Networking for Community Based Inclusive Development (CBID)

Participant Manual

Volunteer Level

NAD – The Norwegian Association of Disabled

ACKNOWLEDGEMENTS

The Norwegian Association of the Disabled (NAD) have developed this Universal *Networking for Community Based Inclusive Development (CBID)* Training Package at the request of many stakeholders working in this sector.

The package draws on a range of CBID packages developed and rolled out in Malawi, Zambia, and Zanzibar between 2016-2021. NAD worked in collaboration with Flourish Development Consulting UK, the Malawi Council for the Handicapped (MACOHA), the CBR Zambia Support Programme, the Madrasa Early Childhood Programme Zanzibar (MECPZ) and many of their partners and collaborators in all three countries. The Universal package was piloted in Uganda in collaboration with NAD Uganda and other stakeholders who gave valuable feedback. Our grateful thanks to the Governments in all four countries, and to all of the individuals and organizations that have contributed to the development of this training package, or whose resources have been drawn on for the sessions.

Our grateful thanks are also extended to the World Health Organization (WHO). The CBR Guidelines are the primary resource for the training, along with the UN Convention on the Rights of Persons with Disabilities (UN CRPD) Most of the illustrations within the training package are reproduced with the kind permission of WHO.

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The logo used throughout the CBID training package represents inclusion: the diverse elements are included equally in the whole.

FOREWORD: NORWEGIAN ASSOCIATION OF DISABLED

The perception as well as the content of CBR, Community Based Rehabilitation, has changed substantially over the years. When initiated in the 1970s, the strategy had a medical focus. CBR workers were trained to, and largely expected to respond hands-on to the various disability related needs of persons with disabilities in the community. Since then CBR has evolved to become a broader and more holistic developmental approach with the aim of fulfilling the human rights of persons with disabilities, whether it is about accessing good education, getting appropriate health services, earning an income, being included in society or actively contributing to the development of society. This transition is reflected in the emergence of ***CBID***, Community Based Inclusive Development, as a new name of the strategy to reflect its broader scope. CBID is implemented by a broad network of stakeholders including organizations of persons with disabilities (OPDs), social workers, volunteers, community members, service providers, persons with disabilities and their family members, and others who mobilize resources and support within the community for the purpose of developing a disability inclusive society.

In order to secure a harmonized development of CBID aligned with the CBR Guidelines (2010) and the UN CRPD and Agenda 2030, it was considered important to develop CBID training packages that could be used by all stakeholders using CBID as a strategy for their intervention. Building on experience gained in the field of CBID across the African continent, a set of training packages has been developed for staff and volunteers engaged in CBID in Africa and beyond, covering all levels from management through workers to volunteer level.

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NAD – The Norwegian Association of Disabled

ACRONYMS

The following acronyms are used throughout the package:

CBID	Community Based Inclusive Development
CBMI	CBM International
CBID TP	Community Based Inclusive Development Training Package
CBR	Community Based Rehabilitation
CRC	Convention on the Rights of the Child
IDDC	International Disability and Development Consortium
IE	Inclusive education
ILO	International Labour Organization
LTP	Long Term Plan
NAD	Norwegian Association of Disabled
NGO	Non-Governmental Organization
OPD	Organization of Persons with Disabilities
PHC	Primary Health Care
PWD	Persons with disabilities
PWID	Persons with intellectual disabilities
SDGs	Sustainable Development Goals
UN CRPD	United Nations Convention on the Rights of Persons with Disabilities
UNICEF	United Nations Childrens Fund
UDHR	Universal Declaration of Human Rights
UN	United Nations
WHO	World Health Organization

INTRODUCTION

This *Networking for Community Based Inclusive Development (CBID)* Training Package has been devised in line with, and draws on, the World Health Organization (WHO) Guidelines on Community Based Rehabilitation (CBR) and the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD). The Norwegian Association of Disabled (NAD) funded its development.

This CBID Training Package was developed with the aim of facilitating the mainstreaming of disability issues in all sectors. CBID is a rights-based and development-oriented approach to enhance the quality of life for persons with disabilities and their families. The approach aims to ensure their right to inclusion and active participation in their families and communities through the programmes, networking and collaboration of a range of stakeholders.

The need to develop a comprehensive training package was identified to train personnel from various disciplines and service providers and to orient decision makers at all levels on strategies for promoting disability as an integral component of development at national, regional, district and community levels.

By delivering training and championing the capacity building of the health, education, livelihood, social and empowerment sectors, stakeholders will be better equipped to mainstream disability in their sectorial policies, programmes, budgets, resource mobilization and allocation, planning, implementation, monitoring and evaluation, and reporting routines. They will also be empowered to establish CBID Networks to promote and increase collaboration to achieve inclusive development.

This package has been modified from the country-specific packages developed for Malawi, Zambia and Zanzibar as a Universal package which can be delivered in any appropriate setting. It was piloted in Uganda. It has been developed in response to a demand from stakeholders in many African countries for training materials on CBID and is relevant for many African countries as well as some contexts outside of Africa. The *Networking for CBID* Training Package will be strengthened by the training team enriching and domesticating the sessions with local information, case studies, statistics, laws and policies, and cultural considerations.

FROM CBR TO CBID

The shift in language from Community Based Rehabilitation (CBR) to Community Based Inclusive Development (CBID) has been widely discussed over recent years. This summary presents the benefits of promoting CBID over CBR.

Originally, when the World Health Organization introduced CBR in the 1970’s it was focused on medical treatments and related interventions, and rehabilitation was its cornerstone. Through basic and specialized health services, rehabilitation reduced the consequences of disease or injury and improved health, function and quality of life[1]. Health personnel provided service provision for rehabilitation. Over time CBR has evolved to become a strategy that promotes inclusion, participation and empowerment of persons with disabilities, and facilitates access to existing services and a range of coordinated interventions across the health, education, livelihood, social and empowerment sectors for persons with disabilities and their families[2]. These interventions are summarised in the CBR Matrix within the CBR Guidelines[3]. While provision of rehabilitation services remains a critical aspect of CBR, it is one of many interventions of the holistic interventions provided not only by health personnel, but also by a range of other personnel from all sectors.

CBR increases participation and social inclusion of persons with disabilities through rehabilitation, equalizing opportunities and poverty reduction[4]. It is a rights-based and development-oriented approach for promoting inclusive development. It is a strategy now implemented by more than 100 countries as an effective tool to achieve the rights of people with disabilities in line with the UN Convention on the Rights of Persons with Disabilities (UN CRPD).

Although CBR is now much more than just rehabilitation, the use of the word in the CBR title may imply that interventions are still focused only on clinical interventions, and that persons with disabilities must be ‘rehabilitated’ in order for them to lead full and dignified lives. CBR is a term that some development stakeholders, including many Organizations of Persons with Disabilities (OPDs), may not understand in its current sense, as they view it as a medical strategy. There are also CBR actors whose approach remains very traditional and does not promote or facilitate the empowerment of people with disabilities, who further fuel this perspective. Furthermore, some stakeholders working in specific areas of the CBR Matrix such as inclusive education, access to justice, inclusive sports, culture and arts, may not be aware of the CBR Matrix and do not associate themselves as CBR stakeholders. This can limit their support of CBR, their collaboration with other actors, and their recognition of the relevance of CBR to them and their work.

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[1] World Health Organization (2014)

[2] NAD (2010)

[3] World Health Organization, UNESCO, International Labour Organization & International Disability Development Consortium. (2010). Community-based rehabilitation: CBR Guidelines. World Health Organization.

[4] ILO, UNESCO and WHO (2004)

This transition of CBR to a broader based strategy was reflected in the emergence of CBID, Community Based Inclusive Development, as a new name to reflect its broader scope.

In contrast to the term CBR, the term CBID is more recognised as a strategy that is relevant to all. It is seen as focusing on outcomes for persons with disabilities in the wider community.

CBID is achieved when barriers are removed at different levels of society, enabling active participation in development work across all sectors. Inclusive development results from the adoption and implementation of rights-based development approaches that respect differences and acknowledge and accept diversity as part of human life. Inclusive development engages society to remove all barriers that exclude persons with disabilities. It builds capacity and supports people with disabilities to lobby for their own inclusion.

Inclusive development respects equality of human rights for persons with disabilities and promotes their full participation in, and access to, all aspects of society[5].Inclusive development is a global strategy that development stakeholders identify with and see as their responsibility.

It should be emphasised that the term CBR is not wrong or outdated, and some stakeholders may prefer to continue to use the term CBR. However, by using the term CBID in place of CBR, NAD and other stakeholders involved in developing this training package feel that we can more strongly encourage everyone to take responsibility for the inclusion of all. CBID emphasizes that persons with disabilities are an integral component of the Sustainable Development Goals (SDGs) that '*leave no one behind'*.

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[5] CBM (2012)

CONTENTS

UNDERSTANDING DISABILITY

The International Classification of Functioning, Disability and Health (ICF) is the World Health Organization's (WHO's) framework for health and disability. ICF puts the concepts of 'health' and 'disability' in a new perspective by recognising that every person can experience a limitation in their health and in that way experience some disability. The ICF therefore 'mainstreams' the experience of disability.

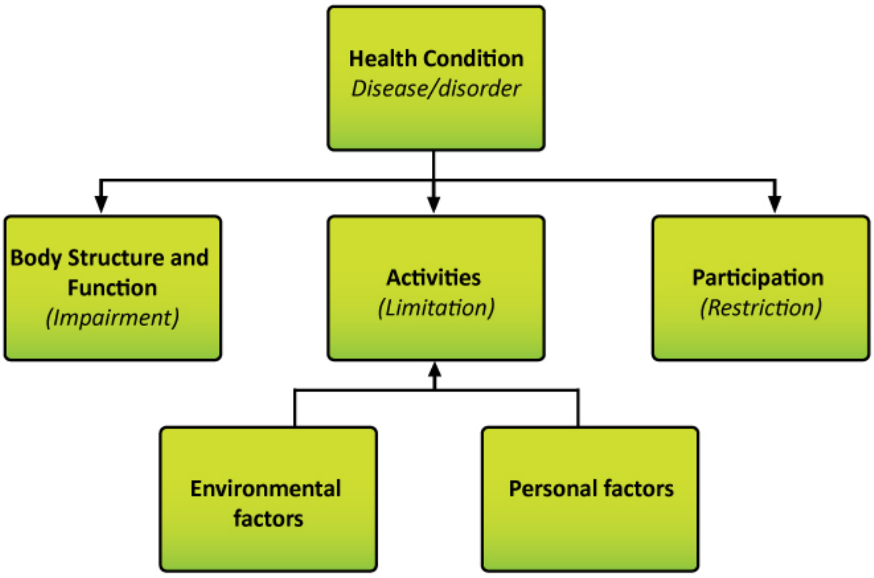
ICF looks at the *health experience* of any individual who has had an impairment or health disorder. ICF classifies health and wellbeing, describing the situation of each person within the range of health and health related areas as well as within the context of environmental and personal factors. The ICF looks at how an individual functions in three areas, namely:

- *body functions and structures*
- *activities* (tasks or actions carried out by an individual)
- *participation* (involvement of the individual in society, or in daily living).

Activities and *participation* describe what a person does or can do or not do. This does not depend on the individual alone but also on the social, physical and attitudinal environment in which the individual lives. As a result of a health condition, changes may occur in the b*ody structure and function* of a person, and in his or her *activities* and *participation*. For example, a body *structure and function* change for a person with a spinal cord injury would be a change in their muscle power function. An *activity* limitation would be difficulty moving and walking. A *participation* restriction might be their restricted participation in employment.

The WHO International Classification of Functioning, Disability and Health (ICF)

Disability is the outcome of an interaction between health conditions and impairments and the physical, human-built, attitudinal, and social environment.



ICF framework examples:

Example	**Body structure and function**	**Activities**	**Participation**
Man who loses a leg in an accident:	*balance and walking ability changed*	*Cannot climb a ladder*	*Cannot do job as builder*
Girl born with a visual impairment:	*Cannot see*	*Cannot read written materials*	*Cannot use school books*

Disability is diverse and might affect one or more of the following aspects of a person:

- Vision
- Movement
- Mental aspects: Thinking, remembering, learning
- Hearing
- Communicating
- Mental health
- Social relationships.

Causes and categories of disabilities

Disability can be **congenital** – a disability that a person is born with such as hydrocephalus, cerebral palsy, Down's syndrome, a club foot, or bowed legs, extra fingers or toes, or syndactyly of toes or fingers (webbed), cleft lip or palate, spina bifida, deafblindness, or leg length discrepancy. It can also be **acquired** – a disability that is acquired for example as a result of a sickness, or injury. This category includes poliomyelitis, paralysis (paraplegia, quadriplegia, hemiplegia), TB spine, leg length discrepancy as a result of a fracture or break to the bone, or a mental health disability such as bipolar disorder.

Scale of disability

The World Health Organization/World bank (2011) estimates that persons with disabilities represent approximately 15% of any population (15 people out of every 100). However, official census figures are usually much lower. Disability is under-reported in most countries. Factors include:

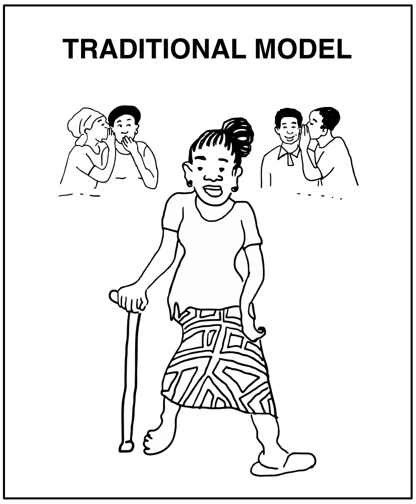
- Family members with disabilities may be hidden inside the home
- Information on family members with disabilities may not be presented during a census.
- People/head of households do not admit to their disability on a census form.
- How disability is defined in census - a census is generalised on various population and housing dynamics, and lacks specificity on disability, therefore the form limits the scope of data captured.

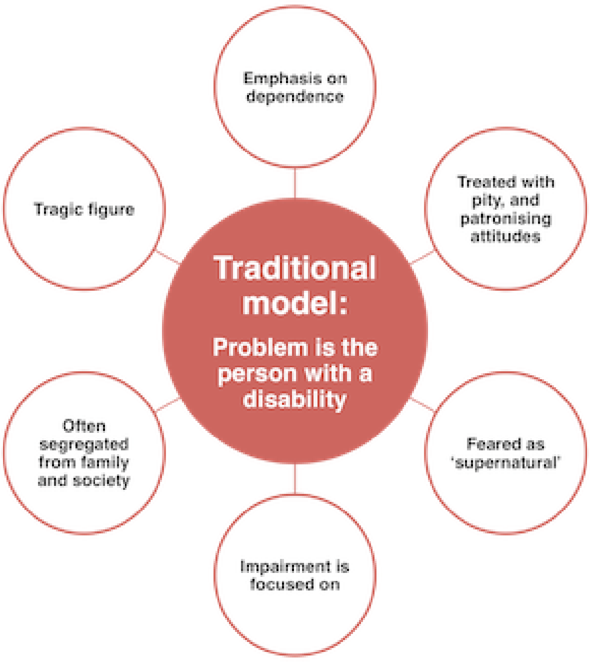
MODELS OF DISABILITY

The way that disability has been viewed has changed over time through various perspectives or ‘lenses’ (like a camera lens). These are often called ‘models’. The models of disability are:

A) The Traditional model

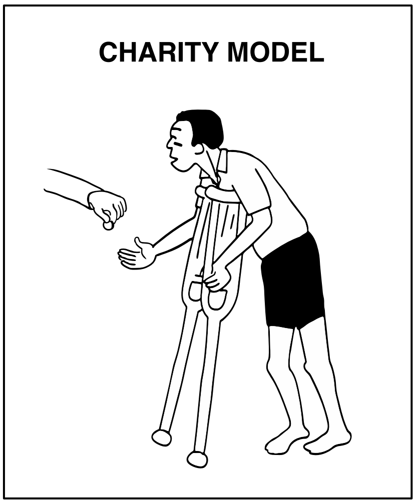
In the Traditional model, disability is seen as a result of a curse – a consequence of an evil that the person with a disability or one of the family members might have done. People with disabilities are perceived not to be part of the human race and cannot access their human rights in any way. In this model, people with disabilities are treated with pity, and/or fear. The person is seen as a tragic victim. The problem is the person with a disability.

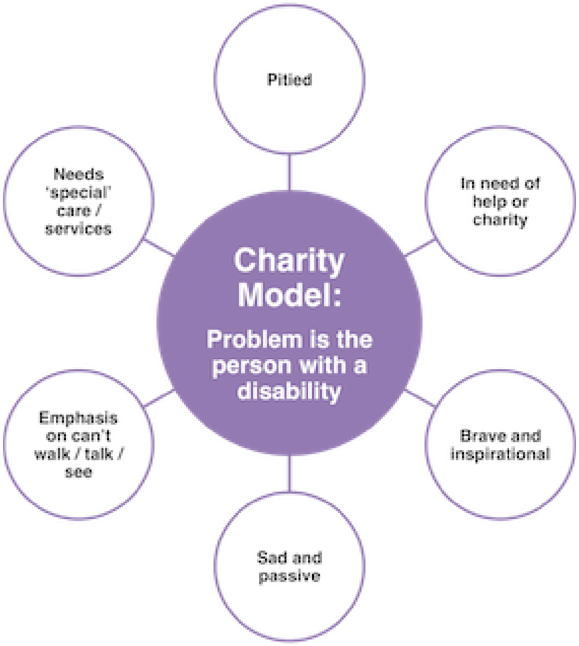




B) The Charity model

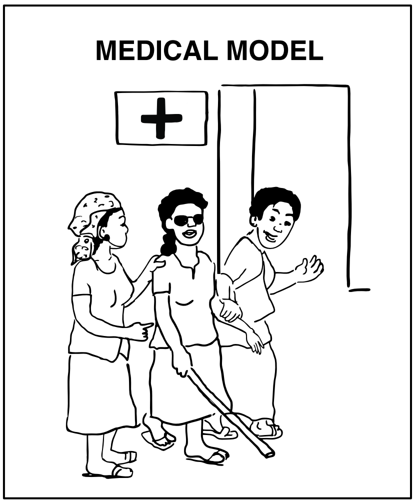
In the Charity model disability is seen as a defect in the body structure and function such as the loss or malfunction of a limb or part of a limb. This makes them unable to participate in society and to fend for themselves. Persons with disabilities are pitied and treated as objects of charity and welfare to be cared for by others, unable to help themselves or be independent. Their needs are seen in terms of being ‘special’. Within the Charity model some persons with disabilities perceive themselves as powerless, useless, non-contributing individuals. They are usually not aware of their rights or able to access them. The problem is the person with a disability.

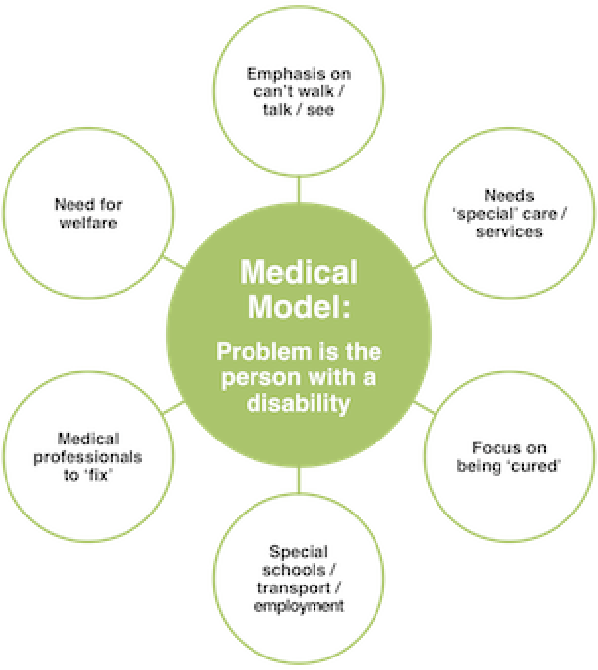




C) The Medical model

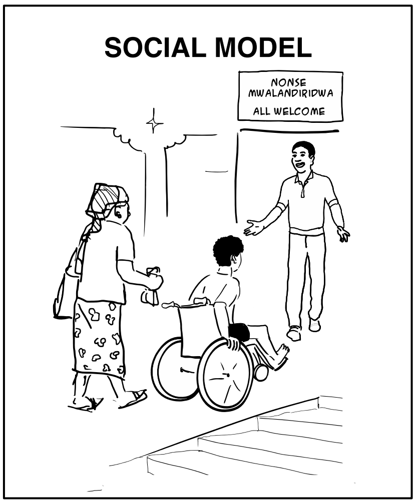
As science and medicine developed, disability was commonly viewed in biological or medical terms. The Medical model looks at disability as different from the 'normal' - caused by an underlying disease or other health condition. The Medical model focuses on the impairment that requires 'fixing' by a medical professional for the individual to be a 'normal' member of society. Disability is viewed as a 'problem' that belongs to the disabled individual. Their 'rights' are only seen in relation to accessing medical treatment to 'fix' them.

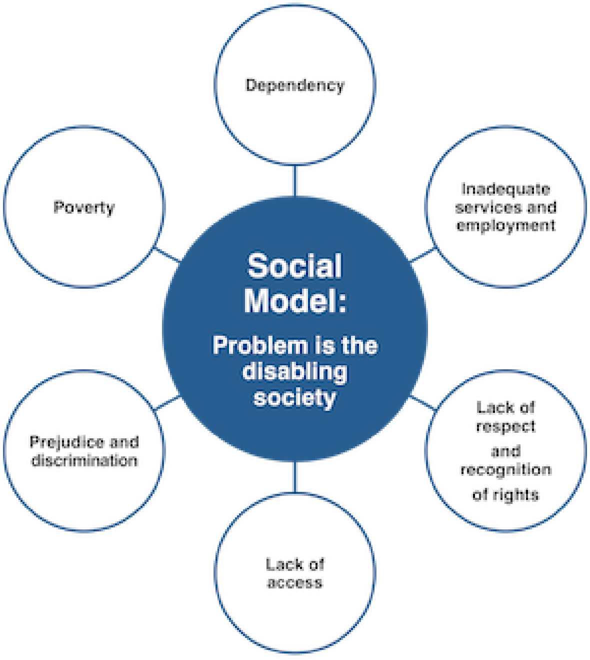




D) The Social model

In the 1960s and 1970s the disability movement grew in strength and argued that disability is not "located" in an individual body at all, but is created by the way society is organized in relation to individual difference – through stigma and discrimination, and through indifference to the accommodations that persons with disabilities may need to participate fully in society. The Social model considers that it is society that disables people, by designing everything to meet the needs of the majority of people who are not disabled. There is recognition within the Social model that it is the responsibility of society, rather than of the person with a disability to remove barriers so that the person can access their rights.

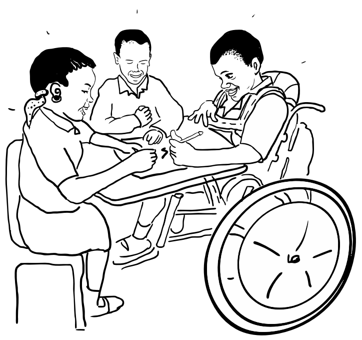




E) The Rights-based model

This model is closely related to the Social Model and takes universal human rights as a starting point. Persons with disabilities are seen to have a right to access all aspects of life within their society on an equal basis with others. Consequently, society has the responsibility to change to ensure that all people have equal possibilities for participation. Persons with disabilities are often denied their basic human rights.

RIGHTS-BASED MODEL



The models do not manifest in a continuum – with one model succeeding or replacing another. There are elements of all models of disability in most countries. It should also be emphasized that the rights-based model does not reject medical treatment, but incorporates the positive aspects of the medical model. It promotes that medical interventions be provided in line with a rights-based approach that puts persons with disabilities at the heart of decisions that affect their lives.

The rights-based model also does not reject all charitable acts such as support of persons with disabilities to access assistive devices or training. The model recognizes that in the absence of a fair society, people with disabilities need support while the barriers they face in society still exist and while they are unfairly marginalized and stigmatized, and stopped from achieving their potential. It recognizes that acts of charity or support should always be provided in a way that gives respect and dignity to the person receiving it and should be considered not as charity, which often has negative connotations, but as good citizenship in the light of the equalities that exist that make it necessary. Such good citizenship has had a positive impact on the lives of many persons with disabilities while society has, and continues, to deny them their rights. The rights-based model contains the positive aspects of all the other models.

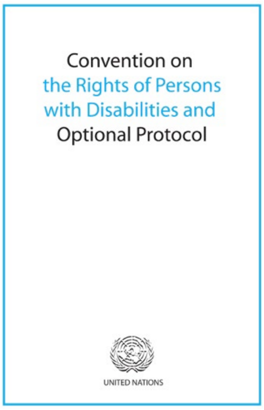
HUMAN RIGHTS AND A RIGHTS-BASED APPROACH

There are policy and legal instruments that outline laws, policies and guidelines that affect the rights of persons with disabilities.

At **community level** persons with disabilities are more empowered to demand their rights when they have knowledge about them. CBID volunteers as well as family members of persons with disabilities need to be aware of these rights and championing them at every opportunity.

International instruments

The United Nations Convention on the Rights of Persons with Disabilities (UN CRPD)



Convention on
the Rights of Persons
with Disabilities and
Optional Protocol

UNITED NATIONS

The United Nations Convention on the Rights of Persons with Disabilities (UN CRPD) is widely considered to be the most important International treaty on disability.

The UN CRPD was designed to change the way persons with disabilities are viewed and treated in their societies. It is a tool for ensuring that persons with disabilities have access to the same rights and opportunities as everybody else – including their access to society, education and employment. Persons with disabilities are covered by other UN rights and convention documents, but the CRPD specifically spells out the rights of persons with disabilities to be included within their own communities.

More information can be found here:
https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

Article 1 of the UN CRPD describes its purpose as follows:

The purpose of the present Convention is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The general principles of the UN CRPD are outlined in Article 3. The principles are listed as:

a. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
b. Non-discrimination;
c. Full and effective participation and inclusion in society;
d. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
e. Equality of opportunity;
f. Accessibility;
g. Equality between men and women;
h. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

The UN CRPD has 50 articles covering a broad range of areas and you are encouraged to read the UN CRPD in full. Articles include:

Article 5 - Equality and non-discrimination: Everyone is entitled to the equal protection and benefit of the law without discrimination.

Article 6 – Women with disabilities: Countries must take all appropriate measures to ensure that women with disabilities are able to fully enjoy the rights and freedoms set out in the UN CRPD.

Article 7 – Children with disabilities: The best interests of the child must be a primary consideration in all actions concerning children with disabilities.

Article 8 – Awareness-raising: Countries must raise awareness of the rights, capabilities and contributions of persons with disabilities.

Article 9 – Accessibility: Persons with disabilities have the right to access all aspects of society on an equal basis with others including the physical environment, transportation, information and communications, and other facilities and services provided to the public.

Article 10 – Right to life: Persons with disabilities have the right to life. Countries must take all necessary measures to ensure that persons with disabilities are able to effectively enjoy this right on an equal basis with others

Article 11 – Situations of risk and humanitarian emergencies: Countries must take all necessary measures to ensure the protection and safety of all persons with disabilities in situations of risk, including armed conflict, humanitarian emergencies and natural disasters.

Article 16 – Freedom from exploitation, violence and abuse: Persons with disabilities have the right to be protected from all forms of exploitation, violence and abuse, including their gender-based aspects, within and outside the home.

Article 17 – Protecting the integrity of the person: Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.

Article 18 – Liberty of movement and nationality: Persons with disabilities have the right to a nationality and liberty of movement.

Article 19 – Living independently and being included in the community: Persons with disabilities have the right to live independently in the community.

Article 20 – Personal mobility: Countries must take effective and appropriate measures to ensure personal mobility for persons with disabilities in the manner and time of their choice, and at affordable cost.

Article 21 – Freedom of expression and opinion, and access to information: Persons with disabilities have the right to express themselves, including the freedom to give and receive information and ideas through all forms of communication.

Article 24 – Education: Persons with disabilities have a right to education without discrimination. Countries must provide reasonable accommodation and individualised support to maximise academic and social development.

Article 25 – Health: Persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination.

Article 26 – Habilitation and rehabilitation: Countries must take effective and appropriate measures to enable persons with disabilities to develop, attain and maintain maximum ability, independence and participation through the provision of habilitation and rehabilitation services and programmes.

Article 27 – Work and employment: Persons with disabilities have the right to work, including the right to work in an environment that is open, inclusive and accessible.

Article 28 – Adequate standard of living and social protection: Persons with disabilities have the right to an adequate standard of living including food, water, clothing and housing, and to effective social protection including poverty reduction and public housing programmes.

Article 29 – Participation in political and public life: Persons with disabilities have the right to participate in politics and in public affairs, as well as to vote and to be elected.

Article 30 – Participation in cultural life, recreation, leisure and sport: Persons with disabilities have the right to take part in cultural life on an equal basis with others, including access to cultural materials, performances and services, and to recreational, leisure and sporting activities.

Article 31 – Statistics and data collection: Countries must collect information about persons with disabilities, with the active involvement of persons with disabilities, so that they can better understand the barriers they experience and make the Convention rights real.

The 2030 Agenda for transforming our world

The 2030 Agenda for sustainable development is an agenda for peace and prosperity for people and our planet. It is made up of 17 Sustainable Development Goals (SDGs) covering a wide range of topics as shown below. It has been endorsed by all member states of the United Nations.

The following information on the 2030 Agenda is taken from the United Nations website https://sdgs.un.org/2030agenda

Preamble This Agenda is a plan of action for people, planet and prosperity. It also seeks to strengthen universal peace in larger freedom. We recognise that eradicating poverty in all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development. All countries and all stakeholders, acting in collaborative partnership, will implement this plan. We are resolved to free the human race from the tyranny of poverty and want and to heal and secure our planet. We are determined to take the bold and transformative steps which are urgently needed to shift the world onto a sustainable and resilient path. As we embark on this collective journey, we pledge that no one will be left behind. The 17 Sustainable Development Goals and 169 targets which we are announcing today demonstrate the scale and ambition of this new universal Agenda. They seek to build on the Millennium Development Goals and complete what these did not achieve. They seek to realize the human rights of all and to achieve gender equality and the empowerment of all women and girls. They are integrated and indivisible and balance the three dimensions of sustainable development: the economic, social and environmental.

The goals The Goals and targets will stimulate action over the next fifteen years in areas of critical importance for humanity and the planet:

People We are determined to end poverty and hunger, in all their forms and dimensions, and to ensure that all human beings can fulfil their potential in dignity and equality and in a healthy environment.

Planet We are determined to protect the planet from degradation, including through sustainable consumption and production, sustainably managing its natural resources and taking urgent action on climate change, so that it can support the needs of the present and future generations.

Prosperity We are determined to ensure that all human beings can enjoy prosperous and fulfilling lives and that economic, social and technological progress occurs in harmony with nature.

Peace We are determined to foster peaceful, just and inclusive societies which are free from fear and violence. There can be no sustainable development without peace and no peace without sustainable development.

Partnership We are determined to mobilize the means required to implement this Agenda through a revitalised Global Partnership for Sustainable Development, based on a spirit of strengthened global solidarity, focussed in particular on the needs of the poorest and most vulnerable and with the participation of all countries, all stakeholders and all people.

The interlinkages and integrated nature of the Sustainable Development Goals are of crucial importance in ensuring that the purpose of the new Agenda is realised. If we realize our ambitions across the full extent of the Agenda, the lives of all will be profoundly improved and our world will be transformed for the better.

Universal Declaration of Human Rights (UDHR)

The United Nations General Assembly proclaimed the Universal Declaration of Human Rights (UDHR) in 1948 as a universal standard of achievements for all peoples and all nations. It declares that human rights are universal – to be enjoyed by all people, no matter who they are or where they live.

Summary of the Universal Declaration of Human Rights:

- Everyone is free and we should all be treated in the same way.
- Everyone is equal despite differences in skin colour, sex, disability, religion, language for example.
- Everyone has the right to life and to live in freedom and safety.
- No one has the right to treat you as a slave nor should you make anyone your slave.
- No one has the right to hurt you or to torture you.
- Everyone has the right to be treated equally by the law.
- The law is the same for everyone, it should be applied in the same way to all.
- Everyone has the right to ask for legal help when their rights are not respected.
- No one has the right to imprison you unjustly or expel you from your own country.
- Everyone has the right to a fair and public trial.
- Everyone should be considered innocent until guilt is proved.
- Everyone has the right to ask for help if someone tries to harm you, but no- one can enter your home, open your letters or bother you or your family without a good reason.
- Everyone has the right to travel as they wish.
- Everyone has the right to go to another country and ask for protection if they are being persecuted or are in danger of being persecuted.
- Everyone has the right to belong to a country. No one has the right to prevent you from belonging to another country if you wish to.
- Everyone has the right to marry and have a family.
- Everyone has the right to own property and possessions.
- Everyone has the right to practise and observe all aspects of their own religion and change their religion if they want to.
- Everyone has the right to say what they think and to give and receive information.
- Everyone has the right to take part in meetings and to join associations in a peaceful way.
- Everyone has the right to help choose and take part in the government of their country.
- Everyone has the right to social security and to opportunities to develop their skills.
- Everyone has the right to work for a fair wage in a safe environment and to join a trade union.
- Everyone has the right to rest and leisure.
- Everyone has the right to an adequate standard of living and medical help if they are ill.
- Everyone has the right to go to school.
- Everyone has the right to share in their community's cultural life.
- Everyone must respect the 'social order' that is necessary for all these rights to be available.
- Everyone must respect the rights of others, the community and public property.
- No one has the right to take away any of the rights in this declaration.

Protocol to the African Charter on Human and People's Rights on the Rights of Persons with disabilities in Africa

African Heads of State adopted the Africa Protocol on the Rights of Persons with Disabilities on 31 January 2018. The African Disability Protocol (ADP) builds on the rights enshrined in the UN CRPD and the UN Declaration of Human Rights. The protocol has an African relevance, and its adoption is recognized as a great success as the protocol reflects a legal instrument from an African perspective. The next step is for the ADP to be ratified by African governments, adopted and implemented.

National Instruments

As well as International Instruments, every country also has a range of national instruments relevant to how disability is viewed, and how the rights of persons with disabilities are recognised. Some instruments may be specifically related to disability – such as a Disability Act, or they may include references to disability, such as a section within an Education Act or Policy. Instruments include:

- The Constitution
- Acts
- Laws
- Policies

It is essential to have a good knowledge of your country's Constitution, Acts, Laws and Policies as they relate to the rights of children, women and men with disabilities in your country.

A Rights Based Approach

The UN CRPD promotes the view that people are disabled by different barriers in society, rather than by their impairment or difference, because society is not organised to consider their needs. Such barriers might be physical, or they can be caused by people's attitudes or rules. The impact of a person's impairment is acknowledged, but disability is seen as being created by society's failure to accommodate persons with disabilities.

When we look at disability from the perspective of the UN CRPD – which puts the responsibility of disability onto society rather than with the individual person, we look at people with disabilities as people who have rights – rather than as people who are problems or who don't 'fit'.

This change in perspective marks a major shift, and helps us to look at all aspects of life from the perspective of promoting disability inclusive development – advocating for, and finding solutions to the inclusion of people with **all** types of disabilities in **all** aspects of life. This is a human rights-based approach.

INTRODUCTION TO CBR/CBID

Community Based Rehabilitation (CBR) / Community Based Inclusive Development (CBID)

- CBR, or CBID as it is increasingly referred to - was initiated by the World Health Organization in 1978.
- It is practiced in more than 100 countries of the world.
- Its aim is to enhance the quality of life for persons with disabilities and their families; to meet their basic needs; and to ensure their inclusion and participation.
- Now a broad approach by a range of stakeholders to improve the equalization of opportunities and social inclusion of persons with disabilities.
- The CBR Guidelines were published in 2010 as a response to a need to provide a common understanding of the concepts and principles of CBR as a comprehensive rights-based approach.
- CBR Guidelines are based on the principles of the UN CRPD.

The word ‘rehabilitation’ in CBR now refers to measures in health, education, livelihoods etc. that must be implemented to promote active participation and equalisation of opportunities for persons with disabilities.

Although CBR has its roots in health, the fact that "R" is linked to health tends to give the wrong impression that CBR as a strategy is health oriented in approach. Nowadays, the replacement of the "R" with "ID" in CBID promotes the concept that the strategy aims to achieve mainstreaming of disability across sectors, leading to more equitable participation, access to services and opportunities and ultimately resulting in empowerment by persons with disabilities.

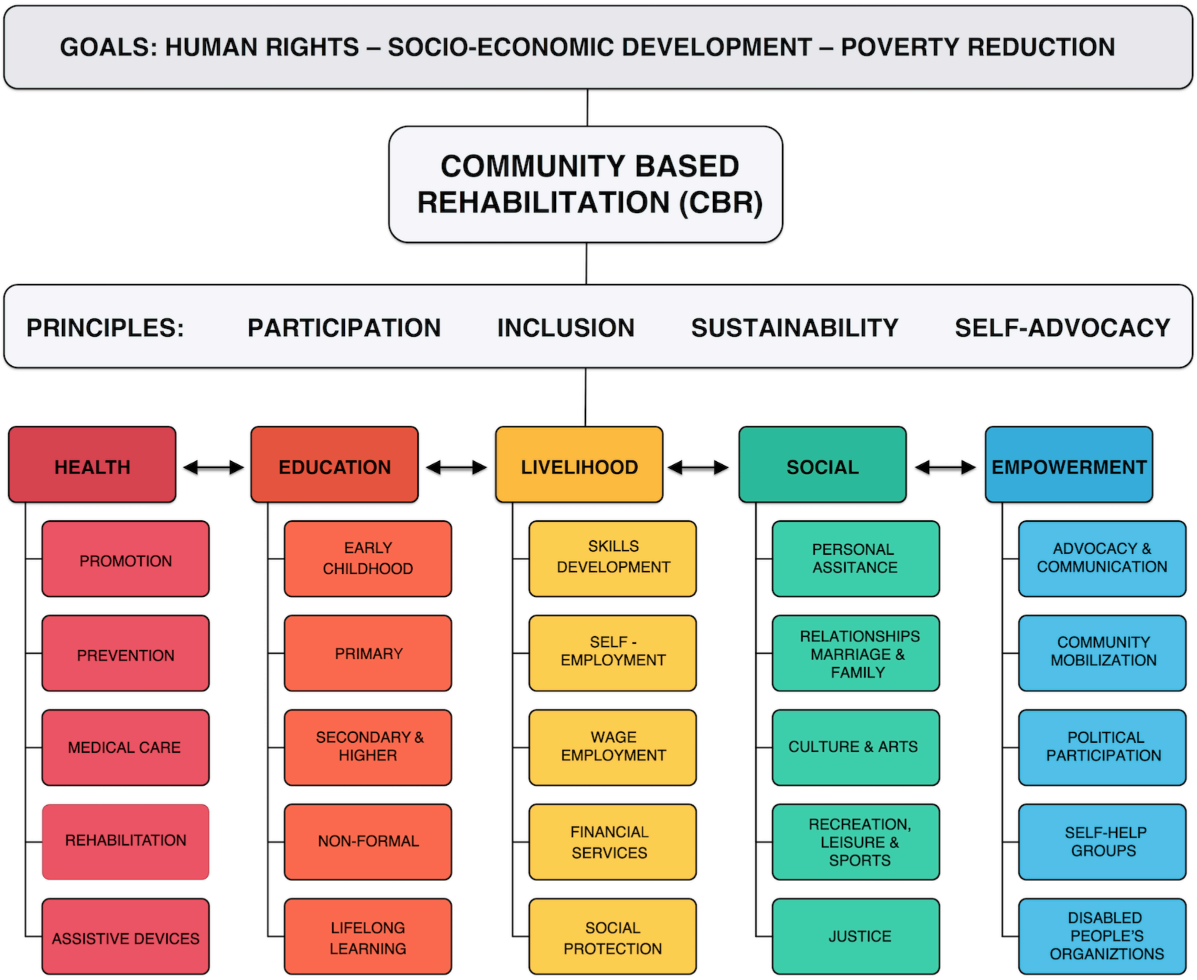
Objectives of the CBR Guidelines

- To develop and strengthen CBID programmes in line with the UN CRPD.
- To promote CBR as a strategy for CBID to assist in the mainstreaming of disability.
- To support stakeholders to meet the basic needs and enhance the quality of life of persons with disabilities and their families by facilitating access to the health, education, livelihood and social sectors.
- To encourage stakeholders to facilitate the empowerment of persons with disabilities and their families by promoting their inclusion and participation in development and decision-making processes.

Implementation of CBID

- Implementation of CBID is through development structures, services and facilities at local government level.
- It is supported by enabling policies and legislation with the active involvement of persons with disabilities and their families.
- Close collaboration/networking between stakeholders, as well as resource mobilisation and utilisation, plays a key role in the effective implementation of CBID.

- Core actions under CBID are:
    - Identification of persons with disabilities
    - Needs assessment
    - Provision of simple therapeutic interventions
    - Education and training of family and community members
    - Referral and follow up services
    - Service delivery within localities
    - Awareness raising and advocacy on inclusion
    - Community networking
    - Capacity building for different cadres
    - Supervision and monitoring
    - Resource mobilisation.



CBR’s development away from a very narrow medical approach to one that now covers all areas of a person’s life led to the development of a CBR Matrix to provide a common framework for CBID programmes. Divided into five components, each component has five elements. The CBR Matrix is a useful tool for CBID planning.

Usually, CBID programmes only work in some of the areas of the CBR Matrix, but other development projects might work in other areas. Overall, the aim is that all areas are covered by different stakeholders – as all are needed by persons with disabilities.

The CBR Matrix summarizes the goals of CBR/CBID:

- Human rights
- Socio economic development
- Poverty reduction.

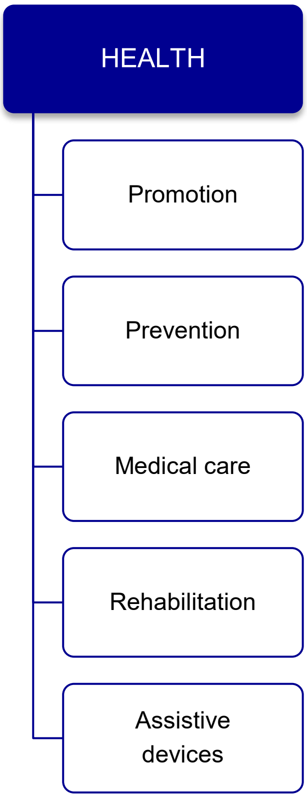
and the underlying principles of CBR/CBID:

- Participation
- Inclusion
- Sustainability
- Self-advocacy.

Sources:

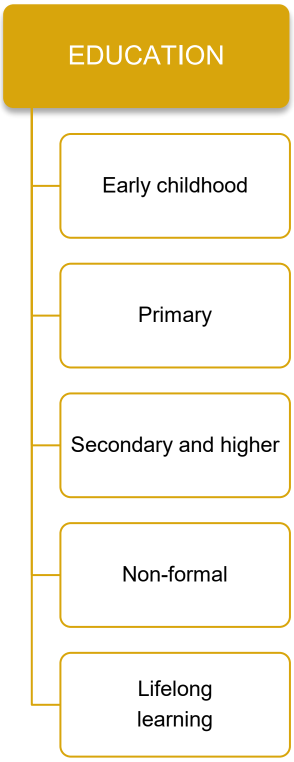
World Health Organization, UNESCO, International Labour Organization & International Disability Development Consortium. (2010). Community-based rehabilitation: CBR Guidelines. World Health Organization

Health



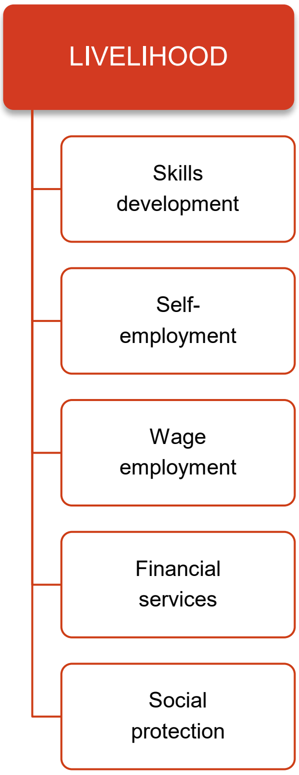
	Role of CBID
Promotion	• To identify health promotion activities at local, regional and national level and work with stakeholders to ensure access and inclusion for persons with disabilities and their family members. • To ensure that persons with disabilities and their families know the importance of maintaining good health and encourage them to actively participate in health promoting actions.
Prevention	• To ensure that communities and relevant development sectors focus on prevention activities for persons with disabilities and non-disabled people. • To provide support for persons with disabilities and their families to ensure they can access services that prevent development of negative health conditions or secondary complications.
Medical care	• To work in collaboration with persons with disabilities and their families and medical services to ensure that the former can access services designed to identify prevent, minimize and/or correct health conditions and impairments.
Rehabilitation	• To promote, support and implement rehabilitation activities at the community level and facilitate referrals to access more specialized rehabilitation services.
Assistive devices	• To work with persons with disabilities and their families to determine their needs for assistive devices and facilitate their access and ensure maintenance repair and replacement.

Education



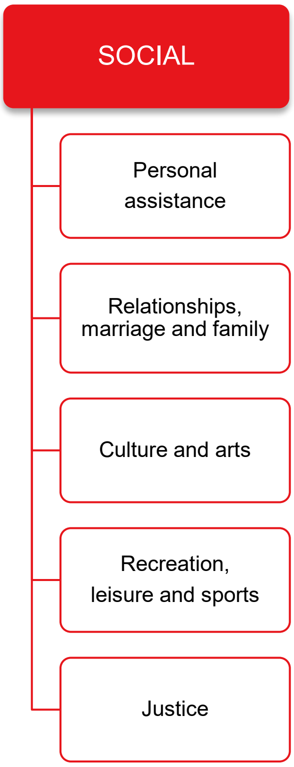
	Role of CBID
Early Childhood	• Identify families with children with disabilities. • Interact and work closely with the families and their communities. • Assist in laying the foundations for all activities in the child's life.
Primary	• Collaborate with primary education systems to create inclusive local schools. • Support families and children with disabilities to access primary education in their local community. • Develop and maintain links between the home, community and schools.
Secondary and higher	• Facilitate inclusion with increased access, participation and achievement for students with disabilities. • Work with school authorities to make the environment more accessible and the curriculum more flexible.
Non-formal	• Work with non-formal programmes e.g. adult literacy programmes to ensure that persons with disabilities are able to access educational opportunities in inclusive settings. • Help persons with disabilities to access educational opportunities that are suited to their own needs and interests.
Lifelong learning	• Provide persons with disabilities with continuous learning opportunities to prevent their social exclusion, marginalization and unemployment.

Livelihood



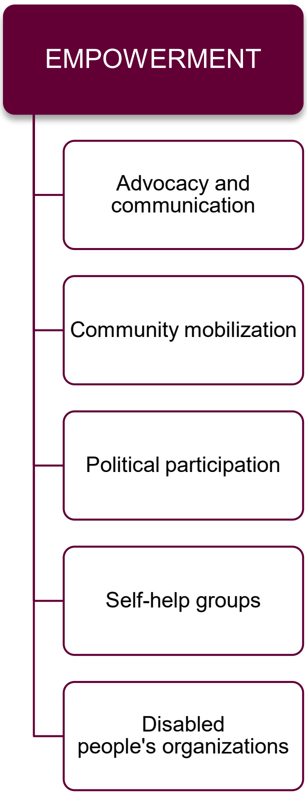
	Role of CBID
Skills development	• To enable persons with disabilities to access work opportunities, by actively promoting and facilitating the acquisition of relevant knowledge, skills and attitudes.
Self-employment	• To encourage and support self-employment by assisting persons with disabilities and their families, either individually or in groups, to access skills development and financial and material resources.
Wage employment	• To enable persons with disabilities to access and retain wage employment, by working to increase equal access and treatment in the workplace, as well as access to services that lead to wage employment.
Financial services	• To identify, facilitate, and promote access of persons with disabilities to financial services.
Social protection	• To facilitate the access of persons with disabilities to mainstream or specific social benefits. • To promote the provision of, and inclusion of persons with disabilities in, social protection measures.

Social



	Role of CBID
Personal assistance	• To support persons with disabilities to access and actively manage the personal assistance necessary to live with self-determination and dignity.
Relationships, marriage and family	• To support persons with disabilities to have fulfilling relationships with members of their families and communities.
Culture and arts	• To work with relevant stakeholders to enable persons with disabilities to enjoy and participate in cultural and arts activities.
Recreation, leisure and sports	• To promote increased participation of persons with disabilities in recreation, leisure and sports activities. • To provide support to mainstream organizations and programmes to enable them to offer appropriate and accessible recreation, leisure and sports activities.
Justice	• To promote awareness of the rights of persons with disabilities. • To provide support to persons with disabilities and their family members to access justice when they face discrimination and exclusion.

Empowerment



	Role of CBID
Advocacy and communication	• To support persons with disabilities to develop advocacy and communication skills. • To ensure that the environment provides appropriate opportunities and support to allow persons with disabilities to make decisions, and express their needs and desires effectively.
Community mobilization	• To mobilize the communities to ensure that: • Negative attitudes and behaviour towards persons with disabilities and their families change. • The community is supportive of CBID. • Disability is mainstreamed across all development sectors.
Political participation	• To ensure that persons with disabilities have the information, skills and knowledge to enable them to participate in political processes and have access to opportunities to participate. • To ensure that disability issues are visible so that they are included into processes of political decision-making.
Self-help groups	• To provide support and assistance to persons with disabilities and their families to form new self-help groups and to support the capacity of existing ones to help them achieve greater impact. • Where mainstream groups, such as women's groups and microcredit groups already exist, to work with them to promote the inclusion of persons with disabilities and their families.
Disabled People's Organizations	• Work as a partner with disabled people's organizations where they exist. • Provide assistance as and when appropriate to support the formation of disabled people's organizations where they do not exist.

BARRIERS TO PARTICIPATION

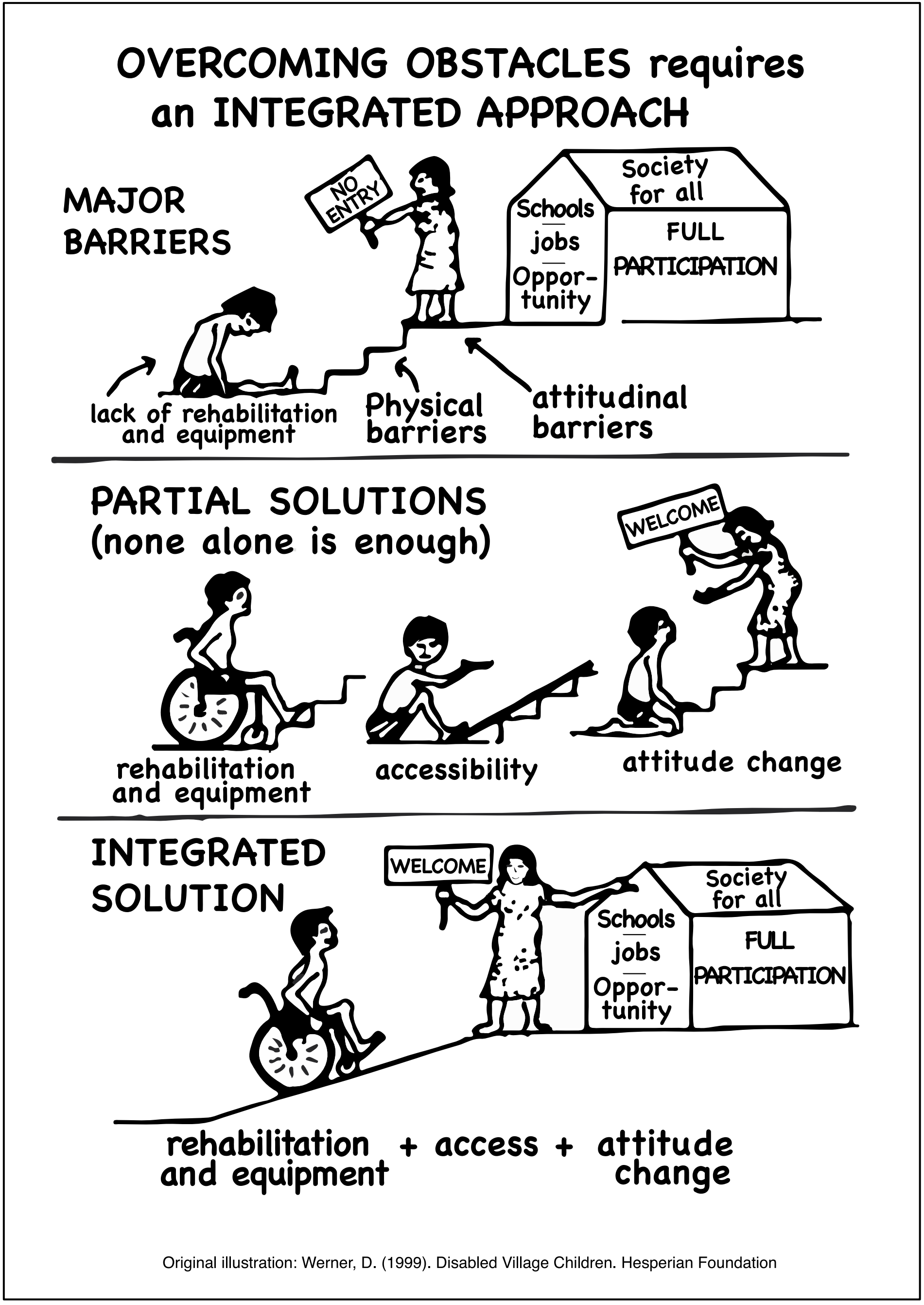
Attitudinal barriers: Persons with disabilities routinely face prejudice and discrimination. They are often assumed to be incapable and unintelligent. They are frequently treated with pity or fear, or avoided because persons without disabilities are unsure how to relate to them. It is common for persons with disabilities to be looked down on as inferior and to be labeled in negative ways. Belief systems are another barrier. Disability is often seen as a curse, given as a result of previous wrongdoing by the individual or their parents. Many of these attitudes are also reflected in the media, or conversely persons with disabilities may be labelled as 'heroes', brave, inspirational, or exceptional if they are able to live independent lives and achieve their goals. This can be patronizing and misleading.

Environmental barriers: Poverty is a major barrier for many people with disabilities as a result of other barriers. There are many physical barriers that prevent persons with disabilities from participation. Public buildings, schools, shops, offices, health centres, markets, and places of worship are frequently inaccessible. Pavements generally lack kerb ramps and public transport is inaccessible. Communication, media and information presents barriers for persons with speech, hearing or visual impairments when the information is not presented in an accessible format, such as Braille and large-letter type or the use of sign language.

Institutional barriers: Institutional barriers include legislation that discriminates as well as inadequate employment laws and electoral systems including the challenges for persons with disabilities to vote. Policies can also be exclusive of persons with disabilities. For example, a vocational training programme where criteria are included that stipulates that trainees should be able-bodied and fit to work. This can exclude persons with disabilities because they are not considered fit enough to work. Institutional barriers can prevent persons with disabilities from participating in many areas such as politics, religious services and employment.

Attitudinal	Environmental	Institutional
• Prejudice • Discrimination • Ignorance • Stigma • Negative language • Pity • Taboo • Superiority/inferiority • Curse • Own attitude	• Poverty • Inaccessible domestic, social and public buildings (clinics, hospitals, schools, places of worship, shops, offices) • Inaccessible transport • Public information systems • Media and communications • Lack of assistive devices	• Laws • Rules and regulations • Policies • Entry requirements • Political disenfranchisement • Health provision • Social services • Belief systems and religion

Overcoming obstacles



Original illustration: Werner, D. (1999). Disabled Village Children. Hesperian Foundation

- There may be different kinds of barriers in the way for persons with disabilities to achieve inclusion such as lack of rehabilitation equipment, physical barriers, and attitudinal barriers as seen in the top picture.
- Overcoming only some of those barriers is not enough – giving someone an appropriate wheelchair here doesn't help them access the building if there are still steps. Providing a ramp isn't useful if the person doesn't have an assistive device. A welcoming attitude isn't enough if the person doesn't have an assistive device or an accessible environment.
- Integrated solutions are needed that address the different barriers that persons with disabilities face. In the third picture all the barriers are addressed and the person has access to school, employment, and full participation in society.

DISABILITY MAINSTREAMING AND INCLUSIVE DEVELOPMENT

Disability integration: providing certain features and arrangements that allow some persons with disabilities to access and participate in their environment in limited circumstances or in reaction to a stated need. Or – mixing groups or persons with disabilities that were previously separate. This approach is reactive rather than proactive – it integrates the person with a disability into an already established structure.

Disability mainstreaming: the consideration of the different conditions, situations, aspirations and needs of persons with disabilities in all policies and programmes at the stages of planning, implementation, monitoring and evaluation.

It is a strategy that ensures that the concerns of persons with disabilities are an integral dimension in any policy or programme design, implementation, monitoring and evaluation.

Disability inclusion: provides all of the features and arrangements that allow all persons with disabilities to access and participate in their environment in advance of any stated need. It is proactive and anticipatory. The goal of inclusion is to facilitate an environment in which no one is or feels left out as a result of their difference. The environment is designed to fit the person.

Inclusive development means that all stages of a development process take into account the needs of persons with disabilities. All persons must be provided with equal access to all areas of life. For example:

- **Inclusive education** requires that there is accessibility of the educational infrastructure including buildings, training materials, teaching and learning methods and assessment systems and that learners with disabilities be included in general education.
- **Inclusive health** requires accessible buildings and equipment, appropriately trained health care providers and accessible information. It includes early assessments for children, early identification and referral systems.
- **Inclusive livelihood** requires access to areas including vocational training, skills development, financial services, placement services, wage employment and social protection initiatives.
- An **inclusive social** sector requires that there is equal availability to persons with disabilities for areas including recreation, arts and social activities, sports, and the justice system.
- **Inclusive empowerment** includes the opportunity for people to participate in decisions that affect their lives and to political participation.

Story 1: Integration

A small village school built on a hilly area in a rural area had about 50 students. None of the children had disabilities but one day, Zola - one of the young girls at the school – fell off an ox cart and was paralysed. Zola needed to use a wheelchair. Her family were supportive and wanted her to finish her education. They met with the Head Teacher at the school who agreed to make a ramp next to the steps at the main entrance and to organize for one of the toilets to be modified so that Zola could continue her classes. The timetable was adapted so that none of her classes were held in the block which was only accessible by a flight of steps, and when it came to lunchtime her friends helped her to get up the three steps into the separate lunch area.

Story 2: Mainstreaming

A small village school in a rural area had about 50 students. When one of the children, Zola, fell off an ox cart and needed to use a wheelchair, the school realized that changes were needed to accommodate Zola and other children with disabilities in the community. While she went through her rehabilitation, they added a ramp to the side of the school to make the classrooms which were only accessible by a flight of steps fully accessible. They also combined two of the toilets in each block so that there was a large accessible toilet in every area of the school. Some new adjustable height desks were purchased to ensure that all children, including Zola, who needed a higher or lower desk could sit comfortably. Staff, pupils and parents were given more information about disability too. The changes also encouraged other children with disabilities to apply to the school because it was now fully accessible to them.

Story 3: Inclusion

A small village school is planned in a rural area. The design takes into account the rights and needs of persons with different disabilities by consulting widely and taking a rights-based approach in line with strong national and international laws and conventions. From the start all of the areas of the school are accessible with ramps, large bathrooms that are easy for everyone to use, lighting that helps persons with poor vision see the board well, clear signs to assist persons with hearing disabilities, and other features that ensure that children with disabilities have their needs met. Staff, pupils, and parents are educated on disability issues and the curriculum meets the needs of different students. When one of the children, Zola, fell off an ox cart and needed to use a wheelchair the school was already fully accessible for her needs and the staff and pupils welcomed her back. Zola already had friends in her class and community with disabilities which also meant she wasn't nervous about returning to school.

WORKING AS A CBID VOLUNTEER

This chapter provides information on the typical skills and attributes needed by a CBID volunteer, as well as an example of how volunteers might be selected, and their reporting systems. The process and criteria used when selecting and managing volunteers will differ by country.

Typically, a volunteer may be male or female, a person with a disability, a family member of a person with a disability, or a non-disabled person. Collectively, volunteers should represent diverse experiences, backgrounds and skills.

Volunteers will **not** be selected if they have a history of abusing children, involvement in gender-based violence (GBV) or in any other violence. They will also not be selected if they are known to have frustrated or discouraged community efforts in the past, or are known to have previously misused community or donated resources or taken bribes.

A CBID Volunteer should be:

1. Able to read and write
2. Able to basic mathematics
3. Reliable
4. Honest and impartial
5. Flexible
6. Available to devote adequate time to the role
7. An active member in community development initiatives
8. Positive and energetic
9. Empathetic and compassionate with a desire to empower others
10. Willing and able to learn, and to adopt a rights-based approach
11. Willing and able to travel to all parts of their assigned area
12. Willing and able to work as part of a team
13. Accountable to the community and the people they serve
14. Willing to work with minimum supervision
15. Able to show initiative to use local resources
16. Willing to serve with minimum incentives

The role and responsibilities of CBID Volunteers are likely to include the following:

1. Promoting a rights-based approach to disability to all community stakeholders
2. Raising awareness in the community about disability to encourage the inclusion of persons with disabilities in family and community life
3. Identification of persons with disabilities
4. Networking and mobilising in the community
5. Providing information about services available within the community
6. Carrying out basic assessments of function
7. Providing information and counselling to family members to enable them to involve, support and assist persons with disabilities
8. Facilitating referral and following up persons with disabilities
9. Facilitating formation and following up self-help groups
10. Advocating for improved accessibility and inclusion of persons with disabilities in health, education, livelihood, social and empowerment sectors within their communities
11. Facilitating production of simple assistive devices/appliances

12. Providing simple therapeutic interventions
13. Data collection and reporting
14. Working as part of the CBID team and referring to others.
15. Mentoring other (non-specific CBID) volunteers on disability and inclusive development.

Typical process of electing CBID Volunteers

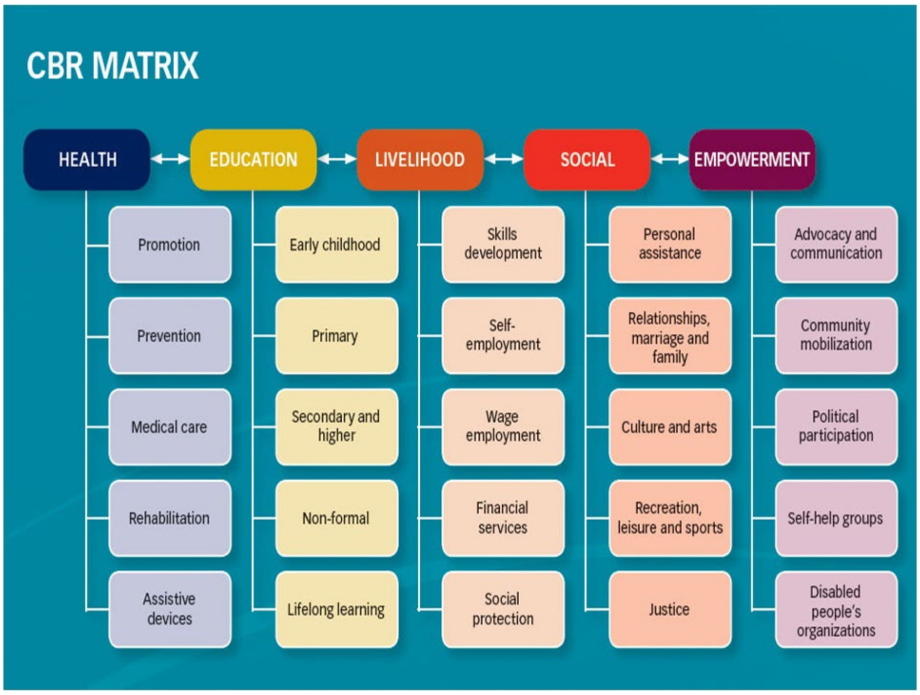
1. A CBID worker meets with the local influential leader
2. Call for community meetings through the influential leader
3. Present the selection criteria for CBID volunteers
4. Community members nominate individuals based on the set criteria
5. Community members vote for required number of individuals that qualify
6. Final list of selected volunteers is presented to the community and influential leader for final approval. Local influential leaders may include Chiefs, Headmen, Councillors, local Member of Parliament.
7. Approved list is used by relevant government dept to plan for training and support.
8. CBID (Government and stakeholders) arranges and conducts orientation/training.

Typical reporting requirements for CBID Volunteers

1. CBID volunteer completes relevant forms.
2. Submits forms and other written reports to an assigned extension worker on monthly basis or after an agreed period.
3. Maintains record of persons with disabilities identified, and referred for assessment and screening and interventions.
4. Maintains record of persons with disabilities and their guardian assisted through other interventions (e.g. counselling).
5. Maintains record of his/her involvement in collaborative efforts towards promoting mainstreaming of disability e.g. awareness raising and advocacy campaigns.

COMPONENTS OF CBID

The following pages summarize the five components of the CBR Matrix and the five elements within each.



Elements of health

HEALTH
- Promotion
- Prevention
- Medical care
- Rehabilitation
- Assistive devices

CBID can facilitate inclusive health by working with the health sector to:

- ensure access for all persons with disabilities
- advocate for health services that:
  - accommodate the rights of persons with disabilities
  - are responsive, community-based and participatory.

The role of CBID is to work with the health sector to ensure that the needs of persons with disabilities and their families are addressed in all aspects of health, across five key areas as outlined below.

Elements of education

- EDUCATION
  - Early childhood
  - Primary
  - Secondary and higher
  - Non-formal
  - Lifelong learning

Access to education is critical for achievement of every individual's full potential.

It is estimated that more than 90% of children with disabilities in low-income countries do not attend school.

The role of CBID is to work with the education sector to make education inclusive at all levels and to facilitate access to education and lifelong learning for persons with disabilities.

CBID workers can provide persons with disabilities and their families with support to connect with school and pre-school authorities and teachers, challenge stigma and discrimination and support the communication and collaboration between the home and the school to help them work in a complimentary way.

Elements of livelihood

- LIVELIHOOD
  - Skills development
  - Self-employment
  - Wage employment
  - Financial services
  - Social protection

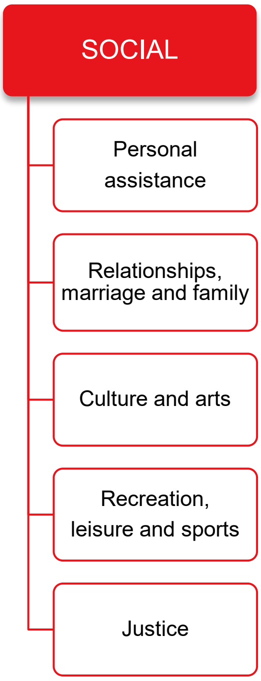
Disability increases the likelihood of being poor, and being poor increases the likelihood of being disabled.

By finding work opportunities individuals with disabilities can:

- Secure the necessities of life
- Improve their economic and social situations, and
- Increase their self-esteem, personal security and status within their family and community.

CBID needs to provide persons with disabilities with support to secure a livelihood that gives them sufficient resources to lead a dignified life, have access to social protection measures, and contribute to their family and community.

Elements of social

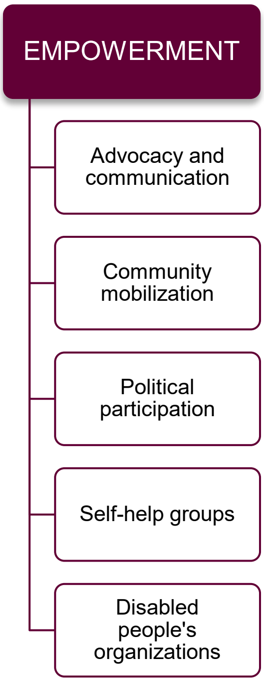


Being actively included in the social life of one's family and community is important for personal development. The opportunity to participate in social activities has a strong impact on an individual's identify, self-esteem, quality of life and social status.

The role of CBID is to:

- Work with all relevant stakeholders to ensure the full participation of persons with disabilities in the social life of their families and communities.
- Provide support and assistance to persons with disabilities to enable them to access social opportunities.
- Challenge stigma and discrimination to bring about positive social change.

Elements of empowerment



Empowerment for persons with disabilities means that they can make their own decisions, work with others to improve their communities, and work with community decision-makers to ensure equal opportunities for all.

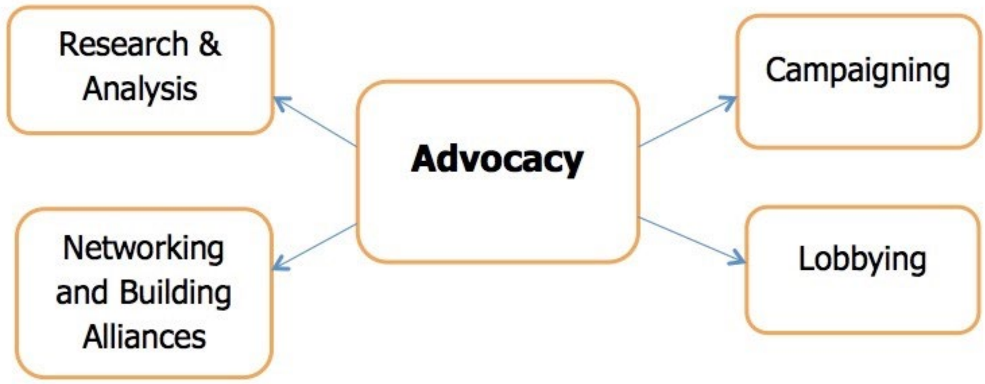
To empower someone may require providing resources, removing obstacles, or strengthening their own resources such as impacting their self-confidence and self-worth.

The role of CBID is to contribute to the empowerment process by promoting, supporting and facilitating the active involvement of persons with disabilities and their families in issues that affect all aspects of their lives. This includes encouraging persons with disabilities to join or to form advocacy groups to influence local government and key community stakeholders to ensure disability inclusion.

ADVOCACY

Advocacy is an activity that aims to influence decisions within economic, political or social systems and institutions. It can be carried out by an individual or a group and can include activities such as media campaigns, public speaking or demonstrations. Advocacy is mentioned throughout the CBR Guidelines as a suggested activity for CBID programmes.

There are a variety of activities that contribute to successful advocacy. Research and analysis can provide evidence to support advocacy. Building alliances with other interested stakeholders can give advocacy efforts more strength. Campaigning can be used to raise interest and awareness. Lobbying is part of advocacy and is the act of attempting to influence the actions, policies, or decisions of officials in their daily life, most often legislators or members of regulatory agencies.



Advocacy by an individual on behalf of him or herself is called self-advocacy. Self-advocacy is about knowing your rights and responsibilities and speaking up for yourself to influence things that affect your life. It is an important part of empowerment.

Persons with disabilities are frequently being told what to do and having their decisions made for them. Their opinions are routinely dismissed. Self-advocacy skills can enable someone with a disability to assert their rights and ensure they can make decisions for themselves. It may be simple decisions such as what to wear or eat, or more fundamental decisions such as where to live and who to socialize with.

The role of CBID

Many persons with disabilities are not used to ‘having a voice’ on issues that affect their lives. CBID programmes can help persons with disabilities to find their voice by building their confidence and capacity to participate and advocate, for example, to:

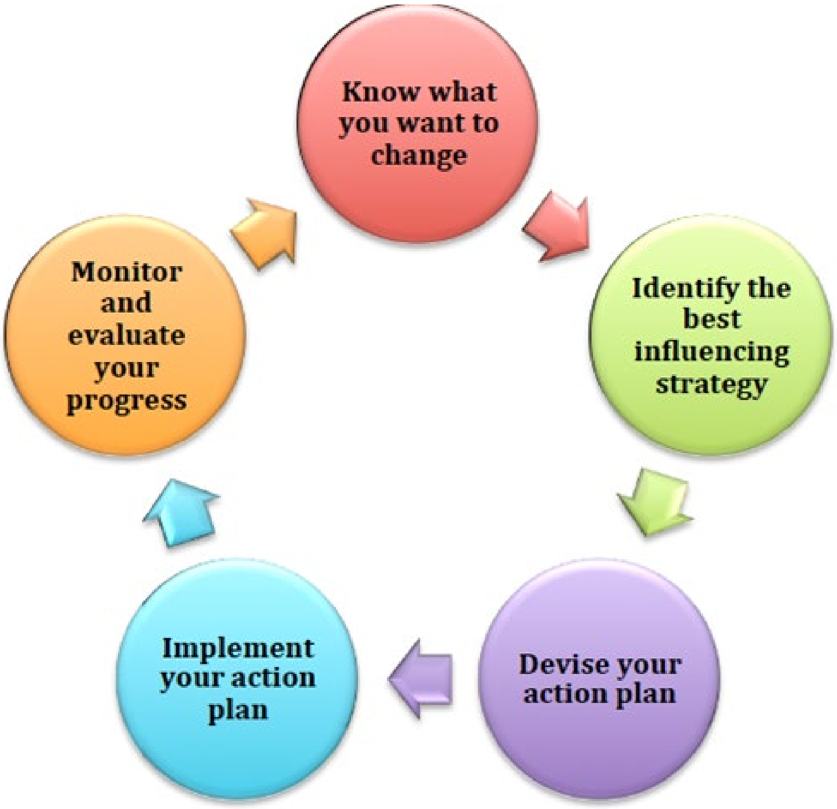
- Raise awareness and understanding of disability issues with public officials, district authorities, schools, private companies, employers and businesses.

- Educate communities about disability, including raising awareness, challenging beliefs, educating people on the causes and effects of disability, and how some illnesses and disabilities can be prevented.
- Raise awareness across society on the rights and responsibilities towards disability that people, organisations and institutions have under the law.

The Advocacy cycle

The advocacy cycle begins with identifying what you would like to **change** – the issue. For example, it could be the inaccessibility of a community recreation hall or an inaccessible village water borehole.

Identifying the best influencing **strategy** may involve gathering and analyzing all of the relevant information to support your advocacy. You will need to be clear on the causes and effects of the issue on which you are advocating. This stage also involves identifying possible solutions to the problem and resources available for the advocacy effort. For example, the problem may be related to the lack of involvement of persons with disabilities and/or their families in committees responsible for vetting designs of public buildings and other services including school blocks, water points and health facilities. Or it could be the lack of capacity of architects on how to design disability inclusive services and facilities. Such constraints contribute to inadequate access to services for persons with disabilities.



The next step is to develop an advocacy **plan**: what you are going to do, when you are going to do it; and who will be responsible for what. The plan may involve arranging meetings with people of influence such as traditional and religious leaders, parent support groups, members of area development committees, local representatives of government departments responsible for planning/building. The meetings would discuss the challenges and agree on measures to address them. Such measures may include undertaking necessary modifications (such as construction of ramps).

The next step is to **implement** the activities to achieve the plan. Next you will **monitor** and evaluate your progress and make any necessary changes to your advocacy plan before proceeding, applying your learning from any successes and mistakes. All these stages require the active involvement of persons with disabilities and/or their families.

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https://www.globaldisabilityrightsnow.org/tools/lobbying-advocacy-skill
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INFLUENCE AND RESPONSIBILITY

Some of the stakeholders with influence and responsibility in the community.

- **Community Based Inclusive Development Workers**
- **Schools and Colleges**
- **Influential Leaders**
- **OPDs and Umbrella OPDs**
- **CBID Networks**
- **International Agencies**
- **Government**
- **Families and Carers**
- **Grant and Subsidy Providers**
- **NGOs**
- **Religious leaders**
- **District Authorities**
- **Medical Personnel**
- **Traditional Healers**
- **Shops and Banks**
- **Radio, TVs and Newspapers**
- **Police**
- **Persons with Disabilities**

COMMUNITY MOBILIZATION

Community mobilization within the CBR Guidelines and Matrix

- Community mobilization (sometimes called social mobilization) is the second element within the 'Empowerment' component of the CBR Matrix.
- The CBR Guidelines define community mobilization as: '*The process of bringing together as many stakeholders as possible to raise people's awareness of, and demand for, a particular programme, to assist in the delivery of resources and services, and to strengthen community participation for sustainability and self-reliance'.*

Goal of community mobilization for CBID

- The goal of community mobilization is to empower communities to remove barriers for persons with disabilities and their families, and play an active role in facilitating their full and meaningful inclusion in all aspects of community life.
- It is about getting people organised to reason together on matters that affect their lives and find solutions to their life challenges.
- It is about raising awareness of the needs of persons with disabilities and being motivated to improve their and their families' quality of life through removing or reducing barriers.
- It is about raising awareness of the needs of persons with disabilities and being motivated to improve their and their families' quality of life through removing or reducing barriers.
- It is about Networking to achieve inclusion: establishing permanent CBID Networks of stakeholders to ensure ongoing communication, and collaboration.

Benefits of community mobilization

A lot can be achieved when people from different parts of the community share a common goal and actively participate in both identifying needs and being part of the solution. Below are some of the benefits of community mobilisation:

- Empowers communities to initiate and control their own development.
- Strengthens different sectors of society to be actively involved in change that supports the full inclusion of persons with disabilities.
- Brings together a variety of CBID stakeholders in the community such as persons with disabilities, family members, self-help groups, organizations of persons with disabilities, community members, local authorities, local leaders, decision- and policy-makers, to highlight and address the range of barriers that exist within the community and to promote equal inclusion.
- It helps to strengthen unity among community members.
- Helps refine, streamline and consolidate views in building a common goal.
- It helps to build awareness on certain issues.
- It encourages communities to be committed and to actively participate in community activities.

Community mobilization and disability inclusive disaster risk reduction (DIDRR)

- Persons with disabilities are one of the most vulnerable groups when a disaster, emergency, or conflict situation strikes a community: the lack of information and warnings in accessible formats; physical and attitudinal barriers; and lack of consideration of their specific needs are some of the factors that may contribute to their vulnerability.
- Community mobilisation is an effective tool for more disability inclusive disaster risk reduction (DIDRR): it brings stakeholders together; considers needs **before,** not after the event; and can influence long-term recovery and reconstruction.
- Persons with disabilities should be involved and consulted in humanitarian action at all stages:
    - mitigation
    - preparedness
    - emergency response and
    - recovery activities.

Community mobilization process

Any number of different stakeholders might initiate a community mobilization programme based on local needs and interests. CBID volunteers can play an important support role in community mobilization initiatives.

1. **Find out about the community**
    - Understand the local environment, community issues and problems
    - Know the local social, political, cultural context including local leadership
    - Know the local attitudes and behaviour towards persons with disabilities

2. **Design a strategy for the process**
    - For awareness
    - For development
    - For changing mind-sets and attitudes

3. **Identify mobilisation techniques**
    - Door to door or one on one
    - Through the chiefs or local leaders
    - Through development clubs or community groups
    - Through sections of the community units i.e. families

4. **Build trust and credibility in the community**
    - Be visible and active in the community and support other stakeholders
    - Know other stakeholders, understand their challenges and work with them
    - Share information with other stakeholders
    - Be honest and transparent and don’t make unrealistic promises

5. **Raise awareness in the community**
    - Increase community members' awareness about disability with simple messages
    - Inspire the community to challenge negative attitudes, pity and stigma faced by persons with disabilities
    - Educate community members that disability isn't just a health issue: it is a human rights and cross cutting issue
    - Consider using group discussions, storytelling, song, drama, posters, film and media.
    - Personal Testimonies of persons with disabilities
    - Commemorations

6. **Motivate the community to participate**
    - Convince community stakeholders that inclusive development benefits all
    - Explain the CBID strategy and its benefits to community stakeholders
    - Invite stakeholders to CBID activities and organize field visits to raise awareness.

7. **Create opportunities for community participation**
    - Mobilize different sections of the community at different times to participate e,g focus on advocating for all schools to be inclusive, or all public buildings to be accessible
    - Identify barriers that might prevent stakeholders from participating such as time constraints, unfavourable weather, family or work responsibilities, or low self esteem
    - Ensure a wide range of stakeholders in the community are involved, to bring their different skills, experience, and areas of influence to different advocacy areas
    - Engage the community in resource mobilisation for identified interventions.

8. **Bring relevant stakeholders together**
    - Map stakeholders to promote their active participation
    - Bring stakeholders together to discuss and agree actions for change
    - Promote and support permanent CBID Networks amongst stakeholders to monitor progress towards common aims
    - Ensure vulnerable and excluded groups are included and fully participating.

9. **Build capacity in the community**
    - Assess the communities' potential, capabilities and knowledge and skill gaps etc.
    - Sensitize the community on development issues in relation to community members' obligations
    - Provide training to people in the community to upgrade their skills and knowledge
    - Network stakeholders to learn from each other's experiences.

10. **Celebrate achievements**
    - Keep stakeholders motivated by recognising their contributions and achievements
    - Hold celebrations to raise awareness of successes
    - Let beneficiaries and their household and communities lead the celebrations
    - Publicise results to attract more interest from all stakeholders.

Sources:

World Health Organization, UNESCO, International Labour Organization & International Disability Development Consortium. (2010). Community-based rehabilitation: CBR Guidelines. World Health Organization

ACCESSIBILITY

Accessibility can be defined as the "ability to use" something. It is used to describe availability, user friendliness and affordability to people. This could be for example, an object, a service, a system, or an environment.

The concept of accessibility is enshrined in the UN CRPD. Article 9 provides a guideline to review, develop, or advocate for policies to improve accessibility including all five areas highlighted below:

- Environment
- Information and communication
- Attitudes and behaviour
- Systems
- Economic

Environment: Relates to physical access to man-made environments such as buildings, pavements, roads, transport, and footpaths, as well as the natural environment factors that can hinder accessibility for persons with disabilities such as rivers, mountains and other rough terrain and high winds. For many persons with disabilities, their accessibility to their environment will also be affected by their provision of an appropriate assistive device.

Information and communication: This includes sign language interpretation, printed materials, signposts, websites and technology. When we talk of accessible communication, it usually means the communication is available in a range of styles so that more people will be able to use it and benefit from it. An example of this is written captions on a TV screen – so that people who cannot hear can read instead.

Attitudes and behaviour: This is one of the main elements of exclusion. Current practice still too often includes pity, hostility, fear and being patronizing, with negative messages being reinforced by arts and media images and representation. For example, parents locking children in the house, or fears of catching epilepsy.

Systems: For example, the education system, local government, legal system, health, and politics, all of which can control the level of opportunity for persons with disabilities to participate in society.

Economic: Economic accessibility, or affordability relates to people's ability to pay for services without financial hardship. The close relationship between disability and poverty means that persons with disabilities frequently lack economic access to services they require.

How to improve accessibility:

Making adaptations and modifications using appropriate standards can improve accessibility. It is also important to engage and involve persons with disabilities themselves for their input on how the environment, facility and/or service can be made accessible.

The provision of services and infrastructure through CBID provides a great opportunity for ensuring accessibility for persons with disabilities from the design phase of programmes and services.

A rights-based approach to CBID means leaving no one behind, so accessibility considerations are needed for different impairments. Accessibility begins at the household level, then goes to community, then district, then national. CBID workers can help improve accessibility at the household level – such as by ensuring an accessible toilet, and at community level – for example looking at accessibility in places of worship.

It is everybody's responsibility to ensure accessibility for persons with disabilities. Accessibility begins in the home, and then more broadly in the community, and up to nationally – access at every level is important to achieve an inclusive society.

Examples of accessibility standards to follow:

Ramp: 1:15 or 1:20 gradient. **Width:** minimum 1.30m. **Landing:** 1.5m.
Front door: minimum 0.90m wide
Internal doors: minimum 0.80m wide
Door handle: between 1m to 1.10m from ground
Corridors and pathways: minimum 1.30m width
Light switches: between 0.90m and 1.20m from ground
Wash basins: 0.80m from ground

REFERRAL AND FOLLOW UP

One of the key 'roles and responsibilities' of CBID workers identified in the CBR Guidelines is given as: *providing information about services available within the community, and linking persons with disabilities and their families with these services via referral and follow-up.*

Referral is the act of directing a person to a place where they can get further advice or treatment such as for a consultation, review, or other action. An example would be referring someone in the community to be tested for HIV.

Follow up is a process of reviewing a situation or an earlier intervention to monitor its status or success. An example of follow up would be to visit a community member who had been referred to a vocational training course to check if they were attending and to discuss any challenges.

Referral services within a community are required for a variety of issues including health, educational, vocational, and social services. For example, one of the 'desirable outcomes' of the **health** component of the CBR Guidelines is: *CBR personnel are knowledgeable about medical care services and able to facilitate referrals for persons with disabilities and their families for general or specialized medical care needs.*

Referral may be to specialised services at national, regional or district level, and could be services provided by government, NGOs or the private sector. Many persons with disabilities, for example, require referral to specialized rehabilitation services such as for prosthesis, wheelchairs or hearing aids as well as follow-up support to ensure that these services are received and continue to meet their needs on an ongoing basis.

Persons with disabilities also need general health services as well as any specialist services they may need related to their disability. However, there are often barriers preventing persons with disabilities from accessing mainstream services such as physical access or attitudes of personnel. It is therefore important to support them to identify appropriate services for their needs.

CBID programmes need up-to-date information on services that can support persons with disabilities in all areas of their lives. For example, in the **livelihoods** sector persons with disabilities might be referred to either mainstream or specialized services providing vocational training, apprenticeships, financial services, career counselling, or employment placement services.

In the **education** sector, referral might be to primary or secondary education, or to non-formal education opportunities such as home-based learning, a vocational skills centre or community initiatives to complement formal sector learning opportunities. Follow up is critical to ensure that the referral has resulted in a positive outcome for the person with a disability. For example, a person could be referred to an educational environment that turns out not to be conducive to their learning if the environment does not meet their specific needs.

Volunteers should ensure they have a good overview of all the services available in the community so that they can refer as necessary in line with the referral procedures in place, and follow up to ensure that the services are meeting the needs of the individual.

Importance of early identification and referral

Early childhood is defined as the period from prenatal development to eight years of age. For children with disabilities, it represents a critical time to ensure their access to interventions that can help them reach their full potential. Early childhood development (ECD) is a generic term that refers to a child's cognitive, social, emotional and physical development. Child development is a process through which children progress from dependency on caregivers in all areas of functioning during infancy, towards growing independence at primary school age, through adolescence and into adulthood. Skills develop in different areas through what are called milestones which involve mastering certain simple skills before moving onto more complex ones.

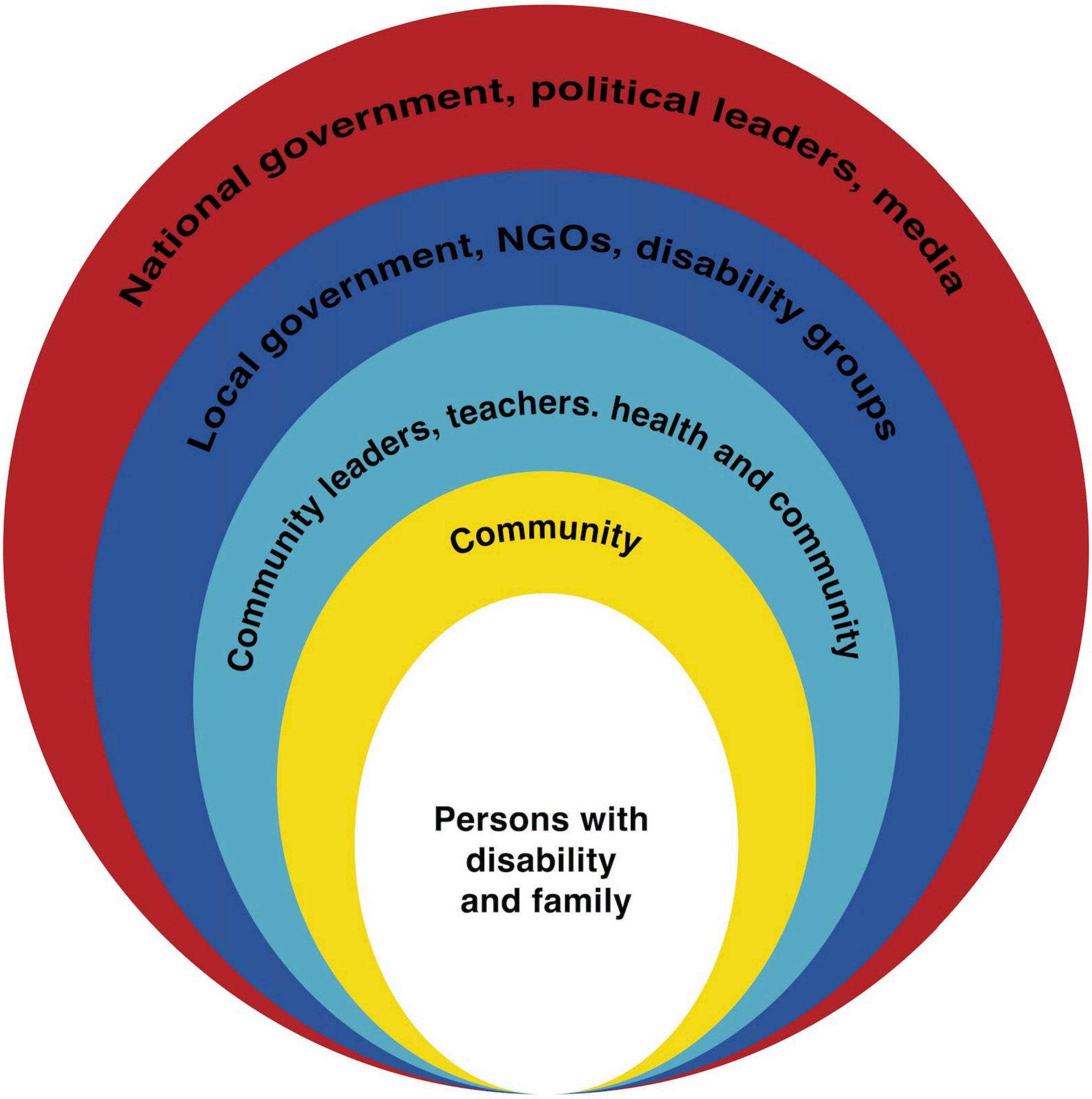
When children do not attain the milestones in the usual way for their age, they are said to have developmental delay. Developmental delays are measured using assessment methods and may be mild, moderate or severe.

Developmental delays can be caused by different factors including poor health habits during pregnancy, poor birthing methods, inadequate stimulation, malnutrition, or chronic ill health. Developmental delay may not be permanent, but when it is identified it can provide a basis to identify children who may experience a disability.

For this reason, early detection and identification through CBID initiatives is important so that children can be referred to specialists who can plan interventions in collaboration with family members aimed at addressing delays and creating the best environment for the child's development. Examples of interventions might include specialized medical, habilitation and/or rehabilitation services (e.g. therapy and assistive devices); family support (e.g. training and counselling); or social and psychological support. On an economic level, children with disabilities who receive good care and developmental opportunities during early childhood are more likely to become healthy and contributing adults.

STAKEHOLDER MAPPING AND CBID NETWORKING

The roles of the different stakeholder groups are outlined in the CBR Guidelines.



Roles and responsibilities of the different stakeholder groups

Persons with disabilities and their families
Their roles may include:
- playing an active role in all parts of the management of the CBID programme
- participating in local CBID committees
- being involved by volunteering and working as CBID personnel
- building awareness about disability in their local communities, e.g. giving information on specific disabilities
- Identifying barriers and advocating for their removal.

Community members
CBID can benefit all people in the community, not just those with disabilities. CBID programmes should encourage community members to:
- participate in training opportunities to learn more about disability
- change their beliefs and attitudes that may limit opportunities for persons with dis-
- abilities and their families
- address other barriers that may prevent persons with disabilities and their families from participating in the life of their communities
- lead by example and include persons with disabilities and their families in activities
- contribute resources (e.g. time, money, equipment) to CBID programmes
- help address the causes of disability
- provide support and assistance for persons with disabilities and their families where needed.

NGOs and civil society
The roles and responsibilities of NGOs and civil society organizations and groups will vary depending on their level – international, national, regional or community and may include:
- developing and implementing CBID programmes where there is limited government
- support
- providing technical assistance, resources and training for CBID programmes
- supporting the development of referral networks between stakeholders
- supporting CBID programmes to build the capacity of other stakeholders
- facilitating regional and international experience sharing amongst CBID practitioners and policy makers
- support pilot, catalytic projects modelled for sharing and replication and scaling up
- mainstreaming disability into existing programmes and services
- supporting the evaluation, research and development of CBID.

Organisations of persons with disabilities (OPDs)
Their roles and responsibilities may include:
- representing the interests of persons with disabilities
- providing advice about the needs of persons with disabilities
- educating persons with disabilities about their rights and opportunities
- advocating and lobbying for action to ensure that governments and service providers are responsive to these rights, e.g. implementation of programmes in compliance with the UN CRPD and the persons with disabilities Act (2012)
- provision of information in accessible formarts about services to persons with disabilities
- direct involvement in the management of CBID programmes.
- monitoring the implementation of disability programmes
- tracking of national budgets and expenditure reports
- facilitating networking and resource sharing among OPDs
- training relevant NGOs in disability mainstreaming.

Government

Disability issues should concern all levels of government and all government sectors, e.g. the health, education, employment and social sectors. Their roles and responsibilities might include:

- taking the lead in the management and/or implementation of national CBID programmes
- ensuring that appropriate legislation and policy frameworks are in place to support
- upholding the rights of persons with disabilities as per ratified UN protocols
- developing and funding a national policy on CBID, or ensuring CBID is included as a strategy in relevant policies, e.g. rehabilitation or development policies
- providing human, material, and financial resources for CBID programmes
- ensuring persons with disabilities and their family members are able to access all public programmes, services and facilities
- developing CBID as an operational methodology or service delivery mechanism for providing rehabilitation services across the country.
- To develop disability inclusion policy

CBID Cadres:

(a) CBID managers

Some of the roles and responsibilities of a CBID programme manager may include:

- facilitating each stage of the management cycle
- building and maintaining networks and partnerships both within and outside the community
- ensuring that all key stakeholders are involved in each stage of the management cycle and are kept well informed of accomplishments and developments
- building the capacity of communities and ensuring disability issues are mainstreamed into the development sector
- managing day-to-day activities by delegating tasks and responsibilities
- supporting and supervising CBID personnel, e.g. ensuring CBID personnel are aware of their roles and responsibilities, meeting regularly with CBID personnel to review their performance and progress, and organizing training programmes
- managing information systems to monitor progress and performance.

(b) CBID personnel

CBID personnel are at the core of CBID and are a resource for persons with disabilities, their families and community members. Their roles and responsibilities include:

- identifying persons with disabilities, carrying out basic assessments of their function and providing simple therapeutic and other interventions such as home adaptations
- educating and training family members to support and assist persons with disabilities
- providing information about services available within the community, and linking persons with disabilities and their families with these services via referral and follow-up
- assisting persons with disabilities to come together to form self-help groups
- advocating for improved accessibility and inclusion of persons with disabilities by making contact with health centres, schools and workplaces
-
- raising awareness in the community about disability to encourage the inclusion of persons with disabilities in family and community life.

Case study
In Zambia, the CBID programme team realised that a lot of great work was taking place in different sectors for the inclusion of persons with disabilities such as in education, health, livelihoods, social and empowerment, but there was little collaboration or cooperation between the sectors. One sector didn't know what another was doing. Even within sectors there was a lack of information sharing. So, for example, a person with a disability might get access to education, but then struggle to access a job because they didn't know about opportunities available. Or someone would be running a vocational training programme and would welcome persons with disabilities to apply, but persons with disabilities who would benefit didn't hear about the programme. Within government structures, budget lines were allocated to disability issues but OPDs in some Districts didn't apply because they had no knowledge of them, so budgets were unspent. *The Zambia CBID Support Programme decided to establish WhatsApp groups in each District and they identified two committed and dynamic coordinators to manage each group – at least one of whom was a person with a disability. The Zambia CBID Support Programme provided advice and support on setting up the WhatsApp groups, such as setting terms of reference and rules, and giving information on core CBID concepts for the Co-ordinators to share. They also established another WhatsApp group where the coordinators could share information and experiences.* *Four years after they were established the Network of WhatsApp groups are thriving, and information is being shared far and wide within and between Districts. Membership ranges from 30 members to 100 members, and includes stakeholders from Government at all levels and all sectors, OPDs, service providers, individual persons with disabilities, members of parliament, village leaders, and others. There are District CBID Networks now in place in over 25% of Districts, and the number is still growing.* *As the numbers have increased, Provincial Coordinators have also been identified among the District CBID Network leadership to help coordinate the CBID District Networks in each Province.* *Positive results have included:* • *more persons with disabilities hearing about opportunities for education, employment, training, and medical services* • *duty bearers being held to account and accessible* • *duty bearers having a greater understanding of the needs and potential of persons with disabilities* • *greater awareness about budget provisions for disability issues* • *persons with disabilities understanding more about their rights under international and national laws and instruments* • *different sectors working in a more collaborative way and avoiding duplication* • *stakeholders coming together as a united voice in advocacy and awareness efforts* • *Learning taking place between districts – a success in one district is shared and then often replicated in other districts.*

Sources:

World Health Organization, UNESCO, International Labour Organization & International Disability Development Consortium. (2010). Community-based rehabilitation: CBR Guidelines. World Health Organization

APPROPRIATE LANGUAGE

The use of language and words describing persons with disabilities has changed over time, and it is important to be aware of the meaning behind the words we use when talking to, referring to, or working with persons with disabilities. Disrespectful language can make people feel excluded and can be a barrier to full participation - hence the need to use language that empowers. Respective language needs to acknowledge that persons with disability are, like everybody else, persons first.

Respectful words to describe persons with disabilities

Here are some ways that persons with disabilities are described. This list includes “out-dated language” – terms and phrases that should not be used. This list also includes respectful words that should be used to describe different disabilities.

Disability	Unacceptable language	Acceptable language
Any disability	Disabled person, a person living with a disability	A person with a disability
Blind or Visual Impairment	The blind, Blind person	Person who is blind Person with a visual impairment
Deaf or Hearing Impairment	The Deaf, Deaf -and-Dumb, Deaf-Mute	Person who is deaf Person who is hard of hearing Person with a hearing impairment
Speech/Communication Disability	Dumb, “One who talks bad"	Person with a speech / communication disability
Learning Disability	Retarded, Slow, Brain-Damaged, “Special ed”	Learning disability, cognitive disability, person with a learning or cognitive disability
Psychosocial Disability	Hyper-sensitive, Psycho, Crazy, Insane, Wacko, Nuts	Person with a psychiatric disability, Person with a mental health impairment
Mobility/Physical Disability	Handicapped, “Special,” Deformed, Cripple, Gimp, Spastic, Spaz, Wheelchair-bound, Lame	A person who uses a wheelchair, a person with a mobility or physical disability,
Albinism	Albino	A person with albinism
Intellectual Disability	Retard, Mentally retarded, “Special Ed”	A person with an intellectual disability
Short Stature, Little Person	Dwarf, Midget	A person of short stature Little person

Sources

Including Disabled People in Everyday Life – A practical guide (1999), Save the Children UK.