

REVIEWS

The Role of Community-Based Rehabilitation in Poverty Reduction

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ABSTRACT

Over the last thirty years Community-based Rehabilitation (CBR) has emerged as an effective method of providing rehabilitation services to the population with disabilities in developing countries. Although CBR programmes have been recognised as a strategy for poverty reduction by the World Health Organisation (WHO, 2003), CBR workers and their managers face the challenge of understanding the causes and effects of poverty, and contributing towards poverty alleviation.

The purpose of this paper is to describe the role of community-based rehabilitation in poverty reduction. A brief review on Community-Based Rehabilitation and Poverty Reduction is followed by an assessment of different models of disability, to find which one provides the best framework to understand the overall picture of disability and poverty.

The Capabilities Approach, developed by Amartya Sen and Martha Nussbaum, seems to offer a sound basis to understand the relationship between poverty and disability.

This paper concludes that CBR can play a crucial role in poverty reduction programmes by expanding the capabilities of people with disabilities.

Key words: *Community-based rehabilitation, poverty reduction, capabilities approach.*

INTRODUCTION

Community-based rehabilitation (CBR) is considered as a tool for social change and to fight the war on poverty (WHO/DAR & IAARF, 2002; Chatterjee et al, 2009; Shrestha & Deepak, 2009). Despite the extensive literature on CBR, the conception of poverty and its impact on disability are not well understood (ILO, UNESCO, WHO, 2004).

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There is a dynamic relationship between disability and poverty (Eide & Ingstad, 2011; Mitra et al, 2011). In international development literature, poverty and disability have been identified as part of a “vicious circle”; disability increases the risk of poverty and circumstances of poverty raise the risk of disability. On one hand, people with disabilities are much less likely to find employment, women with disabilities are more vulnerable to physical violence and sexual abuse, and children with disabilities are much less likely to be literate and more vulnerable to malnourishment and early death. On the other hand, poor nutrition, risky working conditions, lack of access to education, health care, transportation, communication, employment, war and conflict, and natural disasters all increase the risk of disability (DFID, 2000; UN, 2011).

The consequence of this cycle is that people with disabilities and their families “are usually amongst the poorest of the poor” (DFID, 2000). According to United Nations (2014), approximately 15% of the world’s population or possibly 20% of the world’s poorest citizens have a disability of one form or another. It is too difficult to break out of “the vicious cycle of poverty and disability” (DFID, 2000; UN, 2014). Thus, poverty and disability reinforce each other; each is both a cause and a consequence of the other, contributing to increased vulnerability and exclusion (Barnes, 1991; Beresford, 1996; DFID, 2000; Turmusani, 2003; Braithwaite & Mont, 2009; Hughes, 2013).

The Millennium Development Goals (MDGs) are a UN programme for reducing poverty and promoting human development. Despite this, disability was not specifically included in the MDGs (Yeo & Moore, 2003; Eide & Ingstad, 2011). The most important reason for this exclusion is that “people with disabilities themselves are not empowered enough” (Eide & Ingstad, 2011).

The international development targets are unlikely to be achieved unless the rights and needs of people with disabilities are taken into account (DFID, 2000; WHO & World Bank, 2011; ILO, 2014). Specific steps are required to ensure that people with disabilities are able to participate fully in the development process, and claim their rights as full and equal members of society (DFID, 2000). Therefore, an integrated approach is required, linking poverty and disability with empowerment strategies and changes in attitudes.

Objective

The purpose of this paper is to describe the role of CBR in reducing poverty. Starting with a brief review on Community-Based Rehabilitation and Poverty

Reduction, the paper assesses which models of disability can provide the best framework to understand the overall picture of disability and poverty, and then explain show the relationship between poverty and disability can be better understood under Sen's and Nussbaum's capabilities approach.

Community-Based Rehabilitation

Community-based rehabilitation was introduced by the World Health Organisation (WHO) at the Alma-Ata conference in 1978, as an effective method of providing rehabilitation services to people with disabilities in the global context. Over the last twenty five years, CBR has emerged in developing countries in response to the inadequacy of financial and professional services (Lysack & Kaufert, 1994; Peat, 1998; Boyce, 2000). International agencies define CBR as:

“A strategy within general community development for the rehabilitation, equalisation of opportunities and social inclusion of all people with disabilities. CBR is implemented through the combined efforts of people with disabilities themselves, their families, organisations and communities, and the relevant governmental and non-governmental health, education, vocational, social and other services” (ILO, UNESCO, WHO, 2004).

CBR views disability as the concern of the whole community, rather than as an individual matter. One of CBR's assumptions is that improving the quality of life in a limited way for all people with disabilities is better than greatly improving the quality of life for a few people (McColl et al, 1997). Therefore, CBR makes services accessible to more people with disabilities and their families, in the most cost-effective and culturally appropriate way (Peat, 1998; Boyce, 2000).

CBR is practised differently throughout the world, due to the diversity of cultures and communities; however, CBR programmes have some common features. CBR is intended to change attitudes in the community toward the acceptance of disability, to promote the social integration of people with disabilities, to provide opportunities in education and employment, to protect the rights of people with disabilities and to empower them (Miles, 1996; McColl et al, 1997; Peat, 1998; Mitchell, 1999; Thomas & Thomas, 1999; Boyce, 2000; Kendall et al, 2000; Turmusani et al, 2002). CBR also aspires to fight poverty by providing a range of vocational skill-development and income-generating activities (WHO/DAR, & IAARF, 2002). Consequently, CBR not only has been recognised as a community development model for empowering people with disabilities and

their communities, but is considered to be a strategy for reducing poverty as well (WHO, 2003).

Community-Based Rehabilitation and Poverty Reduction

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

CBR programmes -

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

In 2002, the WHO's review of CBR identified an urgent need for CBR programmes to ensure that governments include persons with disabilities in mainstream community development programmes and poverty-reduction schemes. The review also stressed the importance of focussing on the persistent poverty that affects the majority of people with disabilities (WHO, 2003, 2004).

Accordingly, CBR programmes can be effective in reducing poverty through strategies within community development, such as providing education for children with disabilities, encouraging employment for youth and adults with disabilities, and promoting the participation of people with disabilities (especially women) in community activities (ILO, UNESCO, WHO, 2004). However, as the

Joint Position Paper (2004) points out, the skills of CBR workers and their managers are inadequate to overcome the difficulties of their work. Therefore, this joint paper suggests that CBR workers and their managers need to be empowered by ensuring they have a good understanding of the causes and effects of poverty so that the CBR programmes can then make contributions towards alleviating poverty. Finally, it calls “for action against poverty that affects many people with disabilities” (ILO, UNESCO, WHO, 2004).

Models of Disability and Overlapping Concepts of Disability and Poverty

The three important models of disability- namely, biomedical, social and ICF models – are reviewed here, in order to understand which one is closest to the overlapping concepts of disability and poverty.

According to the medical (or biomedical) model, disability is a problem of the individual that is directly caused by a disease or some other health condition. People are regarded as persons with disability on the basis of being unable to function as "normal" persons do (Mark, 1997; McLean&Williamson, 2007). This model has been criticised because many dimensions of disability, such as social, economical and cultural aspects, are absent.

In contrast to the biomedical approach, the social model locates disability not in an impaired body, but in an excluding and oppressive social environment. If disability is defined as social oppression, people with disability who face poverty can be seen as the collective victims of an uncaring, discriminatory society (Oliver, 1990, 1999; Williams, 2001).

"ICF attempts to achieve a synthesis, in order to provide a coherent view of different perspectives of health from a biological, individual and social perspective" (WHO, 2001). The ICF model works well for capturing the dual role of person and environment in disability and poverty. The inclusion of 'contextual factors' allows for a more balanced picture of disability. This model can help to describe the process of functioning and disability by focusing on a number of elements.

Broadly speaking, capturing the general picture of this problem is not as simple as presenting a two-fold role between a medical model and a social model. Although the effects of poverty on disability can be measured partly by ICF mechanism, the range of issues which are addressed in the ICF Model is limited to issues related to health (Herr et al, 2005). There is a need for a broader approach which is understandable for all interdisciplinary specialists

who are interested in the field of disability, from health science professionals to policy-makers.

This paper presents the capability approach as a useful framework for understanding disability and poverty problems.

Capability (Capabilities) Approach

An important theory which offers a sound basis to ponder over the multidimensional nature of poverty and disability is the capabilities approach.

This approach, developed by Amartya Sen and Martha Nussbaum, has come to play a major role in social theory and normative economics over the past 30 years. It has gained support among academics, as well as among international agencies and non-governmental organisations (Alkire, 2002; Pogge, 2005).

Since 1990, the United Nations Development Programme has published the Human Development Report annually, which is partly based on the capability approach (Alkire, 2002; Robeyns, 2006; UNDP, 1990–2008). In these reports, human development is defined as “a process of enlarging people’s choices”, which is achieved “by expanding human capabilities and functionings” (UNDP, 2000). Today, more than 500 countries report on human development using the capabilities approach framework (Robeyns, 2006).

The idea of “capability” means “the opportunity to achieve valuable combinations of human functionings -- what a person is able to do or be” (Sen, 2005). According to Sen, poverty can be identified in terms of “capability deprivation.” In his view, income is not the only instrument in generating capabilities (Sen, 1999). Instead of that, deprivation results from the interaction among the resources available to the person, personal characteristics (impairment, age, and gender) and the environment. Thus, poverty can be seen as a person’s failure to achieve basic capabilities, or the failure to choose what he/she values.

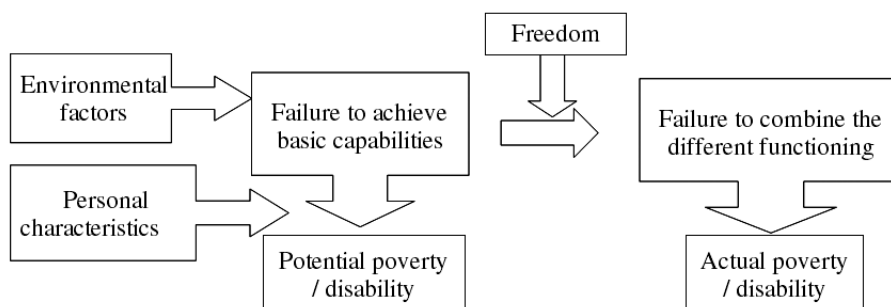
Sen’s priority in developing the capability approach has been to provide a better framework for the conceptualisation of human development and for the analysis of poverty. He suggests that the frameworks usually used in welfare economics are too narrowly based on income generation or distribution (Anand et al, 2005; Clark, 2005; Pogge, 2005). The capability approach represents a “non-welfarist” view. It replaces the traditional narrow view of poverty as a low level of income or the inability to obtain goods and services with a multidimensional view (Martinetti, 2000; Alkire, 2002).

The concept of capability is the bridge that links poverty and disability with human development (Welch, 2002; Osmani, 2005; Sen 2005; Mitra, 2006). Capability means “the opportunity to achieve valuable combinations of human functioning — what a person is able to do or be” (Sen, 2005). Sen has argued that well-being is best understood in terms of capabilities. The higher the level of a person’s capabilities, the higher is the level of his/her well-being (Gasper, 2002; Clark, 2005).

According to Sen, poverty can be defined as “capability deprivation”. His perspective is that income is not the only instrument in generating capabilities (Sen, 1999). In assessing poverty, Sen considers that the relationship between income and capability would be strongly affected by some parametric variations such as: the age of the person, gender and social roles, location (areas prone to flooding or drought), epidemiological atmosphere (through disease in region) and by other variations over which a person may have only limited control. Therefore, according to Sen (1999), some personal characteristics such as disability or illness not only reduce one’s ability to earn an income, but also make it harder to convert income into capability since a person with more disability or more seriously ill may need more income for aid and treatment to achieve the same functioning. Finally, in terms of capabilities, deprivation results from the interaction among the resources available to the person, personal characteristics (impairment, age, and gender) and the environment. Thus, poverty can be seen as a person’s failure to achieve basic capabilities or the failure to choose what he/she values.

Similar to poverty, disability can be defined as capability deprivation, or failure to achieve basic capabilities (Welch, 2002; Terzi, 2005; Mitra, 2006). Although deprivation can result from the nature of the impairment, it is not the only cause for it. In light of the capability approach, the relationship between impairment and capability is more important than impairment itself. In fact, this relationship is affected by the age of the person, by gender, by geographical place, and by culture. However, though these factors are important, the actual disability is a failure to combine the different functioning, or a failure to choose what he/she values (Figure 1).

Figure 1: Poverty and Disability based on the Capability Approach



Central Human Functional Capabilities and Community-based Rehabilitation

In recent years, there has been more and more literature reporting the usefulness of the Capabilities Approach to understand, analyse, and assess disability (Baylies, 2002; Sherlock & Barrientos, 2002; Mitra, 2006; Robeyns, 2006; Terzi, 2005; Welch-Saleeby, 2007; Morris, 2009; Reindal, 2009; Trani et al, 2009; Orton, 2011; Polat, 2011). Despite the growing body of literature on the capabilities approach, its application has been largely overlooked within the context of community-based rehabilitation.

The capabilities approach holds that the goal of both human development and poverty reduction should be to expand the capability that people have to enjoy “valuable beings and doings” (Alkire, 2002). The author argues that CBR programmes can play a crucial role in reducing poverty by expanding the basic capabilities of people with disabilities. But what are these basic capabilities?

Sen’s capability approach (2004) is deliberately incomplete. His main concern is to show how the capability approach can be shared by differing persons, even opposing philosophical ideas. The intention behind this is to allow different scholars with different backgrounds to work on common issues (Alkire, 2002). In contrast to Sen, Nussbaum (2000) made a list of central human capabilities, with the express intention that these should provide the basis for “constitutional principles that should be respected and implemented by the governments of all nations, as a bare minimum of what respect for human dignity requires”. Nussbaum’s list is an effort “to summarise the empirical findings of a broad cross-cultural inquiry”. In fact, the items on Nussbaum’s list of basic capabilities are to be regarded as the objects of “a specifically political consensus”, rather than “a comprehensive conception of the good”. Her list must be considered

as “a list of very urgent items that should be secured to people” (Nussbaum, 1997-1998). Nussbaum’s Central Human Functional Capabilities (CHFCs) include: Life; Bodily Health; Bodily Integrity; Senses, Imagination and Thought; Emotions; Practical Reason; Affiliation; Other species; Play; and, Control over One’s Environment (Nussbaum, 2000).

CBR programmes could be considered as the opportunity to achieve or extend CHFCs. The implications for framing these capabilities to CBR programmes are presented on Table 1. For each capability, examples are given as to how the CBR programmes could be operationalised. The CHFCs encompass five key components- health, education, livelihood, social, and empowerment- from the CBR Matrix (WHO et al, 2010).

Accordingly, the CBR Matrix can be applied to reflect the capability of improving quality of life, promoting health and managing lifestyle, gaining employment, participating in self-expressive and creative activities, and planning one’s life. Or, extending capabilities to move freely from place to place, to be safe from violation, assault, discrimination, and abuses; to express feelings; to have attachments to family and friends; to manage stress and anxiety; to have meaningful relations and interactions; to improve communication skills; to have access to various environments; to develop friendships, social interaction, and participate accordingly; to promote relationships with animals, plants, and the world of nature; to engage in leisure and recreational activities; to choose who governs you; to develop decision-making skills and speak up for yourself; and to make adaptations to the environment to be as independent as possible.

Table 1: Central Human Functional Capabilities: Definitions, CBR Matrix components, and Implication in relation to CBR programmes

Central Human Functional Capabilities	CBR Matrix component	Implication in relation to CBR programmes
1. Life: The capability for physical survival.	Health	Promoting health and preventing diseases, enhancing quality of life
2. Bodily Health: The capability to have good health.	Health/ Empowerment	Addressing physical health, advocating for adequate shelter and basic nutrition, and addressing reproductive health

3. Bodily Integrity: The capability to move freely from place to place.	Health/ Social/ Empowerment	Building basic skills, addressing mobility issues, providing training to reduce safety risks in moving freely from place to place, giving clients necessary tools, providing communication devices, advocating for reasonable accessibility, and empowering people with disabilities to advocate for themselves
4. Senses, Imagination and Thought: The capability to use the senses, imagine, and think.	Health/ Education/ Social/ Empowerment	Promoting literacy, providing a range of activities such as painting and playing, and helping people with disabilities and their families to have pleasurable experiences
5. Emotions: The capability to form attachments to things and persons outside ourselves; to love those who love and care for us.	Health/ Education/ Social/ Empowerment	Developing basic skills in early childhood development, improving families' relationships and friendship, helping people with disabilities engage in activities and groups, helping people with disabilities to reintegrate into their lives after a traumatic event, and providing knowledge and sympathy and support to help people with disabilities and their families to manage their fears and anxiety
6. Practical Reason: The capability to form a conception of the good and to engage in critical reflection about the planning of one's own life.	Education/ Social/ Empowerment	Providing people with disabilities with the necessary information to make their own decisions and assist them to exercise the autonomy and control over their environment as much as possible
7. Affiliation: The capability to live for and towards others.	Health/ Education/ Social/ Empowerment	Helping people with disabilities to identify their interests and needs, developing social skills and friendships, advocating for them, educating family members to develop their social network, and providing assistive technology as needed to reintegrate into society
8. Other Species: The capability to live with concern for and in relation to animals, plants and the world of nature. The capability for connection with nature and other species.	Social	Respecting people with disabilities' beliefs, values and interests in relation to the world of nature, promoting empathy and relationships to non-human beings

9. Play: The capability for being able to laugh, to play, to enjoy leisure activities.	Social	Engaging people with disabilities in leisure activities and recreational activities in order to help them to maintain their quality of life and to achieve a balance in daily life
10. Control over one's environment: The capability for the exercise of control over environment, including political control.	Livelihood/ Empowerment	Promoting relevant skills, developing awareness and decision-making, helping people with disabilities gain and retain employment, empowering them to advocate for themselves and supporting their caregivers to advocate for them, identify barriers and adapting their environments to participate in their society, and assisting them to access available resources

CONCLUSION

This paper develops a new conceptual framework for poverty reduction within CBR programmes. It demonstrates that the CBR Matrix is in line with CHFCs at the conceptual level, and reflects the CHFCs. While it explains the importance of expanding the basic capabilities of people with disabilities to reduce their poverty, it contributes to suggesting some strategies for poverty reduction within CBR programmes.

This is intended as a preliminary step towards understanding the role of community-based rehabilitation in poverty reduction; however, further studies are needed to explore how Nussbaum's CHFCs may be actually translated into CBR assessments and interventions.

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