ix) Implement the recommendations in the Biwako Millennium Framework (BMF) toward an inclusive barrier-free and rights-based society for persons with disabilities in the region.
- (x) Require multinational agencies to report on inclusive disability programming in their annual narrative and audited statements.
- (xi) Support and strengthen collaboration and coordination at the subregional levels among governments and NGOs to share concerns and collaborate in the formulation of common priorities, policies, and strategies in the implementation of the BMF.
- (xii) Coordinate and profile research and development initiatives and best-practice initiatives.
- (xiii) Include disability in legal and policy reform nationally and across sectors to increase the participation of people with disabilities in society.
- (xiv) Suggest a project in sector areas to investigate discriminatory practices toward people with disabilities.
- (xv) Establish and monitor guidelines for conducting consultations and managing the process of decision making.

8. Participation

- (i) Increase the level of consultations between disabled people's organizations (DPOs) and sectoral ministries, civil society, and the private sector.
- (ii) Increase the representation of people with disabilities in political and electoral processes.
- (iii) Increase national and local representation in governing councils/committees of government and sector-specific department policies and programs and task forces related to legislation development, review, and monitoring.

- (iv) Identify people with disabilities to participate in management of disability-specific services and disability services mainstreamed in sector initiatives.
- (v) Include consultations of DPOs and beneficiaries in public and private sector development initiatives.
- (vi) Hire people with disabilities as consultants and disability experts in design, implementation, and analysis of research and evaluation activities (surveys, focus-group meetings).
- (vii) Employ people with disabilities as advisors to government and development agencies on the needs of people with disabilities and to monitor disability policies and guidelines.
- (viii) Conduct evaluations and other forms of information collection that directly involve beneficiaries in the process from design to implementation and dissemination of results.

9. Access

- (i) Design insurance and pension policies based on needs and not on disability categories that separate the causes of disability by virtue of the history and nature of the cause (e.g., a war veteran with a land mine injury and a land mine victim who is a child receive significantly different levels of support although both were war casualties).
- (ii) Make mainstreamed and disability-specific projects and services across sectors accessible to the most vulnerable people with disabilities, particularly in rural communities.
- (iii) Increase access to the services and programs that people with disabilities require for community integration (e.g., school, employment, health, and vocational and other rehabilitation).
- (iv) Make public buildings accessible according to international standards.
- (v) Collect information on disability that is based on the International Classification of Functioning, Disability and Health (ICF) classification or similar data development systems through census or disability-specific profiling.
- (vi) Distribute public information in different media forms for those with sensory disabilities.
- (vii) Develop and disseminate public information on disability and development issues related to prevention, health promotion, and environmental awareness.

3. Disability in Promotion of Citizenship by Development Agencies

10. Knowledge

- (i) Improve access to information and knowledge on disability by providing literature on disability for Asian Development Bank (ADB) staff and other agencies.
- (ii) Conduct disability awareness and participation training for ADB and executing agency personnel involved in country strategy and program (CSP) and project implementation to promote positive attitudes and aggressive disability programming in poverty reduction strategies.

- (iii) Conduct research and analysis on best-practice approaches to disability and development.

11. Inclusion

- (i) Apply and monitor UN Standard Rules for the Equalization of Opportunities for Disabled Persons in ADB and other donor and multilateral agencies.
- (ii) Revise the UN standard rules, including the establishment of a UN convention on the rights of disabled people.
- (iii) Analyze the implications of addressing the needs of people with disabilities by modifying the Millennium Development Goals (MDGs).
- (iv) Revise the MDGs to make specific reference to the inclusion of the needs of people with disabilities and to express clearly the rights of people in the MDG agenda.
- (v) Implement the paradigm shift from a charity-based to the rights-based inclusive citizenship approach, especially the perspective of the right to development and the imperatives for equal attention to the needs of women and children.
- (vi) Implement the ESCAP agenda for the second Decade of Disabled Persons, 1993–2002, and fully engage in the next decade agenda, 2003–2012.
- (vii) Include disability in ADB's country poverty analysis, specifically in the country risk and vulnerability profile mandated in ADB's social protection strategy and, if the needs assessment demonstrates the group as a priority, ensure that disability is reflected in the CSP.
- (viii) ADB should develop a “policy” on disability.
- (ix) Include the needs of people with disabilities in participation and gender policies; allocate financial resources to mainstream disability in CSPs and poverty reduction strategy papers (PRSPs) and programming.
- (x) Coordinate donor assistance toward a comprehensive, integrated program for reconstruction and, in areas of conflict, reconciliation in order to minimize duplication and maximize reach to and participation of the most vulnerable.
- (xi) Collaborate with partner countries and ESCAP to identify and support agencies that could be centers for facilitating coordination, exchange of information, and networking of DPOs and other NGOs involved with government in disability and development.

12. Participation

- (i) To reach people with disabilities more effectively, recruit people with disabilities as ADB consultants, staff, and project personnel by establishing an equal opportunity policy for people with disabilities and specifically encouraging people with disabilities to apply in job announcements.
- (ii) Conduct more participatory country studies on disability.
- (iii) Include people with disabilities and their advocates in all stages of the CSP and PRSP process from development to implementation and monitoring.

13. **Access**

- (i) Collect relevant information on disability using vulnerability profiles and other database development strategies.
- (ii) Make ADB buildings and information resource materials accessible according to international standards.
- (iii) Include the most vulnerable of the population of people with disabilities in rural and urban communities in programming in all sectors.

4. Disability in Gender

14. **Knowledge**

- (i) Educate women in vocational and other rehabilitation programs to prepare disabled women for careers and gainful employment.
- (ii) Increase the understanding by disabled women and their families of the rights of people with disabilities and strategies for accessibility in their home.
- (iii) Increase capacity of health service personnel to offer informed and sensitive health services and education, addressing the needs of girls and disabled women in such areas as nutrition, family planning, community-based rehabilitation (CBR), and primary health care.
- (iv) Educate disabled women in leadership, participation, and other strategies for empowerment to build confidence and capacity to effect change.
- (v) Increase capacity of disabled women's groups in management, small business development, and proposal writing and related strategies for securing financing from donors and other sources.
- (vi) Increase capacity of governments and NGOs to prioritize issues of women with disabilities in development efforts.
- (vii) Increase capacity of researchers involved in disabled women's issues to conduct investigations through participatory approaches, using socially and culturally sensitive theory to the development and implementation of services.
- (viii) Conduct research on abuse and the perpetrators of abuse of disabled women and girls.

15. **Inclusion**

- (i) Target interventions that support the establishment and capacity building of disabled women's groups and women's groups for families with disabled children.
- (ii) Governments and international NGOs that give financial assistance to national governments for women's development programs must include a component for and insist on including the development of girls with disabilities in their terms of reference.
- (iii) Integrate disabled women's needs in gender policies and programs.
- (iv) Governments and NGOs should be pressured to adopt recommendations from the Fourth World Conference on Women in Beijing, 1995.
- (v) Development efforts must be comprehensive to help disabled women access their full range of options.

- (vi) Establish quota measures for educating and employing disabled women and girls.
- (vii) ADB's mission policies should allow payment for accommodation that makes possible participation by people with disabilities.
- (viii) Gender analysis should include analysis of disability.
- (ix) Disallow involuntary sterilization, contraceptives, and abortion.
- (x) Establish scholarships and incentives for increasing the participation of girls and women in education programs.

16. Participation

- (i) Include disabled women, particularly those in rural communities, at all levels of decision making in policy and programming as administrators, professionals, consultants, partners, and field staff.
- (ii) Seek the advice, expertise, and involvement of disabled women in all policy, research, and relevant conference initiatives that affect women.
- (iii) Hire women's disability groups to educate governments, NGOs, and other agencies in gender and disability awareness.
- (iv) Offer free legal aid to disabled women and girls who have been subjected to exploitation, domestic violence, or sexual abuse.
- (v) Make primary education compulsory for disabled girls.
- (vi) Women's NGOs should establish networks with disabled girls and women and include them in program activities.

17. Access

- (i) Make battered women's shelters and rape crisis centers available to disabled women, including prostitutes who are disabled.
- (ii) Similarly, make reproductive health centers accessible to these women.
- (iii) Undertake leadership education and other community development education to reach out to disabled women.
- (iv) Adapt work schedules and work environments to women.
- (v) Make accessible for disabled women and girls, devices for mobility, domestic chores, and education and for workplace requirements.
- (vi) Collect data on the needs and profiles of disabled women.
- (vii) Governments should impose restrictions on media to refrain from portraying negative and stereotyped images of girls and women.

5. Collecting Information on Disability

18. Knowledge

- (i) Create and share disability knowledge and information that promotes positive attitudes toward disability, a barrier-free environment, and awareness of the disability network of resources in order to change attitudes in support of inclusive policies and project implementation for and with people with disabilities.
- (ii) Study cases in which disability has been successfully mainstreamed to understand how it happened.

- (iii) Educate people with disabilities and other stakeholder groups in the principles and practice of research and evaluation.

19. Inclusion

- (i) Conduct national censuses and other information collection mechanisms to ensure that there is access to information on people with disabilities and that it is properly reported in national statistics, by adding disability indicators in national census, household, and any other surveys that may be developed.
- (ii) Conduct in-depth and targeted household surveys in which disability questions are included that are uniform in order to make cross-country comparisons.
- (iii) Conduct public awareness campaigns to profile positive experiences of disability; the media strategy should take into account the type of media and the timing of the information campaign; radio, TV, and billboards should make information accessible to all people, including those with sensory disabilities (such as visual and hearing impairments).
- (iv) Include research and evaluation on disability as core components of project and program management across sectors.

20. Participation

- (i) Include people with disabilities and consult DPOs with expertise in the design and implementation of information collection and dissemination activities.
- (ii) Include people with disabilities in a critical review of evaluations and research.
- (iii) Include beneficiaries in the design, implementation, and analysis of research and evaluations as well as the dissemination of results.

21. Access

- (i) Develop information systems that collect reliable, valid, and culturally appropriate information.
- (ii) Collect information that demonstrates how poverty reduction strategies reach and benefit the most vulnerable people with disabilities.
- (iii) Disseminate information to stakeholders.

ADDITIONAL CASE STUDIES

1. Case studies from development projects executed by agencies other than ADB are listed in Table A7.1. The area of primary and secondary focus in terms of its major contribution toward improving the lives of people with disabilities and the livelihood of their communities is also listed.

Table A7.1:Case Studies by Sector, and KIPA “Clear Direction” Framework

Sector*	K	I	P	A
A. Employment				
1. Employment of Persons with Disabilities in the Private Sector, Sri Lanka	x			x
2. Enhancing Employability of Persons with Disabilities, India	X	x	x	x
3. Navigating the Waters Project: Enhancing Employability of Persons with Disabilities, Canada	x	x	x	x
B. Education				
1. Integration of Disabled Children in School, Sri Lanka	X	x		x
C. Community Services: NGOs				
1. Sunera Foundation for Performing Arts, Sri Lanka	X		x	x
2. Accreditation and Monitoring of Programs for Blind Persons, India	x			
D. Community Services: Independent Living				
1. Breaking Barriers for Children and Empowerment of DPOs, Philippines	X		x	x
2. Bangladesh Protibandhi Kallyan Somity	X		x	x
E. Community Services: CBR				
1. The Role of the Family in the CBR Team Approach, India	X		x	
2. CBR Mainstreamed in Primary Health Care, Bosnia-Herzegovina	x	x	x	x
F. Health				
1. Awareness Will Help To Combat Leprosy, India				x
G. Appropriate Technology				
1. Trust Prosthetics and Orthotics Program, Cambodia	X			x
H. International Development Agencies				
1. Action on Disability and Development	X		x	x
2. How People with Disabilities Take Challenges to Make Changes	x		x	x

Legend: X: primary focus, x: secondary focus, **x**: most important contribution of the secondary focus.
 ADB = Asian Development Bank; CBR = community-based rehabilitation; DPO = disabled people's organization; KIPA = knowledge, inclusion, participation, and access; NGO = nongovernment organization.

* Note: These sectors are not parallel to ADB sectoral classification.

A. Employment

1. Employment of Persons with Disabilities in the Private Sector

Sector:	Employment/labor
Goal(s):	Technical independence and environmental awareness
KIPA Focus:	Inclusion and access
Country:	Sri Lanka
Participating Agencies:	Employers Federation of Ceylon (EFC) and International Labour Organization (ILO)
Beneficiaries:	All people with disabilities

2. Background: In Sri Lanka, 20 years of conflict have increased the number of people with disabilities among the most economically productive age group of the country. It is an accepted fact that people with disabilities are the poorest among the poor. There are programs that provide training for people with disabilities but there is still the challenge of securing gainful employment. Further, potential employers perceive people with disabilities as economically weak and nonproductive.

3. Goal: The goal was to change the attitudes of private sector employers through enhanced awareness and demonstration of the economic productivity of people with disabilities.

4. Strategy: The EFC designed and conducted a disability awareness workshop in collaboration with the ILO office in Colombo, targeting leaders in the private sector. During the workshop, lessons learned by their member organizations were shared and discussed. EFC sensitized 35 participating employers to management issues related to the employment of people with disabilities. They highlighted the capacity and skills of people with disabilities to be economically productive. A specialist from ILO, medical consultants, and members of EFC participated in the discussion and developed awareness as to existing labor laws, policies and practices, ILO standards, etc.

5. Outputs: The workshop led to the identification of potential placement of people with disabilities in the private sector, the establishment of a website to promote public awareness and access to information, and the creation of a placement database.

6. Results: *Inclusion.* Employers who participated agreed to hire nearly 60 people with disabilities. To coordinate and sustain this initiative, the EFC has appointed a steering committee to monitor employment trends and to establish a more effective system for screening applicants and recommending them to private sector establishments. *Access.* As a result of the workshop, more than 1,500 persons with disability registered in the database and employers have access to information regarding potential candidates for recruitment. The challenge is for other members of the EFC and other employers' networks, such as that of the chamber of commerce, to replicate the initiative taken by EFC.

2. Enhancing Employability of Persons with Disabilities

Sector:	Employment/ labor
Goal:	Technical independence
KIPA Focus:	Knowledge and participation
Country:	India
Participating Agencies:	Association of People with Disabilities (APD)
Beneficiaries:	All people with disabilities

7. Background: Realizing the importance of economic rehabilitation of people with disabilities to gain recognition, acceptance, and dignity in society, the APD began as a training center for enhancing employability and motivation for self-employment. The New Training Centre to provide formal technical training and the Advanced Training Centre to provide advanced technical skills with shop-floor experience were set up in 1975 to fulfill the needs of economic rehabilitation of trainees with physical disabilities.

8. Goal: The idea of a home-based program was conceived in 1976 for the purpose of economic rehabilitation of people who were home bound because of the severity of disability, inaccessibility due to geographical and logistic constraints, etc..

9. Strategy: APD was envisaged to act as a mediator between industry and workers based in their home or in small ancillary cooperatives. Support of family members was an essential ingredient. Several experiments were tried that had positive impact on promotion of self-employment among the people with disabilities.

10. Output: APD developed 3 ancillary units formed by people with disabilities of different types under the home-based program during 1994–2002. Ability in Disability was the first one, set up in 1994 for supply of mechanical subassemblies to Motor Industries Co. (MICO), a prominent manufacturer in the automobile sector. Fifteen persons run the Ability in Disability unit, of whom 3 have locomotor disabilities and 10 are visually impaired. Ten are women. The unit is subjected to audit conforming to ISO standards by MICO. The APD Utpadana Society was the second unit in the series, set up in 1999 and engaged in supply of electronic subassemblies and components to major electronic industries, such as Indian Telephone Ltd. and Bharath Heavy Electricals Ltd., Bangalore. Of the 32 people in the unit, 24 have locomotor disabilities and 2 are hearing impaired. The third was the Creative Skills Society, set up in 2002, with 14 persons—10 with a hearing impairment and 4 with locomotor disabilities—working to meet requirements of a small-scale electronics industry in Bangalore. APD is gradually withdrawing from the units to allow them to develop into self-managed industrial units owned by people with disabilities, in order to prove their entrepreneurial and managerial capabilities.

11. Major challenges encountered were building competence, instilling confidence, removal of attitudinal barriers, a paradigm shift in the perception of people with disabilities and society, reduction in perpetual dependence on APD, fear of failure, lack of entrepreneurial capabilities, maintenance of quality of products, abuse of facilities offered by the government, and undue expectation of people with disabilities from society.

12. Results: *Knowledge*. APD became a role model by its exemplary efforts and experience in empowering people with disabilities to attain economic self-reliance and lead dignified lives. The APD has expanded its area of operations gradually over 4 decades to encompass physiotherapy, orthotic appliances, horticulture, CBR, urban slum outreach, community health, and integrated education. *Participation*. Over time, APD has ensured that people with disabilities lead the decision making regarding its strategic development.

3. Navigating the Waters Project: Enhancing Employability of Persons with Disabilities

Sector:	Employment/Labor
Goal(s):	Technical and functional independence and environmental awareness
KIPA Focus:	Access, knowledge, and participation
Country:	Canada
Participating Agencies:	Canadian Association of Independent Living Centres (CAILC) and 22 partner IL centers
Beneficiaries:	All people with disabilities

13. Background: Navigating the Waters has been a national employment project in Canada since 1997. The Opportunities Fund, Human Resources Development Canada, funds this project. During 2001–02, 22 of the 25 independent living resource centers (IL centers) in Canada implemented Navigating the Waters across Canada. Each center had a career development facilitator. The facilitators work with individual consumers to support people to develop career plans, help identify appropriate resources, and link them with employment training and job opportunities. CAILC started in 1985 as a national umbrella organization to provide support and training to the IL centers, which are autonomous, community-based, nonprofit, registered charitable organizations, with volunteer boards of directors. They are run by and for people with disabilities. Core activities include information and referral, peer support, skills training/individual advocacy, and research and development/special projects. The IL philosophy promotes choice and empowering people with disabilities to be actively involved in the decision-making process in all aspects of their lives. It encourages people with disabilities to take risks and be integrated into mainstream society with the supports needed to lead independent lives. Funding of IL centers is based on private fund raising, foundation grants, and donations from members. The main support to the operating budget is from government funding at the federal, provincial, and municipal level.

14. Goal: The overall goal is to assist people with disabilities to access the employment market toward community integration and economic independence. In the 2001–02 project, the objective was to support people with disabilities— mental health (197, 25%), hearing (42, 5%) agility (133,16%), visual (37, 5%), speaking (1), intellectual (98,12%), motor skills (79, 10%), learning (68, 9%), and other (149,18%)—in the database to identify employment interests and opportunities and training requirements, and to obtain employment.

15. Strategies: Each program is developed differently in each center but has the following common elements.

- (i) Working with people with a broad range of disabilities and with multiple disabilities, often those for whom there are few services in the community or with whom service providers do not know where to start.
- (ii) Building networks by connecting with other employment-related agencies and placement programs, as well as employers and other local groups; conducting outreach to remote communities, in job fairs, and by making presentations in the local schools and to other groups. These include multicultural groups, women's organizations, mental health organizations, and school boards.
- (iii) Forming partnerships by establishing formal agreements with other community organizations, government agencies, and other agencies to work together and create more access to resources.
- (iv) Working one-on-one with consumers where they are located, and guiding and supporting, rather than leading and providing, to the extent needed, building trust with the consumer, spending quality time, listening, and helping plan.
- (v) Providing and sharing information, making referrals, and organizing, including setting up volunteer placement programs.
- (vi) Providing infrastructure for support, information, meetings, and building relationships.
- (vii) Skills training, public relations, workshops, mock interviews, and preparing employment proposals.

16. Output: Of the 827 persons, 27% were employed; 35 were involved in volunteering, 76 participated in skills/education, and 9 received work experience; some 27% have established a long journey program—they have identified the need for more long-term support and development before employment can be considered.

17. Results: Access to employment is the major outcome of this project. Since 1997, more than 3,550 people with disabilities have been supported to secure employment or to improve their employability as a result of project interventions. *Knowledge development* and *Participation* are the other two outcomes—building the capacity and confidence of people with disabilities to identify skills and opportunities and to seek employment with the support of the facilitator.

B. Education

1. Integration of Disabled Children in School

Sector:	Education
Goals:	Functional and technical independence
KIPA Focus:	Knowledge, access, and inclusion
Country:	Sri Lanka
Participating Agencies:	Teacher Training College Maharagama, Ministry of Education
Beneficiaries:	Teachers, inclusive of those with disabilities; and children with visual impairment, hearing impairment, and intellectual disabilities

18. Background: The program consists of an in-service, institutional, teacher training program with a duration of 2 years, after which teachers should be able to

- (i) identify and recognize the most common impairment and give proper recommendations, while concentrating on a person's area of disability;
- (ii) carry out individual or group work with children with special education needs (special schools classes, etc.);
- (iii) support and give advice to all other members of the staff of schools on disability;
- (iv) assist in in-servicing regular teachers;
- (v) produce simple teaching and learning material;
- (vi) maintain and repair special equipment, such as braille, hearing aids, etc.;
- (vii) communicate with other authorities dealing with the welfare of people with disabilities, such as health and social services personnel, and bring about effective consultation in planning, delivering, and evaluating services; and
- (viii) provide the required instructions to the parents of children with disabilities who need special education, e.g., children with learning disabilities.

19. Strategy: The course consists of lectures, observation visits, discussion, video films, case studies, practical work, and teaching assignments. There are two compulsory components: teaching practice of not less than 45 days with children, and a special study project based on written research. In addition, there are three internal exams, 1 qualifying test after the first year conducted by the Department of Examination, and final exam at the end of the second year. There is a staff of 6 persons with master degrees (two for visually impaired, two for hearing impaired, and two for cognitive disabilities.)

20. Outcomes: *Knowledge*. Participants receive good knowledge of teaching methodologies. *Inclusion*. Inclusive education is currently accepted as an integrated system. People are aware of the program and an appropriate policy is in preparation.

C. Community Services: Nongovernment Organizations

1. Sunera Foundation for Performing Arts

Sector:	Community services in the performing arts
Goals:	Functional and technical independence and environmental awareness
KIPA Focus:	Knowledge and access
Country:	Sri Lanka
Participating agencies:	Sunera Foundation with representatives from the AMICI Dance Theatre Company and cofounder of the Butterflies Theatre Group Panel of Puppetry of the Arts Council of Sri Lanka (sunera@slnet.lk)
Beneficiaries:	Physically and mentally disabled (differently) persons, victims of ethnic conflict (trauma), and people without disability.

21. Background: Sri Lanka has many young people who were born with mental and physical disadvantages or have been traumatized and marginalized by civil war. There is

a lack of self-esteem/confidence among such vulnerable populations and lack of awareness of their needs. Sunera Foundation helps to integrate disadvantaged young people into the normal stream of life through activities that enable them to develop their creative talents.

22. Goal: The goal is to develop the creative talents of these people, which will act as therapy, especially in cases of trauma; develop their leadership qualities; integrate all ethnic groups with each other, as well as the nondisabled with the disabled; train potential leaders to be future trainers and workshop leaders; and develop the notion of amity and harmony among all groups by working closely together.

23. Strategy: The Sunera Foundation has functioned for 4 years. To organize the performing arts program, the Foundation has trained 14 young men and women in the knowledge and skills for conducting workshops in the performing arts and for working with vulnerable populations. The activities include creative workshops in the local community. Parents are encouraged to participate and involved, such as by bringing their children to attend, helping out during the workshop, and encouraging others to join. All members of the community are welcome to take part. A national group is selected to design and implement a major stage production in local theaters throughout Sri Lanka. The theme of the production and the selection of the players are conducted in a participatory way to promote inclusion, team building, and effective decision-making skills.

24. Output: Each year approximately 30 workshops are held on a regular and continuing basis. In the last 4 years, around 1,500–2,000 persons have participated in the program. A parent's organization has been established, with each workshop promoting networking and self-help and also leading to the identification of new members to join the workshops. Several workshops on dance, drama, music, art, and puppetry were conducted for 100 children from refugee camps in the war zone in collaboration with the United Nations Children's Fund (UNICEF). A two-year training program for 30 young trainees was conducted with funding from the United Kingdom Department for International Development. The Butterflies Theatre Group, consisting of 45 disadvantaged as well as nondisadvantaged and professional young people of all communities, has conducted three major stage productions.

25. Results: *Technical independence.* Participants have gained knew knowledge in creative arts. *Management for social action.* For all participants, there has been the opportunity to enhance self-esteem through sharing experiences, traditions, and languages creatively, and in working in groups. This has led to better harmony and new friendships among ethnic groups and better appreciation of each other's role in society. *Inclusion.* People with disabilities have been included among the artistic community. Disability and other issues related to vulnerable groups and conflict have been included in the cultural activities of the community. *Environmental awareness.* Community awareness building has been fostered through the performing arts. There has been increased awareness of the needs of people with disabilities by the population of Sri Lanka and internationally.

2. Accreditation and Monitoring of Programs for Blind Persons

Sector:	Community services
Goal:	Management for social action
KIPA Focus:	Inclusion and knowledge
Country:	India
Participating agencies:	Blind People's Association (BPA)
Beneficiaries:	Persons with visual impairments

26. Background: BPA Ahmedabad in the state of Gujarat is one of the largest and oldest disability organizations in India. Apart from implementing its own programs directly, the organization provides professional consultancies and appraises and monitors projects funded by international agencies. BPA has worked intensively to facilitate linkages of blind welfare organizations with mainstream organizations.

27. Goal: The comprehensive rehabilitation of people with all categories of disabilities through education, training, support services, research, and community-based interventions.

28. Strategy: BPA supports both institutional and community-based programs. A wide range of learning and training material has been developed. BPA promotes a cross-disability and multiagency approach, with a focus on convergence of available services and integration in mainstream development. Programs are designed to provide a balance between interventions at the community level and referrals to specialist institutions. Critical success factors include the selection of appropriate workers, effective training, and workable mode of operation. Major areas of intervention include education and comprehensive rehabilitation for people with disabilities; development of technical aids and appliances; interventions for special education needs of children with disabilities; community-based rehabilitation program; creating employment opportunities for people with disabilities; and strengthening other nongovernment organizations (NGOs) through networking.

29. Results: *Inclusion.* Examples include addressing cross-disabilities issues; promoting decentralization; facilitating linkages between government and community-based organizations; resource mobilization for sustaining other NGOs; networking with various government ministries and NGOs; lobbying government; addressing the needs of the disabled; diversifying from one disability to cross-disability; promoting employment of people with disabilities; integrated education programs; and promoting and facilitating home-based interventions for people with disabilities. Future areas for mainstreaming for inclusion include convergence with the Department of Rural Development; lobbying the Department of Health for improved health delivery services; lobbying the Ministry of Labour for ensuring 3% reservation for people with disabilities in all jobs; and making the work environment accessible to people with disabilities. *Knowledge.* The following have been carried out: capacity building of NGOs; skill upgrading for people with disabilities; reaching out to the parents of the disabled through grassroots-level organizations and motivating them to organize themselves; acting as an intermediary for providing accessibility to information for people with disabilities; and networking with the private sector to promote more employment opportunities for people with disabilities.

D. Community Services: Independent Living

1. Breaking Barriers for Children and Empowerment of Disabled People's Organizations

Sector:	Community services
Goal:	Functional independence
KIPA Focus:	Access, knowledge, and participation
Country:	Philippines
Participating Agencies: (PTU)	KAMPI, Danish Society of Polio and Accident Victims
Beneficiaries:	Children with disabilities

30. **Background:** The Breaking Barriers-Philippines (BBP) project (1995–1998), a partnership of KAMPI—the national federation of organizations of people with disabilities in the Philippines—and PTU, was the first project of its kind in the Philippines. It was a pioneering effort by people with disabilities aimed at addressing the rehabilitation needs of children with disabilities.

31. **Strategy:** People with disabilities were involved in the planning, conceptualization, and administration of BBP. They recruited, screened, and selected nondisabled professionals who provided the specific technical expertise to run the project. The Danish International Development Agency provided the funds through PTU.

32. **Outputs:** Five stimulation and therapeutic activity centers (STACs) were established in five pilot regions. The project overshot its goal of providing services to 1,000 beneficiaries by at least 50%. Beneficiaries received free rehabilitation services, school placement services, and referrals to other facilities. Other achievements included awareness campaigns on disability; policy research and formulation, and advocacy in the areas of employment, accessibility, health care, legislation, and education; concepts and action plans on integrating disabled children and young adults in mainstream services; devices and technical aids to beneficiaries in need; generating support from local government units that took over the operation of STACs after the project ended; and livelihood skills training and small capital grants to augment the often limited income of parents of disabled children. The STACs were accredited as government partners in the provision of rehabilitation and other services. Some 25 colleges and universities in the Philippines have designated the STACs as training facilities, which has augmented STACs' personnel and generated revenue through donations from student interns.

33. **Results:** *Knowledge.* BBP led to a further project, Breaking Barriers for Children (BBC), 1998–2003, which added more features and components to make the services for children with disabilities much more comprehensive and sustainable. It has succeeded in fostering awareness and nurturing the goodwill and social-civic mindedness of communities and citizens at large. *Access.* By the end of 2001, the BBC had served more than 7,000 children with disabilities and there are now 60 CBR centers. *Participation.* BBP and BBC have demonstrated how people with disabilities from a donor country like Denmark can be instrumental in supporting efforts of their counterparts in a developing country like the Philippines, to break barriers and stereotypes and become catalysts of change for their own development.

2. Bangladesh Protibandhi Kallyan Somity

Sector:	Employment/labor
Goals:	Technical and functional independence and environmental awareness
KIPA Focus:	Knowledge, participation, and access
Country:	Bangladesh
Participating Agencies:	<i>Bangladesh Protibandhi Kallyan Somity (BPKS)</i> ³⁸
Beneficiaries:	All persons with disabilities, their families, communities, local authorities, professional groups, national institutions

34. Background: There are an estimated 13 million disabled people in Bangladesh and they are overwhelmingly poor. There is an urgent need for basic support services, and for greater acceptance of these people in the general community, to enable them to participate in the mainstream development process. BPKS was established as an NGO in 1985 by the current Executive Director, Md Abdus Sattar Dulal, whose own disability was the impetus behind creating BPKS. BPKS designed a development and rights-based program, Persons with Disabilities' Self-Initiative to Development (PSID). Under this program, persons with disabilities are directly involved in the planning, decision making, implementation, management, and ownership of the program and related activities, from the local to national level. Economic empowerment is a major focus of PSID.

35. Goals: The two goals of BPKS are to ensure the equal rights, opportunities, and participation for all people with disabilities in the mainstream development process, and to eliminate prejudice and discrimination against them.

36. Strategies: Under the PSID program, persons with disabilities become members of PSID units at the grassroots level. A baseline survey is conducted to establish the range of disabilities in the area. Once an area is chosen, BPKS establishes an office as a focal point from which to provide the following services:

- (i) training to develop the skills of local people, such as home-based therapy, production and maintenance of devices, health referral services, and information on prevention;
- (ii) enrollment of children in mainstream education, after talks with families and education authorities. BPKS offers training for teachers to learn teaching methods for disabled children and also offers incentives for schools to install ramps, adapt materials, and provide nutritious food;
- (iii) creating a safe and accessible environment by installing appropriate latrines and tube wells, and teaching better hygiene and safety practices;
- (iv) facilitating economic opportunities for people with disabilities through a weekly savings program, skills training, job placement services, access to local financial institutions, and loan support from BPKS; and

³⁸ bpkspm@agni.com

(v) advocacy and coordination services at the local and national level through committees and by lobbying national and international organizations.

37. Output: Twelve disabled people's organizations (DPOs) were established during 1996–2003. At present there are 7,840 disabled members in Bangladesh. Funds are being used for income-generation activities and the further development of local organizations. More than 48,000 people with disabilities have directly benefited from BPKS's services.

38. Results: *Behavioral change and empowerment.* People with disabilities are becoming more confident and are attaining the skills they require to fully participate in the community. This is resulting in greater opportunities for education, employment, and leisure activities. The positive changes in thinking, attitudes, and practices in communities also pave the way for integration of these people into mainstream community life and further encourage them to improve the quality of their own lives with information and technical support from DPOs. *Sustainability of organizations.* PSID develops self-sustaining local organizations by and for people with disabilities.

E. Community Services: Community-based Rehabilitation

1. The Role of the Family in the Community-based Rehabilitation Process

Sector:	Community-based rehabilitation (CBR)
Goal:	Management for social action
KIPA Focus:	Knowledge and participation
Country:	India
Participating agencies:	Spastics Society of Tamil Nadu (SPASTN)
Beneficiaries:	People with disabilities and the community

39. Background: A woman abandoned by her husband, Mrs. Gajalakshmi has three daughters and her youngest daughter, Anusuya, now aged 12 years, is a severe quadriplegic child. She took Anusuya to SPASTN and out of her interest in the activities learnt all the therapy activities and speech interventions needed to help her child. As a result, she now runs the services at the center and educates other parents on their children's rehabilitation needs.

40. Strategy: Mrs. Gajalakshmi helped a visiting CBR team in forming a self-help group of 18 women with disabilities from her village. She gave her own land for collective income-generation activities and put up a small hut there with community contributions. Through the self-help group she takes up social causes to the village leaders about the concerns of people with disabilities. As a remarkable milestone, Mrs. Gajalakshmi stood for the ward member post in the local elections, nominated by the village panchayat leader himself. In an ironic twist, her husband became blind from drinking toxic liquor. Mrs. Gajalakshmi took him back and he is now fully dependent on her. In spite of now having to look after two people with disabilities in her own house, she runs the local SPASTN center and continues to be a role model to everyone with disabled family members.

Results: Mrs. Gajalakshmi's valuable contribution is in *knowledge*, promoting low-cost rehabilitation aids and appliances made of mud, bricks, clay, plantain barks, etc. This has helped most of the parents in rural areas to *participate* by following up programs at home to maintain the functional position required by their children.

2. CBR Mainstreaming in Primary Health Care, Bosnia-Herzegovina

Sector:	Community-based rehabilitation
Goals:	Functional independence, environmental awareness, and management for social action
KIPA Focus:	Access, knowledge, inclusion, and participation
Country:	Bosnia-Herzegovina
Participating agencies:	Ministries of health, Federation of Bosnia-Herzegovina and Republika Srpska, the World Bank, International Centre for the Advancement of Community Based Rehabilitation (ICACBR)
Beneficiaries:	People with disabilities and the community

41. Background: Bosnia-Herzegovina experienced 4 years of conflict in which more than 200,000 lives were lost and more than 50,000 persons were injured and disabled, including 5,000 persons who lost a limb. During the conflict, CBR services and strategies were introduced and established by ICACBR in collaboration with the Ministry of Health and WHO. In November 1995, the Dayton Peace Accord was signed and the process of postconflict reconciliation, rehabilitation, and reconstruction began. The Government and the World Bank identified disability and the need for quality services as a priority for the national reform of its rehabilitation system within the health sector.

42. Goal: The overall goal was to help people with disabilities return to economically productive and social lives in their communities by restoring and improving the quality and scope of rehabilitation services delivered as part of the health care system.

43. Strategy: CBR was determined to be the core component in a continuum of prosthetic/orthotic and essential hospital rehabilitation services. The World Bank and other donors supported the civil works and reconstruction of existing primary health care, hospital, and CBR centers. ICACBR led the project design, policy development, clinical and management education of CBR personnel, and research. The Government was responsible for taking ownership of the CBR centers and establishing the legislation for financing them, including salaries for more than 400 personnel.

44. Output: By 2003, there was a network of 42 CBR centers in rural and urban communities serving more than 40,000 people with disabilities and their families annually, regardless of physical disability, geographic location, ethnic origin, age, and sex. In addition, ICACBR is now collaborating with the Government of Japan and the Ministry of Health to make CBR a truly national program by establishing 17 new CBR centers using the model already introduced.

45. Outcomes: *Access and knowledge*. The project made rehabilitation services accessible in rural and urban communities. *Inclusion*. CBR is a core element of the primary care system as a publicly funded program. *Participation*. People with disabilities have become increasingly formally involved in decision making related to project design

and policy reform in the Federation and increasingly expected to participate in social reform. The project has ensured that a core component of the program involves people with disabilities as decision makers and participants in project activities.

F. Health

1. Awareness Will Help To Combat Leprosy

Sector:	Health
Goal:	Environmental awareness
KIPA Focus:	Access
Country:	India
Beneficiaries:	People with disabilities and the community

46. Early diagnosis and elimination of misconceptions prevalent among the public about leprosy were the theme of an exhibition organized jointly by the Indian Leprosy foundation and Gerlets Hospital at the central suburban railway station on 25 January 2003 as part of the World Anti-Leprosy Week celebrations in India. The exhibition included posters on symptoms, diagnosis, and treatment of the disease, and pamphlets were distributed. Such exhibitions are held in busy places, such as railway stations, to create an awareness of the disease and screening people who needed treatment. Regarding misconceptions about leprosy, it was pointed out that it was the least infectious disease and multidrug therapy had been made available, facilitating early treatment. The incidence rate decreased considerably in Tamil Nadu from 733,000 in the 1980s to 13,000 in 2003. Special footwear for leprosy patients was also on display. (From *The Hindu*, 26 January 2003, p. 3)

G. Appropriate Technology

1. Trust Prosthetics and Orthotics Program

Sector:	Appropriate technology
Goal:	Functional independence
KIPA Focus:	Knowledge and access
Country:	Cambodia
Beneficiaries:	Persons with lower and upper limb amputations

47. Background: When the Cambodia Trust (CT) began in Cambodia in 1991, a civil war was being fought in the northern provinces and there were numerous land mine victims. There was unexploded ordnance and many victims and fatalities of mine accidents. CT began with one clinic and assisted people with amputations by providing artificial limbs.

48. Strategy: While government capacity is poor, collaboration with the Government is good and all parties are interested and work toward improving and developing legislation for people with disabilities through regular meetings and through a coordinating body, the Disability Action Council. Strategic plans have been developed for CT by the board of trustees in consultation with staff in the field. Initially CT's target group was mine victims. However, it soon became apparent that there were other people with different disabilities, such as people with polio who needed orthotic devices rather

than artificial limbs. Once people were mobile through devices or wheelchairs, they asked for access to income-generation activities. Employment is not part of CT's mandate, so it set up a community work project. Through which it supports and funds people with disabilities to gain access to mainstream NGOs, schools, and income-generation schemes. CT also conducts regular village surveys to find people with disabilities who would benefit from the services it can provide.

49. **Results: Access.** The CT workers assess They assess access to social life and assess the socioeconomic situation of the village, examining opportunities of income generation. CT facilitates access to schools for children by providing mobility aids, talking to the school director, providing information for teachers, and where necessary making modifications to buildings. *Inclusion.* CT is beginning to partner with other organizations and government ministries, a sign of good collaboration in the interests of people with disabilities. *Knowledge.* Monitoring and evaluation are ongoing processes at CT and it is part of the management review team's responsibility to make sure that the results are analyzed and action taken. *Participation.* In community projects, people with disabilities and their families are involved in the decision-making processes of their action plans. If the plan is unrealistic, CT staff counsel families about their activities, their income-generation potential, and their vision for their future.

H. International Development Agencies

1. Action on Disability and Development, United Kingdom

Sector:	Community services
Goal:	Management for social action
KIPA Focus:	Knowledge and participation
Country:	Cambodia
Participating Agencies:	People with disabilities and their organizations
Beneficiaries:	All people with disabilities

50. **Background:** Economic empowerment for people with disabilities faces many challenges in Cambodia, with approximately 40% of the people living in poverty. There is little legislation on disability. Therefore, such organizations as Action on Disability and Development (ADD), have developed their vision, mission statement, and strategies based on international best practices and in line with directives, guidance, and collaboration with other organizations and agencies working in this sector.

51. **Goals:** The overall goals are to support organizations of people with disabilities in their campaign for the rightful inclusion of disabled adults and children in society to build strong associations of people with disabilities; promote self-advocacy and influence; promote access to rehabilitation services and other development opportunities; promote economic empowerment; provide information and education; and promote recreation, sport, and cultural activities.

52. **Strategy:** To meet its 5 goals, ADD has developed village activities and national advocacy actions. Community members of ADD's activities recently participated actively in long-term (5 years) strategic planning to influence and voice their opinions on the direction and approach the organization should take. ADD is a member of the national coordinating body, the Disability Action Council, in which it promotes advocacy work

through funding and active participation. ADD supported the drafting of the Disability Act that is with the Council of Ministers for approval.

53. Output: At the village level, ADD's most significant contribution is the formation of village- and commune-level structures: 137 self-help groups and 3 federations. Self-help groups are an avenue for people with differing disabilities to express their interests and needs, gain access to public services by identifying barriers, discuss problems, analyze causes, and develop solutions. These may either be local or national and include networks with other organizations. A federation is a body of 9 people with disabilities at the commune level with the role of: representing disabled persons in the commune, supporting self-help groups through management of activities, leading in issues of advocacy, facilitating and monitoring implementation of the Disability Act, asserting an inclusive environment at local levels, and collaborating with local authorities. Many of the self-help groups work on practical issues of poverty reduction through savings plans, credit schemes, income-generation projects, and other rehabilitation initiatives. Some self-help group members have acquired income and employment skills, which have raised their confidence and helped the communities to accept people with disabilities and acknowledge them as people with abilities.

54. Result: *Inclusion*. Behavioral changes within communities toward people with disabilities are beginning to be documented by ADD. All the senior management of the institution are Cambodians.

2. How People with Disabilities Take Challenges to Make Changes

Sector:	International agencies involved in disability
Goal(s):	Independence
KIPA Focus:	Knowledge, access, and participation
Country:	Bangladesh
Participating Agencies:	ADD
Beneficiaries:	People with disabilities

55. Background: ADD has assisted Mahfuja Akhter Shapla, a disabled person now aged 18. She was born in a typical village of Bangladesh. Her family members lived on less than \$2 a day; they could not provide nutritious food for their children. About 55% of children in the village under the age of 5 were underweight; the children were not immunized and sanitation was very poor. Almost 90% of people with disabilities come from a similar economic situation. Disabled women are not well represented within the disability movement in the country and are usually forgotten by the women's movement and by the majority of development agencies and governments.

56. Goal: The goal is to empower girls and women like Shapla throughout Bangladesh.

57. Strategy: Shapla joined the self-help groups (grassroots DPOs) of people with disabilities at her village in 1995, supported by ADD Bangladesh. Subsequently, Shapla was admitted into class five in her village high school, participated in the group meetings and decision-making process, became aware of the plights and rights of people with disabilities, developed her leadership capacity, and was elected leader of federations of

grassroots DPOs. She continued her regular education in the mainstream school and received computer training in the local town.

58. Output: After going through the empowerment process, Shapla completed secondary education. She has plans for higher education and assisted her mother to run an informal school in their community. She also started a computer training center in her village to train other young people.

59. Results: Access. The case of Shapla clearly illustrates that if persons with disabilities have the opportunity or access to education and organizations, they can change their life and contribute to their family and society. Participation: Shapla joined the group of 2,000 disabled people who have made changes in their own lives and to remove social barriers for other disabled people in the country. Knowledge. ADD has built the capacity of DPOs in Bangladesh. They can now work with more disabled people with fewer resources. The reasons for success were experience and expertise of ADD and empowerment of people with disabilities.