The Role of Community-Based Rehabilitation in Poverty Reduction:
A Comparative Study among Iran, Malaysia, and Indonesia

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# Table of Contents

**EXECUTIVE SUMMARY** .................................................................................................................. VI  
**INTRODUCTION** .............................................................................................................................. XII  
1. **CONCEPTUAL FRAMEWORK AND METHODOLOGY** .............................................................. 1  
   1.1 **OVERVIEW OF COMMUNITY BASED-REHABILITATION** ...................................................... 1  
   1.2 **THE ROLE OF CBR IN POVERTY REDUCTION** ................................................................. 2  
   1.3 **CBR MATRIX** .......................................................................................................................... 4  
   1.3.1 **Health**: .................................................................................................................................. 4  
   1.3.2 **Education**: ............................................................................................................................ 5  
   1.3.3 **Livelihood**: ............................................................................................................................ 5  
   1.3.4 **Social**: .................................................................................................................................... 6  
   1.3.5 **Empowerment**: ...................................................................................................................... 6  
   1.4 **GENERAL CONCLUSIONS ON IMPLEMENTING CBR STRATEGIES** ............................. 7  
   1.5 **METHODOLOGY & FRAMEWORK FOR EXAMINE CBR STRATEGIES** ............................ 7  
2. **OVERVIEW OF CBR PROGRAM IN THE COMCEC MEMBER STATES** ................................. 9  
   2.1 **POVERTY AND DISABILITY IN THE COMCEC MEMBER STATES** ................................. 9  
   2.1.1 **The relationship between poverty and disability in monetary terms** ................................. 11  
   2.1.2 **The relationship between poverty and disability in non-monetary terms** ......................... 14  
   2.2 **CBR STRATEGIES FOR POVERTY REDUCTION** ................................................................. 14  
   2.3 **SUMMARY OF CBR STRATEGIES FOR POVERTY REDUCTION** .................................... 18  
3. **CASE STUDIES** .............................................................................................................................. 20  
   3.1 **IRAN** ......................................................................................................................................... 20  
   3.1.1 **Background** ....................................................................................................................... 20  
   3.1.2 **Socioeconomic status of people with disabilities** .............................................................. 20  
   3.1.3 **History and background of CBR in the country** ................................................................ 23  
   3.1.4 **The association of people with disabilities in the country** .................................................. 30  
   3.1.5 **The CBR governance** ......................................................................................................... 33  
   3.1.6 **CBR services for people with disabilities** ......................................................................... 37  
   3.1.7 **Best practice** ...................................................................................................................... 40  
   3.1.8 **The Way forward** .............................................................................................................. 44  
   3.2 **MALAYSIA** .............................................................................................................................. 45  
   3.2.1 **Background** ....................................................................................................................... 45  
   3.2.2 **Socioeconomic status of people with disabilities** .............................................................. 46  
   3.2.3 **History and background of CBR in the country** ................................................................ 51  
   3.2.4 **The association of people with disabilities in the country** .................................................. 52  
   3.2.5 **The CBR governance** ......................................................................................................... 53  
   3.2.6 **CBR services for people with disabilities** ......................................................................... 56  
   3.2.7 **Best practice** ...................................................................................................................... 57  
   3.2.8 **The Way forward** .............................................................................................................. 66  
3.3 **INDONESIA** ............................................................................................................................... 68  
   3.3.1 **Background** ....................................................................................................................... 68
3.3.2 Socioeconomic status of people with disabilities ........................................ 69
3.3.3 History and background of CBR in the country ........................................ 74
3.3.4 The association of people with disabilities in the country .......................... 78
3.3.5 The CBR governance ................................................................................. 81
3.3.6 CBR services for people with disabilities ................................................ 87
3.3.7 Best practice ................................................................................................. 99
3.3.8 The way forward .......................................................................................... 101

4. CROSS CUTTING RECOMMENDATIONS ......................................................... 103
   4.1 CBR NATIONAL POLICY .......................................................................... 103
   4.2 THE ASSOCIATION OF PEOPLE WITH DISABILITIES IN THE COUNTRY .... 104
   4.3 CBR SERVICES FOR PEOPLE WITH DISABILITIES ................................. 104

BIBLIOGRAPHY .................................................................................................. 107
List of Figures

Figure 1: Disability Prevalence Rates ................................................................. 9
Figure 2: Disability Prevalence Rates in some Countries .............................. 10
Figure 3: High Income OIC Member Countries and YLD .............................. 11
Figure 4: Upper-Middle Income OIC Member Countries and YLD ............ 12
Figure 5: Lower-Middle Income OIC Countries and YLD .............................. 12
Figure 6: Low Income OIC Member Countries and YLD ............................. 13
Figure 7: The Relationship between OIC Countries and YLD based on Monetary term ... 13
Figure 8: The Relationship between HDI and YLD in OIC Countries .......... 14
Figure 9: CBR Programs in OIC Member Countries ...................................... 15
Figure 10: The Relationship between the Components of CBR Matrix ....... 19
Figure 11: Percentage of Male and Female among People with Disabilities .... 21
Figure 12: The Level of Education .................................................................... 21
Figure 13: The Level of Employment ................................................................. 22
Figure 14: The Level of Occupation ................................................................. 23
Figure 15: Identified People with Disabilities through CBR Programs ........ 26
Figure 16: The Number of Rural Areas Covered by CBR Programs ........... 26
Figure 17: CBR Structure in Iran ...................................................................... 36
Figure 18: Population of People with Disabilities in Indonesia ................... 70
Figure 19: The Category of Disabilities ............................................................... 70
Figure 20: Disability Prevalence Based on Age ............................................... 71
Figure 21: People with Disabilities who Attending Schools ......................... 72
Figure 22: Education Levels of People with Disabilities ............................... 72
Figure 23: Employment of People with Disabilities ....................................... 73
Figure 24: Sectors of Employment of People with Disabilities ..................... 73
Figure 25: Sectors of Employment of People with Disabilities in 2013 ........ 74
Figure 26: Map of CBR Projects Sites in Indonesia ........................................ 87
List of Tables

Table 1: CBR Matrix ...............................................................................................................4
Table 2: Methodology and Framework for Examining CBR Strategies for Reduction ........................................................................................................8
Table 3: CBR Programs in OIC Countries ........................................................................17
Table 4: Types of Disabilities ............................................................................................25
Table 5: The Number of CBR Programs and the Population of People with Disabilities in Each Province ........................................................................27
Table 6: The Number of CBR’s Facilitators NGOs and Self-help groups in Each province ........................................................................................................33
Table 7: CBR Programs’ Best Practices ............................................................................38
Table 8: Types of Disabilities ............................................................................................46
Table 9: The Number of Enrolment of Students with Learning Disabilities in School ........................................................................................................47
Table 10: Employment Benefits for People with Disabilities and their Employers by Various Governmental Agencies .....................................................................48
Table 11: The Number of People with Disabilities Joining the Open Employment with Support of Job Coaches ........................................................................49
Table 12: The Numbers of CBR, People with Disabilities, Supervisors, and Staffs........55
Table 13: The Number of People with Disabilities who were Supported by CBR into Employment from 2012 to 2014 ........................................................................61
Abbreviations

CBR   Community based rehabilitation
DPOs  Disabled People Organizations
IDDC  International Disability and Development Consortium
GOs   Governmental Organizations
NGOs  Non Governmental Organizations
OIC   Organization of Islamic Cooperation
SHGs  Self Help Groups
UN    United Nations
UNDP  United Nations Development Program
YLD   Years lived with Disabilities
WHO   World Health Organization
WHO/DAR  World Health Organization’s Disability and Rehabilitation
Executive Summary

This study presents research findings on the best-known practices of community-based rehabilitation (CBR) for the reduction of poverty of people with disabilities in OIC Member States. CBR can be considered as a tool for social change and as a method of reducing poverty in OIC Member States. The five domains of the CBR matrix considered in this study are:

1. Health
2. Education
3. Livelihood
4. Social
5. Empowerment

The matrix can be used as a planning tool to implement CBR activities in OIC Member States. The five domains of the CBR matrix may be considered as indicators of poverty and disability.

Case Studies

This study presents three case studies among OIC Member States to identify the best CBR practices for the reduction of poverty and to raise awareness for policy makers in the COMCEC Member Countries. The key findings of the case studies were:

1. Iran- Iran became one of the leading countries in the implementation of CBR programs in the Asia Pacific region at the national level. The government has recognized the need for the reduction of poverty amongst people with disabilities through CBR programs. CBR programs have been implemented in all thirty-one Iranian provinces. There were some challenges for the development and implementation of CBR programs in Iran. Human resources and funding for CBR activities were the major challenges. Due to lack of adequate trained personnel and limited governmental funding, CBR programs were assigned to NGOs in 2008 but the monitoring of CBR programs still is a task of Iranian Welfare Organization. By implementing CBR programs through NGOs, CBR programs became much more effective than before. The best practices of CBR programs in Iran aimed towards the reduction of poverty amongst people with disabilities include: raising public awareness, educating the families, creating income generation activities through the ‘master-trainee’ approach, creating self-help groups, establishing rural council Funds, and increasing accessibility and mobility.

2. Malaysia- The CBR programs in Malaysia have developed over the last three decades under the supervision of the Department of Social Welfare in collaboration with communities and other agencies such as the Ministry of Health, the Ministry of Education and the Labour Department. CBR is a national program that was implemented through three models: Home Based, Centre Based and Centre-home Based. The Centre based model is becoming the more common methods for the implementation of CBR activities. Since the centers have been organized as a fixed training program for the participants,
the systemic evaluations of programs is possible. The best practices of CBR programs in Malaysia that aim towards the reduction of poverty amongst people with disabilities include: Supported Employment, Employment Transition Program, CBR Economic Empowerment Project, and Self-Advocacy Program. By initiating such programs, the number of people with disabilities who were supported by CBR to gain employment increased remarkably from 2012 to 2014. The development and implementation of such programs require a strategic collaboration between government ministries and agencies, community units, and community based organizations.

3. Indonesia- CBR in Indonesia has been operating for more than 25 years. CBR was acknowledged as an effective approach to solving problems associated with disability and as a strategy to reduce poverty amongst people with disabilities. However, despite the rapid growth in the implementation of CBR, the programs did not have a high rate of success. Therefore, persistent efforts were required to develop CBR field programs, particularly those related to the reduction of poverty amongst people with disabilities. There were several challenges to the development and implementation of CBR programs in Indonesia. Firstly, the majority of CBR programs implemented were based on projects initiated separately by GOs, NGOs and DPOs. As individual projects, there were limitations in time, budget and resources, all of which affected the sustainability of the CBR programs. Secondly, there was a lack of coordination among CBR initiators by GOs, NGOs and DPOs as well. However, recently there have been efforts to promote CBR, from project based oriented CBR to national CBR program. That meant the government had committed to developing a national CBR Action program and allocating sufficient budget. Those needed closely cooperation and coordination among all stakeholders including with NGOs, DPOs and community as well. In the past, the role of people with disabilities and their organizations (DPOs) majorly focused on influencing change in public policy, but recently their role has increased in promoting and implementing CBR. The best practices of CBR programs in Indonesia aimed towards the reduction of poverty amongst people with disabilities include: early detection, stimulation and intervention, primary rehabilitation therapy, family based care, self-employment and skills development, CBR in disaster response, self-help groups and disabled people organizations.

Despite the differences in the implementation of CBR programs between Member States, this study has identified the best practices and cross cutting recommendations that have been specified according to the three key areas of CBR programs:

- CBR as a national program
- The association of people with disabilities in the country
- CBR services for people with disabilities
CBR as a National Program

Best Practice

Several OIC Member States have recognized CBR programs as a strategy for the reduction of poverty among people with disabilities. From 57 OIC Member Countries, 30 OIC countries have implemented CBR programs. In Upper-Middle Income OIC Member Countries, such as Iran and Malaysia, CBR is considered a national policy. In Lower-Middle Income OIC Countries, such as Indonesia, CBR has not yet become a national program. In such countries, the implementation of CBR is majorly initiated by NGOs or DPOs; CBR has not been coordinated and managed by the government. It may be because Indonesia began a process of quick government decentralization in 1999 from a formerly strong centralized government structure. To guarantee the implementation of CBR programs in rural areas, national CBR programs in collaboration with NGOs has been found to be the best practice for the reduction of poverty among people with disabilities.

Cross Cutting Recommendations

CBR must be identified as a national program

CBR has been recognized as a strategy for community development to reduce poverty. Only 30 OIC countries from 57 OIC Member Countries have CBR programs. By considering the structure of government, it is recommended that the other 27 Member States adopt CBR programs to ensure that governments include persons with disabilities in mainstream community development programs and poverty-reduction schemes. Based on our findings, human resources and funding for CBR activities were the major challenges. Due to the lack of adequately trained personnel and limited governmental funding in low income Member States, it is recommended that Member States consider the monitoring of CBR programs as part of their national policy objectives but allow NGOs and DPOs to implement CBR activities. Such a system has been found much more effective than the implementation of CBR activities solely by government agencies or by NGOs and DPOs.

CBR programs and activities for the reduction of poverty amongst people with disabilities should be integrated into existing programs in the community

Due to the limited funding available for CBR activities, CBR programs and activities for the reduction of poverty among people with disabilities should be integrated into existing programs in the community or existing governmental services. CBR can become more effective as part of poverty alleviation programs. The inclusion of CBR programs into existing programs or services must be considered as part of the national action plan. The inclusive education may provide a good example of how CBR program could be integrated in the existing services.

The role of government in developing and implementing CBR must be very clearly formulated
Different government ministries and agencies within Member States are responsible to develop a national action plan against poverty and social exclusion. The involvement of different ministries and organizations is crucial to the empowerment of people with disabilities for the reduction of poverty. General coordination between ministries and NGOs is required. It is recommended that the implementation of CBR be coordinated and managed by the government.

Standards for measuring disabilities

As the measure of disability is often not standardized in developing countries, there is a need for standards for the purpose of measuring disability. Member States are responsible for applying standards and assessments for measuring disabilities. The International Classification of Functioning, Disability, and Health (ICF), which developed and endorsed by the 54th World Health Assembly in May 2001, is a most useful unifying framework for common, worldwide accepted definitions of disability and rehabilitation. The aim of the ICF is to provide a unified and standardized language for describing and classifying health domains and health-related states and hence to provide a common framework for health outcome measurement. ICF is the world standard for conceptualizing and classifying functioning and disability. The WHO’s approval of the ICF may guide Member States in their future work for the purpose of measuring disability.

The Association of People with Disabilities in the Country

Best Practice

The involvement of NGOs and associations of people with disabilities in CBR programs is often the best practice in the implementation of CBR activities. NGOs are expected to raise their own funds. NGOs play a vital role in social mobilization at the community level. They allow communities to respond to people with disabilities’ needs. NGOs have played key roles in advocacy, such as pushing for better services in the health and education sectors. In OIC Member Countries, different types of associations of people with disabilities may participate in CBR programs. These include national associations, charitable organizations, non-governmental organization, and self-help groups.

In some countries, such as Indonesia, the role of associations of people with disabilities has played an important role in the implementation of CBR programs and is considered an effective strategy in the inclusion people with disabilities in their societies.

Cross Cutting Recommendations

Self-help groups

Self-help groups (SHGs) have distinct purposes and are formed by people with a common problem or situation. These self-help groups consist of people with disabilities alongside their families and volunteers. The specific objectives are the
development of business skills through the exchange of experience and information to create credit fund microfinance, and the development of savings among target groups. The outcome of the creation of self-help groups in CBR programs includes the social and economic empowerment of people with disabilities and their families.

Training NGOs

This study has been aimed at producing clear examples of the roles of NGOs’ workers and volunteers in the implementation of CBR programs. Based on these findings, it is recommended that Member States consider the training of NGO workers as part of their national policy objectives. Investment for one to two weeks of training from Member States is needed to ensure efficiency in the implementation of CBR activities.

CBR Services for People with Disabilities

Best Practice

The CBR matrix develops a new conceptual framework for the reduction of poverty through CBR programs. The matrix involves five key components including health, education, livelihood, social and empowerment. It provides an evaluation framework for the analysis and assessment of poverty. Member States must aim to address the reduction of poverty through the implementation of CBR matrix components. This study can contribute to the production of new strategies for the reduction of poverty through CBR programs. It demonstrates the importance of expanding the basic capabilities of people with disabilities for reducing their poverty, rather than solely focusing on income generation activities.

Cross Cutting Recommendations

Access to health care for people with disabilities

People with disabilities experience poorer health and face more challenges to access health services. Member States must increase mechanisms to facilitate the inclusion of persons with disability in ongoing health services, disease prevention, and health promotion programs through identifying barriers and methods of removing them, and providing collaboration with different government ministries and agencies.

Building inclusive education systems

Education is a lifetime learning process. People with disabilities experience the lack of adequate education at a higher rate than people without disabilities. Member States must address major barriers to the implementation of inclusive education policies and commit to establishing a more inclusive education systems. As inclusion requires the placement of children with disabilities in the regular school systems, reforms are required in the education system in various areas, including the creation of positive attitudes, the preparation of the schools for necessary changes, encouraging parents to send their children with disabilities to school, supporting children with disabilities to attend school, and training teachers and school staff.
**Enhancing Livelihood for people with disabilities**

Member States can promote the livelihood of people with disabilities and their families through CBR programs. CBR activities help improve persons with disabilities’ economic and social situations through providing opportunities for skills development, self-employment, wage employment, financial services, and social protection.

**Improving social skills for people with disabilities**

Member States must support programs and activities that aim to enable the participation of people with disabilities in their families and community life. CBR programs are effective in helping people with disabilities improve their social skills and promote positive images of themselves in the community through working across seven key areas: personal assistance, relationships, marriage and family, culture and arts, recreation, leisure and sport, and justice.

**Promoting empowerment of people with disabilities in achieving poverty eradication**

Member states must facilitate the integration of people with disability and increase their accessibility to services. CBR programs can facilitate the empowerment process by raising awareness, building skills, and providing opportunities for participation through working across five key areas: advocacy and communication, community mobilization, political participation, self-help groups, and disabled people organizations.
Introduction

Poverty alleviation occupies a significant place in the agenda of the COMCEC as nearly 350 million people in the OIC Region live under US$1.25 a day (COMCEC poverty Outlook 2014). A special focus on multidimensional poverty in the OIC Region is provided by COMCEC poverty Outlook 2014.¹

Disability is viewed to be significantly associated with greater multidimensional poverty in the majority of developing countries (Mitra, Posarac, Vick, 2013). There exists a dynamic relationship between disability and poverty (Eide & Ingstad, 2011; Mitra et al, 2011). In literature regarding international development, poverty and disability have been recognized as part of a “vicious circle”; poverty is both a cause and result of disability. Disability increases the possibility of poverty and poverty raises the potential risk of disability. There is a much lower chance for people with disabilities to find employment, women with disabilities are much more exposed to physical violence and sexual abuse, and children with disabilities are much less likely to be literate and are at a higher risk of malnourishment and early death. On the other hand, lack of proper nutrition, dangerous employment conditions, decreased access to education, bad health care, transportation, communication, employment, war and conflict, and natural disasters all increase the potential chance of disability (DFID, 2000; UN, 2011).²

The Millennium Development Goals (MDGs) are a UN program for the reduction of poverty and promoting human development. Despite this, disability was not explicitly included in the MDGs (Yeo & Moore, 2003; Eide & Ingstad, 2011). The major reason for this omission is that “people with disabilities themselves are not empowered enough” (Eide & Ingstad, 2011).

The international development goals are unlikely to be fulfilled unless the rights and needs of people with disabilities are taken into consideration (DFID, 2000; WHO & World Bank, 2011; ILO, 2014). Detailed steps are required to guarantee that people with disabilities are able to fully participate in the development process, and claim their rights as full and equal members of society (DFID, 2000). Therefore, an integrated method is required, connecting poverty and disability with empowerment tactics and changes in attitudes.

In response to the inadequacy of financial and professional services, community-based rehabilitation emerged in developing countries as an effective method of providing rehabilitation services to people with disabilities (Lysack & Kaufert, 1994; Peat, 1998; Boyce, 2000). CBR can be considered as a tool for social change and to fight a war on poverty (WHO/DAR & IAARF, 2002; Chatterjee et al, 2009; Shrestha & Deepak, 2009).³

³ibid
Based on multidimensional poverty concepts, this study aims to identify the best practices for reducing poverty within CBR programs in some COMCEC Member Countries. This study raises awareness for the policy makers towards policy recommendations.

The policy recommendations will be developed under the comparative analysis of CBR programs among:

- Iran,
- Malaysia,
- Indonesia.

The main objectives of the study are:

1. Raising awareness for policy makers in COMCEC Member Countries towards policy recommendations on reducing people with disabilities’ poverty;
2. Identify the best practices for reducing poverty within CBR programs;
3. Enhancing the understanding of CBR managers and workers regarding CBR activities toward the alleviating poverty.

In the CBR Matrix, the roles of CBR programs in poverty reduction are categorized through five key components - health, education, livelihood, social, and empowerment (WHO, UNESCO, ILO, & IDDC, 2010).

This report is structured as follows:

**Scope** - Setting out the key concepts and definitions CBR programs to provide the conceptual and policy framework for the rest of the report. The methodology used to carry out the research is also set out

**Overview of CBR programs in OIC Member States** - Reporting on the use of CBR programs in OIC member countries

**Case Studies** - Reporting on the research carried out on the CBR strategies for the reduction of poverty in three OIC Member States and our recommendations for those countries.

**Next Steps** - Providing a conclusion and cross cutting recommendations that could be considered by all OIC Member States.

To explain the role of CBR in the reduction of poverty in OIC countries, Chapter 1 reviews CBR and its matrix, and explains the framework for the examination of CBR strategies. Chapter 2 overviews the CBR programs in COMCEC Member States, describes poverty and disability in the COMCEC Member States, and discusses CBR strategies for poverty reduction. Chapter 3, the findings from the case studies on the three OIC Member States along with the recommendations relevant to each of the case studies are presented. Chapter 4 concludes the report and provides suggestions for the next steps; these are cross cutting recommendations for the design of CBR strategies for the reduction of poverty amongst people with disabilities that can be considered by all Member States.
1. Conceptual Framework and Methodology

This section provides the conceptual and policy framework for the report, overviews community-based rehabilitation concepts and the link between CBR and poverty reduction policies. We conclude this section by describing the methodology and framework used for the study, based on the descriptions provided and the link between policies.

First, relevant literature, publications and studies will be reviewed. Second, some key informants will be interviewed. Third, based on the literature and the interviews, a framework will be developed in order to assess the main activities of CBR for poverty reduction. Fourth, based on the proposed framework, the stakeholders of three case studies of COMCEC member countries (Iran, Malaysia, Indonesia) will be interviewed to discuss the key programs and policies to gather evidence for the best practices and strategies for poverty reduction. Finally, the common themes for the best practices and strategies for poverty reduction will be identified across the three countries.

1.1 Overview of Community-based Rehabilitation

Nearly 80% of people with disabilities live in developing countries (UN, 2011). Only 2% of children with disabilities in these countries receive any form of education or rehabilitation (UN, 2011, WHO/ World Bank, 2011). A variety of rehabilitation services have been implemented globally to respond to the needs of over one billion people with disabilities in the world today.

According to the literature, the four recognized models for rehabilitation service delivery are the biomedical model, independent living, community-based rehabilitation, and client-centered rehabilitation (McColl et al., 1997). Disability is viewed as a problem at the level of the individual, and defines in terms of impairments in biomedical model. Impairments are connected with a range of medical needs for people with disabilities, therefore expertise is needed to identify and respond to these needs (Bickenbach, 1993). The model of rehabilitation services depends upon “trained professionals and well-equipped facilities” (McColl et al., 1997, p. 511).

Independent living and client-centered rehabilitation arose in developed countries. The independent living model emerged in response to a need to remove social and environmental barriers to living independently, for working-age people with disabilities in the United States in the early 1970s (Batavia & McKnew, 1991; Lysack & Kaufert, 1994). The independent living model aimed to ensure people with disabilities had access to housing, health care, transportation, employment, and education, and could be mobility. These aims were achieved through self-help and peer support, research and service development, and referral and advocacy (McColl et al., 1997).

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4 ibid
5 ibid
In client-centered rehabilitation, “the clients know what they want from therapy and what they need” (Law, 1998, p. 92). In other words, they are the experts on their service needs, and can make choices and have control over all available service delivery (McColl et al., 1997). Rehabilitation therapists are viewed as facilitators who create an environment to assist change, enhance self-esteem, and promote independence and empowerment of people with disabilities (Law, 1998; McColl et al., 1997).

In 1978 at the Alma-Alta conference the World Health Organization introduced Community-based rehabilitation. CBR is considered as a community development model to empower people with disabilities within their communities (Peat, 1998; Mitchell, 1999; Kendall et al., 2000). CBR has been recognized as a strategy “for equalization of opportunities and social integration of all people with disabilities” (International Labour Organization, United Nations, Educational Scientific and Cultural Organization, United Nations Children’s Funds, World Health Organization, 2004, p. 2). CBR arose in developing countries in response to the lack of financial resources and experts (Lysack & Kaufert, 1994).

Disability is viewed as the concern of the whole community in CBR, rather than as an individual matter. One of CBR’s principles is that improving the quality of life in a limited way for all people with disabilities is better than significantly promoting the quality of life for a few people (McColl, Gerein, & Valentine, 1997). In order to make services accessible to more people with disabilities and their families in the most cost-effective and culturally appropriate way, interventions have changed from institutions to homes and communities in CBR programs (Peat, 1998; Boyce, 2000).

However, CBR implications are different throughout the world due to the diversity of cultures and communities. Despite that fact, there are some common features of CBR programs. They are intended to change attitudes in the community toward the acceptance of disability, to promote the social integration of people with disabilities, to provide equal opportunities in education and employment, to protect the rights of people with disabilities and to empower them (Miles, 1996; McColl et al., 1997; Peat, 1998; Thomas & Thomas, 1999; Mitchell, 1999; Boyce, 2000; Kendall et al., 2000; Turmusani et al., 2002). CBR also aspires to fight against poverty by providing a wider range of vocational skill development and income-generating activities (WHO/DAR, & IAARF, 2002). Consequently, CBR not only has been recognized as a community development model for empowering people with disabilities and their communities, but is considered to be a strategy for reducing poverty as well (WHO, 2003).

1.2 The Role of CBR in Poverty Reduction

1.2.1 Community-based Rehabilitation and Poverty Reduction

The World Health Organization’s Disability and Rehabilitation (WHO/DAR) team in September 1995, planned an international meeting in Manila (Philippines) on the possibility of implementing CBR in poor urban communities and slums. The
strategies defined in Manila were implemented through the collaboration between WHO/DAR and IAARF from 1996 until 2001. During that time, twelve CBR pilot projects in various parts of the world were set up. In October 2001, representatives of these pilot projects gathered for a final meeting in Bologna (Italy) to prepare a report on the implementation of CBR in urban slum and low-income areas. Several findings were mentioned in their final report.

CBR programs -

are part of community development and are a tool for social change through activities such as the fight against poverty and illiteracy, raising awareness about other health issues, child labour, promotion of human rights, etc; can play an important role in providing a wider range of income-generating activities as well; can enhance awareness about existing laws related to the employment of persons with disabilities; can also provide training and encourage self-employment by providing information about obtaining loans, managing funds, etc. (WHO/DAR, & IAARF, 2002).

The WHO’s review of CBR in 2002 emphasized the importance of focusing on the persistent poverty that affects the majority of people with disabilities. The review also identified an urgent need for CBR programs to ensure that governments include people with disabilities in community development and poverty-reduction programs.

Accordingly, CBR programs have important roles in reducing poverty through strategies within community development, such as providing education, encouraging employment, and promoting the participation of people with disabilities (especially the women) in community activities (ILO, UNESCO, WHO, 2004). But the skills of CBR workers and their managers are not enough to fulfill their roles. Therefore, this joint paper calls “for action against poverty that affects many people with disabilities” (ILO, UNESCO, WHO, 2004).

From 2005 to 2010, CBR stakeholders, WHO, ILO, UNESCO, the International Disability and Development Consortium (IDDC), 180 individuals and almost 300 organizations, generally from low-income countries around the world, drafted the CBR matrix, which provided the scope and structure for the guidelines.

The main objectives of the CBR guidelines are

To provide guidance on how to develop and strengthen CBR programs in line with the CBR Joint Position Paper and the Convention on the Rights of Persons with Disabilities.

To promote CBR as a strategy for community-based inclusive development to assist in the mainstreaming of disability in development initiatives, particularly to reduce poverty.
1.3 CBR Matrix

The CBR matrix was developed to provide a common framework for CBR programs and a new framework for action, as well as practical suggestions for implementation. It was influenced by the UN Convention on the Rights of Persons with Disabilities. The matrix involves five key components – health, education, livelihood, social and empowerment components. Each component includes five elements (WHO, 2010). As indicated by the table below.

Table 1: CBR Matrix

<table>
<thead>
<tr>
<th>Health</th>
<th>Education</th>
<th>Livelihood</th>
<th>Social</th>
<th>Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotion</td>
<td>Early childhood Training</td>
<td>Social development</td>
<td>Personal assistance</td>
<td>Advocacy &amp; communication</td>
</tr>
<tr>
<td>Prevention</td>
<td>Primary</td>
<td>Self-employment</td>
<td>Relationships</td>
<td>Community</td>
</tr>
<tr>
<td>Medical Care</td>
<td>Secondary and higher</td>
<td>Wage employment</td>
<td>Culture &amp; Arts</td>
<td>Political</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Non-formal</td>
<td>Financial services</td>
<td>Recreation, leisure &amp; sports</td>
<td>Self-help groups</td>
</tr>
<tr>
<td>Assistive Device</td>
<td>Life-long learning</td>
<td>Social protection</td>
<td>Justice</td>
<td>Disabled people’s organizations</td>
</tr>
</tbody>
</table>

It is not necessary for CBR programs to implement every component and element of the CBR matrix. The matrix has been planned to select the programs and activities that best meet the communities’ cultures and their priorities and needs (WHO, 2010).

The CBR Matrix focuses on inclusive health, education, livelihood and society to empower people with disabilities in order to achieve their basic human rights, to promote their quality of life, and to alleviate their poverty.

1.3.1 Health

The first component of the CBR matrix is health. It is a multidimensional concept that is influenced by many factors such as social, economics, culture, etc. People with disabilities experience more challenges than people without disabilities to achieve their basic health needs and to access to health services.

There has been increasing literature reporting the links between poverty and health. Some studies show that there is a relationship between poverty and ill health conditions (Kaler 2008; Susser et al. 2008; Rauh et al. 2008). This correlation exists between poverty and lack of awareness, poverty and access to information, and poverty and health conditions (Cutler et al. 2006). Studies show that poverty causes less or lack of access to health services for people with disabilities (Gwatkin et al. 2007; Peters et al. 2008; Banerjee et al. 2004; Strauss and Thomas, 2008).

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8 CBR Matrix , WHO, 2010
Not only does poverty create ill health conditions and increases the risk of disability, but also worst health conditions may increase the risk of poverty by reducing ability to work and decreasing participation and job opportunities (Currie & Madrian 1999; Gertler & Gruber, 2002; van Doorslaer et al. 2006).

CBR programs aim to help people with disabilities to achieve their optimal level of health, through working across five key areas of: health promotion, health prevention, medical care, rehabilitation and assistive devices.

CBR works closely with the primary health care to ensure that people with disabilities and their family members are included in health promotion, health prevention, medical care, and rehabilitation programs. CBR also needs to facilitate people with disabilities’ access to health services and assistive devices; to improve their knowledge about their health; to ensure they do not discriminate on the basis of disability and other factors such as gender; and, to ensure their active participation in their family and community life.

1.3.2 Education

Education is the second component of the CBR matrix. Education is a lifelong learning process, which begins at birth and continues throughout adult life. Lack of adequate education increases the risk of poverty, and poverty is the main cause of inclusive education.

In low-income countries, around 90% of children with disabilities do not attend school (United Nations Educational, Scientific and Cultural Organization (UNESCO). A study of 20 developing countries reveals the relationship between school attendance and having a disability (UNICEF, 2009). Analysis of the World Health Survey (WHS) data in some developing countries such as Bangladesh, Brazil, Dominican Republic, Ghana, Lao, Malawi, Mexico, Pakistan, Paraguay, Philippines, Zimbabwe, shows individuals with disabilities have lower rates of primary school completion and fewer mean years of education completed, and higher rates of multidimensional poverty (Mitra, Posarac, & Vick, 2011).

The Convention on the Rights of Persons with Disabilities endorses the right to “inclusive education system at all levels” (Article 24, para. 1). Inclusive education also is one of the Millennium Development Goals.

CBR works closely with the ministry of education toward inclusive education and lifelong learning for people with disabilities. The elements of education component of CBR matrix are early childhood care and education, primary education, secondary and higher education, non-formal education, and lifelong learning.

1.3.3 Livelihood

Livelihood is the third component of the CBR matrix. Disability may restrict the ability to earn an income or may cause a lower income (Sen, 1999). Disability or illness reduce one’s ability to earn an income, while also making it harder to convert income into capability since a more disabled, or a more seriously ill person, may need more income for aid and treatment to get the same functioning (Sen, 1999, p.74).
Disability may also restrict the type and amount of work a person can do (Contreras et al. 2006; Meyer and Mok 2008),

There are a few studies on the socioeconomic status of people with disabilities. A study of 13 developing countries by Filmer (2008) shows that people with disabilities are in higher risk of being in poverty in the majority of countries. A study of 21 high income and upper middle-income countries also indicates that there is a higher poverty rate among working-age people with disabilities than without disabilities (the Organization for Economic Co-operation and Development (OECD), 2009).

Extensive studies demonstrate that families with members with disabilities have fewer properties than other families (Eide and Loeb, 2006; World Bank, 2009; Eide & Kamaleri, 2009; Palmer et al. 2010; Trani &Loeb, 2010). Based on these studies, people with disabilities and their families are often economically worse off in terms of the household level.

CBR programs can help people with disabilities and their families to improve their economic and social situations through providing opportunities for skills development, self-employment, wage employment, financial services, and social protection. CBR helps them access resources to train and work at community level.

1.3.4 Social

Social is the fourth component of CBR matrix. Individuals' social positions are influenced by the different social responsibilities and activities they have in the community. As a result of the stigma associated with disability, people with disabilities have fewer opportunities to participate in social activities than people without disabilities. Several studies show the lower social status of persons with disabilities (Mete, 2008; UNICEF, 2009).

Disability is understood as a social construct that is largely associated with social oppression and barriers in the social model of disability (Oliver, 1990; Williams, 2001). In this view, society and its institutions through legislation, and social attitudes and barriers are thought to create disability. Therefore, society’s inability to provide the necessary services may potentially exclude certain people, thus, disabling them.

CBR can support people with disabilities to achieve their optimal level of social life through addressing social and environment challenges and removing barriers, improving their social skills, promoting positive images of themselves in the community, and protecting them against stigma. Generally speaking, CBR programs aim to enable people with disabilities to participate in family and community life, through working across five key areas: personal assistance; relationships, marriage and family; culture and arts; recreation, leisure and sport; and, justice.

1.3.5 Empowerment

Empowerment is the last component of the CBR matrix. Empowerment is a development issue that supports people with disabilities in order to achieve their rights and needs. It is a process that facilitates the inclusion and participation of people with disabilities, their family members, and communities in all development
and decision-making processes. Education and disabled people’s organizations (DPOs) act as key elements in empowering people with disabilities through building skills, and providing opportunities for participation (Eide & Ingstad, p.8) (UN Enable, 2007).

The majority of CBR programs are mostly medical model. Disability within the medical approach is defined as a problem at the level of the individual, and viewed as needing correction, and trained professionals and well-equipped facilities (McColl & Bickenbach, 1998). (McLean & Williamson, 2007; McColl et al., 1997, p. 511). Medical model gives considerable power to medical professionals, and disempowers people with disabilities (Oliver, 1990, 1999; Williams, 2001). But the CBR principles and guideline encourage moving CBR programs from solely medical model to a community-based inclusive development model to empower people with disabilities toward more participation and more decision-making to control over their environment.

CBR programs can facilitate empowerment process by raising awareness, building skills, and providing opportunities for participation. In other words, CBR programs empower people with disabilities through working across five key areas: advocacy and communication, community mobilization, political participation, self-help groups, and disabled people organizations.

1.4 General Conclusions on Implementing CBR Strategies

The United Nations Development Programme (UNDP) works to eliminate poverty and reduce inequalities in more than 170 nations. These programs are unlikely to be achieved unless the rights and needs of people with disabilities are taken into account and ensure that people with disabilities are able to participate fully in the development process, and claim their rights as full and equal members of society. Community-based rehabilitation can be considered as a tool for reducing poverty of people with disabilities through facilitating people with disabilities’ access to health services and assistive devices; providing inclusive education and lifelong learning for people with disabilities; providing opportunities for skills development, self-employment, wage employment, financial services, and social protection; helping people with disabilities to participate in family and community life; and facilitating empowerment process by raising awareness, building skills, and providing opportunities for participation.

It is important, however, that governments closely monitor interactions between Health, Education, Livelihood, Social, and Empowerment domains of the CBR matrix in order to provide indicators on poverty and disability.

1.5 Methodology & Framework for Examine CBR Strategies

Based on the literature review described earlier, we selected a framework to assess the poverty reduction strategies reviewed in the study. The three elements of the framework are as follows:

- CBR national policy
• The association of people with disabilities in the country

• Community-based rehabilitation services for people with disabilities

Each element of the framework is explained in more detail below.

**Table 2: Methodology and Framework for Examining CBR Strategies for Poverty Reduction**

<table>
<thead>
<tr>
<th>Element</th>
<th>Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBR national policy</td>
<td>Country at a glance: GDP and per capita, population growth rate, poverty, illiteracy rate and the human development index.</td>
</tr>
<tr>
<td></td>
<td>Socioeconomic status of people with disabilities: the population of people with disabilities, their percentage in the overall population, the literacy rate of people with disability in comparison to the national literacy rate, the employment rate of people with disability, prevalence of poverty amongst people with disabilities</td>
</tr>
<tr>
<td></td>
<td>History and background of CBR in the country: rehabilitation services before the advent of CBR services, the development of CBR in the country and organizational changes</td>
</tr>
<tr>
<td></td>
<td>The CBR governance: the structure of CBR at the national level, which ministry does manage and supervise CBR? How governmental and non-governmental organizations work with CBR at national, provincial, municipal and rural levels?</td>
</tr>
<tr>
<td>The association of people with disabilities in the country</td>
<td>The involvement of NGOs and association of people with disabilities in CBR programs. Amount and types of associations for people with disabilities in the country</td>
</tr>
<tr>
<td>Community-based rehabilitation services for people with disabilities</td>
<td>How does CBR provide health, education, employment, social protection, and empowerment services for people with disabilities</td>
</tr>
<tr>
<td></td>
<td>Identifying the most successful examples of policies and their outcomes</td>
</tr>
</tbody>
</table>

We have carried out our study based on the above framework.
2. Overview of CBR Program in the COMCEC Member States

2.1 Poverty and Disability in the COMCEC Member States

COMCEC poverty Outlook 2014 provides an overview on monetary and non-monetary poverty in the world and in the OIC Member Countries. According to the outlook, almost 350 million people in the OIC countries live in poverty. Although the outlook provides detailed information on poverty, it does not include the correlation between poverty and disability. In order to properly understand the big picture of the relationship between poverty and disability in OIC countries, first this section is intended to overview disability prevalence rates in the world.

“Based on 2010 population estimates – 6.9 billion with 5.04 billion 15 years and over and 1.86 billion under 15 years – and 2004 disability prevalence estimates (World Health Survey and Global Burden of Disease) there were around 785 (15.6%) to 975 (19.4%) million persons 15 years and older living with disability. Of these, around 110 (2.2%) to 190 (3.8%) million experienced significant difficulties in functioning. Including children, over a billion people (or about 15% of the world’s population) were estimated to be living with disability” (WHO/World Bank, 2011).

According to WHO/World Bank World Report on Disability in 2011, the percent with moderate or severe disability in the world is %15.3, in High Income Countries %15.4, Africa% 15.3, Americas %14.1, South East Asia %16.0, European %16.4, Eastern Mediterranean %14.0, Western Pacific %15.0. (See Figure 1)

Figure 1: Disability Prevalence Rates

The measure of disability is often not standardized in developing countries. The lower disability prevalence may be because prevalence rates refer only to persons with severe disability.

Most developing countries report disability prevalence rates below those reported in many developed countries (WHO/World Bank, 2011, Mont, Cheshire, 2013). For

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9 adopted from Mitra, Posarac, Vick, 2013
example, census rate of disability in United States is 19.4, or in Canada is 18.5, but it is lower in Brazil (14.5), and much lower in Ethiopia (3.8), Chile (2.2), and India (2.1). (See Figure 2).

**Figure 2: Disability Prevalence Rates in some Countries**

![Bar chart showing disability prevalence rates in some countries](image)

As the figure shows “the average prevalence of disability from country surveys and censuses, calculated from population-weighted average prevalence, are much lower in low-income and middle-income countries than in high-income countries, and much lower than prevalence derived from the *World Health Survey* or *Global Burden of Disease*. This probably reflects the fact that most developing countries tend to focus on impairment questions in their surveys, while some developed country surveys are more concerned with broader areas of participation and the need for services” (Mitra, Posarac, Vick, 2011).

According to *COMCEC Poverty Outlook 2014*, the total population of the OIC Member Countries accounts for more than the one-fifth of the world’s total population. The COMCEC population is 1.2 billion, so it can be expected that over 210 million have moderate or severe disability.

The aim of this section is to describe the relationship between poverty and disability in monetary and non-monetary terms. Firstly, this analysis will be made for the OIC region in respect to the income categories, namely high, upper-middle, lower-middle and low-income categories. Then, multidimensional poverty situation in these countries will be analyzed with a Human Development Categories (very high, high, middle, low) in relation to Years Lived with Disabilities (YLDs).

Although there is no agreed international standard to measure disability, the prevalence of disability in the world is based of two large data sources: the WHO *World Health Survey* of 2002–2004, and the WHO *Global Burden of Disease* study, 2004 update. This study uses the disability prevalence rates data from the *World report on disability 2011*, which obtained from the *World Health Survey* with the estimates of YLD in 2004 from the *Global Burden of Disease* study (World Health Organization (WHO)/ World Bank, 2011). “YLD have been calculated for the years of full health lost due to disability from incident cases of the disease or injury. The YLD uses a set of core health domains including mobility, dexterity, affect, pain, cognition, vision, and hearing” (WHO/World Bank, 2011). In this research, the

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10 ibid
disability measure is calculated by the World Health Survey in 2004, as it is the most up to date data that is available for all countries in the world.

2.1.1 The Relationship between Poverty and Disability in Monetary terms

High Income OIC Member Countries and YLD

High income refers to an income level of higher than US$12,616. The high income OIC Member Countries are Bahrain, Brunei Darussalam, Kuwait, Oman, Qatar, Saudi Arabia and United Arab Emirates. In this group of countries, the YLD average is 7.371 which is less than other OIC countries and ranges between 6.8(Kuwait) and 8.1(Saudi Arabia).

Figure 3: High Income OIC Member Countries and YLD

![Figure 3: High Income OIC Member Countries and YLD](image)

2.1.1.1 Upper-Middle Income OIC Member Countries and YLD

Upper-middle income refers to an income level that is higher than US$4,086 and lower than US$12,615. The upper-middle income OIC Member Countries are Gabon, Algeria, Libya, Tunisia, Iraq, Jordan, Lebanon, Azerbaijan, Kazakhstan, Turkmenistan, Albania, Suriname, Malaysia, Iran, Turkey and Maldives. In this group of countries YLDs ranges between 7.5(Tunisia and Turkey) and 11(Gabon), with the exception of 19.8 (Iraq). Similar to YLDs in upper-income OIC Countries, the YLDs in upper-middle OIC Countries has a regular pattern. Only Iraq shows an irregular picture in this group. In addition to the mentioned factors for disability prevalence, there are some major factors that can totally changes disability prevalence in countries, such as wars and conflicts. YLDs average in these countries is 9.437.

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**Note:**

11 based on information from YLD in 2004 from the *Global Burden of Disease* study (World Health Organization (WHO)/ World Bank, 2011), & COMCEC poverty Outlook 2014
2.1.1.2 Lower-Middle Income OIC Countries and YLD

Lower-middle income refers to an income level that is between US$1,036 and US$4,085. The lower-middle income OIC Member Countries are Cameroon, Cote d’Ivoire, Nigeria, Senegal, Egypt, Morocco, Djibouti, Mauritania, Sudan, Palestine, Syria, Yemen, Uzbekistan, Guyana, Indonesia and Pakistan. In this group of countries YLDs ranges between 8.0 (Uzbekistan) and 13.8 (Cote d’Ivoire). In the lower-middle group, YLDs average is 11.38. As indicated some major factors, such as wars, will change the prevalence of disability on the country. Therefore because of the continuous conflicts in the Middle East, the prevalence of disability in several countries are abnormally high. Although the table below shows that Syria (7.7) has the lowest rate of YLD, it can not be considered valid because the data has not been updated since the Syrian Civil War.

Figure 5: Lower-Middle Income OIC Countries and YLD

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12 ibid
13 ibid
2.1.1.3 Low Income OIC Member Countries and YLD

Low income refers to an income level that is lower than US$1,036. The low income OIC Member Countries are Uganda, Togo, Sierra-Leone, Niger, Mozambique, Mali, Guinea-Bissau, Guinea, Gambia, Chad, Burkina Faso, Benin, Somalia, Comoros, Tajikistan, Kyrgyzstan, Bangladesh and Afghanistan. In this group of countries YLDs ranges between 8.7(Tajikistan) and 15.3(Afghanistan). In the low-income group, YLDs average is 12.264.

Figure 6: Low Income OIC Member Countries and YLD

In conclusion, disability has a close relationship with poverty. In Upper Income OIC group the prevalence of disability is lower, but it increases as income levels decrease in OIC countries as shown in the table and figure below.

Figure 7: The Relationship between OIC Countries and YLD based on Monetary term

YLDs Average, in High Income OIC countries is 7.371, in Upper-middle Income is 9.437, in Lower-middle Income is 11.38, and Low-Income countries is 12.264.

14 ibid
15 ibid
2.1.2 The Relationship between Poverty and Disability in Non-monetary terms

Human Development Index

When OIC Member Countries are examined in terms of human development approach, a homogeneous composition is observed. In this context, while 3 of the OIC Member Countries (Qatar, United Arab Emirates, Brunei Darussalam) are ranked very high in the human development category, 14 countries (Saudi Arabia, Bahrain, Kuwait, Libya, Oman, Lebanon, Tunisia, Algeria, Malaysia, Turkey, Kazakhstan, Iran, Azerbaijan, Albania) are ranked high, 15 countries (Jordan, Palestine, Egypt, Syria, Iraq, Morocco, Gabon, Suriname, Maldives, Turkmenistan, Indonesia, Uzbekistan, Guyana, Kyrgyz Republic, Tajikistan) are ranked medium and 21 countries (Yemen, Comoros, Mauritania, Sudan, Djibouti, Cameroon, Nigeria, Senegal, Uganda, Benin, Togo, Cote d’Ivoire, Gambia, Mali, Guinea-Bissau, Guinea, Mozambique, Burkina Faso, Sierra Leone, Chad, Niger) are ranked low in the human development category.

If we analyze OIC Member Countries according to their human development category, it is found that YLDs in the very high human development category is averaged at 7.26, in the High Human Development the average is 8.07, in the Middle Human Development the average is 10.064, in the Low Human Development is average at 12.22.

Figure 8: The Relationship between HDI and YLD in OIC Countries

2.2 CBR Strategies for Poverty Reduction

CBR is currently implemented in over 90 countries. CBR is considered as a strategy for community-based inclusive development to assist in the mainstreaming of disability in development initiatives, and in particular, to reduce poverty. CBR strategies for poverty reduction is to support people with disability to meet their basic needs and to enhance their and their families’ quality of life by facilitating access to health, education, livelihood and social sectors, and to encourage stakeholders to facilitate the empowerment of people with disabilities and their families by promoting their inclusion and participation in development and decision-making processes.

This section is intended to review the CBR programs in OIC Member Countries in

16 ibid
two ways; one based on OIC group countries, the other based on CBR Regional Continent Network.

From 57 OIC Member Countries, 30 OIC countries have CBR programs. 8 of the 22 Arab nations in the OIC have CBR Programs, 9 of the 16 in Asian countries, 12 of the 17 African nations, 1 out of the 2 Latin American countries. OIC group countries show in red color and the countries that have CBR programs in the groups show in green color (See figure below).

**Figure 9: CBR Programs in OIC Member Countries**

Some example of different CBR programs in each nation include:

**Arab nations**- Community-based Rehabilitation (Special Education), or CBSE, is an approach to the provision of services for people with disabilities in Jordan, which developed since 1982. CBSE was developed to expand the education of deaf children by using local community resources. The Holy Land Institute for the Deaf is an example of CBSE, which has been enriched by its involvement in the development of CBR programs and outreach work. Such a program has been a valuable experience for a large number of deaf children and their families, and the local communities. After a few schools have undertaken CBSE projects, the Ministry of Education has begun to recognize that there should be more programs for children with special educational needs.

**Asian nations**- CBR programs in Afghanistan started in the 1990’s as a joint program of UN organizations. The CBR programs that were implemented were mostly by the International and National NGOs as part of the poverty reduction plan. In 2009, CBR services were available in 16 provinces out of 34, which covered more than 2500 villages and 85 Districts. More than 200 trained community rehabilitation and developmental workers and 1000 community volunteers were implementing CBR activities in the country.

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17 based on the existing CBR program in WHO data: [http://www.who.int/countries/en/](http://www.who.int/countries/en/) & COMCEC poverty Outlook 2014
**African nations** - In Uganda, the Government started planning for a community based rehabilitation program in 1989. In 1992, the Norwegian Association of the Disabled (NAD) agreed to support the Government in the implementation of CBR. The program was first piloted in the three districts of Kabale, Mbarara and Bushenyi. The CBR program was initiated in 15 sub-counties in each district, and then was developed in six more districts. The Government established management structures to facilitate the implementation of CBR programs, including: policy-making and planning, appropriate administration structures, provision of resources, decentralization, training personnel, onward referral systems and monitoring and evaluation.

**Latin American nations** - From 1986 to 1988, a pilot study of CBR, which was funded by the University of Guyana and the Canadian International Development Agency (CIDA), was carried out with children with disabilities in two rural areas of Guyana. On the basis of the pilot study experience, more CBR programs had funded by international agencies (such as the European Community and Amici di Raoul Follereau (Italy)), in collaboration with Action on Disability and Development, and the National Rehabilitation Committee of Guyana. By implementing such CBR programs, children with disabilities have better opportunities in their communities and people become more aware of issues regarding disability.
Table 3: CBR Programs in OIC Countries

<table>
<thead>
<tr>
<th>OIC Countries Groups</th>
<th>Have CBR Programs</th>
<th>Have not CBR Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arab</td>
<td>Algeria, Egypt, Jordan, Lebanon, Somalia, Tunisia, United Arab Emirates, Yemen</td>
<td>Bahrain, Comoros, Djibouti, Iraq, Kuwait, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Sudan, Syria</td>
</tr>
<tr>
<td>Asian</td>
<td>Afghanistan, Azerbaijan, Bangladesh, Brunei Darussalam, Indonesia, Iran, Malaysia, Maldives, Pakistan</td>
<td>Albania, Kazakhstan, Kyrgyzstan, Tajikistan, Turkey, Turkmenistan, Uzbekistan</td>
</tr>
<tr>
<td>Africa</td>
<td>Benin, Burkina Faso, Cameroon, Cote d’Ivoire, The Gambia, Mali, Mozambique, Nigeria, Senegal, Sierra Leone, Togo, Uganda</td>
<td>Chad, Gabon, Guinea, Guinea-Bissau, Niger</td>
</tr>
<tr>
<td>Latin American</td>
<td>Guyana</td>
<td>Suriname</td>
</tr>
</tbody>
</table>

Also CBR programs are being adopted throughout global regions. 13 OIC member countries (Afghanistan, Bangladesh, Indonesia, Iran, Jordan, Lebanon, Malaysia, Mali, Maldives, Pakistan, Palestine, United Arab Emirates, Yemen) are also members of Asia-Pacific (including Middle-East) CBR Network. The CBR Asia-Pacific Network was established in 2013 by WHO to promote CBR at the regional level and support the National CBR Network members in 36 countries. The aim of the CBR Asia-Pacific Network is to strengthen CBR regionally and globally; to mobilize and support resources and information exchange; to promote disability-inclusive development; to work in line with the United Nations Convention on the Rights of Persons with Disabilities and the Millennium Development Goals; and to promote poverty relief (http://www.cbrasiapacific.net/).

\(^{18}\) ibid
14 OIC members countries (Algeria, Benin, Burkina Faso, Cameroon, Cote d'Ivoire, Egypt, Gambia, Mozambique, Nigeria, Senegal, Sierra Leone, Somalia, Togo, Tunisia, Uganda) are also members of Africa CBR Network (CAN). CAN was established in July 2002 and it is an information & knowledge sharing network for CBR workers in Africa which was set up to support CBR initiatives through documentation of good practices. There are almost many types of CBR programs in Africa, but most CBR programs are financed by external agencies that aim to provide essential services. In Africa, 95% of people with disabilities live in poverty. The objectives of rehabilitation are limited to essential services; namely, to restore abilities or to reduce disabling effects, and provide opportunities for meaningful life.

Azerbaijan is a member of the Europe network (The International Disability and Development Consortium (IDDC)). IDDC is an international association of NGOs and disabled people's organizations (DPOs). They operate in over 100 countries around the world aiming to promote inclusive development.

2.3 Summary of CBR Strategies for Poverty Reduction

CBR programs have crucial roles in reducing poverty through providing opportunities to inclusive health, education, and livelihood for people with disabilities to achieve their optimal level of social life. According to the UN Development Program, *World Development Report 2000/01*, the main causes of poverty are lacks of opportunity, empowerment, and security (UNDP, 2002).

CBR strategies to protect people with disabilities against stigma and discrimination, and empower them to alleviate their poverty are through implementation of the components of the CBR matrix. It must be noted for reducing poverty and promoting people with disabilities’ quality of life, CBR programs have to consider as many components of CBR matrix as they interrelated (see Figure 10). All of these components are of very urgent items that should be secured to people with disabilities.

Although it is not expected that CBR programs implement every component and element of the CBR matrix, CBR stakeholders cannot satisfy the need for one of them by giving a larger amount of another one. All are of central importance and all are distinct in quality.

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Figure 10: The Relationship between the Components of CBR Matrix\textsuperscript{22}

\textsuperscript{22} WHO, 2010
3. Case Studies

3.1 Iran

3.1.1 Background

Iran has the second largest economy and population in the Middle East. In 2014, Iran’s population was approximately 80.8 million\(^{23}\) with a 1.29% population growth rate\(^ {24}\). The population is made up of 51.7% males and 49.3% females. Farsi (Persian) is the official language. Iran is the second largest supplier of natural gas and has the fourth largest oil reserves in the world. In 2014, its Gross Domestic Product (GDP) was approximately 406.3 billion USD. Iran had been in a recession for the past several years, but ever since the second quarter of 2014, its GDP growth rate has been at an average of approximately 3%.

According to HDR 2013 Statistical Centre of Iran UNDATA, Iran’s Human Development Index was at 0.742, the income per capita was 10,695 USD, and Adult Literacy Rate was at 85%\(^ {25}\). The unemployment rate is estimated at 12.2%\(^ {26}\), while unofficial sources’ estimates go up to 20%, and only 36.7% of the population is economically active.\(^ {27}\)

In 2010, nearly 500,000 (0.7%) of the Iranian population were living on less than a $1.25 per day. By raising the poverty line by 0.5 USD, it was estimated that 4%-6% of the population (over 4.5 million people) would be considered to be living in poverty.\(^ {28}\)

3.1.2 Socioeconomic Status of People with Disabilities

Over time and in different national settings, a range of different approaches has been used to address the socioeconomic status of people with disabilities. Standard indicators of individual and household wellbeing, such as education, health, labor market status, and poverty statistics were used to determine the socioeconomic status of people with disabilities.\(^ {29}\) For the purpose of this study, we will focus on the population of people with disabilities, their percentage in the overall population, the literacy and employments rates of people with disability, and the prevalence of poverty amongst people with disabilities. Then, the methods for the identification of disability and the accuracy of the population of people with disabilities will be discussed.

\(^ {24}\) http://www.ir.undp.org/content/iran/en/home/countryinfo.html
\(^ {25}\) http://www.ir.undp.org/content/iran/en/home/countryinfo.html
\(^ {26}\) HDR 2013 Statistical Centre of Iran UNDATA
\(^ {27}\) http://www.worldbank.org/en/country/iran/overview
\(^ {28}\) ibid
According to the latest census report released by Iran’s National Bureau of Statistics in 2011, the population of Iran was 75 million people. Over a million people, 1.4 percent of the population, were reported to have been diagnosed a severe disability. The number of people with disabilities living in rural areas was approximately 400,000, while 700,000 lived in urban areas. The most common disabilities that were reported were mental impairments, at 339,996 (%26 of total disabilities) reported cases, and upper limb impairments at 263,142 (%20 of total disabilities) reported cases. Lower limb impairments were the lowest reported disability at 25,615 (2% of total disabilities) cases. More men than women reported that they had a disability. 637,357 (%63) people with disabilities were male, and 380,302 (%26) were female. Data unavailable for %11.

**Figure 11: Percentage of Male and Female among People with Disabilities**

![Diagram showing the percentage of male and female among people with disabilities]

In Iran the level of education of 853,960 people with disabilities are 460,865 (%45) Illiterate, 205,985 (%20) Primary, 128,529 (%13) Secondary, 47,657 (%7) Higher, and 10,924 (%1) Highest. No data available for 163,699 (%14).

**Figure 12: The Level of Education**

![Bar chart showing the level of education]

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31 ibid
The majority of people with disability who are employed are those with upper limb impairments. The least group of people with disability who are employed are those with mental disabilities. 26% (243,028) of people with disability are included in the Iranian labor force. Of this group of people, 79% (191,982) of people with disabilities are employed and 21% (51,046) are unemployed.

74% (691,136) of people with disabilities are not included in the Iranian labor force. Of this group of people, approximately 10% (68,555) of people are students, nearly 20% (140,422) are women who stay at home, 18% (125,868) of people receive income from other sources. No data available for 52% (356,291).

Figure 13: The Level of Employment

When compared to people without disabilities, people with disabilities have a much higher rate of unemployment. For example, in the range of people between 30 to 39 years old, the unemployment rate for people with disabilities is 63.4%, while the unemployment rate for the same age group for people without disability is about 47.5%.

%4.1 of people with disability are employed in high-level occupations (lawyers, senior officials, managers and professionals). %41.4 of people with disability are employed in mid-level occupations (technicians and assistants, office staff, service staff and vendors, artisans and employees of related businesses, suppliers, processors machines and drivers, armed forces). %54.5 of people with disability are employed in low-level occupations (agriculture, forestry and fishing, workers). 10.4% of people without disabilities are employed in high-level occupations, 50.1% work in mid-level occupations and 39.5% are employed in low-level occupations. As we see in the figure below, the levels of occupation of people with disabilities is higher than people without disabilities in low-level occupations, but it is less in mid and high level occupations.

32 ibid
Overall, people with disabilities are poorer and face significant barriers to employment and education. Due to the lack of appropriate standards and indicators to measure disability in Iran, the methods for the identification of disability and the accuracy of the population of people with disabilities in Iran has been under scrutiny. In Iran, similar to other developing countries, disgrace and shame are often associated with disability. When impairment or disability is negatively portrayed, people with disabilities are subjected to negative social responses. So their parents or their care givers feel ashamed to announce that they have a family member with a disability. As said before, in Iran’s National Bureau of Statistics, only the population with a severe disability was calculated but people with mild and moderate disabilities were ignored. Taking all of this into consideration, it can be estimated that even the population with severe disabilities is higher than the reported %1.4.

3.1.3 History and Background of CBR in the Country

This part is intended first to review first rehabilitation services before the advent of CBR services, and then discuss about the development of CBR in the country and organizational changes.

3.1.3.1 Rehabilitation Services before the Advent of CBR

Similar to many countries of the world, before 1920 in Iran general attitude toward people with disabilities has been negative since a long time. Disability has been portrayed as a negative attribute, and those who live with disability have often been pitied by or even excluded from society.

Rehabilitation was a new concept that was introduced with the advent of the modern age. Until 1920, rehabilitation services for people with disabilities were not present in Iran. If there were any services for helping and supporting the people with disabilities only could be seen in religious forms.

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33 ibid
One of the first major developments occurred in 1920, when a German missionary priest founded the Center for the Blind and then launched a number of people with disabilities institutions and charities centers (Salehpour and man Sereshki 2001).

During 1940s, some NGOs for the education of deaf people, especially for blind were established. Also, there were a few activities for people with disabilities in 1940 by “the Army or the Red Lion” and “Sun Society of Iran” were carried out. For example, in 1941 a Charity Institution for elder people was founded near hospital Doctor Fatemi’s hospital in Tehran to provide medical services for 20 to 30 elderly. Such activities and expansion of training centers for the blind and the deaf, the mentally ill continued in 1960s.

Following World War II, the central government made a concentrated effort to expand medical facilities and to allocate approximately 30% of hospital beds for patients with disability or terminal illness. In 1959, the Council for Aid to Treatment was formed to care for people with disabilities. During this year, three hospitals with 620-beds were established. In 1966, the Society for Persons with Disabilities (Iran Rehabilitation Society) was established with the aim of empowering people with disabilities.

In 1968, the Iranian parliament passed a legislation that essentially introduced rehabilitation in Iran. The Ministry of Labor and Social Affairs oversaw the legislation. In 1969, the “Iranian Rehabilitation Association” was founded under the supervision of the Ministry of Welfare in order to establish vocational rehabilitation. According to this law, the government was obliged to monitor, improve, and strengthen vocational training for people with disability. In that same year, the administration of “Shafa Yahyaeein Rehabilitation Hospital” was reassigned from the Ministry of Health to the Iranian Rehabilitation Organization. The hospital introduced new activities and programs, which added vocational rehabilitation to the existing medical attention the patients were receiving.

The establishment of the Iranian Rehabilitation Association had a significant impact on the expansion of other governmental associations such as the National Association for the Protection of Children, the National Association for the Blind, the National Association for the Deaf. These led to the establishing of nearly 250 NGOs and charity centers for people with disabilities, such as the center for protection of children and adolescents, BASIR center for Blind, BAGHABAN center for deaf, Razi psychiatric rehabilitation Hospital, and Kahrizak Mental Disability Institute (Salehpour and man Sereshki 2001).

In 1976, with the dissolution of the Ministry of Social Welfare, the administration of the Iranian Rehabilitation Association was transferred to the Ministry of Health. Despite all these transition, the Iranian Rehabilitation Association’s programs focused on three areas for the integration of people with disability into society. These included the following:

- Vocational training for physical disabilities
- Vocational training for mental disabilities
- Social Rehabilitation for the end of the rehabilitation programs
Following the 1980 Iranian Revolution, the Revolutionary Council formed the Welfare Organization by uniting 16 institutions and organizations which also included the National Association of the Deaf and Blind Welfare. The main purpose of formation of Welfare Organization was to extend social rehabilitation.

After the Iran-Iraq war (1980-1988), due to the large population of severely wounded soldiers returning from the war, public opinion regarding disability changed rapidly. People viewed disability in a much more understanding manner. It could be seen the development of that protective regulations of people with disabilities, including single article of the law “requiring government to employ ten percent of its required personnel from Islamic Republic veterans and Martyrs relatives”. This lead to the further development of rehabilitation in Iran and the establishment of several major institutions to provide rehabilitation services. Until the 1990s, rehabilitation services for people with disabilities were not present in the rural areas of Iran.

3.1.3.2 The Process of Developing CBR in Iran

CBR has emerged in Iran as an effective and efficient method of providing rehabilitation services of making rehabilitation services accessible to people with disabilities in rural areas over the last twenty-five years.

CBR in Iran began in 1990 with the trip of Dr. Hari Haran, a World Health Organization consular, to Iran. After negotiation Dr. Haran with Iranian Welfare organization, CBR pilot project began in 1991 in the province of Semnam. The first phase of the project focused on the translation of WHO's booklets named "Training in communities for People with disabilities" and training courses for local staff (workers) in two small villages, Biarjomand and Miami. Subsequently, the project initiated in six more provinces, by training doctors, specialists, staffs and volunteers. By 2001, CBR programs had been implemented in all provinces of the country. In 2013, about 80 percent of the rural population were covered by the program. In 2014, about 95% of the population in rural areas of the country were covered by the plan, which is approximately 425 thousand people with disabilities identified and put under coverage. The six types of identified disabilities in CBR programs include:

<table>
<thead>
<tr>
<th>Types of Disabilities</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blinds</td>
<td>11.2</td>
</tr>
<tr>
<td>Deaf and communications problems</td>
<td>13.6</td>
</tr>
<tr>
<td>Physical Movement difficulties</td>
<td>32.4</td>
</tr>
<tr>
<td>Mental Retards</td>
<td>18</td>
</tr>
<tr>
<td>Chronic psychological patients</td>
<td>7.8</td>
</tr>
<tr>
<td>Epileptics</td>
<td>6.2</td>
</tr>
<tr>
<td>Cross disabled persons</td>
<td>10.6</td>
</tr>
</tbody>
</table>

More than 424,514 people with disabilities have been supported by the national CBR program since 1992.

34 Welfare Organization data
Currently, 48839 rural areas are covered by the program; the aim is to provide coverage for the rest of rural villages (1432) by the end of 2015.

Table below shows CBR programs and the population of people with disabilities in each province:
Table 5: The Number of CBR Programs and the Population of People with Disabilities in each Province\(^ {37} \)

<table>
<thead>
<tr>
<th>Province</th>
<th>Capital</th>
<th>Population</th>
<th>Cities</th>
<th>CBR no</th>
<th>Numbers of People with Disabilities in rural areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alborz</td>
<td>Karaj</td>
<td>2,519,078</td>
<td>4</td>
<td>319</td>
<td>2187</td>
</tr>
<tr>
<td>Ardabil</td>
<td>Ardabil</td>
<td>1,302,701</td>
<td>9</td>
<td>1345</td>
<td>8090</td>
</tr>
<tr>
<td>Azerbaijan, East</td>
<td>Tabriz</td>
<td>3,892,407</td>
<td>19</td>
<td>2730</td>
<td>32255</td>
</tr>
<tr>
<td>Azerbaijan, West</td>
<td>Urmia</td>
<td>3,217,514</td>
<td>14</td>
<td>2864</td>
<td>17522</td>
</tr>
<tr>
<td>Bushehr</td>
<td>Bushehr</td>
<td>1,075,120</td>
<td>9</td>
<td>354</td>
<td>8925</td>
</tr>
<tr>
<td>Chahar Mahaal and Bakhtiari</td>
<td>Shahrekord</td>
<td>933,864</td>
<td>6</td>
<td>704</td>
<td>15644</td>
</tr>
<tr>
<td>Fars</td>
<td>Shiraz</td>
<td>4,802,728</td>
<td>23</td>
<td>4221</td>
<td>31227</td>
</tr>
<tr>
<td>Gilan</td>
<td>Rasht</td>
<td>2,589,706</td>
<td>16</td>
<td>2516</td>
<td>16223</td>
</tr>
<tr>
<td>Golestan</td>
<td>Gorgan</td>
<td>1,852,032</td>
<td>11</td>
<td>582</td>
<td>11718</td>
</tr>
<tr>
<td>Hamadan</td>
<td>Hamadan</td>
<td>1,836,337</td>
<td>8</td>
<td>1050</td>
<td>12935</td>
</tr>
<tr>
<td>Hormozgān</td>
<td>Bandar Abbas</td>
<td>1,475,348</td>
<td>11</td>
<td>1143</td>
<td>19597</td>
</tr>
<tr>
<td>Ilam</td>
<td>Ilam</td>
<td>580,722</td>
<td>7</td>
<td>427</td>
<td>5718</td>
</tr>
<tr>
<td>Isfahan</td>
<td>Isfahan</td>
<td>5,093,089</td>
<td>21</td>
<td>667</td>
<td>26917</td>
</tr>
<tr>
<td>Kerman</td>
<td>Kerman</td>
<td>3,068,409</td>
<td>14</td>
<td>2984</td>
<td>23132</td>
</tr>
<tr>
<td>Kermanshah</td>
<td>Kermanshah</td>
<td>2,032,527</td>
<td>13</td>
<td>2482</td>
<td>9139</td>
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<tr>
<td>Khorasan, North</td>
<td>Bojnourd</td>
<td>902,473</td>
<td>6</td>
<td>1296</td>
<td>7369</td>
</tr>
<tr>
<td>Khorasan, Razavi</td>
<td>Mashhad</td>
<td>6,262,380</td>
<td>29</td>
<td>2837</td>
<td>26628</td>
</tr>
<tr>
<td>Khorasan, South</td>
<td>Birjand</td>
<td>690,588</td>
<td>8</td>
<td>1939</td>
<td>9750</td>
</tr>
<tr>
<td>Khuzestan</td>
<td>Ahvaz</td>
<td>4,732,099</td>
<td>18</td>
<td>3482</td>
<td>23147</td>
</tr>
<tr>
<td>Kohgiluyeh and Boyer-Ahmad</td>
<td>Yasuj</td>
<td>690,588</td>
<td>5</td>
<td>1580</td>
<td>9753</td>
</tr>
<tr>
<td>Kurdistan</td>
<td>Sanandaj</td>
<td>1,561,671</td>
<td>9</td>
<td>1631</td>
<td>14120</td>
</tr>
<tr>
<td>Lorestan</td>
<td>Khorramabad</td>
<td>2,589,706</td>
<td>9</td>
<td>2867</td>
<td>16735</td>
</tr>
<tr>
<td>Markazi</td>
<td>Arak</td>
<td>1,475,348</td>
<td>10</td>
<td>787</td>
<td>10890</td>
</tr>
<tr>
<td>Mazandaran</td>
<td>Sari</td>
<td>3,209,666</td>
<td>15</td>
<td>2931</td>
<td>18729</td>
</tr>
<tr>
<td>Qazvin</td>
<td>Qazvin</td>
<td>1,255,615</td>
<td>5</td>
<td>952</td>
<td>5837</td>
</tr>
<tr>
<td>Qom</td>
<td>Qom</td>
<td>1,059,425</td>
<td>1</td>
<td>127</td>
<td>1987</td>
</tr>
<tr>
<td>Semnan</td>
<td>Semnan</td>
<td>1,059,425</td>
<td>4</td>
<td>411</td>
<td>2469</td>
</tr>
<tr>
<td>Sistan and Baluchestan</td>
<td>Zahedan</td>
<td>2,644,639</td>
<td>8</td>
<td>1031</td>
<td>10239</td>
</tr>
<tr>
<td>Tehran</td>
<td>Tehran</td>
<td>12,720,950</td>
<td>13</td>
<td>450</td>
<td>6793</td>
</tr>
<tr>
<td>Yazd</td>
<td>Yazd</td>
<td>1,122,206</td>
<td>10</td>
<td>1143</td>
<td>5893</td>
</tr>
<tr>
<td>Zanjan</td>
<td>Zanjan</td>
<td>1,059,425</td>
<td>7</td>
<td>987</td>
<td>12946</td>
</tr>
<tr>
<td>Iran (Total)</td>
<td>Tehran</td>
<td>78,460,246</td>
<td>342</td>
<td>48839</td>
<td>424514</td>
</tr>
</tbody>
</table>

\(^{37}\) Welfare Organization Data, 2015
As we can see, the Fars province has the most number of CBR programs (4221), and Qom has the least (127). Despite Tehran province’s population of 12 million, it only has 450 CBR programs.

3.1.3.3 The Process of Implementing CBR in Iran

CBR programs in Iran were designed to empower people with disabilities and their families within their communities. One of the assumptions of CBR was that improving the quality of life of all people with disabilities in a limited way could have a much greater impact than greatly improving the quality of life of a limited number of people with disability. Therefore, CBR attempts to make services accessible to more people with disabilities and their families in the most cost-effective and culturally appropriate ways (Miles, 1996; McColl et al., 1997; Peat, 1998; Mitchell, 1999; Kendall et al., 2000; Turmusani et al., 2002). In Iran, programs associated with CBR include medical, social, and vocational rehabilitation. This part will discuss the stages of development of CBR programs in Iran:

- Early ages: medical approach to CBR programs (it was implemented through the PHC system).
- Intermediate ages: multi-sectoral approach to CBR (it was implemented through municipal district personals in town, village or a rural area):
  - use of community volunteers
  - use of community facilitators NGOs

In the early ages

CBR programs were implemented through collaboration with the Primary Health Care (PHC) system in the Ministry of Health between 1991 and 2005. The PHC had an inclusive net in all villages in Iran. The participation of PHC’s health workers consisted of: (1) identification, evaluation and assessment of people with disabilities in their areas; (2) educating the family with using booklets; (3) referral to higher levels of specialized services; and, (4) treatment and medical rehabilitation.

Intermediate ages

The medical approach to CBR program has not only been criticized on the grounds that it depends on experts, but also because many dimensions of disability, such as the social, economic, and cultural factors are absent. In 2006 a contract between the Iranian Welfare Organization and Ministry of Interior (municipalities and rural councils) was signed to develop a multi-sectorial approach to CBR programs. This approach was a more comprehensive approach to CBR programs. In many ways, the needs of persons with disabilities and without disabilities are the same. Extensions of facilities to meet the needs of people with disabilities are essential. Therefore, the multi-sectorial approach can be considered the only approach adept to satisfy the comprehensive needs of people with disabilities. Based on this approach, CBR programs sought to find the relevant partners to meet the different needs of people with disabilities of all ages. In implementing this approach, cooperation between
different government ministries and non-governmental organizations became necessary.

Following the ratification of the contract, mutual cooperation was established between referral systems at the regional, provincial, and local levels. Based on this contract, the Iranian Welfare Organization was responsible to provide two days of training for the municipal district personals in towns, villages and rural areas. After appointing municipal district personnel to implement CBR programs in their areas, a “rural rehabilitation council” was established to facilitate the participation of people with disabilities and to act as a supportive organization to empower people with disabilities. The duties of a rural rehabilitation council included:

- Setting up monthly meetings in regards to problems facing disability in their rural area
- Creating accessible rural environment (such as schools and mosques) for people with disabilities
- Raising public awareness about disability issues
- Providing equipment and accessible mobility for people with disabilities
- Creating a rural council funds
- Developing and supporting organizations of people with disabilities
- Removing barriers for the participation of people with disabilities and their families in social, cultural, recreational activities
- Environmental accessibility for people with disabilities at schools and public places
- Providing vocational training for people with disabilities at rural areas
- Fundraising and community resource mobilization
- Providing supervision for staff and volunteer
- Developing training programs for volunteers
- Recording expense report

Volunteers from throughout the community were used during the multi-sectorial approach to CBR program’s early stages. As the programs become more established, problems linked to community volunteers, changes in the community and changes to the resources were identified.

To overcome such problems, in 2013 the Iranian Welfare organization signed contracts with local Non Governmental Organizations (NGOs) with the aim of implementing CBR activities by assisting municipal district personnel. People working for the NGOs included both paid and volunteers staff. Generally speaking, the benefits gained by assigning CBR projects to local facilitators’ NGOs are:

- To improve the quality and quantity of CBR services
- To expand CBR program based on diverse cultural and social patterns
- To facilitate the participation of people with disabilities and their families in the local community
- To reduce public sector roles in monitoring and facilitating the CBR programs
- To reduce migration from rural to urban environments by creating job opportunities at the local level
- To decrease government expenditure
3.1.4 The Association of People with Disabilities in the Country

This part is intended to deal with the involvement of NGOs and associations of people with disabilities in CBR programs.

There are many different types of disability organizations in Iran, each with their own unique goals. These include national associations (e.g. Iranian National Institute for the Blind, Iranian Autism Association), charitable organizations (e.g. Kahrizak Charity centre, Raed Association), and non-governmental organization (e.g. Bavar association, Naday Iranian Association) (http://iranngonews.persianblog.ir/post/1877/).

The involvement of associations for people with disabilities in CBR programs took off after the Welfare Organization assigned all CBR programs to NGOs.

In 2008, Article 44 of the Iranian Constitution (the privatization law) was passed by the parliament to assign public services to the private sector. In accordance to this law, in 2013 the Welfare Organization supported many facilitators’ NGOs to implement all CBR programs in their regions. To date, there are 253 NGOs responsible for the implementation of CBR activities, of which approximately 70% consist of facilitators’ NGOs.

In this process, local facilitators had be introduced by the rural CBR Council, and approved by the Welfare Organization. Local facilitators were interested in community development and the empowerment for people with disabilities living in villages. They had to meet the following qualifications:

- Interest in the job
- The minimal educational requirements of a diploma had to be met
- Familiarity with village customs and traditions
- Good reputation in their community

Local facilitators consisted of village health workers, village schoolteachers, social helpers, people with disabilities, their family members, and volunteers who were interested in improving the lives of people with disability.

If the population of a village was around a thousand, two facilitators were required to work at least a day per week. If the village’s population was over a thousand, more facilitators would have been needed.

The Executive Facilitators were responsible for:

- The registration of people with disabilities; identification of people with disabilities through visits to homes or during visits to health centers, village administrations, etc.; complete the registration forms including; type of their disability, their abilities and disabilities, their social-economic situation, etc.
- Action for Education in the family; identifying people in need of education; selecting an appropriate booklet and delivering it to the family,
choosing an instructor from the family; visiting homes to assess the progress of the individuals with disabilities.

- Action for reference; identify people in need of referral; helping provide the necessary evidence to refer the person to the appropriate reference level; follow-up after referral.

- Action for Education outside the family; identification of training needs and priorities of people with disabilities; notifications to school administrators and teachers to communicate with the relevant departments; facilitate the removal of barriers to education and social services; reporting training costs.

- Providing rehabilitation devices: identifying the people who need help with their assistive devices; determining the type of devices needed; determining whether rehabilitation devices are available, can built in villages or must be provided from outside the village; connecting with other governmental departments if needed; follow-up after referral; teach how to use rehabilitation devices.

- Action for the creation of employment for people with disabilities; gathering information from the Iranian Welfare Organization about creating jobs for people with disabilities; collecting information about available jobs suitable for people with disabilities in the village; assessing the requirements for employment; skill assessment for finding a career; follow-up.

- Facilitating the access for rural people with disabilities; identify accessibility barriers in people with disabilities’ homes; meeting with local architect in the removal of the obstacle based on the standard CBR Council in coordination with the financial resources of the village; meeting with CBR Village Council to create accessible environments for people with disabilities in their community; educate families in regards the proper repair or rebuild homes to promote independence for people with disabilities

- Providing assistance to people with disabilities; identifying people in need of financial support; report people’s needs to rural rehabilitation council to receive benefits from Social Welfare

- Action for social participation of people with disabilities in cultural, sports and social programs within the community; community awareness; setting up meeting and lectures; preparation of brochures, leaflets, posters and reflection activities in connection with CBR related news in the media

- Action for the creation and development of organizations for people with disabilities; gathering information on how to establish organizations of people with disabilities from relevant experts; identifying and communicating with organizations of people with disabilities in the city; inviting interested people with disabilities in the village to create and connect with other disability organizations; administrative procedures
relating to the registration and the establishment of people with disabilities’ organizations.

In addition to these NGOs, there are 672 self-help groups with distinct purposes that are formed by a group of people facing similar problems. These self-help groups consist of people with disabilities, their families and volunteers. The specific objectives included the development of business skills through the exchange of experience, the gathering of information in order to create credit fund microfinance, and the development of savings among target groups. The results of achieved by the creation of self-help groups in CBR programs were social and economic empowerments of people with disabilities and their families.

All identified people with disabilities (preferably from 15 to 60 years) and their families in rural areas that are covered by the CBR program are eligible for creating self-help groups project.

All the self-help groups’ projects must be initially approved by the rural CBR Council, and then by CBR experts in their proveniences. By considering people with disabilities’ needs, abilities and interests, facilitators consulting with CBR experts offer various self-help groups (such as sewing workshop, agricultural production, production of rugs and carpets and so on). After the approval, each individual with disabilities are eligible to receive a maximum amount of 20 million Rials ($700) for create a self-help group.

After a few years, many self-help groups were stabilized and did not need external aid. These groups established microfinance savings to meet the livelihood needs and strengthen their economic plans to join together to form a network. The table below shows the number of CBR’s facilitators NGOs and self-help groups in each province.
Table 6: The Number of CBR’s Facilitators NGOs and Self-help Groups in each Province

<table>
<thead>
<tr>
<th>Province</th>
<th>CBR’s Facilitators NGOs # no.</th>
<th>Self-help groups #no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alborz</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Ardabil</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Azerbajian, East</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Azerbajian, West</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Bushehr</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>Chahar Mahaal and Bakhtiari</td>
<td>12</td>
<td>25</td>
</tr>
<tr>
<td>Fars</td>
<td>18</td>
<td>74</td>
</tr>
<tr>
<td>Gilan</td>
<td>20</td>
<td>143</td>
</tr>
<tr>
<td>Golestan</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Hamadan</td>
<td>6</td>
<td>22</td>
</tr>
<tr>
<td>Hormozgān</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Ilam</td>
<td>10</td>
<td>2</td>
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<tr>
<td>Isfāhan</td>
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<td>18</td>
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<tr>
<td>Kerman</td>
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<tr>
<td>Kermanshah</td>
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<td>7</td>
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<td>Khorasan, North</td>
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<td>Khorasan, Razavi</td>
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<td>Khorasan, South</td>
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<td>19</td>
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<td>Kohgiluyeh and Boyer-Ahmad</td>
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<td>18</td>
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<tr>
<td>Kurdistan</td>
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<td>Lorestan</td>
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<td>Markazi</td>
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<tr>
<td>Mazandaran</td>
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<td>1</td>
</tr>
<tr>
<td>Qom</td>
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<td>3</td>
</tr>
<tr>
<td>Semnan</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Sistan and Baluchestan</td>
<td>17</td>
<td>31</td>
</tr>
<tr>
<td>Tehran</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Yazd</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Zanjan</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>253</strong></td>
<td><strong>672</strong></td>
</tr>
</tbody>
</table>

3.1.5 The CBR Governance

This part is devoted to discuss the structure of CBR at national, provincial, municipal and rural levels

3.1.5.1 At the National Level

In Iran, CBR is a national program. The highest policy-makers consist of the Ministry of Welfare and Social Affairs, Ministry of Interior (Municipal Organization), and Ministry of Health. The Social Welfare Organization is responsible for the

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38 ibid
management of the CBR programs across the country. The national CBR program’s goal is the empowerment of people with disabilities, their families and communities, regardless of their religion, gender, age or type of disability, through meeting basic needs, facilitating access to health, education and livelihood opportunities, raising awareness, promoting inclusion, reducing poverty, and eliminating stigma.

As brought up earlier, there have been two approaches to the implementation of CBR programs; the medical approach and the multi-sectorial approach. At the earlier ages (1990 to 2005) the medical approach predominated. CBR activities were implemented through a cooperative arrangement between the Welfare Organization and the Ministry of health. Because of inadequate PHC staff and a need for a more comprehensive approach, a contract between the Iranian Welfare Organization and the Ministry of Interior (municipalities and rural councils) was signed to develop a multi-sectorial approach to CBR programs in 2006. Today, CBR programs are monitored by the Welfare Organization, but are implemented through assigned NGOs. The majority of CBR activities have been implemented by nationally assigned NGOs, while International NGOs have not had a role in developing CBR programs in Iran. There has only been international collaboration in regards to disability between the UN High Commissioner for Refugees (UNHCR) and the Iranian Welfare Organization in order to provide medical rehabilitation services for Afghan refugees in Iran.39

3.1.5.2 CBR in Province and District Level

At the provincial level, there has been vertical cooperation between deputies from the three ministries. The CBR structure in the city consists of an expert network of city health officials, city CBR experts and expert system interfaces to monitor CBR activities thought villages and districts.

The implementation of CBR in the provincial or district level has been conducted by registered NGOs. Although the Welfare Organization has given the responsibility of the implementation of CBR activities to local NGOs, there has been an established guideline for follow ups in regards to the activities. Therefore, the CBR activities would become a part of a national program.

Until date, over 27,000 personnel including 10,598 PHC staffs, 10,534 rural municipal personnel, and 6,000 community workers (NGOs’ facilitators) are involved in implementing CBR activities.

The program is decentralized to the community level, with most CBR activities carried out by NGOs’ facilitators. NGOs’ facilitators receive a one to two weeks training, which enables them to implement CBR activities. The key activities of the CBR program include:

- Training family and community members on disability and CBR using the

39 In 2005, CBR for Afghans refugees implemented at Zahedan Shirabad in Sistan and Baluchestan province. Since the date, every year at least about 500 Afghan’s people with disabilities identified and receive CBR services. To date, this project developed to 14 Iranian provinces.
WHO CBR training manual as a guide;

- Providing educational assistance and facilitating inclusive education through capacity building with teaching staff and students, and improving physical access;
- Referring people with disabilities to specialist services, e.g. surgical and rehabilitation services where physiotherapists, speech therapists and occupational therapists are available;
- Providing assistive devices, e.g. walking sticks, crutches, wheelchairs, hearing aids, glasses;
- Creating employment opportunities by providing access to training, job coaching and financial support for income-generation activities;
- Providing support for social activities including for sports and recreation;
- Providing financial assistance for living, education and home modifications.

The CBR executive structure diagram of a multi-sectorial approach is shown on the below. As we can see, the most cooperation that exists between the organizations is at the village level.
Figure 17: CBR Structure in Iran

Ministry of interior

Municipal organizations

Governor’s offices at province level

Disabled organizations at county

CBR Council At country level

CBR Staff At country level

Expert responsible for rural welfare services

Health ministry

Welfare organization

Planning and service development staff of welfare

Representative of treatment deputy

University of Medical Sciences

Health deputy at province

Ministry of welfare and social security

Rehabilitation deputy

Disability organizations at province level

Social affairs office

Urban & rural affair office

Governor’s offices At county level

Disabled organization at provincial level

CBR Council At provincial level

Rehabilitation deputy At provincial level

Intermediary expert for welfare services

Health & treatment network at province

Development deputy of Governor’s offices at province level

Disabled organizations at country

CBR Council At country level

Expert of CBR staff at country level

Rural welfare complex

Rural health home

Disability organizations at county

CBR Council At county level

Base of CBR At county

Intermediary expert for CBR Staff at county level

Rural CBR COUNCIL

Dhyary in village is equivalent to municipality in cities.

Governor’s offices At county level

Social affairs office

Governor’s offices At province level

Disabled organizations at province level

CBR Council At provincial level

Rehabilitation deputy At provincial level

Intermediary expert for CBR Staff at provincial level

Responsible Rural welfare complex

Municipal organizations

Civil organization

Islam political council of village

Rural disabled organization

Rural CBR COUNCIL

Expert of CBR staff at province

Experts of health deputy at province

Expert of CBR staff at county level

Experts of health network at county

Technical and physician (rural health & treatment center)

Islamic council of village

Dhyary (Village)

County offices

Disabled organizations at county

CBR Council At county level

Rural welfare complex

Rural rural & treatment center

Village

Dhyary (Village)

Director of special health & welfare services at province level

Director of special health & welfare services at county level

Technician and physician (rural health & treatment center)

Dhyary in village is equivalent to municipality in cities.

Ministry of interior

Municipal organizations

Governor’s offices at province level

Disabled organizations at province level

CBR Council At provincial level

Rehabilitation deputy At provincial level

Intermediary expert for CBR Staff at provincial level

Responsible Rural welfare complex

Municipal

Civil organization

Islam political council of village

Rural disabled organization

Rural CBR COUNCIL

Expert of CBR staff at province

Experts of health deputy at province

Expert of CBR staff at county level

Experts of health network at county

Technical and physician (rural health & treatment center)

Islamic council of village

Dhyary (Village)

County offices

Disabled organizations at county

CBR Council At county level

Rural welfare complex

Rural rural & treatment center

Village

Dhyary (Village)

Director of special health & welfare services at province level

Director of special health & welfare services at county level

Technician and physician (rural health & treatment center)

Islam political council of village

Rural disabled organization

Rural CBR COUNCIL

Expert of CBR staff at province

Experts of health deputy at province

Expert of CBR staff at county level

Experts of health network at county

Technical and physician (rural health & treatment center)

Islam political council of village

Rural disabled organization

Rural CBR COUNCIL

Expert of CBR staff at province

Experts of health deputy at province

Expert of CBR staff at county level

Experts of health network at county

Technical and physician (rural health & treatment center)

Islam political council of village

Rural disabled organization

Rural CBR COUNCIL

Expert of CBR staff at province

Experts of health deputy at province

Expert of CBR staff at county level

Experts of health network at county

Technical and physician (rural health & treatment center)
3.1.6 CBR Services for People with Disabilities

From the beginning, CBR programs in Iran included six services; Training family; Training outside the family; Referral services; Providing assistive devices; Employment; and Social support.

3.1.6.1 CBR Services at the Beginning

*Training family or education in family*

Training families began after identifying people with disabilities through home to home visits. A CBR worker selects and gives an appropriate CBR educational booklet to selected families. Then, he/she chooses a coach from the family in order to carry out the instructions. The instructions include health promotion, disease prevention, problem-solving and coping skills, etc.

*Training outside the family*

When a person with disability became stabilized, a CBR worker assessed his/her social and vocational skills. Then, they gather information, and based off the information acquired, they assess methods to create jobs for them, or identify common jobs for people with disabilities in the village. Finally, they provide guidance and advice to people with disabilities within their workplaces.

CBR programs provide access to formal education for people with disabilities in their community. Formal education is linked to schools and training institutions. They also provide financial aid opportunities in order to pay for education expenses for the student with disabilities if necessary. Furthermore, they offer non-formal education, which is linked to any educational activity outside the established formal system, such as learning within the workplace. CBR programs make non-formal education accessible for most people with disabilities through providing flexible work practices. Most people with disabilities who work in rural areas are occupied in carpentry, hairdressing salon, beekeeping, and farming, etc.

*Referral services*

The process in which people with disabilities receive specialized services in the field of health care and medical rehabilitation in cases in which their problems cannot be resolved in their residing places with community recourses.

*Providing assistive devices*

After identifying people who need rehabilitation devices and determining the type of devices they need, a CBR worker determines whether it is possible to make the required assistive devices by using local resources or if they should be sent from the city. CBR programs provide assistive devices (such as wheelchair, crutches, walkers, prosthesis and so on) for free. Those who receive assistive devices are trained in using them.
Employment

CBR workers and experts help people with disabilities and their families to improve their economic and social situations by providing opportunities for skills development, self-employment, financial services, and social protection. CBR workers facilitate access to employment by linking patients to community resources and helping training at community level.

Social supports

CBR programs determine people with disabilities who in need financial support such as travel expenses, cost of care and subsidy. By receiving assistance and ongoing support, CBR programs contribute in the elevation of their quality of life.

3.1.6.2 CBR Matrix

In 2013, CBR programs in Iran categorized under the CBR matrix provided a common framework for CBR activities. Although CBR programs have not implemented every component and element of the CBR matrix, the programs have been designed to select the activities that best meet the people with disabilities’ needs in rural areas. CBR activities categorized under CBR matrix are described in the below table:

Table 7: CBR Programs’ Best Practices

<table>
<thead>
<tr>
<th>CBR MATRIX</th>
<th>Successful examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH</strong></td>
<td></td>
</tr>
<tr>
<td>promotion</td>
<td>Identifying people with disabilities, Cooperating with the primary health care (PHC),</td>
</tr>
<tr>
<td></td>
<td>Referring the clients to specialist and follow-ups</td>
</tr>
<tr>
<td>prevention</td>
<td>Distributing booklets and educating families</td>
</tr>
<tr>
<td></td>
<td>Timely vaccinations, care of pregnant women, implementation of lazy eye</td>
</tr>
<tr>
<td></td>
<td>Preventing avoidable diseases such as diabetes</td>
</tr>
<tr>
<td>medical care</td>
<td>Referring people with disabilities to specialist if needed</td>
</tr>
<tr>
<td></td>
<td>Minimizing the effects of impairment</td>
</tr>
<tr>
<td>rehabilitation</td>
<td>Refereeing to rehabilitation experts if needed</td>
</tr>
<tr>
<td>assistive devices</td>
<td>Providing necessary rehabilitation devices, Educating families for building or repairing assistive devices, Creating accessible environments</td>
</tr>
<tr>
<td><strong>EDUCATION</strong></td>
<td></td>
</tr>
<tr>
<td>early childhood</td>
<td>Contributing to the development of inclusive kindergartens in order to accept children with disabilities Providing materials for educating basic concepts in home for children under school age Working with kindergarten and preschool teachers training manual</td>
</tr>
<tr>
<td>primary</td>
<td>Supporting the education of children in public schools through educating their teachers and creating accessible environments Providing scholarships cover full costs of education, including tuition</td>
</tr>
<tr>
<td>secondary &amp; higher</td>
<td>Supporting the education of children in public schools through educating their teachers and creating accessible environments Providing scholarships cover full costs of education, including tuition</td>
</tr>
</tbody>
</table>

41 Welfare Organization Data, and CBR workers and facilitators’ interviews
<table>
<thead>
<tr>
<th>CBR MATRIX</th>
<th>Successful examples</th>
</tr>
</thead>
</table>
| **non-formal** | Supporting the education of children with disabilities at home  
Encouraging them to participate in some outside activities |
| **lifelong learning** | Supporting the education of children in special schools  
Supporting vocational training for the clients  
Providing scholarship and school expenses  
Referring the clients to adult literacy centers  
Providing extra help and facilitate learning and provide incremental opportunities for success for student with disabilities |

**LIVELIHOOD**

| skills development | Supporting vocational training  
Supporting participation in informal educational institutions  
Implementing master-disciple employment model  
Supporting the education of persons with disabilities in mainstream jobs in their neighborhood (the master-disciple) |
| self-employment | Training and making available raw materials  
Helping people with disabilities to sale their products  
Helping to establish their labor unions |
| wage employment | Helping the clients to find a job in government agencies and non-governmental organizations  
Creating or facilitating peer support groups |
| financial services | Providing Low-interest or interest-free loans for people with disabilities  
Supporting self-help groups |
| social protection | Helping to receive disability support pension for whom unable to work  
Supportive services at home  
Referring some clients to hospice and palliative care services if needed |

**SOCIAL**

| personal assistance | Training to perform tasks of daily living activities (eating, dressing, bathing, etc.) |
| relationships & family | Supporting people with disabilities and their families to increase social interaction with the community  
Supporting their marriages |
| culture & arts | Supporting participation in arts and cultural activities |
| recreation, leisure & sports | Supporting in the camps, tours, recreational activities |
| justice | Setting up classes and courses for people with disabilities to information about their legal rights |

**EMPOWERMENT**

| advocacy & communication | Providing accessible infrastructure including transportation, education, health, housing |
| community mobilization | Raising disability awareness in community by presenting lecture, brochure in public places such as mosques, schools |
| political participation | Encouraging people with disabilities to have their own organization |
| self-help groups | Supporting self-help groups  
Supporting access to funding mechanisms and the self-employment of people with disabilities. |
| people with disabilities organization | Facilitating/supporting DPO or self-help groups |
3.1.7 Best Practice

This section collects the best examples of practices in implementing CBR programs in Iran.

3.1.7.1 NGOs’ Facilitators

After assigning the implementation of CBR activities to NGOs, there has been a growth of facilitators’ NGOs. About 70% of these NGOs are local facilitators’ NGOs. To date, there are 253 NGOs that are responsible agencies for implementing CBR activities, of which 70% of them are facilitators’ NGOs. Local facilitators must be introduced by the rural CBR Councils and approved by the Welfare Organization. The main tasks of these NGOs are listed below:

- Identification of people with disabilities
- Completing clients’ needs assessments forms
- Gathering information and documents required for the economic and social needs of clients in order to provide appropriate social support
- Regular visits to the clients’ homes
- Participating in training, retraining and orientation
- Selecting facilitators to educate people with disabilities and their families based on the CBR information booklets
- Referring clients to specialized services in cities and follow-ups with the client
- Providing or building innovative rehabilitation devices
- Referring clients who need specific rehabilitation devices to CBR experts
- Active participation in the CBR village council
- Working closely with CBR experts in planning and implementing CBR activities in their region
- Providing quarterly report to the CBR experts
- Providing disability awareness training to change public attitudes through presenting educational lectures in public places such as mosques and schools by inviting people with disabilities and their families, clerics, teachers, influential people in the community
- Promoting the inclusion of people with disabilities through vocational trainings
- Encouraging and helping clients to develop their own organizations throughout villages
- Improving access and mobility for people with disabilities in rural roads and public places

Although the Iranian government has a very clear policy in regards to CBR, there are limited resources for conducting CBR activities. The benefits of CBR project run by NGOs with the assistance of central and local facilitators are as below:

- Promoting the quantity and quality of CBR services
- Proper use of human resources in the community
- Moving towards job creation
• Reducing the tenure of the rest of the public sector services to the private sector's role as an observer
• Reducing governmental expenses
• Strengthening organizations of people with disabilities and creating networks between them.

3.1.7.2 Income Generation Program in Rural Areas through Master-trainee Approach

One of the best practice examples of CBR activities in Iran is the ‘master-trainee’ model for the employment of people with disabilities.

The Iranian Welfare Organization has provided facilities for the employment of people with disabilities. Providing vocational training throughout their local communities through professional assessment and career guidance in order to determine the type of job best suited for each individual, and monitoring their status and stability for jobs was a very successful example for the empowerment of people with disabilities in their community.

As the vocational training facilities in rural areas in Iran are very limited, CBR programs use non-formal programs for vocational training of people with disabilities. As cited before, the medical approach dominated CBR programs since its launch until 2006. Therefore, the social economic dimension of disability was not prioritized.

Approximately 796 jobs had been created, and the following reasons suggest why the master – trainee approach has been successful:

• The majority of people with disabilities living in rural areas had received vocational training from their families or relatives in their villages, rather than obtaining training from certified vocational training centers;
• Access to vocational rehabilitation services in rural areas was difficult for people with disabilities, more so for females with disabilities;
• It was hard to get small-business loan for people with chronic mental health problems or intellectual disabilities;
• Paying back loans for people with disabilities living in rural areas was very difficult due to the lack of progress in some jobs.

Due to these problems, in 2006, the Iranian Welfare Organization approved the Rural Empowerment project for People with Disabilities through vocational training and employment. The empowerment office for people with disabilities is responsible for the implementation of this project.

Action plans to support the employment of people with disabilities in rural areas through the CBR program was influenced by Iran’s “Comprehensive law of the protection of persons with disabilities rights” 42, and United Nations Convention on

42 “Comprehensive law of the protection of persons with disabilities rights” could be considered as the first protective regulation of persons with disabilities in Iran, which has been approved in 2004.
Disability Rights’ Article 27 (Work and employment)\textsuperscript{43}. In Iran, the guidelines for the protection of people with disabilities in rural employment are as follows:

- All identified people with disabilities in rural areas who are covered by CBR programs can apply for vocational training in their villages;
- They must have had vocational training prior to getting small-business loans; the chosen jobs must fit with their abilities and interests;
- Their ability to use professional training must be approved by a CBR expert, preferably by an occupational therapist; the trainers must be educated for at least for one month or at most six months;
- As an encouragement for the instructors to train people with disabilities, the Welfare Organization must pay monthly training fees;
- The fees paid depend on the working conditions, the training hours and the used materials, all of which is determined by a CBR expert;
- After the training period and obtaining the required skills for creating a job, individuals with disabilities can obtain up to 100 million Rials (about $3000) in non-refundable finance grants in order to launch their own business;

The Iranian Welfare Organization from each province and city are responsible for the supervision and monitoring of the expenditure gone towards the implementation of labor and employment for people with disabilities.

If their business does not have enough capital to satisfy its debts, the Welfare Organization can provide them with a new loan. If the employed person with disabilities develops his/her career and is able to hire one or more people with disabilities, the Welfare Organization could give them a free bonus.

### 3.1.7.3 Self-help Groups

Another example of a successful CBR practice is the ‘self-help groups’. A self-help group is a voluntary association of people with disabilities, their families, and volunteers, whom cooperate together towards their collective goals. These groups have different purposes depending on their situation and their needs. Creating self-help groups has several advantages such as improving their economic situation, increasing the motivation for prosperity, improving the participation of community members and so on.

\textsuperscript{43} Article 27-Work and employment (United Nations Convention on Disability Rights), adopted Dec. 13, 2006, Member States “recognize the right of persons with disabilities to work, on an equal basis with others; this includes the right to the opportunity to gain a living by work freely chosen or accepted in a labour market and work environment that is open, inclusive and accessible to persons with disabilities. States Parties shall safeguard and promote the realization of the right to work, including for those who acquire a disability during the course of employment, by taking appropriate steps…”.

Equality and elimination of discrimination principle, accessible environment, employment of persons with disabilities, has been acknowledged in this law. This law could be considered a way toward guarantee of the rights of persons with disabilities. (http://engineerspress.com/pdf/WSJ/2013-12/a12%20(WSJ-1311212).pdf)
People with disabilities and their families participate in self-help groups to solve economic problems, improve living conditions, increase individual strengths, improve their quality of life, and work towards economic empowerment. Positive outcomes of the creation of self-help groups in CBR programs include the social and economic empowerment of people with disabilities and their families, the increase of knowledge and skills of members of self-help groups in the fields of economic and social development, and the promotion of CBR programs in the fields of social and economic activities.

To date there have been over 600 self-help groups through CBR programs in rural areas throughout Iran. The members of these groups have supported each other through discussions in regards to the obstacles they face, sharing their resources and accomplishing collective activities based on the purposes of the group. For example, some of the aims of these groups include the care of people with disabilities for several hours per week or when needed, the use of their experiences in regards to health promotion and prevention, helping each other search for employment, increasing social participation within the community, promoting their social-economic situation and increasing their members’ role in the community. For example, one of their activities was to collect small savings or provide small loans to launch small businesses such as beekeeping. These groups enhance people with disabilities’ confidence and self-esteem and improve their economic situations. Despite the challenges, it is one of the best examples of CBR activities in Iran.

In Iran, income generation activities of CBR programs have led to improvements in the lives of persons with disabilities. CBR programs have established self-help groups that successfully integrated people with disabilities into the community through their initiatives. There have been many more examples of CBR programs in different reigns, but not much is known about them due to the fact that they have not yet been well published.

3.1.7.4 The Rural CBR Council Funds

It is estimated that the fundamental needs of 60 percent of people with disabilities in rural areas in Iran comprise economic necessities. To facilitate access to funding mechanisms for people with disabilities and to support the implementation of CBR program in the village, the rural CBR Councils established a funding system in rural areas. This council encouraged donors throughout villages and state institutions to provide financial aid to facilitate services for people with disabilities in villages and to meet the needs of people with disabilities.

3.1.7.5 Education in Family

The education of families with individuals with disabilities can guide them towards better understanding their problems and enables them to deal with these problems. By selecting the appropriate booklets and delivering them to the families, and by choosing a coach to follow the booklet’s instructions, there can be an increase in the family’s role in the rehabilitation process and the progress of the individual with disabilities.

3.1.7.6 Raising Disability Awareness in Village
Awareness of the local community in regards to challenges faced by people with disabilities and the need to enhance their social inclusion at all levels is needed. CBR raises public awareness about issues regarding disability through presenting public speeches or by creating a series of posters in order to familiarize people with disability. This empowers persons with disabilities to participate in cultural and economic activities.

3.1.7.7 Accessibility

Another successful example of CBR activities is the appropriate actions taken towards enhanced accessibility. The CBR workers identify accessibility barriers for people with disabilities’ homes, subsequently gathering information to plan for their repair. They meet with the CBR Village Councils to create accessible environments for people with disabilities in their community. CBR workers educate families in regards to the proper repair or rebuilding of homes to promote independence for people with disabilities. People with disabilities’ families along with their communities’ aid built the majority of rehabilitation devices in the villages. About %70 of devices were built within their communities.

3.1.8 The Way forward

CBR in Iran emerged at the beginning of the 90s in order to make rehabilitation services accessible to people with disabilities in rural areas. Although Iran became one of the leading countries in the implementation of CBR programs in the Asia-Pacific region, there were some challenges for the development and implementation of CBR programs in Iran. Human resources and funding for CBR activities were the major challenges. Due to the lack of adequately trained personnel and limited governmental funding, CBR programs were assigned to NGOs since 2013. By implementing CBR programs through NGOs’ facilitators, CBR programs have been more effective because the facilitators work not only for the people with disabilities, but also develop the communities in which they live in. They coordinate changes in the community's motivation, knowledge, and skills in relation to disability issues.

Today, CBR programs have been implemented in all provinces in Iran by using various strategies and methods. Each programs has its own strengths and weaknesses. There is an urgent need for information dissemination so that all provinces can access information about the development of CBR programs in Iran. Every province will be required to make some effort to share its information. Since CBR implementation requires financial backing, there should be closer communication between donor agencies and CBR program implementers. Most donors prefer a charitable approach that is more visible and easier to evaluate. There is a need to spend considerable time and energy convincing donors to increase their awareness in regards to the effectiveness of CBR programs and its activities.
3.2 Malaysia

3.2.1 Background

Malaysia, a federal constitutional monarchy located in Southeast Asia consists of thirteen states and three federal territories. It has a total landmass of 329,847 square kilometers (127,350 sq mi) separated by the South China Sea into two regions, Peninsular Malaysia and East Malaysia (Malaysian Borneo). The capital city is Kuala Lumpur, while Putrajaya is the federal government administrative centre.

Department of Statistics Malaysia (2015a) reported that Malaysia has a population of 31,062,680 with an annual population growth rate estimated at 1.3%.

The Eleventh Malaysia Plan (2016-2020) estimated Per Capita GDP in 2015 is RM 36,937 nationwide. (Economic Planning Unit Malaysia, 2015). The gap on Per Capita GDP (Gross Domestic Products) among some of the 15 states and territories of Malaysia is quite significant. The highest is Kuala Lumpur (Federal territory) with Per Capita GDP of RM 92,802, and the lowest is Kelantan with RM 11,993. This gap reflects the industrial structure of these states. Common factor of states with lower Per Capita GDP is largely lack of manufacturing industries and high dependence on agriculture.

Throughout 2009-2012, the high increase in average household monthly income along with low inflation rate has given a significant effect to the decrease in poverty incidence. The Incidence of poverty in Malaysia decreased substantially from 3.8% in 2009 to 1.7% in 2012. The number of poor households has reduced by 52.7%, from 228,400 to 108,000 during the same period. Reduction in the incidence of poverty has reduced in both urban and rural areas. The incidence of poverty in urban decreased from 1.7% in 2009 to 1% in 2012, while for rural areas from 8.4% to 3.4%. (Department of Statistics Malaysia, 2015b). Households with average monthly incomes of less than RM760 in Peninsular Malaysia, less than RM1,050 in Sabah and less than RM910 in Sarawak are defined as poor (Jala, I., 2015).

In 2012, UNESCO Institute for statistics estimated the literacy rate in Malaysia is at 87.4%, with illiterate population of 1.8 million. It was also reported that more than 93% of Malaysia's people are literate. Even though the illiteracy rate is low, there is still a need to formulate and implement lifelong education programmes. Income-generating and vocational activities is promoted in non-formal education strategies to improve the income of the rural community through skills upgrading, so that rural communities will be involved actively in income-generating programmes that could improve their quality of life (UNESCO, 2012).

According to UNDP report, the Malaysia Human Development Index value for 2013 is 0.773— which is in the high human development category—positioning the country at 62 out of 187 countries and territories. Between 1980 and 2013, Malaysia’s HDI value increased from 0.577 to 0.773, an increase of 34.0% or an average annual increase of about 0.89%. In the same period, Malaysia’s life expectancy at birth increased by 6.9 years, mean years of schooling increased by 5.1 years, expected years of schooling increased by 3.7 years and GNI per capita increased by about
188.3% between (UNDP, 2014).

3.2.2 Socioeconomic status of people with disabilities

3.2.2.1 Population of People with Disabilities

The World Health Organization’s (WHO, 2015) estimated about 15% of the world's population lives with some form of disability, of whom 2-4% experience significant difficulties in functioning. To date, the registered number of people with disabilities with the Department of Social Welfare Malaysia (August 2015), based on voluntary registration, is 351,114 people, 1.13% of total population. There were 35.7% (125,207) female and 64.3% (225,907) male. Majority, that is 57.7% (202,678) are under the age of 19-59. While, 30.1% (105,727) are below 18 and 12.2% (42,709) are age 60 and above.

The Department of Social Welfare categorised people with disabilities into 7 categories of disabilities as shown in the following table (Pendaftaran Orang Kurang Upaya [Registration of Persons with Disabilities], Department of Social Welfare Malaysia, August 2015). The Information Management System for Persons with Disabilities (SMOKU), a data system is used to develop an accurate database.

Table 8: Types of Disabilities

<table>
<thead>
<tr>
<th>Category of Disabilities</th>
<th>No. of people with disabilities</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Learning Disabilities</td>
<td>125,378</td>
<td>35.7%</td>
</tr>
<tr>
<td>Physical Disabilities</td>
<td>119,715</td>
<td>34.0%</td>
</tr>
<tr>
<td>Hearing Disabilities</td>
<td>28,884</td>
<td>8.3%</td>
</tr>
<tr>
<td>Visual Disabilities</td>
<td>31,361</td>
<td>8.9%</td>
</tr>
<tr>
<td>Multiple Disabilities</td>
<td>16,156</td>
<td>4.7%</td>
</tr>
<tr>
<td>Mental (Psychosocial) Disabilities</td>
<td>27,908</td>
<td>7.9%</td>
</tr>
<tr>
<td>Speech Disabilities</td>
<td>1,712</td>
<td>0.5%</td>
</tr>
<tr>
<td>Total</td>
<td>351,114</td>
<td></td>
</tr>
</tbody>
</table>

As shown in the table, learning disabilities is the category with the highest number of people, 125,378, which is 35.7% of the total number of people with disabilities registered. In Malaysia, the term learning disabilities include people with intellectual disabilities and developmental disabilities.

Methods of identification of disability

Registration of persons with disabilities in Malaysia is legislated in the Persons with Disability Act (2008), Section 20 (1). In July 2012, the Guidelines for identification and registration of people with disabilities was enforced by the Department of Social Welfare (2012a). The Garis Panduan Pendaftaran Orang Kurang Upaya [Guidelines on Registration of Persons with Disabilities] stated clearly the objective of registration, definition of disabilities, categories of disabilities, official registration form and procedures to fill the form. This guidelines can be accessed at the Official Portal of the Department.

44 Department of Social Welfare
The assessment of individual is based on the information collected from the registration form which include: biodata of applicant, consent to review medical condition, information of the medical condition, information on the disability, information related to proposed physical aids/personal assistant/etc. and proposal on school placement.

The information provided has to be endorsed by the relevant authorities represented by the medical officers, education officers and welfare officers.

3.2.2.2 Education

To date, there is no record of absolute data of literacy rate of people with disabilities in Malaysia. According to *Quick Facts 2014* of Malaysia Educational Statistics (Ministry of Education Malaysia, 2014:22), there is an increased in the total number of enrolment of students with learning disabilities in primary and secondary Special Education Integration Programme, from 47,392 students in 2012 to 52,914 students in 2014, as shown in the table below. Special Education Integration Programme is a programme for students with learning disabilities in regular schools.

**Table 9: The Number of Enrolment of Students with Learning Disabilities in School**

<table>
<thead>
<tr>
<th>Students/Year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary School</td>
<td>27,096</td>
<td>28,455</td>
<td>28,658</td>
</tr>
<tr>
<td>Secondary School</td>
<td>20,296</td>
<td>22,702</td>
<td>24,256</td>
</tr>
<tr>
<td>Total</td>
<td>47,392</td>
<td>51,157</td>
<td>52,914</td>
</tr>
</tbody>
</table>

The table also indicates that the number of students’ dropout from primary school to secondary school is quite high. However, there is a reduction in percentage of dropouts over the years. The percentage of dropouts from primary school to secondary school in 2012 was 26%, but, it was reduced to 16% in 2014. It is observed that majority of these dropouts are students with significant learning disabilities. Many of these dropouts are transferred to CBRs or non-government organisations (NGOs) by the choice of their parents for alternative educational programme.

*Data Pendidikan Khas* [Special Education Data] (Ministry of Education Malaysia, 2012:36-37) reported there are special schools for students with visual impairment and hearing impairment but the number of enrolment is not significant. In year 2012, only a total of 391 students with visual impairment were enrolled in the special primary schools (250 students) and secondary schools (141 students) for students with visual impairment. There was a record of 1,505 students with hearing impairment enrolled in special primary schools (1,186 students) and secondary schools (319 students) for students with hearing impairment.

There is an increased in number of students with visual impairment, hearing impairment and physical impairment that are enrolled in inclusive programme in regular schools. According to the *Quick Facts 2014* of Malaysia Educational Statistics, the total number of students with disabilities in inclusive programme has

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45 *Quick Facts 2014* of Malaysia Educational Statistics
increased from 562 students in 2012 to 2226 students in 2014 (Ministry of Education Malaysia, 2014). These are mainly students with physical, visual or hearing impairment.

3.2.2.3 Employment

In spite of various measures taken to promote employment for people with disabilities, the unemployment rate is observed to be persistently high. The Labour Department of Peninsular Malaysia only has a record of 6,750 people with disabilities employed in the private sector (Abdullah and See, 2011:114). Last year, the Public Service Department (2014) reported that a total of 3,741 of people with disabilities were employed in the public sector, that is, 0.22% of its total employee of 1,667,055.

The Laporan Statistik [Statistic Report] from the Department of Social Welfare (2013:66) reported that the number of people with disabilities earning RM1,200 and below per month receiving Allowance for Disabled Workers was 65,372 persons in 2013. This figure included people with disabilities working in the open employment and sheltered employment. There was no record on the breakdown of the number of people with disabilities working in the open employment and in the sheltered employment respectively.

The total figures reported by the various agencies above is not the absolute figure of people with disabilities who are employed in Malaysia. There is a need to consolidate the data of all related agencies such as the Labour Department in the Peninsular, Labour Department in the East Malaysia, Social Security Organisation, Inland Revenue Board and Department of Social Welfare.

In the Persons with Disabilities Act 2008, Section 29 (1), the Government endorsed that:

Persons with disabilities shall have the right to access to employment on equal basis with persons without disabilities.

Measures are taken by various related government agencies to promote employment for people with disabilities by introducing employment benefits and incentives for people with disabilities and their employers (Kuno, et al., 2012:27-30):

Table 10: Employment Benefits for People with Disabilities and their Employers
by Various Governmental Agencies

<table>
<thead>
<tr>
<th>Agency</th>
<th>Employment Benefits/Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Labour, Ministry of Human Resources</td>
<td>Business Enhancement Assistant Scheme (BEAS) – Grant for persons with disabilities to set up enterprises to promote self-employment.</td>
</tr>
<tr>
<td>Social Security Organisation, Ministry of Human Resources</td>
<td>Return to Work programme to assist employees who were injured during employment to return to work.</td>
</tr>
<tr>
<td>Inland Revenue Board, Ministry of Finance</td>
<td>Personal tax relief for employees with disabilities (Additional RM6,000 to the basic RM9,000).</td>
</tr>
<tr>
<td></td>
<td>Double tax deduction of remuneration paid to employees with disabilities (Salary: RM12,000/annum. Tax deduction: RM24,000).</td>
</tr>
<tr>
<td></td>
<td>Single tax deduction for expenses spent on equipment and alteration of work environment for employees with disabilities.</td>
</tr>
</tbody>
</table>

Since 2009, the Department of Social Welfare and Japan International Cooperation Agency (JICA) established a joint effort to support participation of people with disabilities in the community. Employment promotion is one of the key focus of this project to enable more people with disabilities, including those with significant disabilities to participate in the society through supported employment (Ogawa, et al., 2011:64).

The Job Coach Programme, being the key component of supported employment was implemented in 2012 by the department. In this programme, Job Coaches are being paid RM15 per hour for up to a maximum of 60 hours of support for each person with disabilities. This approach has proven to be successful in some developed countries such as Japan and the United States. In recent years, it has also shown remarkable results in Malaysia (Kuno, et al., 2012:24).

It was reported in the Project Completion Report (Department of Social Welfare Malaysia and Japan International Cooperation Agency, 2015:18) the number of people with disabilities joining the open employment with support of job coaches had a steady increase over a period of three years. As shown in the following table, in 2012, when the year Job Coach Programme was first implemented, there were only 19 people with disabilities employed with support of job coaches. The number rose to 94 people in 2013 and 260 people in 2014. Majority of those who were supported into employment were people with learning disabilities i.e. 235 people out of total of 373 people. The number of companies that open up job opportunities also increased from 13 in 2012 to 142 in 2014. This achievement has proven that with support, more people with significant disabilities are able to join the open employment.

| Table 11: The Number of People with Disabilities Joining the Open |

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46 Kuno, et al., 2012:27-30
Employment with Support of Job Coaches

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of People with disabilities Employed</th>
<th>No. of Learning Disabled</th>
<th>No. of Visual Impaired</th>
<th>Other Disabilities</th>
<th>No. of Job Coaches</th>
<th>No. of Companies &amp; Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>19</td>
<td>18</td>
<td>0</td>
<td>1</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>2013</td>
<td>94</td>
<td>61</td>
<td>29</td>
<td>4</td>
<td>17</td>
<td>41</td>
</tr>
<tr>
<td>2014</td>
<td>260</td>
<td>156</td>
<td>51</td>
<td>53</td>
<td>63</td>
<td>142</td>
</tr>
<tr>
<td>Total</td>
<td>373</td>
<td>235</td>
<td>80</td>
<td>58</td>
<td>89</td>
<td>196</td>
</tr>
</tbody>
</table>

Wan Abdullah, et. al. (2014), reported that the Business Enhancement Assistance Scheme (BEAS) which is managed by the Labour Department is a business grant introduced by the government for people with disabilities under the Ninth Malaysia Plan (2006-2010) and later continued under the Tenth Malaysia Plan (2011-2015). This program was given an allocation of RM26.5 million to assist people with disabilities to become entrepreneurs and in turn to provide employment opportunities to other persons with disabilities.

BEAS offers an amount of maximum RM100,000, depending on eligibility and fulfilment of conditions and requirements. The assistance is given in the form of equipment needed for enhancement of business, renovation of business premises and marketing of the business product. Since its implementation in year 2007, a total of 860 persons with disabilities have received the assistance under the scheme. The nature of businesses established by the recipients include tailoring, reflexology, provision shop, agriculture, aquaculture, livestock farm, food manufacturing, bakery, furniture manufacturing, auto workshops, printing, photography and accounting.

3.2.2.4 Prevalence of Poverty Amongst People with Disabilities

Islam (2015:176) in his research on the Rights of the People with Disabilities and Social Exclusion in Malaysia concluded that there are disability act, social exclusion act, and welfare policies for fulfilling the needs and rights of the disabled people in Malaysia, but, disabled people in Malaysia are still excluded from the main stream development and their socio-economic conditions are poor. Islam also stressed that social exclusion must be addressed to improve the livelihood of people with disabilities in Malaysia.

There is no data on the prevalence of poverty amongst people with disabilities in Malaysia. Empirical data on disabled people’s socio-economic status in Malaysia is indeed lacking. Such data are much needed to aid the formulation and implementation of effective public and organizational policies that can help improve the socio-economic status faced by the disabled population in Malaysia.

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47 Department of Social Welfare Malaysia and Japan International Cooperation Agency, 2015:18
3.2.3 History and Background of CBR in the Country

According to the history of CBR in the official portal of Community Based Rehabilitation Network (Pemulihan Dalam Komuniti Network, 2015) the CBR approach was pioneered by three physicians and physiotherapists of World Health Organization (WHO) comprising of E. Helandar, P. Mendis dan G. Nelson who produced a draft CBR manual that was nearly 300 pages thick. The Department of Social Welfare Malaysia was involved in the preparation of this manual in 1983 when Malaysia was represented by a welfare officer and a medical officer to examine the draft manual and subsequently provide the opportunity to evaluate and adapt the implementation of this method in an Expert Group Meeting organized by the WHO in Manila.

As a result of this involvement, the Department of Social Welfare in collaboration with the State Health Department of Terengganu, initiated a pilot project in CBR Batu Rakit, in the district of Batu Rakit, Terengganu. A survey was conducted with the cooperation of the community and government departments in the district and involving people from nine (9) villages, a total of 17,149 people. Through this survey a total of 275 disabled persons were identified, that is 1.65% of the population in the district.

The results of the study have convinced the Department to implement the CBR program that was launched in 1984 by the Hon. Minister of Social Welfare. The program began with only 55 persons.

Kuno (2007:107,108) reported that there was a rapid expansion of CBR internationally in the early 1990s. However, these programs according to Kuno were often mere outreach programs for rehabilitative service provision. This trend was also seen in many initial CBR programs in Malaysia. These “CBR programs” he stressed were in fact an extension of the existing institutional based program.

When Department of Social Welfare initiated the CBR program in 1983, CBR workers were purely volunteers from the community. However, due to difficulties in recruiting volunteers, an allowance scheme was introduced at the rate of RM3.50 per hour (Kuno, 2007:111). In 1992, the department adopted a fixed monthly allowance of RM350 and it was raised to RM500 in 1997. These CBR workers became part-time contracted staff of the department although their official status is ‘volunteer’. The financial support for the CBR increased substantially by 2012 as reported in the Buletin PDK 2012 [CBR Bulletin 2012] (Department of Social Welfare Malaysia 2012b:9). The supervisors of CBR are currently paid an allowance of RM1,200 per month (5 day work, 8 hour per day) while the staffs are paid RM800 per month (5 day work, 6 hour per day).

The CBR in Malaysia has progressed and developed over the last three decades with financial support, human resource development program and supervision from the Department of Social Welfare in collaboration with the community and other agencies such as the Ministry of Health, Ministry of Education and Labour Department.
3.2.4 The Association of People with Disabilities in the Country

All non-governmental associations or organizations in Malaysia have to be registered with The Registry of Societies of Malaysia (2015), a department under the Ministry of Home Affairs. In Malaysia, self-help organizations led by people with disability have a history of about five decades. In 1993, Armstrong (1993:192) already observed that self-help movement has become an important element of response to disability and the advancement of people with disability in Malaysia.

The first Society of the Blind was set up in 1964, followed by the Society of the Orthopedically Handicapped in 1976, and the Kuala Lumpur Society of the Deaf in 1987. The first Society of Persons with Learning Disabilities known as Self-Advocacy Society of Persons with Learning Disabilities Selangor and Kuala Lumpur (United Voice) was registered in July 2005 (Yeo, 2007:1). People with learning disabilities are amongst the most marginalized disabled group in the Malaysia. In the last 10 years, through the effort of United Voice and other self-advocacy groups, awareness and advocacy by people with learning disabilities themselves have increased.

According to a comprehensive 451 pages directory compiled by Malaysian Care (2012) there are close to 300 registered NGOs for people with disabilities in Malaysia. This figure included 27 National Organizations such as:

- National Early Childhood Intervention Council, Association of Women with Disabilities Malaysia,
- Malaysian Council for Rehabilitation
- Malaysian Association of Social Worker
- Malaysian Association of Speech Language and Hearing
- Malaysian Confederation of the Disabled
- Malaysian Spinal Injury Association
- Malaysian Physiotherapy Association
- National Council of Spastic Children’s Association in Malaysia
- Malaysian Federation of the Deaf
- National Autism Society of Malaysia
- National Council for the Blind, Malaysia
- National Council for the Mentally Handicapped
- National Stroke Association of Malaysia
- Society of the Orthopedically Handicapped, Malaysia
- Down Syndrome Society Malaysia
- Society of the Blind in Malaysia
- National Council of Welfare and Social Development Malaysia

The national organizations for people with visual, hearing and physical disabilities are well established and they have strong advocates that champion for the rights and well-being of people with disabilities. The Malaysian Confederation of the Disabled (MCD) was formed in 1987 as an umbrella body representing the interests of cross-disability organizations. MCD functions as a consultative and coordinating body for disability organizations at the national level. The organization has played a crucial role in advocating for the Malaysia Persons with Disabilities Act that was enacted in 2008. United Voice, the self-advocacy society of persons with learning disabilities
became part of this coalition since 2005 (Yeo, 2007:81). United Voice is the only organisation for people with learning disabilities that is registered with the Registry of Societies of Malaysia.

To date, there are a total of 508 CBR (Department of Social Welfare Malaysia, August 2015). The setup of CBR is different from the NGOs. While the NGOs are autonomous within the guidelines of The Registry of Societies of Malaysia, the CBRs follow the guidelines set by the Department of Social Welfare. NGOs are expected to raise their own funds with minimal support from the government whereas, the CBRs are highly funded by the government. The NGOs are usually funded by membership fee, international organizations or agencies, private sector, religious bodies, local foundations and contribution from the general public through fund raising efforts.

The NGOs are established mainly in the cities and bigger towns whereas the CBRs are set up in almost every district including the rural areas. The NGOs and CBRs are sometimes invited to disability related training and national conferences or seminars funded by various government agencies. There are also collaboration between the NGOs and CBRs in events such as Paralympics and Special Olympics.

### 3.2.5 The CBR Governance

The organizational structure of the CBR in Malaysia is clearly defined in the comprehensive 139 pages *Garis Panduan Pengurusan Program Pemulihan Dalam Komuniti* [Community Based Rehabilitation Program Management Guidelines] (Department of Social Welfare Malaysia, 2012c:3, 4, 5). The Governance of CBR involves four levels of management:

- **National CBR Committee**, headed by the Director General of the Department of Social Welfare and Chaired by the Director of the Department for the Development of Persons with Disabilities
- **State/Federal Territory CBR Coordinators Committee**, chaired by the State/Federal Territory Director of Welfare and advised by the Director of Department for the Development of Persons with Disabilities.
- **District CBR Coordinators Committee**, chaired by the District Welfare Officer and advised by the Director of State/Federal Territory Department of Social Welfare. Committee members include one officer representative from each of the following agencies and organisations: District Department of Health, Department of Education (Special Education Unit), Department of Labour and other related agencies, NGO and all chairpersons of CBR in the district.
- **Committee of CBR Center** is administered by a committee consist of the local leaders that have keen interest in supporting the development and welfare of disabled people, Zulkefli Mokhtar, a senior officer in the CBR Division, Department of Social Welfare explained (Personal communication: 7.9.2015). Parents of people with disabilities are also encouraged to be in the committee to voice their needs and concern and to have an active role in the development of the centre. The committee raise funds to have their own financial resources
to upkeep and improve the facilities of the centre. Funds are also needed to run healthy programs and activities for the development of the users. The district Welfare Officer is appointed as the advisor while the chairperson is appointed among the local community or parent / guardian. Ex-Officio include representative from the Department of Education (Unit of Special Education), Department of Health Officer, Department of Labour Officer and any other related party.

3.2.5.1 Objectives of CBR

The guidelines for CBR of the Department of Social Welfare (1995) was first drawn in 1995 stating clearly its objectives and strategies. The objectives of CBR Malaysia was revised over the years and the most current were stated in the Buletin PDK 2012 [CBR Bulletin 2012] (Department of Social Welfare Malaysia, 2012b:8) as follows (translated from Bahasa Malaysia language):

- To encourage compassionate attitude, self-reliance and sense of responsibility in the local community for the rehabilitation of persons with disabilities.
- To mobilize local resources for the rehabilitation of persons with disabilities.
- To encourage the use of simple, inexpensive, effective and acceptable techniques within the local context.
- To provide services by using the existing infrastructure within the local organisation.
- To expand the overall services based on the needs of persons with disabilities by taking into consideration the national economy resources.

3.2.5.2 Activities of CBR

The activities of CBR recommended by the Department of Social Welfare (2012c:24) include: morning assembly, morning exercise, self-management activities, gross motor and fine motor skills, language development, basic reading, writing and counting, music appreciation, pre-vocational skills, rehabilitation program and social activities.

Financial management of CBR center

The financial management of CBR centre is given clear guidelines in the Community Based Rehabilitation Program Management Guidelines (Department of Social Welfare Malaysia, 2012c:18-22). The Department of Social Welfare is committed to contribute annual fund for every CBR center nationwide. This annual fund is provided to sponsor the monthly allowance for people with disabilities who are attending the CBR program, staff allowance, rental, equipment, cost of utilities and activities.

Noraini Saruji, a supervisor of CBR Semenyih, a CBR center in the state of Selangor, explained about the financial management of CBR Semenyih as an example (Personal communication: 9.9.2015). The average annual expenses of CBR Semenyih that provides services for 80 people with disabilities, with the support of one supervisor and four staffs, is estimated at RM205,200. This expenses include utility, meals, monthly allowance and travel allowances of supervisor and staffs, monthly allowance
for people with disabilities and cost of other CBR activities. Annual financial support from the Department of Social Welfare is approximately RM150,000. The committee is responsible to raise additional fund in order to cover the total expenses. As shown in this example, the cost of running a CBR is largely sponsored by the Department of Social Welfare. In the case of CBR Semenyih, the committee also raised fund to build their own premise. However, unlike CBR Semenyih, majority of the CBR nationwide are still dependent on rented premises.

**CBR development nationwide**

Over the last 3 decades, the CBR program in Malaysia has evolved and established reaching out to 18,943 people with disabilities in 428 CBRs nationwide by 2010 (Ahmad, 2013:26). In view of the CBR development in Malaysia, Ahmad has the opinion that the CBR program is crucial in meeting the needs of people with disabilities. This program has also benefitted the community in understanding the importance of their involvement in caring, educating, developing and that the welfare of people with disabilities are ensured by sharing the burdens of people with disabilities and their families.

To date, there are 508 CBRs reaching out to 21,089 people with disabilities nationwide. The following table provides the figures of CBRs in Malaysia according to states and federal territories nationwide (Department of Social Welfare, March 2015).

As shown in the table, out of 21,089 people with disabilities, 16,740 attends program at CBR centres whereas 4,349 are given rehabilitation and other services at home.

**Table 12: The Numbers of CBR, People with Disabilities, Supervisors, and Staffs**

<table>
<thead>
<tr>
<th>No.</th>
<th>State or Federal Territory</th>
<th>No. of CBRs</th>
<th>No. of Person with Disabilities Served</th>
<th>No. of CBR Supervisors</th>
<th>No. of Staffs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Perlis</td>
<td>8</td>
<td>252/131 (Center/Home)</td>
<td>8/50</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Kedah</td>
<td>37</td>
<td>1,153/393</td>
<td>37/191</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>P.Pinang</td>
<td>22</td>
<td>1,086/286</td>
<td>22/197</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Perak</td>
<td>39</td>
<td>794/339</td>
<td>39/126</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Selangor</td>
<td>45</td>
<td>2,129/415</td>
<td>45/271</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>WP Kuala Lumpur</td>
<td>11</td>
<td>508/55</td>
<td>11/79</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>N. Sembilan</td>
<td>45</td>
<td>1,026/226</td>
<td>45/215</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Melaka</td>
<td>17</td>
<td>577/310</td>
<td>17/81</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Johor</td>
<td>69</td>
<td>2,040/653</td>
<td>69/368</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Pahang</td>
<td>51</td>
<td>1,211/313</td>
<td>51/236</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Terengganu</td>
<td>45</td>
<td>1,238/195</td>
<td>45/154</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Kelantan</td>
<td>42</td>
<td>1,009/340</td>
<td>42/147</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Sarawak</td>
<td>44</td>
<td>2,119/278</td>
<td>44/286</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Sabah</td>
<td>31</td>
<td>1,508/405</td>
<td>31/162</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>WP Labuan</td>
<td>2</td>
<td>90/10</td>
<td>2/9</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>508</strong></td>
<td><strong>16,740/4,349</strong></td>
<td><strong>508/2,572</strong></td>
<td></td>
</tr>
</tbody>
</table>

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48 Department of Social Welfare, 2015
Based on the CBR Guidelines, all CBR nationwide are monitored by the officers of Department of Social Welfare from national to state and district level.

**Human Resource Development**

There are a total of 508 coordinators, one for each CBR and 2,572 support staffs. The average ratio of a support staff to person with disabilities is 1:8.

It is observed that the human resources engaged by the NGOs are with higher qualification as compared to those in the CBR. Many NGOs are led by people with academic degrees and post graduate degrees. However, the basic entry requirement of a staff in CBR is a minimum SPM certificate, i.e. Malaysian Certificate.

The supervisor is required to have an additional minimum five years of working experience in CBR. The age of staff may range from 18-60 years old. The staff are expected to have interest and commitment to work with people with disabilities, compassionate and patient.

Human resources of CBR are pivotal in providing quality services in CBR to promote better quality of life for people with disabilities who are attending CBR program. To ensure quality services in CBR, supervisors and staff are encouraged to equip themselves by attending courses sponsored by the Department of Social Welfare that are conducted at the National Council of Welfare and Social Development Malaysia (2015). Though it is costly to conduct courses for so many CBR staff nationwide, this investment is necessary to improve the health, education and livelihood of people with disabilities who are attending the CBR program. This contribution from the government is a strategic approach to reducing poverty of people with disabilities nationwide.

Some of the basic courses which all staff are expected to attend are:

- Basic Social Work Course: Level 1-4
- Child Growth, Development and Care
- Early Intervention for Children with Disabilities
- Basic course on Management of Children with Special Needs
- Early Childhood Education and Care Course: Level 1-4
- Care and Education for Children with Learning Disabilities
- Coping with stress

Since 2010, the Department of Social Welfare has introduced and sponsored new courses to enable staff to carry out program such as Economic Empowerment Program, Supported Employment and Job Coaching and Self-advocacy Program. These enhancement courses have helped the human resources of CBR to be better equip themselves to provide quality services and to achieve the objective of CBR Program in Malaysia in line with the United Nation Millennium Development Goals.

**3.2.6 CBR Services for People with Disabilities**

The CBR programs are based on three models: Home Based, Centre Based and
Centre-home Based. The services provided in CBR in general include these five key components: Health, Education, Social Development, Livelihood and Empowerment. However, not all CBR implement all these services, since the services provided is based on the needs of the community. Some new CBRs may focus mainly on intervention, therapy, health and education if they are reaching out only to young children. Those CBRs that have a range of all ages would include all the relevant components of services.

According to the lead officer of the CBR Division of Department of Social Welfare, Suhaiza Ahmad, majority of the users of CBRs in Malaysia are people with learning disabilities (developmental and intellectual disabilities) and people with multiple disabilities (Personal Communication: 19.8.2015). For example, in CBR Semenyih, 95% of its users are people with learning disabilities and multiple disabilities ranging from 1 year old to 40 years old. According to Saruji, 20 of these users have severe cerebral palsy and they need intensive support. Due to lack of man power and the varied needs amongst the users, many CBR centers like CBR Semenyih have to arrange their weekly program into two groups. Those who are non-mobile attend program on Monday and Tuesday and users who are mobile attend program on Wednesday and Thursday.

Friday is a Home Visit day. Each staff are expected to visit about 2 to 3 persons each Friday. Users who are not able to attend program at the CBR center will be visited twice a month. Users who attend program at the CBR center will be visited by rotation – twice a year for each individual. Parents will be consulted during the home visit to discuss the progress in the development of each individual. A standard form is used as a check list to monitor the development of the individual. Physio therapy will be given to individuals who require, during home visit.

Besides this weekly program, there are also occasional weekend activities such as an outing, participating in events, sports, overnight stay and inter self-advocacy group meetings or activities. These activities promote socialising with volunteers and peers outside of CBR center.

3.2.7 Best Practice

All activities at the CBR are based on the five key components that will be further explored with some good practices being highlighted.

3.2.7.1 Health

On the whole, the health care of most CBR is good if there is sufficient of support from the health care officers, according to Ahmad (Personal communication: 19.8.2014). Due to lack of health care officers in some region, CBR are affected in term of health care services for the users. To overcome the insufficient services provided by health care officers in some CBR, staffs are being trained to do basic rehabilitation program such as basic physio therapy, self-help skills and Activities of Daily Living (ADL).

In most CBR, a physio therapist from the Ministry of Health will visit once a month.
Medical doctor and nurses visit once a month or once in every two months to conduct medical check-up and monitor the development progress of each user. Dentist and dental care nurses visit twice a year for dental care of all users. The health officers has an official CBR Health Registration Book, as shown in the following picture, for each CBR to monitor development and health condition of each individual.

In 2012, the *PDK Ku Sihat: Garispanduan dan Manual Aktiviti* [My Healthy CBR: Guidelines and Activity Manual] was published (Department of Social Welfare Malaysia *et. al.*, 2012:6) to promote better health services in collaboration with the Ministry of Health. *PDK Ku Sihat* is a program that focuses on healthy lifestyles to cultivate healthy eating and regular physical activities among the trainees to improve their quality of health.

**PDK Ku Sihat Activity Program**

**A) Health Assessment**

To ensure all trainees are in good health, monitoring their growth and development needs to be undertaken and recorded as follows:

a. The format for monitoring and recording provided in the guidelines include the following aspects:
   - Biodata
   - Current diagnosis
   - Information on health condition
   - Development history
   - Physical examination

b. Anthropometry record
   This record include height and weight.

c. List of Issues
   Health issues faced by trainees will be monitored and recorded by health officers during their periodical visit.

d. Action plan and execution
   The necessary action plan will be executed by health officer in consultation with parents or guardians to address health issues identified. If medical treatment is needed, the individual will be referred to the nearest government hospital.

**B) Healthy diet**

Information and guidance on the following aspects:
   - Basic nutrition guide
   - The main concern in nutrition for persons with disabilities
   - Sample monthly menu
   - Checklist to prepare healthy food
• Safe food preparation
• Selection of raw food
• Food storage
• Preparation and handling of food
• Kitchen cleanliness assessment form

C) Physical Activity Guidelines

Information and guidance on the following aspects:
• Guidelines on physical activities
• Benefits of physical activities
• Safety aspects during physical activities
• Exercises guide
• Physical activities ideas

This 92 pages guidelines also included a sample activity plan, monitoring and evaluation procedures as well as task and responsibilities of all parties involved.

Medical Expenses and Assistive Devices

Medical expenses for all persons with disabilities who use the services provided by the general hospitals and government clinics are free of charge. Financial assistance for artificial or assistive devices such as hearing aids, artificial arms or legs, calipers, wheelchairs and crutches is available from the Department of Social Welfare for those in need (Department of Social Welfare 2013:80). It was reported that the department spent RM4,708,289 in purchase of these aids for people with disabilities nationwide in 2013.

3.2.7.2 Education

The Quick Facts 2014 of Malaysia Educational Statistics (Ministry of Education Malaysia, 2014:22) reported only 517 children with disabilities enrolled in 142 special pre-school classes nationwide. According to Mokhtar (Personal Communication: 7.9.2015), CBR centres become the only option available for many children with special needs to have their early education since most of the pre-school classes are quite reluctant to enrol them due to lack of knowledge to educate children with disabilities and lack of manpower. CBR introduce the basic learning on reading, writing and counting. Those who have acquired basic skill of reading, writing and counting, the respective CBR centre would refer the child to Special Education School under the Ministry of Education.

Saruji recorded that an average of 5 out of 6 children (83%) from her CBR center are transferred to Special Education School under the Ministry of Education annually (Personal Communication: 9.9.2015). Some children, an average of 3 to 4 students annually, upon completion of secondary education in special schools are transferred back to CBR for adult services, if they are unable to progress to vocational institutions or employment. Ahmad also commented that this is a common scenario in most CBR nationwide (Personal communication: 19.8.2015).
The objective of CBR is for rehabilitation rather than education. Therefore, most education initiatives are conducted in a non-formal approach. The first preference is always for children with disabilities to attend special education provided by the Ministry of Education. Mokhtar informed that the CBR Division has recently taken some steps to develop a common teaching module to be used by CBR nationwide to ensure that every CBR centre meets the minimum standard of educational level being taught to school going aged children who are dependent on CBR for education.

In most CBR, like CBR Semenyih, supervisors take the initiative to source teaching materials and develop their own visual aids to meet the needs of the children in their respective CBR. The picture below showed some books used by Saruji and her colleagues to develop reading, writing and counting teaching materials for their CBR children. These are a series of Educational teaching aids developed for children with autism by the Autism Education Lab, Education Faculty of National University of Malaysia.

Individualized Education Program is being practiced as much as possible. Individual development progress is recorded for each user in their personal file. Children in CBR are also given opportunity to learn how to use the computers and access to internet. More CBRs are now equipped with computer lab. Pre-vocational education is also being introduced in some CBR within their limited resources and facilities.

3.2.7.3 Livelihood

Economic Empowerment Program

Vocational training is listed as one of the activities in CBR. It was observed that vocational training in most CBR were limited and focused mainly on handicraft due to lack of facilities and equipment. In 2012, Economic Empowerment Program was introduced to promote income generating activities in CBR (Department of Social Welfare Malaysia 2012b:12).

Objectives of Economic Empowerment Program

- To enhance the abilities, capacity, capability and skills of adults with disabilities in the CBR
- To create employment for persons with disabilities in CBR
- To train persons with disabilities to be independent in society
- To diversify the vocational activities in CBR
- To create public awareness that persons with disabilities have equal rights to contribute to the community development

This program was implemented by providing workshops and courses for skill development such as sewing marketable products, farming, handicraft, mushrooms cultivation and bakery. According to the report of CBR Division in the Department of Social Welfare (August 2015), 87 CBR centers have initiated Economic Empowerment Program and benefitting 624 persons with disabilities. The lowest average income per person was RM20 and the highest average income was RM650. This program has helped enhanced the vocational skills of CBR users and some of them are able to progress into open employment with support from job coaches of
The Melindo CBR Economic Empowerment Project is benefiting 14 trainees, age range from 17 to 44 years old. These trainees are paid an allowance based on the production and the sales of products. In additional to the allowance from this project, the trainees are also receiving the monthly Disabled Workers Allowance of RM350 from the Department of Social Welfare. This project was registered as a small enterprise in 2009. A project grant was approved by the Department of Social Welfare for the purchase of equipment and initial capital for product materials.

As the business grew, this enterprise was moved to a rented premise for more space. This premise is also used as a Guest House for the community to earn additional income. The trainees are involved in the management and the housekeeping of this guest house as part of the vocational training program of Melindo CBR (Melindo CBR, 2013). This project aims to provide skill based training to prepare more trainees for open employment.

Employment is hard to come by in a small town like Mambong in the state of Sarawak. The Mambong CBR Economic Empowerment Project was established in 2013 to create employment for its trainees. This project is now benefiting 10 trainees. Parents are supportive of this project. They would volunteer to provide support whenever needed at the farm and in marketing the products. These products are sold in the nearby mini markets, schools, parents and neighbourhood. (Mambong CBR, 2013)

Since Supported Employment was initiated in Malaysia in 2009, many staffs of CBR attended Job Coach training course sponsored by the Department of Social Welfare and conducted by Job Coach Network Malaysia to promote employment for persons with disabilities in Malaysia. By the end of 2014, 453 CBR staffs and 188 Department of Social Welfare officers nationwide had attended Job Coach training courses.

The number of people with disabilities who were supported by CBR into employment increased remarkably from 2012 to 2014. In 2012, only two persons with disabilities from CBR were employed in the open employment with support from one job coach. By 2014, 155 persons with disabilities were supported into open employment by 75 job coaches (Department of Social Welfare Malaysia and Japan International Cooperation Agency, 2015:18).

Table 13: The Number of People with Disabilities who were Supported by CBR
into Employment from 2012 to 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>No. of CBR</th>
<th>No. of Persons with Disabilities</th>
<th>No. of Job Coaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>2013</td>
<td>3</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>2014</td>
<td>69</td>
<td>155</td>
<td>75</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td>205</td>
<td>101</td>
</tr>
</tbody>
</table>

The increased in the number of people with disabilities being employed with the implementation of supported employment has urged the Department of Social Welfare to place more emphasis in implementation of supported employment in all CBR that have vocational training or economic empowerment programme.

**Employment Transition Program**

Yeo (2007:121, 2010:42-43), advocates for Employment Transition Program to be implemented in Malaysia, emphasized at the Asia Pacific Supported Employment and Job Coach Seminar held in Kuala Lumpur in May 2015, on the need to implement Employment Transition Programme in Special Education Programme in secondary schools as well as in NGOs and CBR centers that have adult services. Employment Transition Programme implementation should be a national agenda to prepare more persons with disabilities for employment.

The Performance Management and Delivery Unit (PEMANDU) of the Prime Minister’s Department has initiated pilot project on Employment Transition Program in Special Education Schools. This program will be collaborating with NGOs and CBR centers to provide employment support for persons with disabilities. Such programme will enable more people with significant disabilities to work in gainful open employment. Employment Transition Programme, Yeo explained, require collaboration amongst key stake holders such as the Department of Special Education, Department of Social Welfare, Department of Skill Development, NGOs, CBR and the Private Sector (Yeo, 2015).

**Social Protection**

According to the CBR Management Guidelines (Department of Social Welfare Malaysia, 2012c:20, 21), all persons with disabilities who attend a CBR program are paid a monthly allowance of RM150. Those who have profound disabilities and require intensive care will be given monthly allowance of RM300.

The Economic Empowerment Program participants who are earning below RM1,200 monthly are entitled to monthly Allowance for Disabled Workers of RM350. This is the same allowance program entitled to those who are working in the open employment and earning below RM1,200. This incentive has a positive impact in motivating more people with disabilities to work either in the sheltered or open employment. This allowance has helped reduced the burden of transportation cost incurred for people with disabilities to travel from home to work, especially for people with mobility impairment.

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49 Department of Social Welfare Malaysia and Japan International Cooperation Agency, 2015:18
Everyone who attends the CBR program is expected to join the Group Insurance Scheme which cost RM50 per person annually. Since the purchase of this insurance is compulsory, RM50 of allowance of each person is deducted annually by the management of CBR, to pay for their insurance premium.

3.2.7.4 Social

Social skills are promoted from early childhood in the CBR program through various approaches. These skills are practiced during activities and meals whereby children are motivated to develop self-help skills. Basic social skills that are cultivated in CBR may include greeting others, participating in group activities, team work, manners, basic personal safety, inter-personal skills, sexuality and spiritual awareness.

Music and cultural activities are promoted at most CBR where singing and dancing is included in their activities. CBR Semenyih for example, has their own percussion band which include the young children and the adults.

People with disabilities in CBR have the opportunities to socialize with the community through volunteer programme and community activities. The CBR is open to community through plan program such as social activities or friendly games with student volunteers from local institutions or volunteers from the community. These activities could be indoor or outdoor activities. Some companies from private sector sometimes would sponsor CBR for an outing event to visit places of interest or picnic by the beach or park.

Social skills development in CBR: Greeting others, having meals independently, personal care, personal space, relating with family members and friends.

Occasionally, CBR Semenyih organises weekend sleep over activities where teenagers and adults of about 10 to 12 people learned to plan their own activities, cook their own meals and have fun experiencing staying away from home. During the sleep over, spiritual awareness is also instilled – for the Muslims for example, learning how to prepare oneself before prayers and learning to recite prayers will be taught.

Most CBR are involved in Special Olympics. Through these sports events, participants have the opportunities to meet and play with peers from other CBR. Some even have the opportunities to participate in National and International games.

Social Activities in CBR: (adding photos? If not, this heading can be deleted)

Wan Fadlina Wan Husain, a senior welfare officer of the Selangor state, has the opinion that parents and guardians play an important role in instilling and enhancing social skills in their children. Many basic social skills are developed during childhood through the influence of family lifestyle and family values. Such awareness is shared with the parents by the CBR staff. Parents who take the trouble to reinforce social skills learned in CBR will see a better impact in social skills development in their children (Personal communication: 14.9.2015).

In recent years, social skills development program for users in CBR is enhanced
through self-advocacy program which will be discussed in the following sub-topic on Empowerment.

Samilah Jamel, the supervisor of Seri Murni CBR, Jasin, Melaka, has witnessed the marriage of two couples from two CBR centres, Jasin CBR and Alor Gajah CBR, in the state of Melaka, during her thirteen years of service in CBR. Both couples have mild learning disabilities. They met in CBR and their friendship grew over the years through participation in CBR program. Jamel has the opinion that people with learning with disabilities are capable of coping with marriage if they have good social development and are given proper marriage counselling.

Jamel observed that in recent years, where people with learning disabilities are becoming more independent through sustainable employment, there are more success stories of marriage and parenting. Moral support from their parents play a very important role in helping them to settle in at the initial stage of marriage. Jamal said there are other success stories of marriage of people with learning from CBR centers of other states within Malaysia. (Personal communication: 21.9.2015).

3.2.7.5 Empowerment

About a decade ago, Kuno (2007:120) expressed concern that the content of the manual for CBR in Malaysia focused extensively on rehabilitation and educational interventions, while approaches for empowerment and inclusion are not included. Kuno also noted that few CBR programs included concrete aspects of participation such as to encourage CBR users to go to school and be employed for economic independence as their objectives.

Since 2011, there has been many positive changes in the CBR in Malaysia through the implementation of Social Model approach and in line with the United Nation Millennium Development Goals. Besides, the success in preparing more children to progress on to primary school special education program, CBR is also promoting self-advocacy, economic empowerment program and supported employment which empower people with disabilities to be more independent and to experience inclusion in the community.

Self-Advocacy Program

In 2011, the Department of Social Welfare decided to work with United Voice, the first Self-Advocacy movement for people with learning disabilities in Malaysia to promote self-advocacy in CBR (United Voice, 2011:3, 4). The first self-advocacy conference for CBR was held in June 2011. It was reported in the United Voice Annual Report 2011, that 100 supervisors and staffs of CBRs from the state of Selangor, Negeri Sembilan and Kuala Lumpur attended this conference. This initiative enhanced empowerment for people with disabilities in CBR and created a greater impact of inclusion.

In 2012, Self-advocacy Group Program was included in the CBR program (Department of Social Welfare, 2012b:14). This program promotes inclusion without environmental or attitudinal barrier, based on equal rights.
Objectives of Self-advocacy Group Program

- Increase in knowledge on the concept, importance and skills of Self-advocacy.
- Increase in the ability of each individual to full potential.
- Promote independence and courage to speak up for individual rights to participate in society.
- Create public awareness that people with disabilities are part of the community and have equal rights in community development.

This program was implemented nationwide through six regional CBR Self-advocacy Conference held in 2011 and 2012. The conferences were attended by the CBR Supervisors and State CBR Coordinators.

The program of the conference included the following sessions:
- Session 1: Introduction to self-advocacy
- Session 2: How to develop self-advocate skills
- Session 3: Self-awareness
- Session 4: Developing self-confidence
- Session 5: Awareness on individual rights
- Session 6: How to speak up
- Session 7: Formation of self-advocacy groups
- Session 8: The roles of support personnel for self-advocacy groups
- Session 9: Action plan
- Session 10: Smart partnership through Self-advocacy Network

Training Persons with Disabilities to Self-Advocate

There are currently 58 self-advocacy groups, involving 79 CBR centers nationwide (Department for the Development of Persons with Disabilities, Aug 2015).

The first self-advocacy workshops for people with disabilities in CBR was organised by United Voice in Feb 2012. There were a total of 100 participants, majority were self-advocates from 30 CBR self-advocacy groups. This workshop that was sponsored by the Japan International Cooperation Agency Malaysia, created awareness on the importance of self-advocacy and participants were given opportunities to express their opinions. Some states, such as Kedah and Kelantan organised inter self-advocacy group workshops for groups within the states. Such activities have motivated people with disabilities from each group to strengthen their groups and to take up more leadership roles.

Follow-up workshop are now in planning for all self-advocacy groups nationwide, to equip people with disabilities of CBR to lead and run their self-advocacy groups. This approach will create better inclusion and empower people with disabilities in CBR to be involved in planning, decision making, organizing and running meetings and events for their group.

Leadership skills are being harnessed among people with disabilities through this program. They have learned to run their own groups, make public speeches and learn to advocate for their rights. Some groups have learned to organise inter self-advocacy groups activities to promote better social interaction and promote peer motivation.
To promote the awareness on the rights of people with disabilities, the simplified version of the United Nation Convention on the Rights of Persons with Disabilities (UNCRPD) is taught through the self-advocacy program.

Self-advocacy groups should be formed in every district to empower and impact the lives of more persons with disabilities, in particular those with significant disabilities. Collaboration between the government sectors and NGOs and CBR should be strengthened to support the self-advocacy movement in Malaysia (Yeo, 2007:123).

3.2.8 The Way forward

Over the last three decades, the government of Malaysia is committed in helping the CBR program in Malaysia to reduce the poverty of people with disabilities not only through financial providence but also through strategic management in collaboration with local community.

Funding invested by the Department by the Department of Social Welfare to employ paid staff rather than solely dependent on volunteers, is essential to ensure consistent and quality services in CBR. Human resources of CBR are given support by the Department to be better trained and equipped to serve the people with disabilities in CBR and to achieve the objective of CBR in creating a better quality of life for them through the five key components: Health, Education, Social Development, Livelihood and Empowerment.

It is observed that some CBR centers are better developed than others depending on the community support and economic development of the community. More effort is needed to ensure that CBR located in the poorer economic regions are given better support to enhance the quality of services. There is also a need to further equip CBR human resources to strengthen services provided especially in the development of program such as self-advocacy, economic empowerment and supported employment.

Collaboration with the Ministry of Health and the Ministry of Education has to be strengthened to enhance the services in Health and Education. More man power is need from the Ministry of Health to provide more frequent health care services especially in the more rural areas. It is noted that there is a need for better collaboration with the Ministry of Education to improve on the pre-school education in CBR to enable more children with significant disabilities to progress into integrated and inclusive education in the mainstream schools. The development and implementation of Employment Transition Program in CBR to promote self-advocacy, independent living and employment for people with significant disabilities require a strategic collaboration between the Division of Special Education, Department of Social Welfare, the Labour Department and the Private Sector.

Social Model approach is pivotal in poverty reduction of people with disabilities in CBR. The awareness on the impact of this approach has to be instilled in the CBR Management and human resources to see more progress in poverty reduction.
through the CBR Program in Malaysia.
3.3 Indonesia

3.3.1 Background

Indonesia is a culturally diverse archipelago nation with total number of 17,508 islands of which about 6,000 are inhabited that scattered between 6 degrees north latitude to 11 degrees south latitude and from 9 degrees to 141 degrees east longitude. Straddling equator, the archipelago is on a crossroads between two oceans, the Pacific and the Indian Ocean, and bridges two continents, Asia and Australia. This strategic position profoundly influences the country's culture, social and political life, and the economy. Total Area of Indonesia is 1,919,440 sq km. The five main islands are: Sumatra, Java, Kalimantan, Sulawesi and Papua. Indonesia’s other islands are smaller in size.

Population of Indonesia is the fourth largest population in the world consisting of 237.6 million people in 2010 and the projection in 2013 is about 249 million. 57% of population lives on the island of Java. More than 300 ethnic groups are represented in Indonesia, where as the Javanese make up 40%, Sundanese 15 %, Indonesian Chinese make up a little less than 1% of the total population and the rest from its smaller islands. Bahasa Indonesia, a form of Malay, is the official language and English, Dutch, Javanese and indigenous dialects are also spoken. Just under half the population is urbanised, with 9.12 million living in the capital, Jakarta. Annual population growth rate of Indonesia (2010-2013) was about 1.42 %. The religion plays an important role in Indonesian culture with approximately 86% of the population is Muslim.

The entire Indonesian population has only been under the dominion of central rule since around the 1920’s, and cultural and religious differences have fueled internal conflict throughout its history. Indonesia gained independence from Dutch colonial rule in 1945 by its own struggling. The constitution from 1945 embodies five principles of the state philosophy, called Pancasila, namely monotheism, humanitarianism, national unity, representative democracy by consensus, and social justice. Indonesia is a republic with a presidential system. The power is concentrated in the central government. The President of Indonesia is both the head of state and the head of government where as the maximum term for any president is five years. The president is elected by direct popular vote. Free elections in 1999 made Indonesia the world’s third most populous democracy. It has embraced new freedoms and is focused on consolidating the political system, fighting poverty, improving education and defeating terrorism and corruption. Since then, Indonesia has developed a vibrant civil

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50 www.asiaworldindonesia.com/indonesia-at-glance
51 Central Bureau Statistics (Jakarta: BPS, 2014)
52 www.asiaworldindonesia.com/indonesia-at-glance
society and has undergone an aggressive government decentralization process. Significant economic growth and societal change have led to improved social indicators, but regional discrepancies abound, district government capacity is often weak, and income inequality has grown.

With a labour pool of 117.4 millions, Indonesia ranks fifth in the world in terms of available workforce. Dramatic economic growth at the end of the last century led to a big change for the largely agricultural working population. Now nearly half work in the services industry, 38.3% remain in agriculture (rice, cassava, cocoa, palm oil, coffee, beef and poultry) and 12.8% work in industry. Unemployment was a moderate 6.6% in 2011 but labour unrest due to low wages is an ongoing problem. Indonesia per capita income was $5200 in 2012 (1 US : 12,000 Rupiah) and Human Development Index was 0.684 in 2014.

Poverty reduction efforts in Indonesia have shown meaningful progress, which is demonstrated by the reduced proportion of people living under the national poverty line, i.e. from 15.10 % in 1990 to 11.66 % in 2012 even when the Poverty Depth Index went down from 2.70 to 2.08 during the same time period. The rate of GDP growth per worker strengthened from 3.52 % in 1990 to 5.04 % in 2011. Additionally, a reduction was observed in the proportion of people suffering hunger between 1989 and 2010 as the prevalence of under-five children with low weight went down from 31 % to 17.9 %.

An effort to achieving universal primary education in Indonesia is demonstrated by the implementation of basic 9-year education. In 2011, the Net Enrolment Ratio (NER) in primary education reached 95.55 %; Proportion of pupils starting grade 1 who complete primary school was 96.58 %; and the literacy rate for the population aged 15-24 years reached 98.75 % for women and 98.80 % for men.

3.3.2 Socioeconomic Status of People with Disabilities

Figures on the population of people with disabilities in Indonesia are not quite clear. Data is collected by Central Bureau Statistics (BPS) and related ministries/bodies, such as Ministry of Social Affair, Ministry of Education and Ministry of Health. They collect data of people with disabilities based on their interest and needs. Data and numbers vary mostly due to different definitions and concept of disability that influences different indicators of disability survey.

For that reason, on May 2014 Central Bureau Statistics developed an instrument of survey and a guidance book of how to carry out disability survey. The survey itself
will be carried out in the last 2015. Hopefully, through the single disability survey there will be available valid data and information related disability in Indonesia that can be utilized by all ministries and bodies.

Population of people with disabilities, last update from Indonesia government through Central Bureau Statistics (BPS) as the result of the National Economic and Social Survey in 2012 was 6,515,500 people from 244,919,000 total population of Indonesia in 2012, or approximately 2.45% of the total population.\(^5^7\)

**Figure 18: Population of People with Disabilities in Indonesia\(^5^8\)**

Central Bureau Statistics (BPS) also demonstrated the category of people with disabilities such as people who have visual impairment 15.93%, hearing impairment 10.52%, speaking impairment 7.12%, multiple disabilities: hearing and speaking impairment 3.46%, physical impairment 33.75%, mental retardation/ intellectual disability 13.68 %, multiple disabilities: physical and mental retardation 7.03% and mental illness 8.52 %.\(^5^9\)

**Figure 19: The Category of Disabilities\(^6^0\)**

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\(^{57}\) Central Bureau Statistics (BPS), National Economic and Social Survey (Jakarta: 2012)  
\(^{58}\) ibid.  
\(^{59}\) ibid.  
\(^{60}\) ibid
This survey reported disability prevalence based on the age. The figure below shows that prevalence of disability increases in a row with the increasing age\textsuperscript{61}.

**Figure 20: Disability Prevalence Based on Age\textsuperscript{62}**

![Disability Prevalence Based on Age](image)

3.3.2.1 Education of People with Disabilities

Education is one of the fundamental right for every human and citizens. A positive law in Indonesia assert that every citizens including disabled people has the right and the same chance to obtain a quality education service. However in the reality, education for disabled people is still distinguished with non-disabled people. Education facilities for disabled people in Indonesia mostly exist only in urban areas and concentrated on Java Island.

In 1986, by the letter of Minister Education and Culture wich number 002/U/1986 about integrated education for children with special needs or disabilities, mentioned that children with special needs or disabilities have the same opportunity to gain appropriate education services in regular schools\textsuperscript{63}. In 2006, the government of Indonesian started to develop integrated education to become the concept and implementation of inclusive education. However until now it has not yet become a national program.

Law No. 20 of 2003 concerning the National Education System stipulated the obligation to equal education for people with disability\textsuperscript{64}. Government Regulation No.

\textsuperscript{61} ibid.

\textsuperscript{62} ibid

\textsuperscript{63} Minister Education and Culture Indonesia the letter number 002/U/1986 : Integrated education for children with special needs or disabilities (Jakarta: 1986)

\textsuperscript{64} Law No. 20 of 2003 The National Education System (Jakarta: 2003)
10 of 2010 included a requirement that each level of education must admit students without discrimination, including discrimination on the basis of physical and mental condition\textsuperscript{65}. Those law and regulation were very good, however their implementation were not optimal.

Health Research and Development Body, Ministry of Health in 2013 reported that people with disabilities who did not attend schools at all and droop out from elementary school were 47.8\% comparing with people with disabilities who attended school were 52.2\%\textsuperscript{66}.

**Figure 21: People with Disabilities who Attending Schools\textsuperscript{67}**

They were who attending schools (47,8\%) consisted of graduated elementary school 11,7\%, graduated junior high school 7,6\%, graduated senior high school 7\%, graduated Diploma and Bachelor (S1) 6,4\%.

**Figure 22: Education Levels of People with Disabilities\textsuperscript{68}**

\textsuperscript{65} Government Regulation No. 10 of 2010 (Jakarta: 2010)
\textsuperscript{66} Health Research and Development Body, Ministry of Health: Basic Health Research (Jakarta: 2013)
\textsuperscript{67} Health Research and Development Body, Ministry of Health in 2013
\textsuperscript{68} ibid.
The UNDP Indonesia in 2012 reported that the national literacy rate for the population aged 15-24 years reached 98.75 % for women and 98.80 % for men. Unfortunately there is no available data related to literacy rate of people with disabilities.

### 3.3.2.2 The Employment of People with Disabilities

The employment rate of people with disabilities in Indonesia is not clear. Some data provided, but some contradicitive with other. Indonesian Ministry of Social Affair held a research using international standard of ICF (Classification of Functioning, Disability and Health) about employment of people with disabilities. This research demonstrated that unemployment people with disability in productive age were about 74.4 %, and so just 25.6 % who have employment.

**Figure 23: Employment of People with Disabilities**

![Employment and Unemployment](image)

While those who have employment they work at many sectors such as: 17% in agricultural sector; 18.6% in industrial sector; 23.9% in trading sector (general trading) and 13% in other sectors.

**Figure 24: Sectors of Employment of People with Disabilities**

![Sectors of Employment](image)

Meanwhile, another data available on the research of basic health in 2013 mentioned that 14.4% of people with disabilities aged more than 15 years were unemployment, 6 % employee, 8 % entrepreneur, 10.2 % farmer, laborer and fisherman and 9.2 % others.

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69 Indonesian Ministry of Social Affair

70 ibid

71 ibid
Different data and numbers mostly due to different definitions and concept of disability and different indicators of survey.

Indonesia UNDP reported that poverty reduction efforts in Indonesia have shown meaningful progress. People living under the national poverty line in 1990 was 15.10% reduced to 11.66% in 2012. However, data and information specifically related to poverty among people with disabilities are not available.

3.3.3 History and Background of CBR in the Country

Historical context of CBR in Indonesia cannot be separated by the history and development of CBR in Asia Pacific region and international as well. Internationally in 1978, the Alma Ata Declaration of "Health for All by the Year 2000" called for the delivery of primary health care services in the community. Primary health care services were supposed to include rehabilitation services for people with disabilities. The World Health Organization (WHO) responded by developing the concept of CBR in the early 1980’s. The original concept was designed to deliver primary rehabilitation services in the community.

CBR in Indonesia was firstly initiated by the oldest NGO working in children with disability issues in Indonesia namely YPAC (Indonesian Society for the Care of Disabled Children). YPAC itself was started in Solo by Prof.Dr. Soeharso in response to the polio epidemic that occurred in Indonesia the early 1950’s. Within a short time their efforts expanded to include providing assistance to other groups of children with physical disabilities such as cerebral palsy. The institutional model that was
developed has proven successful and over the years many children have been educated and assisted in other ways. YPAC has grown to where it now includes 16 institutions located throughout Indonesia.

In 1978, after realizing that institutional services were not able to provide assistance to children living in the rural areas of Indonesia (70 % of the population), YPAC was started to develop their own concept of rehabilitation in the rural areas, which its programs focused on children with cerebral palsy. In early 1981’s YPAC developed their concept of rehabilitation in rural areas to become their own concept of CBR with primary rehabilitation therapy services and early detection programs for disability in young children. By 1983 they developed manuals and training community volunteers, still in Central Java province, to provide assistance to people with disabilities in their own communities. During the next few years the idea proved successful and the number of programs were increased. In 1986 a separate section of the YPAC Head Office was created, namely the CBR Development and Training Center, to handle this expansion. Since then the Center has continued its rapid growth. In 1989 the office and training facilities were officially opened. In 1991 the first international CBR workshop was held in these facilities. In 1992 an outreach CBR program was started in North Sulawesi in partnership with the local YPAC. Also in 1992 the status of the Center was changed from being a section of the Head Office group to a branch organization with its own Board of Directors.

From 1981 until 1992, the approach and strategy of CBR in Indonesia more focused on services delivery for individual with disability who lives in rural areas. That approach was called community oriented services where rehabilitation professionals delivered their services for community and people with disability in solving their problems. A team of rehabilitation professionals such as doctors, physical therapists, occupational therapists, speech therapists, social workers, nurses, special teachers, etc., worked as a team of mobile rehabilitation unit or an out-reach program unit to bring their services to community and people with disability in rural areas. Here rehabilitation service was viewed as a medical, educational, vocational and social service that was delivered directly to individuals with disabilities. As a service, rehabilitation was seen to be a sequence of preventive and curative treatment measures for individuals. Disability issues were viewed as individual issues or individual problems faced by individuals with disabilities. This emphasized on where professionals worked with people with disabilities to treat a specific problem. Even if it was a holistic treatment, the role of people with disability as the recipient of service was relatively passive. The professionals were subject and decision-maker but people with disability were often seen to be the locus of the rehabilitation problems and were, therefore, the sole target of rehabilitation.

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74 Introduction to CBR Development and Training Center Solo (Solo: CBR-DTC, 1994)
Through the long process in early 1993 many CBR practitioners realized that that approach did not suffice when considering the total problems faced by people with disability in their community. The quality of life of all community members, regardless of whether they were people with disability or not, was dependent on their social and physical environment. So, an approach of rehabilitation was not enough without considering the social attitudes, beliefs and behaviors barrier of the community. Since people with disability can develop in their community were most often affected by the social attitudes, beliefs, and behaviors of the community in which they reside.

Meanwhile, the 1993-2002 Asian and Pacific Decade of Disabled persons called for using CBR as a specific strategy for implementing rehabilitation activities in communities. The agenda for action for the Asian and Pacific Decade of Disabled Persons focused on implementation of CBR when it called for "development of community-based approaches as a means of access to rehabilitation services” and "expansion of the role of existing rehabilitation services". In 1994 joint petition paper of WHO, ILO and UNESCO about Community-Based Rehabilitation for and with People with Disabilities was published. This document enlarged the concept of CBR by defining it as being a strategy within community development. In April 1997 the concept of CBR was further expanded and defined when UN-ESCAP published Understanding Community Based Rehabilitation.

The new awareness among Indonesian CBR practitioners and the external situation above affected the development process of CBR in Indonesia. Since then, starting in 1994 many CBR practitioners in Indonesia applied community development approach in developing and implementing CBR. The CBR within community development approach is to facilitate community and people with disability so that they are able to analyze their problems, to define their needs, to identify community resources, to develop priorities, to make a plan of action and to monitor and evaluate the action taken. CBR within community development approach believe that the problems faced by people with disabilities in their daily lives are not only the result of their individual impairments, but are also the result of the attitudes and beliefs of the communities in which they live. The problems that result from negative attitudes (social acceptance, opportunities for income, opportunities for education, etc.) must be resolved if people with disabilities are to have equal opportunities and if they are to achieve full participation. For these reasons, the CBR programs are directed towards the whole community, as well as the individual members who happen to have a disability.


Understanding Community Based Rehabilitation, ESCAP document number ST/ESCAP/1761, 1997

In 2000, Millennium Development Goals (MDGs) was adopted by United Nations members including Indonesia. Even its content did not mention specifically about people with disabilities but some goals of MDGs were relevant to persons with disabilities, such as to eradicate extreme poverty and hunger, to achieve universal primary education and to promote gender equality. In 2003 the second Asian and Pacific Decade of Disabled Persons was started (2003-2012). As a framework of actions for the governments and all stakeholders in implementing mandate of the second Asian and Pacific Decade of Disabled Persons, a document of "Biwako Millennium Framework (BMF)" was published with its main theme was "Inclusive, Barrier-free and Rights-based Society for Persons with Disabilities". BMF emphasized on the change of disability paradigm, from charity approach to inclusive and right-based approach. BMF consisted of 7 priority areas and 4 strategies. One of the recomended strategy was strengthened community based approach through CBR.

Some CBR organisations in Indonesia mostly NGOs responded MDGs and BMF by developing and implementing seven priority areas of CBR those were:

- Self Help Group of people with disabilities, related family and parent associations
- Women with disabilities
- Early detection, early intervention and education
- Training and employment
- Access to built environments and public transport
- Access to information and communications
- Poverty alleviation. Meanwhile the government developed a National plan of action on disability and disability statistic.

In 2004 joint position paper of WHO, ILO and UNESCO about CBR: A Strategy for Rehabilitation, Equalization of Opportunities, Poverty Reduction and Social Inclusion of People with Disabilities was published. This document stressed on CBR as an effective approach in poverty reduction. Poverty reduction became main issue of this document because most of people with disabilities in Asia and Pacific region still live in poverty. This document also emphasized on the important of role all sectors in CBR, such as social, health, education, manpower, media, private sector, and community members. Coordination of CBR implementation in all levels such as: national, province, district, sub-district and village level was also very essential.

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On December 26, 2004 a devastating earthquake struck Aceh and Northern Sumatra Island. The quake triggered tsunamis. On May 27, 2006 earthquake struck Jogjakarta and Central Java. In addition to the great loss of life, the earthquake and tsunami also caused major damage to property, livelihood and infrastructure. To respond post tsunami and earthquake disaster, many organizations both GO and NGO initiated to support community by implementing and developing CBR. Many organizations adopted CBR approaches and strategies to respond disaster tsunami and earthquake.

The Government of Indonesia signed in 2007 the UN Convention on the Rights of Persons with Disabilities, but has yet to ratify it. This convention has significantly affected the implementation and development of CBR in Indonesia. Many CBR organizations have been very active in promoting right of people with disabilities in their CBR programs. They believe that CBR is most effective way in promoting right of people with disabilities.

In 2007 draft of CBR Guideline was developed. Hopefully this guideline would useful and could be used by CBR initiators in every countries which are different situation contexts. CBR practitioners in Indonesia has been active to be involved in the validation process of the guideline. CBR Guideline applies a matrix of CBR which consists of 5 components: health, education, livelihood, social and empowerment. In 2010 CBR GUIDELINE was launched. Most of CBR organizations in Indonesia now use this guideline for implementation and development of CBR.

3.3.4 The association of people with disabilities in the country

The movement of the rights struggle for People with Disabilities was started in 1952 initiated by Prof. Dr. Soeharso. He, in the beginning, built The Organization of RC (The Rehabilitation Centrum) in Solo for helping people with disabilities with various kinds of program such as medical rehabilitation, vocational rehabilitation and social rehabilitation. Some social organizations were born from these rehabilitation programs as the self-actualization avenue of people with disabilities after the rehabilitation in RC, such as Badan Pembinaan Orang Cacat (BPOC), Yayasan Shelter Workshop (YSW), Yayasan Paraplegia and Yayasan Bhakti Nurani.

The Organization of Badan Pembinaan Orang Cacat (BPOC) works in the field of sport for people with disabilities in Indonesia which is now well-known as NPC National. Shelter Workshop Foundation (YSW) is the association of people with disabilities that gives shelter to them who need job, Paraplegia Foundation helps people with spinal cord injury and Bhakti Nurani Foundation as the association of social movement helps people with disabilities after the rehabilitation in RC. Besides, Prof. Dr. Soeharso also built an organization which had special purpose to help children with disabilities named Indonesian Society for the Care of Disabled Children (YPAC).
The association of people with disabilities based on the kinds of disability are born from those organizations, they are:

- PERTUNI, was built in 1966, consists of people with visual impairment and blind. It has more than twenty thousand members in October 2011, which is divided into 29 province PERTUNIs and 167 PERTUNI branches. They strive for helping more than two million blind people in Indonesia.

- GERKATIN or The Movement for People with Hearing and Speaking Impairment, was in Jakarta on February, 23rd, 1981. This association consists of people with hearing and speech impairment. GERKATIN is a legal member of Indonesia National Board of Social Welfare (DNIKS) and Federasi Tuna Rungu Indonesia (The World Federation of the Deaf – WFD). It helps 6 million people with deaf and speech impairment in Indonesia.

- Some of people with disabilities who have physical impairment built Communication Forum Among Physical Disability (FKPCT). It is an organization of people with disability in Indonesia, which was built in 1994, as the replacement of Bhakti Nurani Foundation because they don’t active anymore. FKPCT doesn’t have further development as an organization of the deaf and speech impairment.

Those organizations are getting involved in the International movement like the International Association of Blind and The UN-ESCAP. They often have meeting among those local associations, and in the year of 1989, the leaders of those associations agreed to build a national association which facilitates all the local associations. Thus, the national association was declared as The Union of Disabled People of Indonesia (Persatuan Penyandang Cacat Indonesia) PPCI.

PPCI as the association protector in Indonesia will become a national coordination for all those local associations and civil social organizations which work in the rights of people with disabilities. PPCI, on their progress, runs their own program and can’t become a place for people with disabilities in Indonesia to get their rights. PPCI as an organization also rises some protests since they have branches in provinces and districts but they don’t want to cooperate with other local associations which makes the movement of people with disabilities becomes slower.

As the effect of the development of the people with disabilities movement both nationally and internationally for helping the rights of people with disabilities and its full participation then some new organizations are born which are more progressive and active, they are:

- Himpunan Wanita Penyandang Cacat Indonesia (HWPCI) is a social organization whose members are women with disabilities (visual impairment, hearing and speaking impairment, physical impairment, and mental retardation). HWPCI was
built in Jakarta on September, 9th, 1997 as the answer of the global demand of women with disability. Their program is mainly for the movement of those women in politics, leadership of people with disabilities, and national accessibility. Nowadays, HPWCI has branches in 33 provinces.

- The National Consortium for the people with disabilities rights
- There are many people with disabilities organizations in Indonesia which work professionally but they are not involved in the local associations and PPCI. These profession organizations built an association called The National Consortium for the people with disabilities rights which struggles CRPD that is ratified and implemented in Indonesia. This Consortium is fairly new in Indonesia but their programs are pretty progressive and their struggle for CRPD ratification has been successful. They are now struggling to revise the national law for people with disabilities, that is Law No.4 /1997 which is no longer applicable for the needs of people with disabilities in Indonesia.

3.3.4.1 The Role of Associations of People with Disabilities in CBR

CBR is a strategy of the people with disabilities rights struggle which has many advantages. The key of CBR approach is community participation. Associations of people with disabilities are the component of community. Those associations have a strong role in struggling their rights and support the development of CBR. Some of their roles in CBR are:

*The National Action Plan (NAP)*

Associations have great role in the national action plan. These days PPCI and WHPCI actively take part in preparing, monitoring and making evaluation of NAP. Besides, another DPOs struggle how the rights of people with disabilities could be included in NAP of National Human Right Commission (KOMNAS HAM) and National Women Right Commission (KOMNAS PEREMPUAN). Their struggle has a significant result that is KOMNAS HAM facilitates the CRPD ratification in Indonesia. There is an issue that KOMNAS PEREMPUAN would make people with disabilities as one of the working units. They have started to protect people with disabilities from violence and ask them to participate in politics regionally, provinces and districts. These inclusive acts become a regular agenda of KOMNAS HAM and KOMNAS PEREMPUAN. Nowadays, we have many inclusive WCC (Woman Crisis Centre).

*Introduce CBR to the Community*

The role of associations of people with disabilities in the late 10 years is fairly good in promoting CBR as an effective strategy in solving disability issues. The movement of people with disabilities using CBR strategy has been in a good progress. Their participation has changed gradually the community’s point of view about disability and their participation. The associations hold some campaigns inclusively and through media.
Introduce CRPD to the Society

Indonesia was the one of the countries that signed CRPD and struggled for the ratification. After 5 years struggling, CRPD was ratified in 2011. The associations participate actively to put great effect of CRPD to the society.

Associations Participate in National Development Planning Process

The Indonesian declaration of local autonomy in the year of 2000 became a very important moment in the movement of human right of people with disabilities in Indonesia. The changing of the national development planning is a good chance for the inclusive programs to enter Indonesia. Associations start to get involved in the development planning process. Their acts result an inclusive policy in the government both national and local level.

Advocacy

There are two advocacies in the role of associations which are still developed continuously. Those advocacies are to build community awareness on the rights of people with disabilities and to mainstream the right of people with disabilities into the community.

Associations Take Part in the CBR Implementation on the Grassroots Level

Associations took part directly in the CBR implementation program especially in Central Java, Yogyakarta and East Java. The CBR programs initiated by associations mostly concern on advocacy and social inclusion in the community. Recently, the Minister of Social Affair launched a program called “Village Inclusion” (Desa Inklusi) in Jogjakarta. This event was the DPO movement to realize inclusive program locally. The 12 associations from 12 provinces declared that the program of “Village Inclusion “is the movement of right of people with disabilities in the grassroots level by using CBR’s strategy.

3.3.5 The CBR Governance

3.3.5.1 CBR in National Level

There are 3 ministries in the service of people with disability program in Indonesia. They are Ministry of Social Affair, Ministry of Health and Ministry of Education. The Ministry of Social Affair handles social and vocational rehabilitation, Ministry of Health handles medical rehabilitation, and Ministry of Education handles educational rehabilitation. Those 4 kinds of rehabilitation: social, vocational, medical and educational are for people with disability which are done by using two approaches
namely institutional based approach and non-institutional based approach. Institutional based approach is the approach of rehabilitation for people with disability which is done in the institution such as the centre of social – vocational rehabilitation, hospital, clinic, special school, etc. Non-institutional based approach is the approach of rehabilitation for people with disability which is done in the society such as mobile rehabilitation unit, out-reach program, and CBR.

There are some laws or government regulation related to people with disability in Indonesia such as Law No 4 / 1997 about People with Disability, Law No. 19/2011 about the Adoption of the Convention of the Rights of People with Disability, Law No. 11/ 2009 about Social Welfare, and Law No. 36/ 2009 about Health. Unfortunately, there is no law or regulation specifically related to CBR.

In national level, each ministry implements CBR based on its task or duty. There is no coordination among the ministries or multi-sectoral coordination which involves CBR. Even though there is multi-sectoral coordination, it just for general coordination which doesn’t relate to CBR. There is no special task force or special team formed to do CBR at national level. CBR has not become a national program. The government does not have multi-level CBR management structure and leader. They also do not have special budget regularly for CBR development. The implementation of CBR is more initiated by NGO or DPO which has not been coordinated and managed by the government.

Ideally, the government has at least two roles in CBR those are first, to make the law or regulation about national CBR and; second to coordinate, facilitate, and support the implementation of CBR by NGO or DPO. Meanwhile NGO or DPO conducts and develops technically the CBR project in grass root level. Unfortunately, up to now there is no clear regulation or policy about CBR from the government. CBR is only mentioned in the National Action Plan and it has not been formulated in the form of concrete policy from national level to village level. Recently, the government allocates budget to CBR but it is too small, not national scale and not allocated regularly. The budget is just for funding the government’s CBR pilot projects.

Meanwhile, some National and International NGO in Indonesia have been implementing and developing CBR since 1980s. The people with disabilities associations (DPO) have also been taking a part in the development of CBR. NGO and DPO have been implementing and developing CBR based on pilot projects in some regions, districts and villages. They have been implementing and developing CBR sporadically, separate and sometimes without communication one to each other. They do CBR based on their interest and in accordance with their vision and mission. Some of them develop CBR in the field of basic therapy rehabilitation, income generating, early detection, intervention and stimulation, inclusive education, community awareness, advocacy, etc. Many successful reports came up but they were not documented and communicated well.
Recently many CBR practitioners aware that it is important to have coordination, communication and cooperation among CBR in Indonesia, GO, NGO, and DPO as well. For that reason, they formed Indonesian CBR Alliance. It is an alliance formed from GO, NGO and DPO to develop and implement CBR in Indonesia. This CBR alliance is hoped to become a means of communication, interaction, cooperation and coordination among the initiators of CBR in Indonesia that would encourage CBR becoming national program which is not based oriented on the project only.

3.3.5.2 CBR in Province and District Level

The implementation of CBR in province or district level is influenced by the system of regional autonomy. Indonesia has done the system of regional autonomy since 15 years ago which each province and district or regency has rights to manage their own district autonomously. The authority and decision to manage CBR in the province and district level is given to the local government. There are some local government initiative in doing and developing CBR using the budget of their own. Some other ones do not do the same thing.

The local government that implements CBR is mostly influenced by the advocacy and support from NGO and DPO that working in the areas, but it is not because of the authority and the policy from central government. The idea of the CBR development and implementation always comes from NGO or DPO not the central government. NGO and DPO usually have cooperation with the local government to implement and develop CBR due to limitation of resources. Mostly NGO and DPO really aware, based on their experience, that CBR programs and activities should be integrated into existing programs in the community or existing services of government and its mainstream program, because:

- One of the arguments against CBR program is that there are not enough people with disabilities in one area to support specialized services. When services for these people with disabilities are integrated into the work of community and government that already have a developed infrastructure and monitoring, evaluation and management systems they become feasible. For example: early detection, intervention and stimulation program should be integrated into Integrated Health Post (Posyandu) and Early Childhood Education program, Primary rehabilitation Therapy program can be integrated into Community Health Center (Puskesmas) program, etc.
- The fact of limited resources, both human and financial, has resulted in extremely limited services for people with disabilities. On the other hand, many government organizations working at the grassroot level have personals who have already been trained and are experienced in working in the community. Inclusion CBR program into their existing programs is more effective and efficient way in solving disability problems.
• To establish new infrastructure and CBR system separated from existing system and services in the community and government is too expensive and its implementation is not easy.
• Community development program should involve all stakeholders and its program must be multi-sectoral and interdisipliner. For that reason, disability programs must be inclusive not exclusive. It is very important for coordination among all stakeholders.
• Exclusiveness of disability program has difficulties for sustainability, because its program is very specific and its target group is too narrow. On the other hand, the key of sustainability of program is started from community participation and community decision. If the program’s benefiterries are just a few people with disabilities, so that difficult to mobilize all community resources.

The governance of CBR implementation in the province or district level throughout Indonesia varies mostly due to different situation contexts, needs, definitions and concept of CBR. In some districts, there is special team established for CBR. The role of the team is especially to manage CBR in the district level whose members are from some institutions and government bodies. In any other districts there is not established special team related to CBR. Therefore, the activity of CBR would become a part of their routine program without adding “a special task”, but they need a leading sector, usually social office as a leading sector. The involvements of CBR in the province and district level are:

• The province or district government gives permission, legitimacy and protection in the whole process of CBR implementation.
• The Social Office (Dinas Social) cultivates the activities of CBR through Sub-district Social Worker (TKSK) and Community Social Officer (PSM) and gives recommendation to some referral.
• The Vocational Workshop (Loka Bina Karya) in district level provides workshop on vocational training for people with disabilities who come from Village CBR.
• The Health Office takes a part in the CBR activities through their policies in the reference Community Health Center (Puskesmas) for giving primary rehabilitation therapy and efforts of prevent disability.
• The Education Office (Dinas Pendidikan) gives permission and policy in the implementation of inclusive and integrated education and also regular school in early childhood education (PAUD), kindergarten (TK), elementary school, junior high school, and senior high school.
• Related institutions, organizations, foundations both GO or NGO which work related in the field of disability issues could become a referral for people with disability from local CBR village.
• The hospital, clinic rehabilitation could become a referral to do surgery or the other kinds of medical rehabilitation.
3.3.5.3 CBR in Sub-district Level

In sub-district level usually there is not established special team related to CBR. Therefore, the activity of CBR would become a part of their routine program without adding “a special task”. The leading sectors are usually Community Health Center (Puskesmas) and Sub-district Social Workers (TKSK). The roles of CBR in sub-district level are:

- The government of sub-district gives permission, protection and guidance to the implementation of local CBR village.
- Community Health Center (Puskesmas) becomes the reference for the cadres of CBR, family, the people with disability and the other people who have relationship with medical rehabilitation, prevention of disability, detection and early intervention, and the other kinds of health services in general.
- Sub-district Education Office takes a part in guiding and coordinating the implementation of inclusive education program and integrated education.
- The Sub-district Social Workers (TKSK) actively take a part as a guide and they coordinate the implementation of CBR in the village.
- The Family Planning Workers (PLKB) take a part in the prevention of disability through counseling about early detection and intervention by some activities in Integrated Health Post (Posyandu).

3.3.5.4 CBR in Village Level

CBR in village level is the implementer of direct CBR programs. The main role of CBR in village level is played by community members, people with disability, family, village government, and many local organizations. Mostly CBR at village level is organized and facilitated by the CBR Cadres. The CBR Cadre is group of volunteers who working on CBR voluntary. CBR Cadres are community members (villagers) who really concerns on disability issues and want to help people with disabilities and families. They may come from representative of various community organizations, such as: village government officer, Integrated Health Post (Posyandu), women organization, youth organizations, informal leaders, teachers, etc. Many of them are people with disabilities themselves and parents of children with disabilities. They all join to a group called CBR Cadres.

The following is the process of CBR governance at village level:
First, the CBR initiator mostly from NGO or DPO should have coordination and collaboration with local village government. The CBR initiator has to get a coordination and collaboration letter from Head of Village Government. After that, to start CBR, the CBR initiator organizes Social Preparation Activities. The objective of social preparation is to make sure that community members including people with disabilities and their families are ready to do and to develop CBR in their villages. Such activities of social preparation are:
• To conduct coordination among informal community leaders, people organizations, civil society, such as: women organizations, religion organizations, Posyandu, Youth organizations, etc, to make sure those organizations would participate in CBR program.

• To conduct coordination meeting with available services organizations in community, such as: special schools, regular schools, clinic, Community Health Center, hospital, etc.

• To develop and maintain a good communication and interaction with people with disabilities and their families.

The CBR initiator then conduct participatory meeting to facilitate community members so that they can identify their problems, collect data of people with disabilities and their families, identify the needs of people with disabilities, families as well as community, analyze available and potential resources, develop priorities and make a plan of action. To achieve the effective result of participatory meeting, mostly CBR initiator applies participatory methodologies such as: Participatory Rural Appraisal (PRA), Participatory Action Research, etc. The participatory meeting is started the sessions with a focus group discussion which include a general introduction to disability issues and to CBR. This is followed by an open discussion about what is disability, who are people with disabilities, their problems and their needs. Why community needs to establish CBR and what is CBR? All process resulted in getting better understanding about disability issues particularly people with disabilities issues and CBR. Finally community members conclude all the process of the meeting by developing community action plan. This concrete action plan which could be able to solve the problems of the people with disability in their surrounding by analyzing the problem and existing resources.

After that, the community members form Village CBR Cadre whose members are those who take a part arbitrary in the management of Village CBR. The CBR Cadres record the baseline data of the people with disability and formulates their needs. The CBR Cadres conduct data collection of people with disabilities by doing 3 steps of activities, namely: Identification, Screening and Assessment. Identification is to find out people with disabilities in the community, to find out children with the sign of disabilities. Screening is to know more closely with people with disabilities and children with disability and their specific needs. In the screening process, collecting data is done more specific and detail through interview, observation and several tests. Finally, assessment is to process of collecting data/information about people with disabilities that would be used to determine what kind of services or intervention that suitable for them.

It is important to note that CBR Cadres are volunteers not professional. Therefore, transfer of practical knowledge and skills from CBR professionals to CBR Cadres how to do, manage and develop CBR is very important. For that reason, training on CBR for cadres is very essential. The goal of the training is to increase knowledge and skills of CBR Cadres and to give experience that will enable and inspire them to develop CBR in their own village. The kinds of training and material provided based
on the needs and action plan. Beside the training, mentoring is also done after CBR cadres accomplished all levels of training, where trainers/professionals visit to the villages and train, coach and advise cadres in certain areas of difficulties.

After CBR Cadres get sufficient training, they start to do CBR based on their action plan. There are many actions of CBR at village level such as:

- Community awareness
- Income generating
- Family forum/parent association
- Primary rehabilitation therapy
- Early detection, intervention and stimulation
- Disability prevention
- Advocacy
- Inclusive education, etc.

In doing those action plans, the CBR cadres must work with local organizations and use maximally available resources such as village government, social organizations, school teachers, village midwife, religious leaders, etc. Usually, CBR cadres have regular meeting to monitor and evaluate their action. They involve community members, people with disabilities, family and also local village government to do the evaluation process.

Figure 26: Map of CBR Projects Sites in Indonesia

= CBR Projects Sites

3.3.6 CBR Services for People with Disabilities

3.3.6.1 CBR Services in Health Component

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82 Jonathan Maratmo, Head of Disability Information Training Research and Development Center
The CBR Matrix demonstrates kinds of CBR services in health component, generally many sectors included such as: health promotion, disability prevention, medical care, rehabilitation and assistive devices. Those sectors have still very broad meaning. This CBR study focuses on available CBR services in the grass root village level in many CBR projects in Indonesia. Mostly all services in health component are included in CBR projects in Indonesia, however the CBR projects are usually more specific and detail. In some cases, one activity of CBR project may cover many sectors in health component. For example early detection and intervention program covers disability prevention, health promotion and medical care. Primary rehabilitation therapy covers medical care, rehabilitation and assistive devices.

**CBR Services: Disability prevention, early detection, intervention, stimulation, health promotion and medical care in Posyandu (Integrated Health Post)**

Disability prevention, early detection, intervention, stimulation, health promotion and medical care services have being done at Posyandu (Integrated Health Post) in village level. Posyandu is government program in the village which is concerned about promoting the health for children under five years old. One village has 3 until 10 Posyandu, depends on the population of village, which is managed by 5 cadres in each Posyandu. Posyandu cadres are trained community volunteers. The Posyandu activities are immunization service, distributing supplementary nutrition, baby weighing and child care consultation, health promotion and primary medical care for children under five. All of those activities are carried out once a month. Up to now the Posyandu has been a place for parents to check up on the development and growth of their children. Community Health Center (Puskesmas) at sub-district level provides technical and professional support regularly to Posyandu, due to the part of Puskesmas programs are implemented in Posyandu.

CBR program encourages disability inclusive in Posyandu activities, so that Posyandu includes some activities related to children with disabilities. Posyandu cadres have got sufficient training on disability prevention, early detection, intervention and stimulation. In Posyandu, detection of childhood disability can be done at 3 levels. First, parents/mothers used poster of “Childhood Development Stages” and “Signs of Disability” is the basic level called screening for disability. The next level is called simple assessment, it happened when a child is looked at more closely by Posyandu cadres. The Cadres have learned specific simple task, the test in “Early Detection” and “Special Activities” manuals, to check to see whether the parents’ suspicions are correct. If the simple assessment suggested there is a problem than the child goes to the third level of detection that is evaluation by a professional usually done by therapists or doctors in Community Health Center (Puskesmas) or clinic in sub-district level and then to hospital in district level.
In CBR program, available rehabilitation service in village grass root level is primary rehabilitation therapy. It is important to note that primary rehabilitation therapy is basic therapy that can be done by volunteers: by families or parents and community volunteer or CBR Cadres. In implementing primary rehabilitation therapy services, family and CBR Cadres or community volunteer must be supported and facilitated by professionals (doctors, physical therapists, occupational therapists and speech therapists). Transfer of basic knowledge and skills from professionals to families and CBR Cadres or community volunteer how to handle people with disabilities at daily basis is very important in doing home and/or community based therapy services. CBR facilitates home and/or community-based therapy services and provide assistance to people with disabilities with a wide range of impairments, enabling them to maintain and maximize their function within their home and community. Where primary rehabilitation therapy services are established in the family and community through CBR, close link to the medical referral system must be done that offer specialized rehabilitation services at sub-district and district level. The mechanism is as follows: if family or CBR cadres cannot handle people with disabilities who need of special treatment, they refer to Community Health Center (Puskesmas) or clinic at sub-district level. If Puskesmas cannot handle because of paramedics and equipment limited, they refer to hospital at district level.

Activities of primary rehabilitation therapy include training basic therapy for families and CBR Cadres and provision of assistive devices. CBR program facilitates community, family and people with disabilities would be encouraged to use maximally the assistive devices and wherever possible to make more simple assistive devices by using local resources. For example, the local carpenter can use his skills to build a special chair. etc. Of course, CBR provides training for local workman how to make appropriate assistive devices by using local resources. However, if it is not available and not possible to make simple assistive devices by using local resources, CBR mobilizes financial resources from community or private
sectors to support assistive devices for people with disabilities. Usually CBR works closely cooperation with the workshop of assistive devices or orthopedic hospital at district level. Sometimes there are available free assistive devices for people with disabilities who come from poor families.

3.3.6.2 CBR Services in Education Component

CBR services in education sector for people with disabilities are aimed to encourage inclusive education and to increase the quality of education. For example: increasing the schools’ capacity to implement the inclusive education, supporting the special schools, and also serving an alternative education. The process is done by increasing the awareness on the children with disabilities’ rights on education, training for teachers and school’s management, parents meeting, and increasing facilities encouraging inclusive education.

*Early Childhood Education*

The CBR Guideline mentions that early childhood education is term refers to education from birth until the start of formal primary education. It takes place in formal, non-formal and informal settings, and focuses on child survival, development and learning – including health, nutrition and hygiene. CBR provides services for early childhood education in Posyandu and PAUD (early childhood education). Due to CBR program, inclusive disability in Posyandu provides more comprehensive services for children under five, because CBR integrates its activities in the Posyandu. So that Posyandu activities are not only immunization service, distributing supplementary nutrition, baby weighing and child care consultation, but also early detection, intervention, stimulation to examine whether the child does the milestones at his/her age. All of those activities are carried out once a month. Up to now the Posyandu has been a place for parents to check up on the development and growth of their children.

The PAUD develops and grows up recently in numbers and quality throughout Indonesia. Every single village has been established PAUD. Different with Posyandu that is conducted by volunteer/ cadres, PAUD is conducted by professional teachers. Posyandu emphasizes on development and growth of children in term of health and education, however PAUD emphasizes just on education process: the development of social, language and cognitive skills of children. Recently, many early childhood educations are welcoming and inclusive for all children. So that children learn to play together, accept the differences between them and help each other.

*Special Schools*

Special schools are resource of CBR. Even though there are many disadvantages and limitations of special schools however their existence are still needed. Children with a
lot of support needs attend special schools that are segregated from mainstream schools. In many cities in Indonesia special schools are often residential, and children usually live away from their families and communities.

In Indonesia special schools can be categorized into many kinds, namely: special school is just for visual impairment children (SLB A), special school is just for hearing and speaking impairment children (SLB B), special school is just for mentally / intellectual impairment children (SLB C), and special school is just for physically impairment children (SLB D). Recently, there is special school is just for children with autism (SLB Autism). Other kind of special schools is Sekolah Dasar Luar Biasa (SDLB). SDLB is special school that accepts many kinds of children with disabilities in one school. So, one class is just for visual impairment, one class is for hearing and speaking impairment, etc. Special schools are available from elementary school level up to senior high school level; even their number is still very limited. They accept children with disabilities depend on types of disabilities.

Although mostly CBR projects emphasize inclusive education, but special schools are a reality for many children and families, they may be the only education option available for children. However, special schools are usually located in the central town and its cost more expensive than regular schools. The limitation of special school and its facilities causes many children with disabilities have limited opportunity to get appropriate education services. For that reasons, recently many CBR projects support and encourage special schools to become resource center for inclusive schools.

**Inclusive Schools**

Inclusive school focuses on changing the system of mainstream school to fit the all students rather than changing the students to fit the system. In implementing inclusive schools program, there are many persons involved (e.g. children with and without disabilities, parents, principals, regular teachers, special teachers, school’s staffs, Education officers). All of persons should be committed to accepting responsibility for the learning outcomes of children with disabilities. To become inclusive schools, there are some components of regular schools must be modified and organized due to the different needs of children, that are: educational program, educational material, methods, facilities, process of educational services, and learning evaluation. CBR services encourage inclusive education and to increase the quality of education. CBR builds regular schools’ capacity to implement the inclusive education, supports the special schools to become resource center for inclusive schools. The development of inclusive schools now is still in the process.

**Non-formal Education**
A wide range of non-formal education programs have been operating in the community in Indonesia. Mostly they are conducted by private sectors, and some are conducted by government. These programs are usually oriented on skills development like vocational training such as: computer, sewing, music, dance, mechanic reparation, etc. CBR provides non-formal education services by identifying existing non-formal education programs which suitable for people with disabilities. CBR program also provides consultation services to prepare people with disabilities to take non-formal education such as course, training, workshop based on their interest and needs. Some CBR programs also establish non-formal education to become inclusive program. Those inclusive programs encourage the enrolment of people with disabilities in all types of programs. CBR program also ensures that teaching is conducted in accessible places and that teaching formats are accessible.

Alternative Education

In some areas, wherever formal and non-formal education services are not available, some CBR projects support and encourage an alternative education. Normally education takes place within a designated building, but alternative education does not take place within building. Inclusive education does not literally mean putting every single child with a disability into a school building. Some children with disabilities can still be included in education process, even when they are receiving their education at home or at Sanggar Belajar. Home-based learning is an alternative education for people with disabilities. CBR Cadres and volunteer teachers usually provide education services for people with disability at home. Other CBR project also develop alternative education by establishing Sanggar Belajar. The Sanggar Belajar is inclusive place for children who want to learn something. The education structure, learning structure, and curriculum must be formulated together. Many children including children with disabilities have been enjoying in Sanggar Belajar.

3.3.6.3 CBR Services in Livelihood Component

Skill Development

Many CBR projects in Indonesia support some skill development programs. Generally, there are 3 types of program provided such as:

- **Basic skill.** This is given to the young people with disabilities who have interest to work and in having business. This training equips people with disability with some skills such as the life skill, self-concept and problem solving. These programs are organized by some private sectors, either engaged in CBR or institutional based services. CBR program is done inclusively.
- **Technical skill.** This program mostly is organized by the government through some ministries such as Social Affair, Labor, Women Empowerment and Cooperative Ministry. However, recently the private sectors and community
also more involve in this activity. Many kinds of training of technical skill for people with disabilities, such as: mechanical engineering, sew, mechanic, offset printing, computer, animation, organic agriculture, traditional herb processing, handicraft, and etc.

- **Professional skill.** This training is for professional people with disabilities such as: business management, business plan, and marketing. This program is mostly organized by the private sectors and NGOs.

*Self-employment*

Entrepreneurship is the biggest program of productive age of people with disabilities in Indonesia. The program of entrepreneurship is to empowerment of small businesses and cooperatives. CBR program facilitates some activities for people with disabilities to do entrepreneurship. There are various steps of activities implemented, such as: feasibility study (research), preparation of persons with disabilities through assessment, training, technical assistance including monitoring, and evaluation. This program is organized by CBR at the field level.

CBR facilitates entrepreneurship program for people with disabilities which covers: *Entrepreneurship development.* This CBR project usually employs with the following steps:

- Potential study. This study is done to some small business potential that could be able to grow and evolve. It results The Map of Business Potential which covers business sector, type of business, business scale, and market potential.
- Feasibility business study. This study is done to see feasibility of each unit and group which is prospective to be funded (additional capital for expansion or new establishment)
- Business funding. This funding is managed by Self-Help Group. The fund resources could come from: investment (business cooperation), business capital, loan, revolving fund, grant or the combination of those alternatives.
- The preparation of people with disabilities themselves. By doing assessment, people with disabilities should prepare themselves toward these aspects below:
  - Draw up the business execution which would be agreed. There would be an employment contract or loan agreement from that execution agreement that refers to the business planning then the supply of the fund could be done afterward.
  - The training to people with disabilities which covers management business and technical training. This training is organized in accordance with their needs based on Training Needs Assessment.
  - The aid of business equipment
- Technical Assistance. It aims to give technical assistance from the drawing up of business planning to the implementing of business. The kinds of technical assistances are:
o Giving technical helps to the units or groups for solving their problem such as human resources, management, technique, production and market.

o Giving some helps through consultation which is held by the experienced networks in the real business sector and community development.

o Strengthening market. It is done in the 3 kinds of activities:
  Cooperating with the networks
  Facilitates the cooperation among people with disabilities that has associated unit.
  Monitoring and fund evaluation based on the request of fund resources.

• Business consultation
  This program is an effort to give assistance to people with disabilities individually or group in term of economical aspect, preparing them to be back to their own place or working in the formal sector. Nowadays, this program services many people with disabilities throughout Indonesia by doing internet online and face to face consultation.

Wage Employment

There are many people with disabilities who have interest to work in the formal sector. This CBR program facilitates people with disabilities in the competition of becoming workers generally. They activities such as:

• Soft skill training
• Awareness raising to the government and company
• Advocacy Law No 4/ 1997 about people with disabilities related to 1% quota of people with disabilities rights to work in the formal sector
• Cooperate with foreign labor
• The placement of people with disability workers in the companies
• Joint evaluation with the stakeholders.

Financial Services

There is no special financial service just for people with disabilities. The fulfillment of financial services for people with disabilities in Indonesia is inclusive obtained in various ways: in the groups of saving and loan, business group, pre-union, union credit, and etc. Mostly financial services bodies above are inclusive disability.

Social Protection
As members of community, people with disabilities have social protection program, that is the same protection with community in general, especially who live in poverty. The Social Affair Ministry has social safety nets program that gives bail for community members who live in poverty including people with disabilities, which is given once a year. However, the number who received aids is still low. This year the government has been proclaimed a social protection for people with disabilities to include in the service of Social Protection Body (BPJS), but the premium of people with disabilities is paid by the government.

3.3.6.4 CBR Services in Social Component

Personal Assistance

Personal assistance depends on the needs of people with disabilities. In Indonesia, personal assistance is mostly done by family members or relatives of persons with disabilities. Because Indonesian culture, the relationship between people with disabilities with their families or relatives is mostly close. Particularly for daily care and personal assistance, family members and relatives supports are essential. CBR program also encourages every family to become personal assistance for its members who have disability. That is based on local culture and wisdom.

In addition, peer to peer assistance is very important for people with disabilities. For many people with disabilities just need consultation and peer counseling. Peer counseling and consultation make them acceptable, open and relax, those are helpful for them. However, for people with disabilities who need more personal assistance, they can contact to agencies or foundations that provide personal assistances. This usually costly, so just rich people with disabilities can enjoy these services.

Relationship, Marriage and Family

CBR facilitates this program, by establishing support group of people with disabilities. This group is by and with people with disabilities. This program is to become part of the peer to peer counseling program. Usually, people with disabilities who have been married often give support to others who would get marry. Mostly the first problem comes from family members. The family members impeach that marriage would be hard and can raise a new problem with people with disabilities. By visiting regularly among people with disabilities, they can give explanation and awareness to the family members.

In Klaten District and Yogyakarta province after the earthquake, this program more emphasizes to the family rescue since they get disability because of the disaster. A lot of people who become disability have been abandoned by their partner. The support of this group becomes so important which has high responsibility to bring a good condition of couple with disabilities. Peer to peer program becomes a line to bring back their confidence as a healthy couple with their disability.
Culture and Arts

People with disabilities can participate in the culture and arts activities. CBR facilitates some aspects as follows:

- People with disabilities are encouraged to be active in the voluntary forum and art and culture groups in the community. On the other hand, people with disabilities can invite the youth community groups to be active in the art and culture groups of people with disabilities.
- Organizing the culture and art activities inclusively in the community
- Developing inclusive learning Al-Quran, inclusive disability (people with disabilities as teachers or students).
- Drawing competition for inclusive children.

Recreation, Leisure and Sport

Recreation and leisure have become the needs of people with disabilities in Indonesia. The creative programs are made and initiated by people with disabilities themselves. Ikatan Motor Roda Tiga (IKMT) is special Disabled People Organization (DPO) that has main program to campaign the rights of people with disabilities through recreation and leisure activities. Together they go to some recreation and leisure places every month. IKMT inspires the community and family to change their negative image. This IKMT grows so fast in Indonesia. This recreation is a direct way to campaign physical accessibility which would impact on the transformation views to the real support of physical accessibility.

Justice

The access to the justice is mostly organized by DPO as the leading sector. The access program to justice for people with disabilities in Indonesia is very strong. There are some struggles for DPO to access justice, such as:

- Protection and legal aid for people with disabilities: this program is a program for people with disabilities accompaniment that gets course case.
- The access toward justice. Advocacy on the law enforcement is for opening the access for people with disabilities in the justice as the witness, judge, or lawyer. The advocacy on the law enforcement is also done for doing affirmative action to some cases which involves people with disabilities. For example the deaf has the rights to give testimony legally. The blind also has the same rights.
- The training is given to people with disabilities about paralegal, legal awareness.
- Nowadays, there are a lot of regions that have inclusive WCC (Woman Crisis Center) in Indonesia. The Women National Committee cooperates with DPO in the region to realize the protection of women with disabilities rights.
3.3.6.5 CBR Services in Empowerment Component

Advocacy and Communication

The Advocacy for people with disabilities in Indonesia was started in 2000, together with the government declaration of participatory development program. The advocacy is divided into two realms; they are: self-advocacy and the advocacy of government policies.

Self-advocacy

It emphasizes more to make people with disabilities to able to talk about their rights in the law, tradition, and in the government point of view. This kind of advocacy is emphasized on the abolishment of communication barriers and it supports them to be able to make self-representation of people with disabilities so that they would have the same rights to speak as the Indonesian citizen.

The advocacy of policies:

- The advocacy for the implementation of Law about people with disabilities rights, the inclusive regulation changes and the ratification and implementation of CRPD. This program is organized by DPO, NGO, and other civil society.
- Mainstreaming advocacy (inclusiveness) the people with disabilities rights in the regional or national development policies. This program brings changes in the national policy. Almost all ministries have run National Action Plan mandate, however the implementation is still far from expectation.

Community Mobilization

Community mobilization is a way to get the community endorsement, in order to make the community being active in the movement of people with disabilities. This mobilization is done by the community of CBR in Indonesia which could be in some models:

- Taking a part in the other regional community organization such as the youth group, women group, children group, HIV AIDS.
- Developing some inclusive groups as the volunteers of people with disabilities activities.
- Collaborating with the biggest women organization in Indonesia that is called PKK.
- Getting involved in the various kinds of associations in Indonesia

They have some programs:
• The campaign of children and people with disabilities rights
• The education of HIV AIDS to the community
• To build the community capacity with the volunteerism concept
• The combined event with the theme of urban development

Political Participation

“Political rights must be seized by people with disabilities”, which is the motto of people with disabilities in Indonesia. Their political activity in Indonesia was started in 1999. They have two big programs:
• For people with disabilities: the education of political rights is implemented in the national and regional level. This is important because there are many people with disabilities who think that their political rights are not important and this thought doesn’t bring any effect on their life. It is important to build their awareness that they have the equal rights with other people.
• For government and political parties: to increase disability sensitiveness on the political system in Indonesia.

Self-Help Group

CBR program at district level facilitates the establishment of self-help group of people with disabilities. Self-help group is a group by, with and for people with disabilities. They realize that they need to develop their skills and personality as part of achieving their full potential. People with disabilities themselves make decisions and take control of their own lives. The activities of self-help group are to build capacity of its members in leadership and management, to develop peer counseling, campaign, advocacy and income generating programs. The relationship between CBR and self-help group is very clear. In some places, CBR establishes self-help group, provides training and build capacity for self-help group. Self-help group itself is key group to implement and develop CBR programs.

On the other hand, many self-help groups were born from the parents association such as the association of parents with autism children, the association of parents with deaf children, and etc. The Indonesian group of the deaf is the strongest group to help creating sign language for the deaf.

Recently, self-help group of people with disabilities grows up and develops rapidly throughout Indonesia, especially in Java Island.

Disabled People Organization

Disabled people organizations have strong role in struggling their rights and support the inclusive development. Even though their activities are not related specifically to CBR but in general they apply approach and strategies of CBR. They are active and have great role in the development of national action plan. They involve actively in National Human Right Commission (KOMNAS HAM) and National Women Right
Commission (KOMNAS PEREMPUAN). They do advocacy. There are two advocacies which are still developed continuously. Those advocacies are to build community awareness on the rights of people with disabilities and to mainstream the right of people with disabilities into the community.

DPO took part directly in the CBR implementation program especially in Central Java, Yogyakarta and East Java. The CBR programs initiated by DPO mostly concern on advocacy and social inclusion in the community. Recently, the Minister of Social Affair launched a program called “Village Inclusion” (Desa Inklusi) in Jogjakarta. This event was the DPO movement to realize inclusive program locally. The 12 local DPOs from 12 provinces declared that the program of “Village Inclusion “is the movement of right of people with disabilities in the grassroots level by using CBR’s strategy.

3.3.7 Best Practice

3.3.7.1 Health

CBR services which included disability prevention, early detection, intervention, stimulation, health promotion, medical care and primary rehabilitation therapy services have being done at Posyandu (Integrated Health Post) in village level. Originally Posyandu was community initiative program concerning about promoting the health for children under five years old. However, now Posyandu had been adopted by the government to become national program in the village which was concerned about promoting the health for children under five years old. The Posyandu activities were immunization service, distributing supplementary nutrition, baby weighing and child care consultation, health promotion and primary medical care for children under five. Up to now the Posyandu has been a place for parents to check up on the development and growth of their children. Community Health Center (Puskesmas) at sub-district level provided technical and professional support regularly to Posyandu. CBR program encouraged disability inclusive in Posyandu activities, so that Posyandu included some activities related to children with disabilities. Posyandu cadres had got sufficient training on disability prevention, early detection, intervention, stimulation and primary rehabilitation therapy. If the simple assessment suggested there was a problem that the cadres could not handle, than the child referred to the evaluation by a professional usually done by therapists or doctors in Community Health Center (Puskesmas) or clinic in sub-district level and then to hospital in district level.

3.3.7.2 Education

In education component CBR was done by increasing the awareness on the children with disabilities’ rights on education, training for teachers and school’s management, parents meeting, and increasing facilities encouraging inclusive education. Inclusive school focused on changing the system of mainstream school to fit the all students rather than changing the students to fit the system. In implementing inclusive schools program, there were many persons involved (e.g. children with and without
disabilities, parents, principals, regular teachers, special teachers, school’s staffs, education officers). To become inclusive schools, there were some components of regular schools must be modified and organized due to the different needs of children, that were: educational program, educational material, methods, facilities, process of educational services, and learning evaluation. CBR built regular schools’ capacity to implement the inclusive education. CBR also supported the special schools to become resource center for inclusive schools.

3.3.7.3 Livelihood

Self-employment through entrepreneurship program was the biggest CBR program for people with disabilities in Indonesia. This program was to empowerment of small businesses, income generating and cooperatives of people with disabilities. CBR programs facilitated people with disabilities to do entrepreneurship, such as feasibility study, assessment, training, skills development, technical assistance, business consultation including business monitoring, and evaluation. Many CBR programs also provided capital for income generating both grant or loan system. This program was usually organized by CBR at the grass-root level and self-help group of people with disabilities themselves. Many CBR programs applied “revolving loan fund” system for group of people with disabilities. For skills development of people with disabilities, many CBR programs facilitated 3 types of skills development such as: basic skill, technical skill and professional skill development.

3.3.7.4 Social

Obviously the role of family and relatives of persons with disabilities towards personal assistance, relationship, marriage, family and other social issues of people with disabilities were very important in Indonesia. Because Indonesian culture, the relationship between people with disabilities with their families or relatives was mostly close. In addition, peer to peer assistance, peer counseling and consultation was also very important. CBR facilitated this program, by establishing support group of people with disabilities. This group was by and with people with disabilities themselves. Peer counseling and consultation had made people with disabilities felt acceptable, open and relax. People with disabilities can participate in the culture and arts activities by organizing the culture and art activities inclusively in the community, such as the development of inclusive learning Al-Quran inclusive disability (people with disabilities as teachers or students). Ikatan Motor Roda Tiga (IKMT) was local Disabled People Organization (DPO) that had main program to campaign the rights of people with disabilities through recreation and leisure activities. Together they went to some recreation and leisure places every month. IKMT inspired the community and family to change their negative image. This IKMT grew so fast in Indonesia. This recreation was a direct way to campaign physical accessibility which would impact on the transformation views to the real support of physical accessibility.

3.3.7.5 Empowerment

CBR program at district level facilitated the establishment of self-help group (SHG) of people with disabilities. Self-help group was a group by, with and for people with disabilities. They realized that they need to develop their skills and personality as part of achieving their full potential. People with disabilities themselves made decisions
and took control of their own lives. The activities of self-help group were to build capacity of its members in leadership and management, to develop peer counseling, campaign, advocacy and income generating programs. Recently, self-help group of people with disabilities grew up and developed rapidly throughout Indonesia, especially in Java Island. Meanwhile, disabled people organizations (DPO) had strong role in struggling their rights and supporting the inclusive development. They were active and had great role in the development of national action plan. They did advocacy in order to build community awareness on the rights of people with disabilities and to mainstream the right of people with disabilities into the community. DPO took part directly in the CBR implementation program especially in Central Java, Yogyakarta and East Java. The CBR programs initiated by DPO mostly concern on advocacy and social inclusion in the community.

3.3.8 The way forward

Indonesia has laws or government regulation related to people with disability such as Law No 4 / 1997 about People with Disability and Law No. 19/2011 about the Adoption of the Convention of the Rights of People with Disability. However, there is no law or government regulation specifically related to CBR. The government should has at least two roles in CBR those are first, to make the law or regulation about national CBR and; second to coordinate, facilitate, and support NGO and DPO to implement CBR. Meanwhile NGO or DPO conducts and develops technically the CBR project in grass root level. For the way forward, regulation or policy about CBR from the government must be clearly formulated. CBR must be formulated in the National Action Plan and it must have concrete policy from national level to village level. The government should allocate the budget to CBR regularly and at national scale: from national level until village level.

Now CBR is acknowledge as the most cost-effective means of reducing poverty by achieving equality and full participation of people with disabilities within their own families and communities. However, concept and implementation of CBR grow rapidly and that has not always been successful in its many forms, nor is it accepted by everyone as the best approach to work towards achieving equal opportunity and full participation of people with disabilities in the community. Therefore, continues efforts are required to develop better techniques for implementing CBR field programs particularly related to poverty reduction of people with disabilities.

CBR should be considered to be a focused community development program in the field of disability, that enables community members to obtain a better understanding of disability issues; and provide a positive environment for, and improve the quality of life of people with disabilities. Implementation and development of CBR in Indonesia should be based on the understanding that the problems faced by people with disabilities in their daily lives are not only the result of their individual impairments, but were also the result of the attitudes and beliefs of the communities in which they live. Therefore, CBR programs consider with three different, but interrelated “disability issues”. One is rehabilitation services delivered directly to the individual with disability. It is also important to sure that rehabilitation services are made available for people with disabilities at the family and community level. The second is development of a better, more positive understanding among families and
community members, about the problems of disability. This is necessary to not only improve the social environment for people with disabilities, but to also limit the extent of handicap that results from an impairment or disability. It is also important to sure that rehabilitation services are made available for people with disabilities at the family and community level. The third is advocacy to influence the change of public policies and regulations those included disability sensitiveness.

There is a good commitment from government to establish CBR as a national program, it is not only project based oriented. As national program, CBR applies multi-sectoral and multi-discipline approach. Coordination among the ministries or multi-sectoral coordination which involves CBR would be very essential. The government should establish special task force or special team to do CBR at national, province, district and village level. The government should have multi-level CBR management structure and leader. They should have special budget regularly for CBR development. The implementation of CBR in grass root level is more initiated by NGO or DPO that should be facilitated and coordinated by the government. CBR should become a national program for poverty reduction of people with disabilities. Because CBR should be the most cost-effective means of reducing poverty by achieving equality and full participation of people with disabilities within their own families and communities.

CBR programs and activities for poverty reduction of people with disabilities should be integrated into existing programs in the community or existing services of government and its mainstream program, because to establish new infrastructure and CBR system separated from existing system and services in the community and government is too expensive and its implementation is not easy. The fact of limited resources, both human and financial, has resulted in extremely limited services for people with disabilities. On the other hand, many government organizations working at the grassroot level have personals who have already been trained and are experienced in working in the community. Inclusion CBR program into their existing programs is more effective and efficient way in solving disability problems. When CBR programs and services are integrated into the work of community and government that already have a developed infrastructure and monitoring, evaluation and management systems they become feasible.

CBR is cost-effective means of reducing poverty by achieving equality and full participation of people with disabilities within their own families and communities. Therefore, the role of people with disabilities and their families is very essential. For the way forward, it is very important to establish self-help group as a group of representative of people with disabilities at grass root level and family forum as a forum of families of children with disabilities. They should be formed and developed.
4. Cross Cutting Recommendations

Although there are differences in the CBR strategies that are used through three case studies for the reduction of poverty, this study has identified cross cutting policy recommendations based on some common themes for OIC Member States. According to these themes, the identified recommendations are as below:

4.1 CBR National Policy

4.1.1 CBR must Identified as a National Program

OIC Member States, such as Iran and Malaysia, have identified CBR programs as national programs for the reduction of poverty amongst people with disabilities. Because CBR has been identified as the most cost-effective means of reducing poverty by achieving equality and the full participation of people with disabilities within their own families and communities, governments should have strong commitments to the establishment of CBR as a national program. As national programs, coordination among the ministries and multi-sectorial coordination is crucial to the implementation of CBR. The governments should establish special task forces or special teams for the implementation of CBR at national, provincial, district and village level. They should have special budgets established for CBR development. Regulation or policy about CBR must be clearly formulated by the government. CBR must be formulated in the National Action Plan and must have concrete policy from national to village level.

4.1.2 CBR Programs and Activities for the Reduction of Poverty amongst People with Disabilities should be Integrated into Existing Programs in the Community

Based on our findings, human resources and funding for CBR activities were the major challenges. CBR programs and activities for the reduction of poverty among people with disabilities should be integrated into existing programs in the community or existing governmental services, because the establishment of CBR programs separate from existing programs requires much funding and the implementation of such programs is not easy. The inclusion of CBR programs into existing programs is considered a more effective and efficient way for solving issues facing disability. When CBR programs and services are integrated into community and government establishments that have already developed an infrastructure and monitoring, evaluation and management systems, they become more feasible. For example: programs of poverty reduction for people with disabilities should be integrated into mainstream programs of poverty reduction in general. Programs of disability prevention, early detection, intervention, stimulation, health promotion, medical care and primary rehabilitation therapy for children should be inclusive at grass root levels. CBR services in the education component should increase the regular schools’ capacity to implement the inclusive education.
4.1.3 The Role of Government, NGO and DPO in Developing and Implementing CBR must be very Clearly Formulated

Different government ministries and agencies within Member States are responsible for the development of a national action plan against poverty and social exclusion. The involvement of different ministries and organizations is crucial to the empowerment of people with disabilities to reduce poverty. General coordination between the ministers and NGOS is necessary. It is recommended that the implementation of CBR must be coordinated and managed by the government. The government should take roles to formulate the law or regulations in regards to a national CBR program and to coordinate, facilitate, and support NGO, DPO and communities to implement CBR. Meanwhile NGO, DPO and communities conduct and develop CBR programs in grass root level.

4.1.4 Standards for Measuring Disabilities

Member States must apply standards for measuring disabilities. The International Classification of Functioning, Disability, and Health (ICF) is an international accepted standard for classifying and measuring disability.

4.2 The Association of People with Disabilities in the Country

4.2.1 The Involvement of Association of People with Disabilities in CBR programs

NGOs play an important role in the social mobilization around issues facing disability. They help to organize communities to respond to people with disabilities’ needs. NGOs have played key roles in advocacy, such as pushing for better services in the health and education sectors. To ensure the implementation of CBR programs in rural areas, national CBR programs in collaboration with NGOs is the best practice for reducing poverty among people with disabilities. In some countries, such as Indonesia, the roles of association of people with disability and NGOs have played major roles in developing of CBR programs. Member States must support CBR programs in order to provide comprehensive and inclusive training for volunteers and NGOs’ workers. Training them would help improve the effectiveness and impact of CBR programs.

4.3 CBR Services for People with Disabilities

4.3.1 Access to Health Care for People with Disabilities

People with disabilities experience poorer health and face more challenges in accessing health services. Member States must increase mechanisms to facilitate the inclusion of persons with disability in ongoing health services and disease prevention and health promotion programs through identifying barriers and ways of removing them, and providing collaboration with different government ministries and agencies.
Disability prevention, early detection, intervention, stimulation, health promotion, medical care and primary rehabilitation therapy for children should be inclusive in the Primary Health Care’s activities. PHC are able to link people with disabilities’ health issues with external resources. The government should take the necessary actions in order to guarantee disability inclusive programs in the PHC. The government should develop the capacity of the PHC and provide the necessary training of disability issues, such as early detection, primary rehabilitation therapy, etc.

4.3.2 Building Inclusive Education Systems

Member States must develop education opportunities for people with various disabilities, and improve accessibility in schools. There is a need for CBR at the National level to link up with the Ministry of Education. CBR services in the educational components are established in order to increase the regular schools’ capacity to implement the inclusive education and supporting the special schools to become recourse center for inclusive schools. Some CBR programs have also established non-formal education to become inclusive program. Those inclusive programs encourage the enrolment of people with disabilities in various types of programs. CBR program also ensures that teaching is conducted in accessible places and that teaching formats are accessible. Government cooperation with NGOs should promote and facilitate the development and implementation of both formal and non-formal education.

4.3.3 Enhancing Livelihood for People with Disabilities

Member States should provide both basic and professional skills training for people with disabilities. More importantly, the develop system to create entrepreneurs of people with disabilities and cooperatives. This requires cooperation with private sectors/businesses, NGOs and DPOs. Member States can promote the livelihood of people with disabilities and their families through CBR programs. CBR activities improve persons with disabilities’ economic and social situations through providing opportunities for skills development, self-employment, wage employment, financial services, and social protection.

4.3.4 Improving Social Skills for People with Disabilities

The role of family and relatives for assisting people with disabilities in daily life as a social component of CBR is essential. CBR programs support every family in becoming personal assistance for their family members who have disability. That is based on local culture and tradition. CBR should facilitate the establishments and the development of self-help groups of people with disabilities. The self-help group is a group by, with and for people with disabilities. This group is effective in taking a larger role for peer counseling, peer consultation, recreation, leisure and other social activities for people with disabilities. Member States must support programs and activities that aim to enable people with disabilities to participate in family and community life. CBR programs are effective in helping people with disabilities to modify, change and improve their social skills, and promote positive images of themselves in the community through working across the seven key areas: personal assistance; relationships, marriage and family; culture and arts; recreation, leisure and sport; and, justice.
4.3.5 Promoting the Empowerment of People with Disabilities in Achieving Poverty Eradication

CBR is an effective strategy in solving issues facing disability by achieving equality and the full participation of people with disabilities within their own families and communities. Therefore, the role of people with disabilities themselves in CBR is essential. It is recommended that CBR should facilitate the establishment and development of self-help groups of people with disabilities (SHG) and disabled people organization (DPO). The relationship between CBR, SHG and DPO is very clear. CBR should facilitate SHG and DPO by providing training and building capacity. SHGs and DPOs themselves are the key groups to implement and develop CBR programs. Empowering people with disabilities not only requires support for the disability sector, but also supports the various development of sectors (health promotion, education, skills development, employment creation, etc) to promote the inclusion of issues facing disability.
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109


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