

CBR : A HISTORICAL PERSPECTIVE

1. Historical Background

Since the initiation of rehabilitation services, the urban persons with disabilities have been the main beneficiaries. The evolution of welfare programmes started in cities and grew from strength to strength in urban settings.

With the passage of time, experts all over the world realized that concentrating services in cities had resulted in lop-sided development with persons in rural areas being deprived of facilities. With the advancement of services, secondary data started becoming available that proved that nearly 84 percent of persons with disabilities in developing countries lived in rural areas. Facts also came to light that the majority of such persons were aged and were thus not eligible to avail training in the urban training institutions.

Experts started feeling that it was a wrong policy to attract the rural persons with disabilities to the cities where the cost of living was high and cheap accommodation was impossible to get. Moreover, urban-based training would be of no use to such persons on their return to his home.

It was also increasingly felt that westernized urban industrial training was not suitable. Millions of persons with disabilities in rural areas cannot be rehabilitated by a few hundred urban institutions. A few rural programmes were started by St. Dunstons, the Vocational Rehabilitation Office in the U.S.A. and the Sight Savers International in Africa. The turning point came when the Uganda Foundation for the Blind started a rural centre in 1954.

2. Action by International Agencies

2.1 World Council for the Welfare of the Blind

At the first General Assembly of the World Council for the Welfare of the Blind in 1954, a resolution for the training and readjustment of rural visually impaired was advocated by Sir

Clutha Mackenzie and backed by Sir John Wilson of the Sight Savers International and Capt. H. J. M. Desai, former Secretary General of the NAB. Thereupon the Assembly unanimously adopted the following resolution:

“The World Council for the Welfare of the Blind believes that the fundamental training and re-adjustment of indigenous rural population should be primarily effected with due regard to their vocational and community background and in the case of newly visually impaired atleast to their past employment (usually as small holders and village craftsmen and in the case women as domestic rural workers) by providing training centres for these specific purposes, instead of concentrating them in cities and towns to be employed in sheltered workshops”.

2.2 Asian Conference: Work for the Blind

The first Asian Conference on Work for the Blind held in Tokyo, Japan, 1955 endorsed the above approach and passed the following resolution:

“The conference, recognizing that the majority of the visually impaired in this region come from agricultural communities, recommends that increased attention be paid by Governmental and other agencies to the location of suitable avenues of employment of the visually impaired who reside in rural areas and introduction of educational and vocational and training services geared towards the resettlement of the visually impaired in such areas. Special attention is drawn to the pilot scheme now being conducted in Uganda”.

These resolutions helped to start a chain of rural training centres for the visually impaired. However, for economic reasons, it was felt that it was not possible to start an adequate number of rural centres for the visually impaired. It was therefore, essential to train and resettle the visually impaired in their own homes through a community based system of delivery of services.

2.3 World Health Organization

The idea of CBR was mooted by the World Health Organization (WHO) when the technical reports of WHO of 1958 and 1969 suggested that rehabilitation services must be considered as a natural and essential part of health care services. They also suggested that developing countries should have a cost-efficient substitute to institutional care.

CBR as a fundamental concept within international health was established by WHO in 1978 in response to the recognition that financial and professional services were inadequate to address the overwhelming disability needs in developing countries. CBR was intended to reach as large a number of people as possible in the most cost-effective and culturally appropriate way. These projects were intended to build partnerships between rehabilitation personnel, communities, families, and persons with disabilities themselves. The idea was that such partnerships would form a conduit for a transfer of skills and knowledge to the grassroots of communities.

The World Health Organization published a Manual entitled *“Training in the Community for People with Disabilities”*. The subsequent versions were revised and published during 1980, 1983 and 1989. The Manual has been used in about 60 countries and has been translated partly or entirely into about 30 languages.

The Manual advocates that rehabilitation provided in institutions generally does not involve the communities in which the people with disabilities live. For rehabilitation to be successful, communities must recognize and accept that people with disabilities have the same rights as other human beings. This may require a significant change in attitude among the members of the community. It has been found that the most effective way of bringing about such a change in attitude is for members of the community to take on the task of rehabilitation.

The 1989 edition of the Manual contains 34 modules and 30 training packages for all categories of disabilities and for all level of functionaries. It also includes guides for local supervisors, community rehabilitation committee, people with disabilities and schoolteachers. It has training packages, seven types of disabling

conditions: persons with difficulty in seeing, difficulty in hearing and speaking, difficulty in moving, difficulty in feeling, strange behaviour, fits and learning difficulty.

This Manual has been very extensively used all over the world. It has played a very significant role in the promotion of CBR.

2.4 International Year for the Disabled Persons

More and more world opinion was being galvanized regarding setting up of rural mobile teams for rehabilitation. The United Nations General Assembly declared 1981 as the International Year of Disabled Persons (IYDP). Its plan of action also concentrated on rural resettlement and issued the following guidelines in Section 12(m):

“To review the services and benefits to ensure that these assist and encourage disabled people to remain and/or become an integral part of the society wherein they live, rather than bring about segregation and isolation”.

2.5 ICEVI Conference

The Third Asian Conference of the International Council for Education of the People with Visually Impairment held at Jakarta, Indonesia, in November 1981, in its Resolution No. 6 states:

“That more community based training programmes for visually handicapped persons be developed in view of the fact that the vast majority of them live in rural areas, this should be based on survey of wage earning activities and task analysis in order to assimilate them into the rural economy within their own environment”.

2.6 United Nations’ Concern for Persons with Disabilities

The World Programme of Action Concerning Disabled Persons adopted by the UN General Assembly by resolution 37/52 on 3 December 1982 encourages Member States, within the context of available resources, to initiate whatever special measures may be necessary to ensure the provision and full use of services needed by disabled persons living in rural areas, urban slums, and shanty towns. Regarding employment, it emphasizes:

“Member States should adopt a policy and supporting structure of services to ensure that disabled persons in both urban and rural areas have equal opportunities of productive and gainful employment in the open labour market. Rural employment and the development of appropriate tools and equipment should be given particular attention”.

2.7 ILO’s Historic Convention

Articles 8 and 9 of the ILO convention (No. 159) and recommendation (No. 168) Concerning Vocational Rehabilitation and Employment (Disabled Persons), 1983, emphasize vocational rehabilitation of the rural disabled:

“Measures shall be taken to promote the establishment and development of vocational rehabilitation and employment services for disabled persons in rural areas and remote communities. Each Member shall aim at ensuring the training and availability of rehabilitation counselors and other suitably qualified staff responsible for the vocational guidance, vocational training, placement and employment of disabled persons”.

Article 20 and 21 of the ILO Recommendation Concerning Vocational Rehabilitation and Employment (Disabled Persons), 1983, outline the following appropriate measures to be taken in this regard:

“Particular efforts should be made to ensure that vocational rehabilitation services are provided for disabled persons in rural areas and in remote communities at the same level and on the same terms as those provided for urban areas. The development of such services should be an integral part of general rural development policies”.

To this end, measures should be taken, where appropriate, to:

- a. Designate existing rural vocational rehabilitation services or, if these do not exist, vocational rehabilitation services in urban areas as focal points to train rehabilitation staff for rural areas;

- b. Establish mobile vocational rehabilitation units to serve disabled persons in rural areas and to act as centres for the dissemination of information on rural training and employment opportunities for disabled persons;
- c. Train rural development and community development workers in vocational rehabilitation techniques;
- d. Provide loans, grants or tools and materials to help disabled persons in rural communities to establish and manage cooperatives or to work on their own account in cottage industries or in agricultural, crafts or other activities;
- e. Incorporate assistance to disabled persons into existing or planned general rural development activities;
- f. Facilitate disabled person's access to housing within reasonable reach of the work place.

These excellent guidelines of the UN and the ILO show the great concern and the very deep involvement at the highest international level in the vocational rehabilitation, training, employment, resettlement, and integration of the rural disabled, including the rural visually impaired. These instruments convey momentous decisions of a historical nature. Their effective implementation would become milestones in the total rehabilitation and integration of the disabled.

2.8 Position Paper on CBR

WHO has been joined by its sister organizations, namely the ILO and UNESCO, in adopting CBR as the most viable strategy to meet the global challenge of disability. This partnership has now been formalized in a joint position paper on CBR (ILO/UNESCO/WHO, 1994). The concept of CBR enlarges the concept of rehabilitation to include all of the services that assist people with disabilities to develop their abilities.

2.9 ESCAP Declaration

The Social Development Strategy for the ESCAP Region Towards the Year 2000 and Beyond was adopted by the Fourth Asian and Pacific Ministerial Conference on Social Welfare and Social Development, held at Manila in October, 1991. The strategy has

the ultimate aim of improving the quality of life of all the people of the ESCAP region. With that aim in mind, the basic objectives of the Strategies are the eradication of absolute poverty, the realization of distributive justice and the enhancement of popular participation. Within the framework of those aims and objectives, the Strategy assigns priority to the regions disadvantaged and vulnerable social groups, including persons with disabilities.

Further to the priority given to the concerns of persons with disabilities in the regional Social Development Strategy, thirty-three countries attending the forty-eighth ESCAP session in April 1992 joined in sponsorship of resolution 48/3 on an Asian and Pacific Decade of Disabled Persons, 1993-2002. In adopting the resolution, the Governments of the region expressed their collective commitment to the full participation and equality of people with disabilities.

The proposed Agenda for action also envisages development of community-based approaches as a means of improving access to rehabilitation services, including through:

- a. Provision of policy, institutional and financial support
- b. Adaptation of existing manuals to meet the needs of communities in diverse cultural, linguistic, and economic contexts
- c. Increase of training of field workers for work in slums and rural areas
- d. Strengthening of the referral system, focusing on the first referral level
- e. Support for people with disabilities and their advocates to initiate and develop community-based rehabilitation (CBR) activities;
- f. Training of advocates and household members in basic rehabilitation techniques
- g. Use of experience gained from the self-help movement of people with disabilities to extend CBR services to persons with mental disabilities
- h. Conduct of research, evaluation and information exchange

2.10 ICEVI - Asia Region Conference

The International Council for Education of People with Visual Impairment convened the Asia Region Conference with the theme “Reaching the Unreached” at Ahmedabad during 9-11 January, 1995. The Conference adopted Plan of Action which emphasize promotion of community based rehabilitation in the Asian Region. The Plan of Action included:

“It is felt that the goal of achieving community based rehabilitation for all persons with visual impairment by the year 2000 A.D. is no longer feasible. ICEVI, therefore projects a target to multiply the present coverage by at least four times in Asia Region. Since the CBR programmes facilitate the services relating to identification, referral and early intervention for children with visual impairment, it is essential that there is effective interaction between CBR and education programmes”.

Like education, a uniform service delivery model cannot be adopted in providing CBR services too. ICEVI strongly emphasizes that minimum standards are assured in the services provided to the clientele as well as the training to field workers.

2.11 Biwako Framework

The Economic and Social Commission for Asia and the Pacific at its fifty-eighth session, adopted resolution 58/4 of 22 May 2002 on promoting an inclusive, barrier-free and rights-based society for people with disabilities in the Asian and Pacific region in the twenty-first century, by which it proclaimed the extension of the Asian and Pacific Decade of Disabled Persons, 1993-2002, for another decade, 2003-2012.

The present document sets out a draft regional framework for action that provides regional policy recommendations for action by Governments in the region and concerned stakeholders to achieve an inclusive, barrier-free and rights-based society for persons with disabilities in the new decade, 2003-2012. The regional framework for action identifies seven areas for priority action in the new decade. Each priority area contains critical issues, targets and the action required.

Paragraph of 55 of the Framework points out that many developing countries in the region are now beginning to augment and replace traditional institutional and centralized rehabilitation programmes and projects with approaches better suited to their social and economic environments of poverty, high unemployment and limited resources for social services. Community-based rehabilitation programmes form the hub of such strategies. The community-based approach is particularly appropriate for the prevention of causes of disability, early identification and intervention of children with disabilities, reaching out to persons with disabilities in rural areas, raising awareness and advocacy for the inclusion of persons with disabilities in all activities in the community, including social, cultural and religious activities. Education, training and employment needs could also be met by this approach. It is essential that persons with disabilities exercise choice and control over initiatives for community-based rehabilitation.

The Biwako Framework adopts Strategy No 10 as regard promotion of CBR. The strategy desires that the Governments, in collaboration with organizations of persons with disabilities and civil society organizations, should immediately develop national policies, if that has not yet been done, to promote community-based approaches for the prevention of causes of disability, for rehabilitation and for the empowerment of persons with disabilities. Community based rehabilitation (CBR) perspectives should reflect a human rights approach and be modelled on the independent living concept, which includes peer counselling.

3. Indian Initiative

A large number of leading NGOs realized during the early 1980s that non-institutional rural projects for persons with disabilities were indispensable. A large number of NGOs developed, presented, implemented and perfected nation-wide programme on promotion of CBR. The major Indian initiatives include:

3.1 PL-480 Project

A Rural Rehabilitation Centre for the Blind was started during 1973 at Madurai with the financial support from PL-480 grant of the U.S.A. The Centre was established under the guidance of renowned experts Major Bridges and Mr. Robert C. Jaekle from the American Foundation for the Blind, U.S.A. (now known as Helen Keller International)

3.2 CBM's Initiative

Mr. Robert C. Jaekle, truly the Father of CBR, joined the Christoffel Blindenmission and initiated a rehabilitation programme for the rural visually impaired in Tiruchirapalli District of Tamil Nadu. He also established a training centre at Musiri for the training of CBR field functionaries.

3.3 NAB RAC Project

During 1981, Capt. H. J. M. Desai, Chairman, Rehabilitation, Training and Employment Committee of the World Council for the Welfare of the Blind, published his book "*Planning Employment Services for the Blind in the Developing Countries*", wherein he strongly recommended that an organizational set-up was needed to be formed which could effectively spread the concept of training, rehabilitation, and resettlement of the visually impaired in their rural surroundings. He strongly advocated the formation of a Rural Activities Committee in every developing country under the national level voluntary agency, which could perform the task of initiating and coordinating such programmes.

A nation-wide project entitled "*Social and Economic Rehabilitation of the Rural Blind*" was promoted by the Rural Activities Committee of the National Association for the Blind during 1983 with the support of the then Royal Commonwealth Society for the Blind now renamed Sight Savers International. The programme was subsequently modified and promoted as Comprehensive CBR Project for the Visually Impaired. This project was implemented by various Agencies all over India and received support from a large number of funding and developmental agencies:

- Sight Savers International
- DANIDA
- NORAD
- OXFAM
- Helpage International
- South Asia Partnership
- World Blind Union

- Ministry of Social Justice & Empowerment
- L.D. Jhaveri Foundation
- Shri Manav Kalyan Trust
- National Institute for the Visually Handicapped
- State Bank of India
- Department of Social Justice & Empowerment
- Raj Shobhag Ashram

The NAB RAC followed the following process for evolving the concept of CBR and developing it as a national movement:

3.3.1 Review of Existing Projects: The NAB RAC decided to review several existing programmes to design a project most suited for the rural visually impaired. Team members of the NAB RAC visited several rural projects including the "*Rehabilitation for the Rural Blind - Musiri Extension Project*" implemented by the South Asia Regional Office of the Christoffel Blindenmission in Tamil Nadu. The project aimed at prevention and cure of visual impairment and imparting training in orientation & mobility, daily living skills, home economics and vocational training to the incurably visually impaired. To achieve these objectives, a team of local Field Workers were imparted training in these skills at Musiri.

The NAB RAC officials also visited the Tata Agriculture Training Centre at Phansa in Gujarat, Rural Mobility Training Centre at Bandung in Indonesia, compiled literature on rehabilitation of the rural visually impaired, discussed various issues with Capt. H. J. M. Desai, Chairman of the NAB RAC, with Mr. Robert C. Jaekle, a renowned Mobility Instructor and Initiator of projects on rehabilitation of the rural visually impaired and other specialists in the field. The Musiri approach to rehabilitation of the rural visually impaired at their door step was found most appropriate and effective.

3.3.2 Modification of the Approach : The Musiri Rural Rehabilitation project considered imparting of vocational training as the ultimate objective. It desired the family to provide further inputs for achieving the economic rehabilitation. The NAB RAC, however, emphasized the need for promoting economic rehabilitation of the visually impaired

as the ultimate objective. It also stressed the need for keeping the project cost low and thus decided not to make investment in infrastructure and capital intensive items. Hence a nation-wide project entitled “*Social and Economic Rehabilitation of the Rural Blind*” was developed and presented to then Director of the Sight Savers International, Sir John Wilson, and the Overseas Director, (late) Mr. Alan Johns. Both showed keen interest in the project, and two projects were financed on a pilot basis.

The first project was initiated during 1983 at Dholka, a backward block of District Ahmedabad in Gujarat. The project was started under the auspices of the Indian Red Cross Society with Mr. Gautam Majumdar, known for his successful mission on eye donation, as Joint Project Director. The project has now become famous as a model of rural rehabilitation and is widely known as the Dholka Project. The second project was initiated at Chikballapur in Karnataka with NAB Karnataka Branch as the Project Implementing Agency and Late Mrs. Ratna Atmaram Rao as the Joint Project Director.

3.3.3 Expansion of Scope : To begin with, four main aspects of the rural rehabilitation projects were:

- a. Prevention and cure of blindness
- b. Social rehabilitation
- c. Economic rehabilitation
- d. Support services : During 1987, it was realized that integrated education is a major issue and that must be included as a component of the project. The NAB RAC involved NAB Department of Education to initiate and monitor this component. Thus the fifth component of the project emerged to be integrated education.
- e. Eye screening and eye check-up : Subsequently, it was observed that it was essential to carry out eye screening of school children and the population as a whole to establish the backlog of eye treatment and eye surgeries. As prevention and cure of blindness were already components of the project, Eye check-up and eye screening were also included as components to enhance the services in this respect further.

- f. Integrated education : Thus the CBR project is comprehensive approach which encompasses all components of eye screening, eye check-up, integrated education, social rehabilitation, support services and economic rehabilitation.

Thus the concept evolved and developed by the NAB RAC is most comprehensive and covers all aspects of prevention & cure, appropriate education, social integration, gainful occupation, income generation and support services.

3.4 District Rehabilitation Centres Scheme

The Government of India launched District Rehabilitation Centre (DRC) Scheme during January 1985 on pilot basis. The pilot project, started in collaboration with the National Institute of Disability and Rehabilitation Research (NIDRR), US Department of Education and UNICEF, aimed at providing a package of model comprehensive rehabilitation services to the rural visually impaired. The objectives of the Scheme were to:

- a. Create awareness that the disabled could be productive if given opportunities and support;
- b. Help the disabled persons cope with problems of daily living and relieve family members of the burden of constantly looking after him;
- c. Establish a comprehensive model of rehabilitation services including
 - Medical intervention,
 - Education,
 - Vocational training
 - Employment
- d. Promotion of voluntary efforts in the area of rehabilitation, and,
- e. Creation of a cadre of multi-disciplinary professionals.

This scheme was launched in eleven different districts in India.

The Indian Institute of Health Management, Maharashtra evaluated the programme during 1989. The evaluation team was headed by

Dr. Nirmala Murthy of the Indian Institute of Management (IIM), Ahmedabad.

The DRC Scheme did have considerable impact, according to the evaluation report, although there are many areas of deficiency which could be improved upon. Although the programme had been 'community located', it had not been 'community based'.

3.5 District Blindness Control Societies

India has launched a National Programme on Control of Blindness since 1963. To begin with, the major focus of this programme was prevention and cure of trachoma and provision of vitamin A for prevention of Xerophthalmia. After the national survey of 1971-74 established that cataract caused almost 55 percent of blindness, cataract became the major focus of this programme. The major emphasis of the programme is on expansion of infrastructure and training of manpower in eye care with the objective of capacity building for cataract surgery. The programme was started with the objective to reduce the prevalence of blindness from 14 per 1000 in 1975 to 3 per 1000 by the year 2000.

The District Blindness Control Societies have been established since 1993 to promote eye care at the grass root level. These societies seek better participation of local administration, government departments viz. social welfare, education and information. The main objective behind this move is to bring eye-care in the mainstream of society and bring about inter-sectoral cooperation. There is a scope for active participation of NGOs devoted to eye care, CBR and rural development.

The rehabilitation of the incurably visually impaired people will include:

- Mobility training of the visually impaired
- Economic rehabilitation of the young visually impaired people
- Education of the visually impaired children in regular schools
- Community education about the specific needs of the visually impaired persons

The District Programme Manager (DPM), a key functionary in the DBCs set up is expected to perform the following functions

in respect to promotion of community based rehabilitation in the area of coverage:

- a. Identify a suitable project implementing agency as per the details given above
- b. Such agency should be assisted to avail financial assistance for the implementation of CBR project in the area. At present such assistance is available. The District Collector would be over all in charge of this scheme.

There is tremendous increase in allocation of financial resources by the Government for promoting eye care services. International support for this purpose has also increased manifold, initially from DANIDA and WHO, and recently a large loan from the World Bank. These national efforts are being augmented by multi-million assistance from the World Bank in seven states of the country over a period of 1994 to 2001. As a result of these efforts and resource allocation, the total number of cataract operations increased from 1.2 million during 1989 to 2.7 million during April, 1996 to March, 1997 (Limburg, 1999), but this is still inadequate to clear the backlog.

A rapid assessment of cataract blindness and surgical coverage in the seven World Bank assisted States conducted during 1998 establishes that in most States, the prevalence of blindness had decreased as compared to situation during 1996. The prevalence, however, continues to be higher in females as compared to males, though there was evidence to show that the utilization of cataract surgical services has increased among women.

The District Blindness Control Society (DBCS) is the first systematic attempt on promoting comprehensive eye care which encompasses CBR along with eye screening, eye treatment, eye surgeries and prevention of visual impairment. Now, health oriented programmes have also now started recognizing the need for promoting CBR as a part of comprehensive health care approach.

3.6 CBR Network

It is estimated that there are over 800 organizations promoting CBR for persons with disabilities in India. The CBR Network was a platform set up as a result of a Workshop on CBR sponsored by NORAD in September, 1992 and later converted into a legal entity in 1997. The objectives of the National CBR Network are:

- to document CBR approaches, methodologies in India and public policy in favour of CBR
- to publish a CBR frontline digest for workers at the grassroots level
- to share and disseminate information regarding CBR in a partnership market
- to influence public policy in favour of CBR, and
- to establish a database on CBR.

The CBR Network has divided India into four zones - North, South, East and West and leading disability development organizations have been entrusted the responsibility of promoting networking and disseminating information.

Website: <http://www.cbrnet.com>

E-mail : cbrnet@vsnl.com

3.7 Rehabilitation Council of India

Although in the last two decades, several courses for training of physiotherapists, occupational therapists, prosthetic and orthotics engineers, CBR workers, special educators and other personnel have come into being, there is complete lack of uniformity in the syllabi offered by various institutions and organizations. The National Advisory Council for Welfare of the Handicapped felt that uniformity should be achieved. In pursuance of one of the recommendations of the National Council, the Government of India initially set up the Rehabilitation Council of India by a Government resolution. Subsequently an Act of Parliament was passed setting up the Rehabilitation Council of India in 1992. The Act came into force from July, 1993.

The main purpose of the Council is to standardize the syllabi for training of various types of professionals needed in the field of rehabilitation. It also seeks to register those who work in the field of rehabilitation with the object of ensuring that only qualified people render the services to people with disabilities.

Apart from these functions, the Council has also been trying to undertake programmes of continuing Rehabilitation Education so

that the country has a reservoir of trained people who could impart the best possible training to children and adults with disabilities. The object of the programme is to ensure that the knowledge of rehabilitation professionals is updated from time to time so as to provide the best possible service to people with disabilities.

Till date, a huge knowledge base has been developed in CBR which has yet not been fully disseminated to rehabilitation professionals. The Rehabilitation Council of India feels that it is utmost necessary that the knowledge/skills of professionals must be reinforced and updated with modern concept of CBR and its practice. It is therefore, proposed that the First Continuing Education Programme under the banner of the Rehabilitation Council of India should be on updated CBR - its concepts, technology and application.

Methodology : The Continuing Rehabilitation Education Programme on community based rehabilitation has to be developed in two modules:

Module I: *Development of resource persons to form regional CBR faculty. The national resource persons would be identified from across the country with at least five persons from each region.*

Module II : *Development of resource persons to form regional CBR faculty of resource persons for different regions viz. East, West, South, North and central regions. The regional resource persons would be identified from the respective regions with at least 5 persons from each State or Union Territory included in the region. There should be proportional distribution among different categories of disability.*

As a part of the Continuing Education Programme, the Rehabilitation Council of India organized the first expert group meeting on 'Updated CBR - its Concepts, Technology and Application' on 29-30 March, 1995 at Amar Jyoti Charitable Trust, Kakardooma, Vikas Marg, Delhi. The objective of this meeting was to form the national CBR faculty of resource persons.

On successful completion of expert group meeting (Module), the Rehabilitation Council of India decided to organize regional training

Workshops in different regions. The first regional training workshop was organized at Ahmedabad during 28-29 April, 1995. The RCI would organize similar workshops in the other three regions also.

As a part of its Scheme of Bridge Courses, it has covered CBR professionals for completing bridge courses and seeking its registration.

Website: <http://www.rehabindia.com>

E-mail : rehabstd@nde.vsnl.net.in

3.8 National Policy for the Disabled

The Ministry of Social Justice & Empowerment convened National Conference on Welfare of the Disabled during 20-22 September, 1993 to discuss various aspects of disabled welfare. The last session of the workshop was devoted to finalizing of a National Policy document for the disabled. As a part of the National Policy, it was unanimously resolved that a separate scheme of CBR for the Disabled persons in the rural and backward areas already evolved by the Ministry of Welfare should be adopted and implemented. Till this scheme is formally adopted, CBR projects would be funded by the Ministry under the existing scheme of "Assistance to Voluntary Organizations for the People with Disabilities".

3.9 Pilot Project on Medical Rehabilitation

The Ministry of Health, Govt. of India launched a Pilot Project on Medical Rehabilitation on 22nd November, 1995 with all India Institute of Physical Medicine & Rehabilitation as the Nodal Implementing Agency with emphasis on provision of rehabilitation services through primary health care.

The main objective for inclusion of CBR in the Health Care Delivery Services are:

- Prevention of disability causing disorders
- Early detection of disability causing disorders
- Early medical intervention
- Early rehabilitation intervention
- Capacity building of different centres from peripheral up to specialized centres

- Training of manpower required for service delivery, teaching and research activities at different levels
- Equipping / strengthening Primary Health Centres (Wadhwa, 1998)

The rationale for incorporating CBR into health care system is that instead of creating another large vertically structured CBR programme, it appears logical to train the existing health care manpower in different aspects of CBR by equipping them with the knowledge and skills and better equipping all components of Health Care Delivery System in a phased manner, spread over a decade or more, throughout the country.

3.10 Persons with Disabilities Act, 1995

On 22nd December, 1995, the last day of the Winter Session of the Parliament, all the political parties for the first time during this session unanimously consented to consider non-official business and the result was the unanimous passing of "Persons with Disabilities (Equal Opportunities, Protection of Rights & Full Participation) Act, 1995". The President of India gave his assent to the Act on 1 January, 1996 and it came into force with effect from 7 February, 1996.

The main objectives of the Act are to spell out the responsibilities of the State towards the prevention and early detection of disabilities and recognition of the rights of persons with disabilities to enjoy equality of opportunity and full participation in national life.

Apart from the objectives of preventing the occurrence of disabilities, access to free education, reservation in vacancies, provision of aids and appliances, allotment of concessional land and non-discrimination in transport on road and built environment, the Act also envisages promotion and sponsor of research and manpower development programmes on various aspects including CBR.

The Act thus recognizes and endorses the need for promoting research as well as development of human resources in the areas of rehabilitation including CBR. The section on education desires the appropriate government to promote integration of students with disabilities in the regular schools.

3.11 CAPART Initiative on Disability Strategies

The Council for Advancement of Peoples' Action and Rural Technology (CAPART) convened a national convention at New Delhi in February, 1995 as a part of implementation of the Proclamation and Agenda for Action for Asia and Pacific Decade of Disabled Persons. This initiative sought to address a serious concern regarding the poor coverage of rural people with disabilities by the existing services, and the need for special efforts to be made to enable them to participate in rural development programmes.

Based on this consideration, the CAPART has developed a strategy to promote the participation of people with disabilities in programmes for rural development. As a part of this "Disability Strategy", CAPART will extend support to non-Governmental organizations whose project proposals are in consonance with the overall thrust and guiding principles of this Strategy, and which will further its implementation. The focus area of the strategy include:

- a. Social mobilization
 - Organization building
 - Development of training and information materials
 - Programme support
- b. Capacity building
 - Training of development workers
 - Development of training packages and information materials
 - Development of community based support services
- c. Rural infrastructure development
 - Innovations in eliminating physical barriers in the rural built environment
 - Removing barriers in the work place
 - Dissemination of barrier free designs
- d. Indigenous technologies
 - Identification and dissemination of low-cost indigenous technologies
 - Development of information materials on assistive devices
 - Promotion of measures for accident-prevention and safety
 - Training Workshops and exchange visits
 - Evaluation and adaptation of existing technologies
- e. Net working
 - Initiating and supporting rural community networks

3.12 CBR Forum

The CBR Forum for Persons with Disabilities was constituted by Miseoreor, a German funding agency during 1996. It is a Programme Unit of Caritas India, its legal holder. Its mission is to play a proactive and promotional role in CBR of persons with disabilities in India, ensuring wide coverage with focus on the disadvantaged group such as the poor, women and people living in rural areas and urban slums.

The CBR Forum encourages and supports appropriate organizations, programmes and projects for CBR and does not implement the same directly. It also supports measures on prevention of disabilities, appropriate training, creation of public awareness, networking, advocacy, innovations and research in issues pertaining to CBR.

The vision of the CBR Forum is that people with disabilities have equal opportunities leading to improved quality of life and fully participate in a society that respects their rights and dignity.

The CBR Forum is emerging as a leading source of funding for various CBR projects.

3.13 CBR Scheme of the Ministry

The Scheme to Promote Voluntary Action for Persons with Disabilities evolved during 1998 by the Ministry of Social Justice & Empowerment, Government of India, provides grant-in-aid to voluntary organization for the promotion of CBR. The Ministry extends financial support for the following manpower (Ref. No. 21(25)/98-DD-II):

- Rural Rehabilitation Volunteers
- CBR Personnel or Multi-rehabilitation Workers
- Social Workers
- Specialists - Therapists and Educators
- Voluntary Workers
- Project coordinators / Directors

This is first time that the Ministry of Social Justice & Empowerment has given due recognition to the concept of CBR in its major grant-in-aid scheme.

3.14 Bridge Course for CPR Workers

According to the Rehabilitation Council of India, the use of expression CBR is improper due to following reasons:

- Communities are very poor
- People cannot take financial responsibility for the programmes
- Difficult for them to take initiative in a developmental programme.
- During the day, most people in the village are away in the field, hence their involvement is not possible.

As the participation of community in the rehabilitation programme is crucial, the RCI has renamed the programme as “Community Participatory Rehabilitation” and has launched the Bridge Course for CPR Workers.

Objectives

- To involve community in all activities of rehabilitation.
- To mainstream people with disabilities in village community.
- To enhance self esteem and guidance of people with disabilities with involvement of community.
- To engage experts to visit rural areas to offer appropriate assistance and guidance.

Duration: One-month (6 days a week, 24 days) i.e. 145 hours.

Eligibility: Any person who has completed minimum 8th standard and has worked in rural areas for a minimum period of three years.

The Rehabilitation Council of India will provide Registration Certificate to all those people who complete this course as Rehabilitation Personnel. This is a bold step in the right direction as it will provide credibility to the field workers and the concept of CPR.

3.15 CBR Training Modules

To standardize training of CBR volunteers, workers and coordinators the Rehabilitation Council of India has evolved and adopted 3 training courses:

- a. Training for CBR Volunteers - one month duration
- b. Certificate Course for Multi-purpose Rehabilitation Workers- 3 months duration
- c. Diploma in community Based Rehabilitation for Disabled - One year duration.

These courses aim at developing a cadre of trained CBR workers at different levels. The course content for these courses is given in the Appendix.

3.16 Continuing Rehabilitation Education

The Rehabilitation Council of India has introduced the concept of Continuing Rehabilitation Education (CRE) for upgrading knowledge and skills of professionals/personnel working in disability sector. It has evolved these courses for all categories of disability. As regard promotion of community based rehabilitation, the following courses have been evolved:

- Rehabilitation of persons with mental illness in community
- Community based rehabilitation for the locomotor handicapped
- Strengthening community based rehabilitation for the hearing impaired

The Rehabilitation Council of India provides financial support for the following heads of expenditure:

- a. Honorarium to Programme Coordinator
- b. Honorarium for resource persons
- c. Stationery and support material
- d. Boarding & lodging etc.
- e. Contingency, etc.

The scheme encourages use of local resources and availing of services of local faculty. Similarly, scheme desires that the local and regional participants should be encouraged to participate in the programme.

For more details, contact Member Secretary, Rehabilitation Council of India, 23- A, Shivaji Marg, New Delhi 110 015, Phone: 25911964, 25911965, 25913016 Fax: 25911967

3.17 National Program on Rehabilitation of Persons with Disabilities (NPRPD)

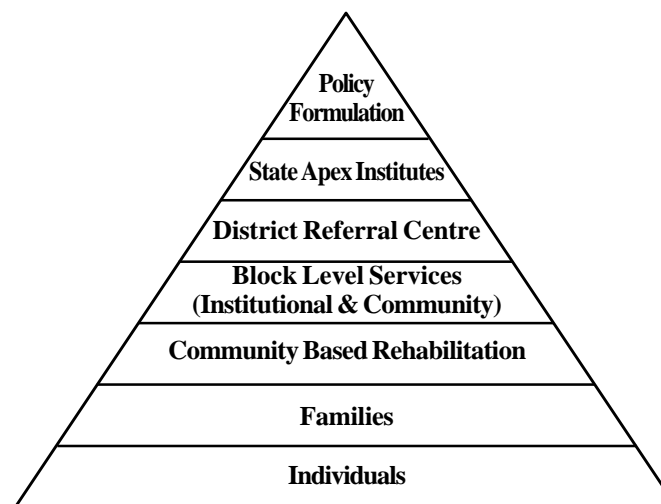
The Ministry of Social Justice & Empowerment has introduced the National Programme for the Rehabilitation of Persons with Disabilities (NPRPD) as a model for State Governments for providing rehabilitation services to such persons. To begin with, this Programme will be launched in 100 district all over the country.

3.17.1 Objectives : The objective of this programme is to promote comprehensive rehabilitation for all persons with disabilities at their doorstep. For this purpose, the programme will have a delivery system right from the State level to the Gram Panchayat level. The envisaged infra structure has the following salient features:

- a. To develop and maintain minimum level of services at each level of service delivery, from State to village level
- b. To provide guidelines to States for assisting them to initiate and strengthen services
- c. To provide appropriate information about most cost effective, efficient and economical models in the field of rehabilitation
- d. The service delivery system should have at least at each level infrastructure for service delivery, provision of assistive devices and availability of trained manpower.
- e. As far as possible, services should be provided at the doorstep of the individuals.
- f. As community based services are cost effective, efforts should be made to provide services using community and family resources.
- g. The State should make efforts to use existing institutions, both in Government as well as Non-government sectors and the local authorities for delivery of rehabilitation services.

3.17.2 Hierarchical Pyramid of Provision of Services

- i. *Provision of Basic Rehabilitation Services & First level of intervention, community based approach.*
- ii. *Middle Level-Provision of Both Institutional & Community Based Services*
- iii. *District Referral Centre :* Essentially Institutional intervention, referral and higher level services- Higher Education, Medical Services, Training Institutes.
- iv. *State Apex Institutes* - basically a referral centre & the highest level institute in the state for provision of selected rehabilitation services & information on other services.
- v. *National Level Policy* formulation, Monitoring & Evaluation & Actual Intervention in a few complicated cases.



3.17.3 Service Delivery: The programme envisages providing the following 4 major services:

- a. Integration in the family and community
- b. Appropriate environment
- c. Medical intervention including medical rehabilitation
- d. Vocational training and appropriate employment

According to the programme, integration with the family is a minimum common denominator for all persons with disabilities. The next step however is their integration in the community. Such integration may be achieved by formulation of suitable training modules, identification of trainers for rehabilitation workers, designing and implementation of training modules. The NPRPD aims at providing comprehensive services to persons with all categories of disabilities.

For more details, contact: The Director, District Rehabilitation Centres Scheme, Ministry of Social Justice & Empowerment, 4 Vishnu Digamber Marg, New Delhi 110 0025

3.18 District Centres for Rehabilitation

The Ministry of Social Justice & Empowerment has introduced the District Rehabilitation Centres Scheme to enhance outreach of the services and cover larger areas through network of rehabilitation services in 100 districts. The Scheme aims at utilizing the existing infrastructure of the State Medical Colleges, rehabilitation centres, Red Cross Societies, local doctors and experts for the purpose of extending services to persons with disabilities. To begin with, 100 districts spread over all India have been identified for this purpose.

The services to be provided on an on-going basis include:

- a. Assessment of existing infrastructure and resources in the district and assessing they're potential.
- b. Identification of persons with disabilities
- c. Issuing of disability certificates
- d. Promotion of prevention of disability through involvement of village level workers, creation of social communication and such other appropriate means.
- e. Setting up of composite fitment centres to provide assessment, actual fitment, provision and follow up and repair of assistive devices

Each fitment centre is allocated a budget of 1.3 million. The salient feature of this scheme is that the fitment centre would undertake only those activities, which the government lays down in its policies and provides funds. Another

important aspect of the scheme is that the National Institutes, Artificial Limbs Manufacturing Corporation of India and the District Rehabilitation Centres would implement it. In other words, various institutes and agencies of the Ministry of Social Justice & Empowerment would manage all the fitment centres.

- f. Promotion of barrier free environment,
- g. Promotion of appropriate educational services and vocational training
- h. Assistance in employment and placement etc.
- i. Providing referral services for higher level education, training and vocations.

The whole programme has been divided into 2 phases, with the first phase focussing on providing rehabilitation in the identified districts and the second to spread out the services to other contiguous districts. The monitoring and evaluation of these programmes may be undertaken by the National Programme on Rehabilitation of Persons with Disabilities (NPRPD). It is proposed to set National Monitoring, Evaluation, Policy Formulation and Training Unit through restructuring of the existing District Rehabilitation Centres.

For more details, contact Director, District Rehabilitation Centres at the address given earlier.

3.19 Community Approaches to Handicap in Development

Most of the work in the field of impairment, disability and handicap has focussed on persons with disabilities and their problems. In case of CAHD, as explained earlier, the focus is shifted to the causes of their problems. The results of this shift are on increased awareness of the "hidden dimensions" of impairment, handicap and disability. The objectives of this approach are to include them in development; to increase resources made available to assist them, to create social changes that will ensure their inclusion as full citizens with equal opportunities and full access to participation.

The objective of a CAHD programme is to eliminate handicap, changing the negative cycle of impairment and disability to positive, through planned and organized interventions that will:

- a. Change the attitude of people and their organizations so that there is equitable sharing of resources locally, regionally, nationally and internationally.
- b. Change the attitude of people and their organizations to eliminate the barriers that result in little or no assistance to disabled persons.
- c. Reduce the impact of impairment and disability on individuals and families through provision of assistive devices.

This project has already been initiated jointly by the Handicap International and the Christoffel Blindenmission on pilot basis in four countries including Tripura in India, 2 projects in Philippines, Dhaka in Bangladesh and Phokhra in Nepal. The training for CAHD is coordinated by Centre for Disability Development (CDD), Dhaka, Bangladesh.

For more details, contact country offices of Handicap International or Christoffel Blindenmission.

3.20 Ashthawakra CBR Scheme

The Department of Social Justice & Empowerment, Govt. of Gujarat has introduced the Maharishi Ashtavakra Yojana for the promotion of CBR for the State of Gujarat. The Department has sanctioned a grant of Rs. 720 million for covering all 25 Districts of Gujarat over a period of 5 years. For the first year 2000-2001, the Department has sanctioned a grant of Rs. 53.7 million for this purpose.

This Scheme envisages covering persons with all categories of disability at their doorstep. As the scheme has been developed and being coordinated by the Authors of this Manual, the scheme follows the implementation plan as outlined in this Manual. This is probably the largest CBR Programme being supported by any State Government in India. The target of this scheme is to cover 6,00,000 persons with disabilities in the State of Gujarat over the next 5 years.

These entire developments world over and in India establish that the concept of CBR is not just a project, programme or a strategy, it is emerging as a movement. The United Nations while evolving a Convention on the Rights of Persons with Disabilities recognized CBR as an option for the promotion of effective and appropriate services for the persons with disabilities.

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