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Regional Office for South-East Asia

Situation analysis of Community-based Rehabilitation in the South-East Asia Region

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Contents

Annexes

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List of acronyms

ADD	Action on Disability and Development
AIFO	Italian Association Amici di Raoul Follereau
APCD	Asia-Pacific Development Center on Disability
ASCoN	Asian Spinal Cord Network
ASSERT	Association for the Equality of the Disabled People of Timor
BCG	Bacillus Calmette-Guerin
BHU	Basic Health Unit
CBM	Christian Blind Mission
CBR	Community-Based Rehabilitation
CDD	Centre for Disability in Development (Bangladesh)
CIA	Central Intelligence Agency
CORDAID	Catholic Organization for Relief and Development Aid
CRPD	Convention on the Rights of Persons with Disabilities
CSID	Centre for Services and Information on Disability (Bangladesh)
DPOs	Disabled People's Organizations
DPR	Disability Prevention and Rehabilitation
DPR Korea	Democratic People's Republic of Korea
DPT	Diphtheria-Pertussis-Tetanus
FY	Fiscal Year
GDP	Gross Domestic Product
HRCM	Human Rights Commission of the Maldives

ICF	International Classification of Functioning, Disability and Health
IDDC	International Disability Development Consortium
ILI	Independent Living Institute
ILO	International Labour Organization
INGO	International Non-Governmental Organization
JDW NRH	Jigme Dorji Wangchuck National Referral Hospital
JICA PED	Japan International Cooperation Agency Planning and Evaluation Agency
LSRD	Life Style Related Diseases
MDGs	Millennium Development Goals
NA	Not Available
NCDW	National Council of Disabled Women (Bangladesh)
NFOWD	National Forum of Organizations Working for Disabled (Bangladesh)
NGDO	National Grassroots Disability Organization (Bangladesh)
NGOs	Non-Governmental Organizations
NVRC	National Vocational Rehabilitation Centre (Indonesia)
PHBC	Population and Housing Census of Bhutan
PHC	Primary Health Care
PWDs	Persons with Disabilities
RCRD Nepal	Resource Centre for Rehabilitation and Development Nepal
RHTO	Hadomi Timor Oan
SCI	Spinal Cord Injury
SEA	South East Asia
SEARO	South East Asia Regional Office
SHIA	Swedish Organizations' of Persons' with disabilities International Development Cooperation Association

SNMRC	Sirindhorn National Medical Rehabilitation Centre
TLM	The Leprosy Mission
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNIFEM	United Nations Development Fund for Women
VSO	Voluntary Services Overseas

Introduction

The 1978 “Health for All” Alma-Ata Declaration promoted health as a human right and prioritized primary health care and community-based approaches. Following the Alma-Ata principles, the World Health Organization (WHO) initiated community-based rehabilitation (CBR) to give persons with disabilities access to rehabilitation in their own communities using mostly local resources. The 2004 Joint Position Paper of the International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO) and WHO repositioned CBR as a strategy for rehabilitation, equalization of opportunity, poverty reduction and social inclusion of persons with disabilities.

Countries in the South-East Asia Region of WHO have been pioneers in the promotion of CBR programmes and projects for more than two decades. Both governments and civil society have been active in this effort. Many of the early CBR programmes at the national level and projects at micro levels started with a focus on medical rehabilitation. Reports about some of the older CBR projects refer to variation in understanding and practice of CBR in some countries in the Region and the gradual change in terms of moving towards a more comprehensive, rights-based approach (Gurung, 1999; Thomas and Thomas, 2002).

The World Health Assembly Resolution WHA58.23 (May 2005), on “Disability, including prevention, management and rehabilitation”, made particular reference to the need “to promote and strengthen community-based rehabilitation programmes linked to primary health care and integrated into the health system”.

WHO is committed to raising the profile of disability, and focusing its contribution on those areas where it can make the greatest difference, namely, in strengthening community-based rehabilitation and medical rehabilitation,

and their links with primary health care, improving data collection, and supporting policy development in accordance with the principles of the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

WHO in partnership with ILO, UNESCO and International Disability and Development Consortium (IDDC), facilitated the development of CBR Guidelines (2010) to provide clear direction on how community-based development initiatives can work to ensure the rights of persons with disabilities, promote respect for their inherent dignity, and aim for an inclusive society, in accordance with CRPD.

In line with its commitment to promoting CBR, the WHO Regional Office for South-East Asia (SEARO) is working towards developing a strategic framework for CBR for the Region. To prepare for this, WHO commissioned the Asia-Pacific Development Center on Disability (APCD), Bangkok, Thailand, to carry out a situation analysis of CBR in 11 Member countries in the Region - Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.

Objectives of the study

The objective of the study was to collect baseline data from the identified countries to provide direction to develop a strategic framework for CBR in the region. The baseline data included:

(1) Data on persons with disabilities;

(2) Community based rehabilitation programmes in governmental and nongovernmental sector;

(3) Links to primary health care and intersectoral involvement;

(4) The role of ministries of health and other ministries in CBR;

(5) The role of institute-based rehabilitation;

(6) Newer approaches;

(7) Rights-based approach to CBR in the Region, and

(8) Successes, innovative ideas and challenges.

Methodology

(1) Constitution of study team

(2) Development of questionnaire to collect data

(3) Desk review of the situation in the 11 countries to collect information, consisting of Web search Documents with APCD and partners/ associates

(4) Collection of information through the questionnaire from selected respondents in the 11 countries to supplement data from desk review

(5) Field visits to Indonesia and Bangladesh to collect in-depth information

(6) Data analysis

(7) Draft report

(8) Presentation at stakeholders' meeting to discuss strategic framework for CBR in the Region

(9) Final report

Results

The results are organized under the following sections:

Section 1: Country profiles, presenting some demographic data, data on prevalence of impairments, categories and causes of impairments, reference to disability in Millennium Development Goals (MDGs), and coverage of CBR.

Section 2: Key stakeholders and programs of governments, presenting details of nodal ministries in charge of disability issues, legislation and policies, programmes for persons with disabilities, role of ministries of health, multisectoral collaboration, government-civil society collaboration and rights-based approaches.

Section 3: Civil society in CBR, detailing roles of national and international nongovernmental organizations (NGOs) and disabled people's organizations (DPOs), and innovative practices.

Section 4: Support systems for CBR, presenting training resources, material resources and institutional support for CBR.

Section 5: Successes and challenges in CBR

Section 1: Country profiles

This section presents some demographic data, followed by data on prevalence, causes of impairments and coverage of CBR in the 11 countries in the Region. Information on DPR Korea is limited to what was available in the public domain; for other countries, information was collected through literature search, questionnaire responses, field visit in the case of Bangladesh and Indonesia, and interviews with some stakeholders in the case of India and Thailand.

Of the 11 countries, 6 are from the South Asia region – Bangladesh, Bhutan, India, Maldives, Nepal and Sri Lanka; and 5 from East Asia – DPR Korea, Indonesia, Myanmar, Thailand, and Timor Leste.

According to the World Bank country classification based on incomes:

- 4 countries - Bangladesh, DPR Korea, Myanmar and Nepal - belong to the low income group;
- 5 countries - Bhutan, India, Indonesia, Sri Lanka and Timor Leste - belong to the lower middle-income group;
- 2 countries - Maldives and Thailand – belong to the upper middle income group.

(Source: http://data.worldbank.org/about/country-classifications/country-and-lending-groups).

1.1 Some demographic data

Table 1: Demographic Data of the 11 countries.

Country	Population	Life expectancy		Literacy		GDP(US$)
		Male	Female	Male	Female	
Bangladesh	15 85 70 535	67.93	71.65	54%	41.4%	$ 1700
Bhutan	7 08 427	66.46	68.19	60%	34%	$ 5500
DPR Korea	2 44 57 492	65.03	72.93	99%	99%	$ 1800
India	1 18 91 72 906	65.77	67.95	73.4%	47.8%	$ 3500
Indonesia	24 56 13 043	68.80	73.99	94%	86.8%	$ 4200
Maldives	3 94 999	72.22	76.8	93%	94.7%	$ 6900
Myanmar	5 39 99 804	62.57	67.33	93.9%	86.4%	$ 1400
Nepal	29 391 883	64.94	67.44	62.7%	34.9%	$ 1200
Sri Lanka	2 12 83 913	72.21	79.38	92.3%	89.1%	$ 5000
Thailand	6 67 20 153	71.24	76.08	94.9%	90.5%	$ 8700
Timor-Leste	11 77 834	65.54	70.47%	Total: 58.6%		$ 2600

Source: CIA World Factbook (2011 estimates)

Appendix 2 provides more detailed demographic data of the 11 countries.

1.2 Prevalence of impairments and disabilities

Reliable data are not available from most countries. In-country surveys quote different figures, due to differences in definitions and methodology. Government surveys usually use an impairment-based definition to identify persons with disabilities, which gives a lower percentage of prevalence, compared to broader definitions.

Table 2: Approximate prevalence figures based on available data.

Country	Prevalence (%)	Source
Bangladesh	NA	
Bhutan	3.4	Population and Housing census of Bhutan (PHBC), 2005
DPR Korea	3.4	North Korea's Federation for the Protection of the Disabled, quoted in "Disabled in North Korea" (2007)
India	2.1 (2001)	Census of India reports
Indonesia	2 to 3 (2007)	Mont, 2007,
Maldives	4.7 (2009)	Human Rights Commission of Maldives (2010)
Myanmar	2.35	Union of Myanmar (2009
Nepal	1.63 (2001)	UNICEF. Situation Analysis of Disability in Nepal, 2001
Sri Lanka	1.6 (2001)	Sri Lanka Census of Population and Housing 2001
Thailand	1.6	The National Statistical Office of Thailand'. Disability survey, 2007
Timor-Leste	4.6 (2010)	

Bangladesh, Indonesia and Sri Lanka are now in the process of undertaking national level surveys. Indonesia is using the International Classification of Functioning as the basis for identification of impairments and disabilities.

From the available data, it is clear that a majority of persons with disabilities in all the 11 countries live in rural areas or far flung islands in the case of Maldives and Indonesia.

Gender

The available data show that more men than women have a disability in Bangladesh, India, Maldives and Timor-Leste, while it is the reverse in Bhutan, DPR Korea, Indonesia, Myanmar, Nepal, Thailand and Sri Lanka.

Category of impairment

In Bhutan, persons with speech and hearing impairment constitute the largest group, followed by those with visual impairment, mobility impairment and intellectual disabilities.

In Democratic People's Republic of Korea, persons with mobility impairment are the largest group, followed by those with visual impairment, hearing impairment and intellectual disabilities.

In India, visual impairment shows the highest prevalence, followed by mobility impairment, speech and hearing impairment and 'mental' problems.

In Indonesia, persons with mobility impairment constitute the largest group, followed by those with speech and hearing impairment, visual impairment, intellectual disability, psychosocial disability and multiple disability.

In Maldives, persons with mobility impairment form the largest group, followed by those with speech and hearing impairment, 'mental' disabilities and visual impairment.

In Myanmar, persons with physical impairment are the largest group, followed by those with visual impairment, hearing impairment and intellectual disability.

The Nepal data show that persons with mobility impairment constitute the largest group, followed by those with hearing impairment, visual impairment, intellectual disability and multiple disabilities.

In Thailand, persons with mobility impairment are the largest group, followed by those with speech and hearing impairment, visual impairment, intellectual disability, and psychosocial/behavioural problems.

In Sri Lanka, persons with mobility impairment form the largest group, followed by those with speech and hearing problems, visual impairment and 'mental' disabilities.

In Timor-Leste, prevalence of visual impairment is the highest, followed by mobility impairment, hearing impairment and intellectual disability.

In all the countries except Bhutan, India and Timor-Leste, mobility impairments show the highest prevalence. Bhutan has a higher prevalence of speech and hearing impairment, while in India and Timor-Leste, it is visual impairment that has a higher prevalence. It is likely that intellectual disability and psychosocial disabilities have been classified together in most countries except Indonesia and Thailand.

Causes of impairments

Bangladesh: Poverty and the resultant poor health care and hygiene, accidents, natural disasters

Bhutan: Poor health care in remote areas, polio

DPR Korea: Poor health care, landmines

India: Poverty and the resultant poor health care and hygiene, traffic and industrial accidents

Indonesia: Congenital factors, poor health care, accidents

Maldives: NA

Myanmar: Congenital factors, age related stroke, accidents

Nepal: Poor health care, congenital factors, accidents

Sri Lanka: Congenital factors, poor health care, traffic and industrial accidents, conflict

Thailand: Age related causes, diseases, accidents

Timor-Leste: Poor health care

With the exception of Thailand and possibly Maldives (both of which are upper middle income countries), poverty and the resultant poor health care, lack of access to health care, lack of awareness, poor hygiene and sanitation, and communicable diseases, are the largest contributors to the causation of impairment and disability in the Region. Thailand has more of old age-related disabilities.

Traffic and industrial accidents are beginning to be a major causative factor as well.

Natural disasters and conflicts have caused impairments and disabilities to some extent in some of the countries.

1.3 Millennium Development Goals (MDGs) and disability

A report of the UN Secretary-General (2009), entitled "Realizing the MDGs for PWDs through the Implementation of the World Programme of Action concerning Disabled Persons and the CRPD" provides an analysis of references to persons with disabilities in MDG country reports, based on a desk review of 80 country reports from all regions between 2003 and 2009. Seven out of the 80 country reports were from the SEA Region: Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal, and Thailand. However, only four out of the seven country reports have references to persons with disabilities: Bhutan (2008), Indonesia (2004), Maldives (2007), and Thailand (2008).

Bhutan (2008) reports that "there is the challenge of adopting a more inclusive approach to improve educational access to and meet the special needs of those with physical disabilities and learning impediments". The report mentions that cultural attitudes in the country may encourage concealment of diseases like leprosy and psychosocial disorders, to avoid resultant stigma and social exclusion.

Maldives (2007) mentions a disability survey that was conducted in 2002.

Indonesia (2004) mentions persons with disabilities among other groups, in relation to social security and assistance systems.

Thailand (2008) states that "less than half the number of people with disabilities was employed and received on average only two-thirds of the

income earned by other workers" and that "approximately three quarters of PWDs either had no or less than primary education."

(Source: http://www.dcdd.nl/data/1252922862208_MDG%20and%20Disability%2064.pdf)

1.4 Coverage of CBR

Data on coverage of CBR in the different countries is limited.

Countries that have a national strategy or programme for CBR, like Bhutan, Myanmar and Sri Lanka have some data. For example, in Bhutan, a pilot CBR project using the PHC infrastructure has been expanded to all districts as on 2007, as part of the government's Ninth Five Year Plan.

In Myanmar, the Leprosy Mission International in collaboration with the Department of Social Welfare has CBR projects in 8 States out of 15 in the country, while data from the CBR programme of the Ministry of Health shows that 28 townships are covered.

In Sri Lanka, the National CBR programme reportedly covers 22 out of the 25 districts.

In Indonesia, CBR is being implemented in 16 out of 33 provinces as part of a national programme.

Maldives reportedly has a national strategy on CBR but coverage is restricted to the capital city of Malé and surrounding areas.

Thailand has a specialized CBR and mobile outreach project operated by the Sirindhorn National Medical Rehabilitation Centre, covering 17 provinces.

In Nepal, the government has started supporting CBR from 2010, with a plan to initiate CBR in partnership with NGOs in all 75 districts.

In India, as on 2006, only 100 out of the 600 districts had some CBR services, and only 6% of villages in the country have access to rehabilitation services within 10 kilometres. In India and Bangladesh, international and national NGOs implement CBR projects in different locations.

In Bangladesh, there is plan for a “CBR Roll-out 2012-2016”, through government and NGO partnership.

National and international NGOs are active in promoting CBR in almost all countries; however, no information is available from DPR Korea.

While it is reasonably clear that CBR programmes exist in almost all countries, their coverage is limited, and many remote rural areas remain unreached. As a result, there are still large numbers of persons with disabilities who are living without access to services in this Region.

Section 2: Key stakeholders and programmes of governments

2.1 Nodal Ministry for disability issues

Table 3: Nodal Ministries

Country	Nodal Ministry
Bangladesh	Ministry of Social Welfare
Bhutan	Ministry of Health
DPR Korea	Ministry of Public Health
India	Ministry of Social Justice and Empowerment
Indonesia	Ministry of Social Affairs
Maldives	Ministry of Health and Family
Myanmar	Ministry of Social Welfare, Relief and Resettlement Ministry of Health
Nepal	Ministry of Women, Children and Social Welfare
Sri Lanka	Ministry of Social Service and Social Welfare
Thailand	Ministry of Public Health Ministry of Labour and Social Welfare Ministry of Education
Timor-Leste	Ministry of Social and Solidarity

In Bhutan and Maldives, the Ministry of Health is the nodal Ministry for disability; in Myanmar and Thailand, the Ministry of Health is acknowledged as one of the nodal ministries; in all the rest, the ministry in charge of “social” issues is the identified nodal agency.

2.2 Legislation and policies

Table 4: Legislation and policies

Country	Legislation and Policies
Bangladesh	National Building Code, 1993 National Policy of Disability, 1995 Disability Welfare Act, 2001 National Action Plan on Disability, 2006
Bhutan	Disability Prevention and Rehabilitation Programme Inclusion of disability in 5 Year Plans Inclusion of disability in laws and regulations related to labour, building code
DPR Korea	Law of Disability Protection, 2002
India	Persons with Disability Act of 1995, modified as The Rights of Persons with Disabilities Bill (Draft), 2011 National Policy on Disability, 2006 The National Trust Act for protection and care of persons with more severe categories of disability, and to provide health insurance cover, 1999 The Rehabilitation Council Act for developing standardization and improving quality of training programmes, 1992 Mental Health Act, 1987
Indonesia	National Plan of Action on Disability (2004-2013) Law no. 8 of 2008 on Accessibility Law no. 4 of 1997 on Disabled Persons
Maldives	General legislation of 1997 and Guidelines (to be confirmed)
Myanmar	National Plan of Action for persons with disability 2010-2012
Nepal	National Policy and Action Plan on Disability, 2006 Protection and Welfare of Disabled Persons Act Inclusion of disability in other laws and regulations
Sri Lanka	Sri Lanka Federation of Visually Handicapped Act, 2007 National Policy on Disability, 2003 Ranaviru Seva Act, 1999, for care and rehabilitation of armed forces and police Protection of Rights of Persons with Disabilities Act, 1996 Inclusion of disability in other laws and regulations

Country	Legislation and Policies
Thailand	Persons with Disabilities Empowerment Act 2007 National Plan on Life Quality Development for Persons with Disabilities (2007-2011) Inclusion of disability in other laws and regulations
Timor-Leste	National Disability Policy, 2011

Specific reference to community based rehabilitation exists in the laws and policies of Bhutan, India, Indonesia, Myanmar, Sri Lanka, Thailand and Timor-Leste.

2.3 Programmes for persons with disabilities

Table 5: Policies and programmes in health, education, livelihoods, CBR

Country	Health	Education	Livelihoods	CBR
Bangladesh	Limited services for persons with disabilities	Inclusive education and special education	Vocational training centres, access to credit from banks, 10% job reservation	Mainly NGO driven
Bhutan	Primary health care system for early identification and medical rehabilitation	Special education	Vocational training centre	Through PHC
DPR Korea	Few rehabilitation centres; INGO supported assistive device centres	Few special schools	Co-operatives for women in capital city	
India	Primary health care; national prevention and control programmes; medical rehabilitation; provision of assistive devices	Universal primary education for inclusive education; special education	Vocational training; special employment exchanges; job reservations in public sector; inclusion in National Rural Employment Guarantee Scheme	District Disability Rehabilitation Centres; scheme of training village level CBR workers ; assistance to NGOs implementing CBR

Country	Health	Education	Livelihoods	CBR
Indonesia	Ministry of Health: primary health care; medical rehabilitation	Special and inclusive education	Vocational training; self employment programmes; quota system and incentives for companies	National CBR programme
Maldives	Medical rehabilitation mainly in capital city, Malé; limited residential care facilities; provision of assistive devices	Special education facilities in some atolls; screening of school age children completed in 2010		National strategy on CBR
Myanmar	Ministry of Health: early identification and intervention; medical rehabilitation through hospitals and through CBR; free health care and assistive devices	Special and inclusive education	Vocational training through centres and through CBR	CBR promotion through Ministry of Health and through some NGO; National Plan of Action for Disability envisages CBR expansion
Nepal	Prevention programs; medical rehabilitation services	Special education	Vocational training; loans for self employment	Support to NGOs implementing CBR
Sri Lanka	Ministry of Health: inclusion of CBR in PHC; free medical rehabilitation and heath care; provision of assistive devices	Ministry of Education: Promotion of special and inclusive education	3% reservation in public sector; vocational training centres; promotion of self employment	National CBR Programme as part of National Disability Policy

Country	Health	Education	Livelihoods	CBR
Thailand	Ministry of Health: free rehabilitation services; SNMRC 's CBR and outreach services; provision of assistive devices; residential care programmes	National Education Act provides for education of children with disabilities; promotion of special and inclusive education	Vocational training centres, loans for self employment; quota for private sector	SNMRC's outreach projects
Timor-Leste	NGO driven, in partnership with Ministry of Health, for early identification and referrals MOH has a community health programme	NGO driven support to inclusive education through CBR, supported by Ministry of Education	NGO driven, self-help groups and livelihood projects through CBR	NGO driven

More details on specific programmes in these countries are available in Appendix 3.

2.4 Role of Ministry of Health

As noted in Table 3, the Ministry of Health is the nodal ministry for disability in Bhutan and Maldives and one of the nodal ministries in Myanmar and Thailand. In these countries, the Ministry of Health is responsible for CBR as part of primary health care (Bhutan and Myanmar), and as part of outreach medical rehabilitation services (Thailand).

Ministry of Health, Bhutan

The policy and programme objectives of the Disability Prevention and Rehabilitation (DPR) and Life Style Related Diseases (LSRD) programme are:

(1) To introduce community-oriented disability prevention and rehabilitation services as an integral part of the comprehensive primary health care delivery system in all remaining districts based on the 1989 WHO manual;

(2) To undertake human resource development in rehabilitation professional and in the knowledge of community rehabilitation at all levels;

(3) To develop/establish a national rehabilitation resource centre for the country;

(4) To diminish the overall impact of disability by reducing:

- the occurrence of disability through prevention, health promotion, and increased awareness, and
- the consequences of existing disability through early detection, early intervention and rehabilitation

(5) To facilitate and coordinate the involvement of other sectors in disability prevention and rehabilitation programmes in making use of the multi-sectoral coordinated approach.

The major achievements of government-supported CBR programmes to date are:

- Identification of children with speech and hearing disabilities initiated in all schools
- In-service CBR training for BHU staff
- Provision of assistive devices (hearing aids, crutches, wheel chairs, walkers, etc.) to those in need
- Provision of artificial limb (prosthesis/orthosis) workshop at Gidakom hospital
- Establishment of physiotherapy unit at four hospitals (i.e. almost all districts have at least one trained physiotherapy technician)
- Early intervention clinic for children with special needs initiated at Jigme Dorji Wangchuck National Referral Hospital (JDW NRH) in Thimphu
- Establishment of audiology unit at JDW NRH
- Provision of training in mental health for health workers in ten districts
- Availability of modern psychotherapeutic drugs in referral and district hospitals (i.e. a few are also available in BHUs)
- Incorporation of disability information collection into Health Management Information System

Basic Health Units (BHUs) under the Ministry of Health in Bhutan provide health services (such as prenatal care, health education, child birth delivery due to complications, medications, dental and eye examinations and care, and minor acute health care services) to people in even the more remote areas. These services include health promotion for persons with disabilities (e.g. educational posters in both English and local language with pictures about drinking during pregnancy and disability (Marchand, 2007).

In the other countries, the Ministry of Health plays a key role in prevention, early identification, early intervention, medical rehabilitation and general health care provision. Where primary health care systems are in place, for example in India, Sri Lanka and Indonesia, there are fairly strong linkages between the PHC system and CBR activities in rural areas. CBR is the 'bridge' between the PHC system and persons with disabilities/families for immunization, maternal and child health care, early childhood development services and referrals; district or provincial hospitals of the Ministry of Health are the specialized referral centres for medical rehabilitation and treatment. CBR personnel in some cases train PHC staff on disability issues.

Early identification and intervention in Sri Lanka

One of the goals of island-wide family health services under the Ministry of Health is to "enable marginalized children and those with special needs to optimally develop their mental, physical and social capacities to function as productive members of society" The programme objectives:

- To implement programmes to address the health needs of marginalized children and those with special needs;
- To establish a multisectoral mechanism to identify and review existing programmes aimed at providing services to these groups, and
- To build the capacities of all categories of health workers regarding their roles in implementing the programmes for marginalized children and those with special needs.

Public health midwives are the front-line workers providing family health services. Their home and clinic-related tasks include:

- Detection of children at risk;
- Early identification of impairment and disability in children 0 – 5 years of age using screening tools, and
- Provision of family care including early and extra stimulation, advice, parenting skills and referral for medical care.

Some statistics: 99.6% of children aged 12 – 23 months have been vaccinated for BCG (99.5%), DPT1 (99.6%), DPT 2 (99.6%), DPT 3 (99.4%) Polio 1 (99.6%), Polio 2 (99.6%), Polio 3 (9.3%), and Measles (97.1%); source: Ministry of Health annual Statistics 2007.

Percent of births attended by skilled health personnel 99 % (2005); Maternal Mortality Rate: 44.3 per 100 000 live births (2005, www.family health.gov.lk), Infant Mortality rate 11.2 per 1000 live births (2003), deaths between 1 – 5 years per 1000 child population 0.93%

2.5 Multi-sectoral collaboration

Ministries responsible for health and 'social' affairs are the key ministries handling disability issues in all the countries. The ministry of education is a key stakeholder for education of children with disabilities in most countries; in some countries, ministries of labour and of women and child welfare constitute other stakeholders within the government system.

Civil society is active in CBR promotion in most countries, except for DPR Korea, and to a less extent in Bhutan and Myanmar.

In all the countries, the nodal ministry is responsible for multisectoral collaboration, but in practice, this is seen as difficult to achieve in most countries.

Some examples of mechanisms for multisectoral coordination in different countries are presented in Table 6.

Table 6: Mechanisms for multisectoral coordination

Country	Mechanism for coordination
Bangladesh	The National Coordination Committee is established to coordinate all the work of the government related to disability.
India	A National Disability Rights Authority is to be established according to the Rights of Persons with Disabilities Act (Draft, 2011) to develop policies, programmes and legislation and to monitor progress towards full equality and participation of persons with disabilities.
Indonesia	The National Development Plan is a guideline for different ministries and NGOs, on rehabilitation services. In 2008, a national CBR alliance was formed for purposes of national coordination of policies and programmes for persons with disabilities.
Maldives	There is a national coordinating committee on disability for policy development and review of progress.
Nepal	A national coordination committee was formed about 15 years ago, with representation from different ministries.
Sri Lanka	The National Council for Persons with Disabilities is meant to coordinate the work of different departments and ministries through policy development and monitoring of progress. Rural rehabilitation committees are formed to facilitate CBR implementation in rural areas.
Thailand	The Prime Minister chairs the National Committee for Empowerment of Persons with Disabilities, which has the authority to formulate policies and monitor progress of protection of rights of persons with disabilities.
Timor-Leste	The Disability Working Group was established to coordinate and follow up policies and programmes for persons with disabilities. The CBR sub-committee of this group is responsible for coordinating and following up on the CBR activities in the country.

Examples of coordination/cooperation between government and civil society

Bangladesh: The National Forum of Organizations Working for Disabled Persons is co-opted by the government for policy development. Civil society, for example, the Centre for Disability and Development and DPOs are resource agencies for training on disability issues for government personnel.

India: Civil society and DPOs are involved in policy development, for example, the National Policy; signing and ratification of CRPD was backed by active advocacy from civil society; the new Act was finalized with inputs from civil society. Civil society members are part of different government

constituted committees on policy, legislation, training, grievance redress and monitoring.

Indonesia: Civil society is part of the national CBR alliance and acts as a resource for the government on policy development, monitoring and training.

Maldives: The National Disability Policy (2007) had inputs from civil society and DPOs; the national coordinating committee has representation for DPOs.

Myanmar: The National Plan of Action for persons with Disability 2010-2012 had inputs from NGOs, INGOs and DPOs.

Nepal: From 2010, civil society, including DPOs is given the responsibility of implementing government supported CBR programmes in all the districts of the country. A National CBR Resource Centre has been developed the Ministry of Women, Children and Social Welfare, Resource Centre for Rehabilitation and Development (RCRD) and Save the Children International.

Sri Lanka: The National Council for Persons with Disabilities and the rural Rehabilitation Committees have representation from civil society and DPOs.

Timor-Leste: The Disability working Group has representation from civil society. Government and civil society work together on awareness raising and celebration of special events.

2.6 Rights-based approaches

The UN Convention on Rights of Persons with Disabilities (CRPD) is the most significant proponent of the rights-based approach in the disability sector today. Table 7 shows how many of the 11 countries of the SEA Region have signed and ratified the Convention.

Table 7: Signatories to the Convention and Ratification

Signed the Convention	Bangladesh, Bhutan, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand
Ratified the Convention	Bangladesh, India, Indonesia, Maldives, Nepal, Thailand,
Ratified Optional Protocol	Bangladesh, Nepal
Not signed	DPR Korea, Myanmar, Timor-Leste

While eight countries are signatories, only six have ratified the convention, and only two have ratified the Optional Protocol. Three countries have not signed the Convention.

A study on the UN Convention by the Commonwealth Foundation, UK (that included Bangladesh and India), found that in the countries that signed and ratified the Convention or were committed to ratification, the major contributing factors were the commitment of the governments; presence of existing policies and legislation on equal opportunities and rights protection that acted as a forerunner for the CRPD in these countries; and the presence of a vibrant civil society that has espoused the rights-based approach to disability issues. DPOs in these countries were particularly influential in working with governments in the drafting of the Convention, and in advocacy with the governments for signing and ratification (Thomas and Rajapakse, 2009).

In line with the above finding, available data from this study shows that many of the governments in SEA Region have started mentioning the need for a paradigm shift from charity-based approaches to a rights-based approach in their policy documents, for example, in India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand and Timor-Leste.

Indonesia is planning a prevalence survey using the International Classification of Functioning instead of the older medical criteria.

Although Timor-Leste is yet to sign the Convention, the principles of CRPD have been considered as the base on which to formulate the National Disability Policy.

In Bangladesh, India, Indonesia, Nepal, Sri Lanka, Thailand and Timor-Leste, there are active civil society groups and DPOs, who advocate with government on rights-based approaches and participation. These groups are represented on government appointed committees on policy and legislation. In India, for example, DPOs and NGOs were involved in the revision of the 1995 legislation to harmonize it with the CRPD.

Bangladesh: Progress of Implementation of CRPD

- 46 Focal Points established in different Ministries and Departments
- Prime Minister's Office to monitor activities of Focal Points
- Progressing towards changing allocation of business of ministries to include disability perspective
- Government Committee established to monitor implementation
- Official Bangla version and popular Bangla version of CRPD published
- Disability Rights Watch Group from civil society established to monitor implementation of the CRPD from a civil society perspective and to produce shadow reports on progress
- Government Committee launched for developing new human rights-based law, with participation from NFOWD
- Parliamentarians' Caucus on Disability formed to promote an inclusive development agenda and rights based approaches.

These are positive developments, indicative of the will (political and civil society) to move towards a rights-based approach. However, achievement at the ground level is uneven; it is clear from the available data that welfare and charity-based perspectives towards persons with disabilities continue to prevail in almost all the countries.

Section 3: Civil society in CBR

Civil society is active in disability issues in Bangladesh, India, Indonesia, Maldives, Nepal, Sri Lanka, Thailand and Timor-Leste. Civil society includes national and international NGOs and country level DPOs.

In Bhutan and Myanmar, the role of civil society is limited, while no information is available from DPR Korea.

In Timor-Leste, and to a large extent Nepal, civil society, led by international NGOs, is more proactive than the government on disability issues. In all other countries, the government remains the major stakeholder; national NGOs promote comprehensive CBR projects at micro levels, and international NGOs provide financial and technical support for NGO efforts and sometimes for government programs.

Of late, mainstream development NGOs have started including disability as a cross-cutting theme in their work in Bangladesh, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand.

Self-help groups and parent/family associations are being promoted in almost all the countries, at village, district and province levels.

The Leprosy Mission Timor-Leste (TLM) CBR programme is implemented in some parts of the country, especially for people affected by leprosy. The CBR programme identified and supported the formation of groups and assisted them in deciding on types of activities to be implemented. Livelihood activities and awareness raising about leprosy are the main activities of these self-help groups that are expanding and becoming known in their communities. They are slowly taking control over their activities, with assistance from the implementing agency in monitoring their activities. There are plans to develop some of these self-help groups into regional DPOs, with support from TLM and the national DPO.

National-level DPOs exist in Bangladesh, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor Leste. Many of these started as single impairment associations of persons, and tend to be largely urban based, with limited membership from persons with disabilities living in rural areas.

Examples of DPOs:

Bangladesh: National Federation of the Blind, the National Federation of the Deaf, the Bangladesh Visually Impaired Peoples' Society.

India: National Association for the Blind, National Federation of Deaf, Disability Rights Group, Association of Persons with Disability.

Indonesia: Indonesian Association of PWDs, Indonesian Association for Disabled Women, Indonesian Blind Union, National Federation for Welfare of the Mentally Disabled, National Federation for Welfare of Indonesian Deaf, Indonesian Board for Disabled Sports.

Maldives: Maldives Deaf Association, Association for disAbility and development.

Myanmar: Myanmar Physically Handicap Association, Myanmar Disabled People's Organization.

Nepal: Nepal Disabled Association, National Association for Welfare of the Blind.

Sri Lanka: Sri Lanka Confederation of Organizations of the Handicapped People, Sri Lanka National Federation of Visually Handicapped, Association of Physically Handicapped, Association of Hearing

Impaired People, Organization of the Parents of the Disabled Persons, Organization of Ladies with Disabilities, Sri Lanka Board of Disabled People

Thailand: Council of Persons with Disabilities of Thailand, the largest umbrella organization of PWDs with 12,000 members nationwide (including Association of the Physically Handicapped of Thailand, Thailand Association of the Blind, National Association of the Deaf in Thailand, and Association for the Retarded in Thailand).

Timor-Leste: Hadomi Timor Oan (RHTO), for all persons with disabilities, East Timor Blind Union.

International NGOs that support CBR in the SEA Region include CBM, AIFO, Leonard Cheshire Disability, Sight Savers, Liliane Foundation, Handicap International, Actionaid (International), Voluntary Services Overseas- VSO, CORDAID, The Leprosy Mission International (UK), Plan International, SHIA and Save the Children.

The voluntary sector in India has been a very active one, in different areas of development, including disability. The 2006 National Policy recognizes the importance of the NGO sector in service delivery and encourages participation of civil society in policy development.

It is estimated that there are about 1.2 million NGOs in India. Data from different sources put the number of NGOs in the disability sector in India between 3000 and 4000. NGOs have played a significant role in services for persons with disability in India, supplementing/complementing the work of the state and often working in areas not reached by the state.

Over the last 10 years, an increasing number of disabled people's organizations have been formed at the national, state and district levels, with the philosophy of "Nothing about us, without us". These groups have been very effective in advocacy and influencing policy.

The role of NGOs in the disability sector in India is best summarized in the 2009 World Bank report: "Overall, the disability NGO movement has contributed greatly to promoting the interests of PWD and awareness of their rights and situations. However, it remains in many ways an under-exploited resource in terms of fully mature partnerships between the public and NGO sectors" (The World Bank, 2009).

Some innovative practices

Bangladesh: The National Forum of Organizations Working for Disabled (NFOWD) is an umbrella organization with over 150 national and international NGOs as members. One hundred and thirteen of these organizations are promoting CBR.

Action on Disability and Development (ADD) in Bangladesh launched a grassroots-level federating body named the National Grassroots Disability Organization (NGDO) in 2004. It now has 92 member DPOs and close to 750 self-help groups in 23 districts, with an overall membership of almost 21 000 persons with disabilities. In 2005 ADD facilitated the formation of a women's federation - the National Council of Disabled Women (NCDW). About 10 000 women with disabilities in 23 districts are members.

India: Local persons with disabilities have formed DPOs (called Viklang Manch) in the states of Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan and Uttar Pradesh, supported in a small way by some international donors. These groups are present across at least 10 districts in each state, and are mainly involved in advocacy and activism to access their entitlements.

Indonesia: Disability advocacy teams are formed in seven districts around Solo City, consisting of (Local Government Units, NGOs, DPOs, and community leaders. The team focuses on inclusion of disability issues in the development agenda with a rights based and inclusive development approach.

Maldives: Handicap International, an international NGO, has contributed to disability policy and disability-related services, such a screening for functional limitations in children, preparation of Maldivian sign language dictionary and facilitation of the Maldives Deaf Association, the Association of disability and Development (a support group for parents and caretakers) and Hand in Hand (established in the aftermath of the 2004 tsunami, for psychosocial support to persons with disabilities).

Thailand: The Sirindhorn National Medical Rehabilitation Centre has a specialized CBR unit and a one-stop mobile outreach programme for medical rehabilitation in rural areas, with support from local NGOs and village health volunteers for organization and follow-up.

In Thailand, the National Office for Empowerment of Persons with Disability (NEP), Ministry of Social Development and Human Security has a loan fund for empowerment of persons with disabilities. This public fund provides financial support to persons with disabilities as well as caregivers, to help shape their career opportunities and improve their life quality. DPOs play an important role in controlling the spending of the fund (7 out of 17 members who make up the fund management sub-committee represent DPOs).

Timor-Leste: In 2008, the Ministry of Education, in collaboration with ASSERT (national NGO) and Plan Timor-Leste (INGO), conducted the first ever national survey for children with disabilities in pre-primary and primary schools around the country.

Fridsro in Sri Lanka has had a long-standing partnership, since 1994, with the central Ministry of Social Services and Social Welfare and the National CBR programme, in implementing CBR throughout the island, besides providing financial and technical support to the Ministry at the central level. The Fridsro CBR process first establishes a dialogue with communities and mobilizes them to set up peer groups and action groups (of persons with disabilities, community members, preschool teachers, parents etc). The CBR project assists these groups when requested, particularly in providing guidance for addressing their issues and harnessing their own resources (e.g., for housing, health, livelihoods, educational opportunity, physical accessibility) and establishing communication with state sectors and other NGOs. Other activities include discussing development problems with communities, individuals and families and helping them implement solutions; providing seed money for livelihoods; training a volunteer force (including persons with disabilities) to work with and for persons with disabilities; liaising with provincial, district and sub-district decentralized state sectors and other NGOs for rights promotion and facilitating their participation, and supporting decentralized administration to set up multisectoral panels.

Section 4: Support systems for CBR

4.1 CBR training

In all the countries, the governments have in-house training courses for their health personnel at different levels, for example, training of basic health workers in Bhutan, or of village health workers in India. While the training course in Bhutan incorporates CBR elements from the 1989 WHO manual, courses for government health workers generally relate to early identification, referrals and prevention of causes of impairments to some extent.

Sirindhorn National Medical Rehabilitation Centre, Thailand, holds CBR training courses focusing on medical rehabilitation for representatives from District Public Health Offices, hospitals, and health centres. During the training, CBR ideas, methods, knowledge of disabilities, and practical rehabilitation skills such as physiotherapy are transferred to the trainees. The trainees take these experiences back to their home locations and become CBR facilitators, acting as conduits for the transmission of knowledge and skills to the communities.

CBR training courses are conducted mostly by NGOs and INGOs in other countries. These courses include training for CBR workers at village level (Bangladesh, India, Indonesia, Nepal, Sri Lanka, Thailand, Timor-Leste) and training for CBR co-ordinators and managers (Bangladesh, India, Indonesia, Sri Lanka, Thailand).

The CBR Basic Facilitators Short Course Training Curriculum run by Resource Centre for Rehabilitation and Development (RCRD), Nepal is recognized by the Government. RCRD has conducted training for 300 CBR workers from 37 out of 75 districts in the country.

The Rehabilitation Council of India has an approved one year diploma course in community based rehabilitation, and a one year post graduate diploma in CBR planning and management, offered by one university.

The University of Indonesia offers a one-month summer course on disability and development focusing on CBR.

In Timor-Leste, efforts are underway to include CBR in the Faculty of Community Development at the National University of Timor Leste.

APCD, Bangkok, has been conducting training to strengthen CBR practices in the Region through a "Participatory Comprehensive Approach" between 2003 and 2005. The participants included 8 persons from Cambodia, 15 from Laos, 9 from Myanmar, 9 from Vietnam and 15 from Thailand. APCD mobilized resource persons for the training from Bangladesh, India, Japan, Sri Lanka and Thailand, all within the Asia-Pacific region. Between 2007 and 2011, APCD conducted seven CBR training courses, attended by 140 participants.

Centre for Disability and Development (CDD) , Bangladesh, has trained more than 12 000 people, through 749 short-term and long-term courses on CBR, disability and development, between 1996 and 2011. Following training, a significant number of CDD partner organizations has initiated disability mainstreaming as one of the priorities. Out of 64 administrative districts, CDD partner organizations are now working in selected sub-districts of 58 districts.

4.2 CBR resource materials

The 1989 WHO Manual (Training in the community for people with disabilities) has been used (and continues to be used) in almost all the countries in the Region.

The 2010 WHO Community-based Rehabilitation (CBR) Guidelines are slowly gaining recognition now, and being officially launched in different countries, for example, in Indonesia, by WHO SEARO in association with the Indonesia CBR Alliance, Ministry of Health and WHO Indonesia.

The CBR Matrix from the Guidelines had become popular even before the Guidelines were officially published, for example, it was used in Indonesia for training of self-help groups and for introducing the concept of personal assistance.

In Bhutan, the CBR Guidelines were used in the formulation of the Disability Prevention and Rehabilitation (DPR) and Life Style Related Diseases (LSRD) programme.

RCRD, Nepal is involved in strengthening CBR-based on the WHO CBR Guidelines, and is developing simple tools for planning, monitoring, reporting, survey, assessment and registration of persons with disabilities at the community level. All the government laws, policies, guidelines, facilities and services related to persons with disabilities have been compiled and published as the 'National Disability Resources Book' and 'Disability Introduction Book' in simple Nepali language. These books have been distributed in 4000 villages in 75 districts in the country.

The National Institutes in India and many NGOs have published materials on disability-related issues, including CBR.

The CBR Development and Training Centre in Solo, Indonesia, has published a set of manuals for CBR workers and managers.

The Ministry of Social Services and Social Welfare, Sri Lanka, in partnership with Fridsro has prepared and duplicated/published material for mid-level workers, volunteers and disabled people and their families:

(6) Including Disability in Development through the National CBR Programme, 2008*, (Sinhala, Tamil, English)*

(7) CBR for Disabled People and Families – knowledge and skills for living independently, An update of the WHO Manual, 2009. (*Sinhala and Tamil*)

(8) Early Childhood Education for Disabled Children, adapted from the WHO Manual, 2009*, (Sinhala and Tamil)*

(9) Range of learning materials for mid-level workers and community volunteers*,* 2008 – 9*, (Sinhala and Tamil)*

4.3 Institutional support for rehabilitation and for CBR

Most countries have national and regional rehabilitation institutions established by the government or by NGOs for referral and specialist support, training and research. Some examples:

Bangladesh: Centre for Rehabilitation of the Paralysed

Bhutan: Jigme Dorji Wangchuck National Rehabilitation Hospital

India: National Institutes for different categories of impairment, regional rehabilitation centres, district disability rehabilitation centres, medical college departments of physical medicine and rehabilitation, non-governmental rehabilitation centres, for example, the Indian Spinal Injury Centre.

Indonesia: Specialized hospitals and rehabilitation centres across most major cities

Myanmar: National Rehabilitation Hospital

Nepal: TU teaching hospital, Hospital and Rehabilitation Centre for Disabled Children; Spinal Injury Rehabilitation Centre.

Sri Lanka: Ragama Rehabilitation Centre

Thailand: The Sirindhorn National Medical Rehabilitation Centre (SNMRC) as the focal point for medical rehabilitation and CBR

Despite these facilities, coverage of persons with disabilities living in remote areas continues to be limited.

The Ministry of Public Health in Thailand has assigned the Sirindhorn National Medical Rehabilitation Centre (SNMRC) as the focal point for medical rehabilitation and CBR, with the aim of providing rehabilitation services for persons with disabilities within their community, in collaboration with education, vocational and social sectors. SNMRC has been supporting CBR activities in the country since 1995.

After the 2004 tsunami, recognizing that the majority of persons with disabilities living in rural areas were unable to access rehabilitation services, the Department of Medical Services of SNMRC set up the Integrated Out Reach Rehabilitation Service initially in six tsunami-affected provinces, through a mobile unit. The project combines disability assessment, registration and medical rehabilitation as a one stop service, provided through a multidisciplinary team. In addition, training programmes have been conducted to build capacity of local communities in preventing causes of impairment and in empowering persons with disabilities. The project started in 2005 in 4 provinces and by 2009 had covered 17 provinces in the country. Between 2005 and 2009, the SNMRC outreach project served about 14 000 persons with disabilities. In all the provinces, local organizations were involved to raise awareness about the project, to identify persons with disabilities in need of rehabilitation services, to liaise with the SNMRC team and carry out follow up in the community.

A user satisfaction survey showed that 87.9% of persons with disabilities were happy with the services received. Persons with disabilities were able to access rehabilitation services, and reported increased capability in performing activities of daily living, and increased confidence in social participation. Families reported a decrease in the burden of caring. Apart from this, SNMRC built capacity of local staff to recognize the rights of persons with disabilities. SNMRC also developed the Medical Rehabilitation Network and CBR network to enhance the capability of persons with disabilities to access health services.

4.4 Learning and exchange across the Region

Over the last decade, learning and information exchange across the Region have been increasing, with agencies like CDD in Bangladesh and APCD in Thailand becoming regional resource agencies for CBR training.

Centre for Services and Information on Disability (CSID), Bangladesh, operates an electronic information exchange network, allowing its members to be updated on issues related to disability and CBR.

The CBR Asia-Pacific Network was formed in 2009 after the First Asia-Pacific CBR Congress, to function as a resource agency to promote networking and information sharing in this Region.

A good example of networking is the Asian Spinal Cord Network (ASCoN), promoted by Livability Ireland, with membership from Bangladesh, Bhutan, India, Indonesia, Myanmar, Nepal, Sri Lanka and Thailand, from the SEA region.

ASCoN was started in 2001 and consists of a group of organizations from Asia that have come together to share and learn from each other in all aspects of spinal cord injury (SCI) management, from initial treatment to community re-integration through CBR services. Commencing initially with 20 member organizations representing eight countries in the Region, membership has increased steadily each year and today there are 74 member organizations representing 18 countries in the region.

The impact of ASCoN has been recorded in several areas:

Networking and information exchange: ASCoN exchanges helped identify common problems and find common solutions, because of similar challenges faced, similar culture and values across the countries. ASCoN facilitated exchange of information, human resources and exchange visits between countries, all of which helped promote professional development in the region.

Awareness: ASCoN helped to promote better understanding of SCI and the importance of its management among governments and other organizations in the region. There is better understanding of needs of persons with SCI among rehabilitation and medical professionals in the different countries.

Service quality and capacity building: Information and knowledge sharing helped to update/upgrade protocols and improve overall management of SCI and service delivery systems in the region. More centres/departments in hospitals were developed through cooperation with government and other agencies. Knowledge and skills were developed/upgraded to manage SCI through conferences, workshops, observership, and access to funds for training and development and development of learning materials, which in turn resulted in increased functional outcomes and improved quality of life for persons with SCI in the Region. A resource group of experts on SCI has been developed for the Asian region.

ASCoN is now recognized internationally, and known for promoting high standards in spinal injury management across a number of countries in Asia. ASCoN has been successful in developing a model which regions in the other parts of the world can use. (http://www.ascon.info/)

Section 5: Successes and challenges in CBR

This section summarizes the factors contributing to successful implementation of CBR, and the challenges faced in 10 of the 11 countries in the Region, based on available data. No information is available from DPR Korea.

Table 8: Successes and Challenges

Country	Successes	Challenges
Bangladesh	Strong civil society, better awareness of disability issues	Poverty and illiteracy among persons with disabilities, Low awareness among some sectors of government, Lack of coordination among CBR implementers
Bhutan	Integration of CBR into PHC, Well trained basic health staff	Poverty, Difficult terrain, Poor awareness among families of persons with disabilities, Lack of professional support staff for CBR, Lack of livelihoods in remote areas
India	Good support from government, Strong civil society and DPOs, Good support systems for training, referrals, information	Large country, many remote areas remain unreached, Poverty, Low awareness in remote areas

Country	Successes	Challenges
Indonesia	Good support from the government, and linkages with primary health care, Good support from community leaders,	Poor awareness among families and communities, Law is not implemented rigorously, Disability is still seen from a charity perspective by some sectors of government
Maldives	Strong civil society	Poor coverage due to topography of atolls, Government commitment is not adequate, Lack of trained professionals
Myanmar	Linkages with PHC, Organization of self-help groups, High awareness n disability issues	Poor coverage of rural areas, Retention of local volunteers, Inadequate understanding of and training in CBR, Low multi-sectoral coordination, Poor networking between government and civil society
Nepal	Active civil society	Mountainous terrain, Low awareness of rights based approaches, Inadequate government commitment, Poor multisectoral coordination
Sri Lanka	Strong government support Active civil society, Motivated community volunteers, Availability of information and material resources	Low multisectoral coordination, Poor networking among different stakeholders, Lack of livelihoods support in rural areas
Thailand	Active civil society and government partnership, Good coverage, Training and resource materials, Monitoring and information systems	Inadequate understanding of CBR, Poverty among persons with disabilities, Poor awareness among families and some local leaders
Timor-Leste	Good partnerships between government and civil society, Government commitment	Lack of trained and skilled personnel for CBR implementation, Low awareness in some sectors of government on disability and development

The key contributing factors to successful CBR implementation in the Region are government commitment to disability issues as evidenced through legislation, policies and programmes; presence of active civil society and DPOs; linkages between PHC and CBR; government-civil society collaboration; and availability of training and material resources.

The major challenges are poor coverage of remote areas; poverty and associated low levels of awareness, illiteracy and limited access to health and rehabilitation services; limited commitment and awareness among some sectors of government; low multisectoral collaboration; inadequate understanding of CBR and rights-based approaches; and lack of sufficient numbers of trained personnel, information and material resources on CBR.

Key findings and way forward

This section highlights the key findings from the situation analysis and issues to be considered in developing a strategic framework for CBR in the SEA Region.

Data on persons with disabilities

According to the World Report on Disability (2011), "Countries reporting a low disability prevalence rate – predominantly developing countries – tend to collect disability data through censuses or use measures focused exclusively on a narrow choice of impairments. Countries reporting higher disability prevalence tend to collect their data through surveys and apply a measurement approach that records activity limitations and participation restrictions in impairments." The Report goes on to recommend ways to improve national disability statistics, moving away from an impairment perspective and using ICF as the framework for collection of data.

The available data in this study show varied rates of prevalence, ranging from 1.6% in Sri Lanka and Thailand and 4.7% in Maldives. It is likely that government surveys used narrow, impairment-based definitions that yielded lower rates, probably focussing on those with moderate and severe categories of impairment. Most governments in developing countries that have limited resources would see this as a practical way of allocating resources for groups that need them the most.

With the focus on rights based approaches in the Region, future surveys in the Region are likely to use broader definitions; this study found that Indonesia is using ICF as the basis for the planned national survey. This is an encouraging trend in collecting data about persons with disabilities and should be followed by other countries too.

Poverty and the resultant poor health care, lack of access to health care, lack of awareness, poor hygiene and sanitation, and communicable diseases, are the largest contributors to the causation of impairment and disability in most countries in the Region. Traffic and industrial accidents are beginning to be a major causative factor as well. Natural disasters and conflict have caused impairments and disabilities to some extent in some of the countries.

Greater efforts are needed to address preventable causes of impairment in all the 11 countries, and CBR programme planning should pay attention to this.

The available data show that the majority of persons with disabilities in all the 11 countries live in rural areas or far flung islands in the case of Maldives. These are also the areas with limited coverage of health and rehabilitation services. This study brought out that while CBR programmes exist in almost all countries, their coverage is limited, and many remote rural areas remain unreached. In the case of persons with disabilities living in poor rural or urban communities, poverty and lack of access to services and opportunities are the biggest challenge and barrier to their inclusion in development processes. Attitudes of family and community members are another barrier, largely due to ignorance and low awareness about what can be possible. Poverty and disability are linked, as studies have shown. Persons with disabilities tend to be poorer than the general population; people living in poverty are more likely than others to become disabled. This study also showed that the majority of the countries in the Region do not refer to persons with disabilities in the MDG reports.

The fact that there are still large numbers of persons with disabilities living in conditions of poverty without access to services in this Region, needs to be highlighted for future CBR planning.

Government policies and programs

As the World Bank Report (2009) on India sums it up aptly, “The slow progress in expanding opportunities for disabled people in India results in substantial losses to people with disabilities themselves, and to society and the economy at large in terms of under-developed human capital, loss of output from productive disabled people, and impacts on households and communities.”

The report, while commending progress made in India, comments that policy commitments of the government remain unfulfilled in a number of areas. The report refers to problems of entrenched societal attitudes, weak institutions and poor accountability mechanisms, lack of awareness on disability among stakeholders including persons with disabilities themselves, and failure on the part of government to involve the NGO sector more effectively. According to the Report, persons with disabilities “remain largely outside the policy and implementation framework.....”

The situation is likely to be similar in many other countries in the Region too, as the findings of this study indicate.

The study findings show that governments are major stakeholders in disability in almost all countries, with the exception of Timor-Leste and to some extent Nepal, where many programmes for persons with disabilities are NGO-driven; and there are various policies and programmes in place for persons with disabilities. Specific reference to CBR exists in the laws and policies of Bhutan, India, Indonesia, Myanmar, Sri Lanka, Thailand and Timor-Leste. This indicates significant progress compared to the situation a decade ago in south Asian countries like Bhutan, Bangladesh, Nepal and Sri Lanka (Thomas M. Thomas MJ. An Overview of Disability Issues in South Asia” Asia Pacific Disability Rehabilitation Journal, 2002; 13(2)

http://www.aifo.it/english/resources/online/apdrj/apdrj202/contents.htm)

Programmes in health and education sectors appear to be more advanced than in livelihoods in most countries.

Coverage of many of these programmes is limited and does not reach persons with disabilities living in remote areas. Another challenge is that while policies and legislation may be in place, their implementation in practice is

not up to expectations. In many countries, awareness on disability and CBR in government is low and needs to be improved.

In all countries, the Ministry of Health plays a key role in prevention, early identification, early intervention, medical rehabilitation and general health care provision. Where the Ministry of Health is the nodal Ministry for disability issues, as in Bhutan, CBR is well integrated into the primary health care system. In other countries where PHC systems are in place, for example in India, Indonesia and Sri Lanka, there are fairly strong linkages between the PHC system and CBR activities in rural areas. CBR is the 'bridge' between the PHC system and persons with disabilities/families for immunization, maternal and child health care, early childhood development services and referrals; district or provincial hospitals of the Ministry of Health are the specialized referral centres for medical rehabilitation and treatment.

Having effective primary health care systems in place facilitates successful CBR implementation.

Multi-sectoral coordination

As this study brought out, multiple ministries have programmes for persons with disabilities and the need for multisectoral coordination is recognized as important in effective implementation of policies. Some useful mechanisms for such coordination are in place across the countries.

However, it is also acknowledged that multisectoral coordination continues to be a challenge in most countries, and needs to be strengthened further.

Rights based approaches

Eight of the 11 countries are signatories to the UN CRPD. There are indications that there is recognition in most countries of the importance of rights-based approaches to disability issues. Many governments in the SEA-Region have started mentioning the need for a paradigm shift from charity-based approaches to a rights-based approach in their policy documents. Countries with active civil society including DPOs, which work in collaboration with governments, have moved further ahead in this regard.

These are positive developments, indicative of the will (in political and civil society sectors) to move towards a rights-based approach. However, achievement at the ground level is uneven; the available data shows that welfare and charity based perspectives towards persons with disabilities continue to prevail in some areas in almost all the countries.

Civil society

Civil society (national and international NGOs and DPOs) is active in almost all the countries, although they are fewer in number in Myanmar and Bhutan.

The study findings have highlighted some innovative practices of civil society groups in disability and in CBR; along with examples of cooperation between government and civil society. Countries with active civil society groups that collaborate with government, have moved ahead with rights-based approaches faster; and showcase more successful CBR programmes, as in the case of India, Sri Lanka and Thailand.

The World Bank (2009) report comment on India, that civil society "remains in many ways an under-exploited resource in terms of fully mature partnerships between the public and NGO sectors", applies equally to other countries in the Region. Likewise, there is a need to improve networking and collective action between different actors in civil society too.

Support systems for CBR

Training, material and information resources on disability and CBR are available in most countries, although some like India, Sri Lanka and Thailand are a little ahead in this regard. Bhutan, Maldives, Myanmar, Nepal and Timor-Leste report that lack of trained personnel is a challenge for effective CBR implementation.

Almost all the countries have some form of institutional support for CBR for referrals, specialist services, training and research.

However, there is a need to increase the coverage, and the quantity and quality of these support systems across countries in the Region. Exchange and learning across the Region needs to be encouraged, as in the example of the Asian Spinal Cord Network (ASCoN). The WHO CBR Guidelines need to be promoted, translated into local languages and used as relevant, applicable and appropriate, across different countries.

Issues to be considered in developing a framework for CBR in SEA Region

- Broader definitions and use of ICF as a framework for data collection on persons with disability, to go beyond the impairment perspective and to include participation and inclusion;
- Attention to programmes to prevent causes of impairment;
- Extension of coverage of CBR, health and rehabilitation services to unreached areas;
- Awareness on disability, CBR and rights-based approaches for government;
- Establishing close links between PHC and CBR;
- Government-civil society partnerships for better implementation of policies and programmes and for rights-based approaches;
- Development and monitoring of mechanisms for multisectoral coordination;
- Increase in coverage, quantity and quality of support systems for CBR across countries in the Region, and
- Promotion of more exchange and learning on CBR across the Region by strengthening the CBR Asia-Pacific Network

Limitations of the study

Out of the 11 countries studied, information from DPR Korea was limited to what was available on the public domain.

In-depth information was collected only from four countries – Bangladesh, India, Indonesia and Thailand. Of the remaining countries, information that was collated from responses to questionnaires and from literature search may not be fully comprehensive or representative. This is a limitation of the methodology of questionnaire survey and desk study.

However, the available information has yielded sufficient data for a fair understanding of the situation in at least 10 of the 11 countries, along with pointers to develop a valid strategic framework for CBR in the Region.

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Annex 1

Country profiles

Bangladesh	
Population	158 570 535 (100.0%)
Age Structure	
0-14 Years	54 328 241 (34.3%)
15-64 Years	96 847 950 (61.1%)
65 Years and Over	7 394 344 (4.7%)
Median Age (Years)	
Total Population	23.3
Male	22.7
Female	23.7
Life Expectancy at Birth (Years)	
Total Population	69.75
Male	67.93
Female	71.65
Ethnic Groups (1998 estimates)	Bengali 98%, other 2% (including tribal groups and non-Begali Muslims)
Religions	Muslim 89.5%, Hindu 9.6%, other 0.9%
Literacy (Age 15 and over can read and write)	
Total Population	47.9%
Male	54%
Female (2001 estimate)	41.4%
Government Type	Parliamentary democracy
Capital	Dhaka
Administrative Divisions	7 divisions
Economy	Bangladesh remains a poor, overpopulated, and inefficiently-governed nation. Although more than half of GDP is generated through the service sector, 45% of Bangladeshis are employed in the through the service sector, 45% of Bangladeshis are employed in the agricultural sector. Garment exports and remittances from overseas Bangladeshis accounted for almost 25% of GDP in FY10.

Bangladesh	
GDP - Per Capita (2010 estimate in 2010 US dollars)	US$1700
GDP - Composition by Sector	
Agriculture	18.4%
Industry	28.7%
Services (2010 estimate)	52.9%

Source: CIA World Factbook (2011 estimates)

Bhutan	
Population	708 427 (100.0%)
Age Structure	
0-14 Years	205 005 (28.9%)
15-64 Years	462 918 (65.3%)
65 Years and Over	40 504 (5.7%)
Median Age (Years)	
Total Population	24.8
Male	25.4
Female	24.2
Life Expectancy at Birth (Years)	
Total Population	67.3
Male	66.46
Female	68.19
Ethnic Groups (1998 estimates)	Bhote 50%, ethnic Nepalese 35%, and indigenous or migrant tribes 15%
Religions	Lamaistic Buddhist 75%, Indian- and Nepalese-influenced Hinduism 25%
Literacy (Age 15 and over can read and write)	
Total Population	47%
Male	60%
Female (2003 estimate)	34%
Government Type	Constitutional monarchy

Bhutan	
Capital	Thimphu
Administrative Divisions	20 districts
Economy	The economy, one of the world's smallest and least developed, is based on agriculture and forestry, which provide the main livelihood for more than 60% of the population. Rugged mountains dominate the terrain and make the building of roads and other infrastructure difficult and expensive. The economy is closely aligned with India's through strong trade and monetary links and dependence on India's financial assistance. Most development projects, such as road construction, rely on Indian migrant labour. Model education, social, and environment programmes are underway with support from multilateral development organizations. Each economic programme takes into account the government's desire to protect the country's environment and cultural traditions.
GDP - Per Capita (2010 estimate in 2010 US dollars)	US$5500
GDP - Composition by Sector	
Agriculture	17.6%
Industry	45%
Services (2009 estimate)	37.4%

Source: CIA World Factbook (2011 estimates)

DPR Korea	
Population	24 457 492 (100.0%)
Age Structure	
0-14 Years	5 466 384 (22.4%)
15-64 Years	16 769 219 (68.6%)
65 Years and Over	2 221 889 (9.1%)
Median Age (Years)	
Total Population	32.9
Male	31.2
Female	34.6

DPR Korea	
Life Expectancy at Birth (Years)	
Total Population	68.89
Male	65.03
Female	72.93
Ethnic Groups (1998 estimates)	Racially homogeneous; there is a small Chinese community and a few ethnic Japanese
Religions	Traditionally Buddhist and Confucianist, some Christian and syncretic Chondogyo
Literacy (Age 15 and over can read and write)	
Total Population	99%
Male	99%
Female (1991 estimate)	99%
Government Type	Communist state one-man dictatorship
Capital	Pyongyang
Administrative Divisions	9 provinces and 2 municipalities
Economy	Large-scale military spending draws off resources needed for investment and civilian consumption. Frequent weather-related crop failures aggravated chronic food shortages caused by ongoing systemic problems. Large-scale international food aid deliveries have allowed the people of North Korea to escape widespread starvation since famine threatened in 1995, but the population continues to suffer from prolonged malnutrition and poor living conditions.
GDP - Per Capita* (2009 estimate in 2010 US dollars)	US$1800
GDP - Composition by Sector	
Agriculture	20.9%
Industry	46.9%
Services (2002 estimate)	32.1%

Source: CIA World Factbook (2001 estimates)

*North Korea does not publish reliable National Income Accounts data; the data shown here are derived from purchasing power parity (PPP)

GDP estimates for North Korea made by Angus MADDISON in a study conducted for the OECD.

India	
Population	1 189 172 906 (100.0%)
Age Structure	
0-14 Years	352 866 393 (29.7%)
15-64 Years	771 476 710 (64.9%)
65 Years and Over	64 829 803 (5.5%)
Median Age (Years)	
Total Population	26.2
Male	25.6
Female	26.9
Life Expectancy at Birth (Years)	
Total Population	66.80
Male	65.77
Female	67.95
Ethnic Groups (2000 census)	Indo-Aryan 72%, Dravidian 25%, Mongoloid and other 3%
Religions (2001 census)	Hindu 80.5%, Muslim 13.4%, Christian 2.3%, Sikh 1.9%, other 1.8%, unspecified 0.1%
Literacy (Age 15 and over can read and write)	
Total Population	61%
Male	73.4%
Female (2001 census)	47.8%
Government Type	Federal republic
Capital	New Delhi
Administrative Divisions	28 states and 7 union territories

India	
Economy	India is developing into an open-market economy, yet traces of its past autarkic (self-sufficient) policies remain. Economic liberalization, including industrial deregulation, privatization of state-owned enterprises, and reduced controls on foreign trade and investment, began in the early 1990s and has accelerated the country's growth. India's diverse economy encompasses traditional village farming, modern agriculture, handicrafts, a wide range of modern industries, and a multitude of services. Slightly more than half of the work force is in agriculture, but services are the major source of economic growth, accounting for more than half of India's output with only one-third of its labour force. India has capitalized on its large educated English-speaking population to become a major exporter of information technology services and software workers. India's long term challenges include widespread poverty, inadequate physical and social infrastructure, limited non-agricultural employment opportunities, insufficient access to quality basic and higher education, and accommodating rural-to-urban migration.
GDP - Per Capita (2010 estimate in 2010 US dollars)	US$3500
GDP - Composition by Sector	
Agriculture	16.1%
Industry	28.6%
Services (2010 estimate)	55.3%

Source: CIA World Factbook (2011 estimates)

Indonesia	
Population	245 613 043 (100.0%)
Age Structure	
0-14 Years	67 144 054 (27.3%)
15-64 Years	163 367 691 (66.5%)
65 Years and Over	15 101 298 (6.1%)

Indonesia	
Median Age (Years)	
Total Population	28.2
Male	27.7
Female	28.7
Life Expectancy at Birth (Years)	
Total Population	71.33
Male	68.80
Female	73.99
Ethnic Groups (2000 census)	Javanese 40.6%, Sundanese 15%, Madurese 3.3%, Minangkabau 2.7%, Betawi 2.4%, Bugis 2.4%, Banten 2%, Banjar 1.7%, other or unspecified 29.9%
Religions (2000 census)	Muslim 86.1%, Protestant 5.7%, Roman Catholic 3%, Hindu 1.8%, other or unspecified 3.4%
Literacy (Age 15 and over can read and write)	
Total Population	90%
Male	94.0%
Female (2004 estimate)	86.8%
Government Type	Republic
Capital	Jakarta
Administrative Divisions	30 provinces, 2 special regions, and 1 special capital city district
Economy	Indonesia, a vast polyglot nation, has weathered the global financial crisis relatively smoothly because of its heavy reliance on domestic consumption as the driver of economic growth. Increasing investment by both local and foreign investors is also supporting solid growth. During the recession, Indonesia outperformed most of its regional neighbours. Its debt-to-GDP ratio in recent years has declined steadily because of increasingly robust GDP growth and sound fiscal stewardship. .

Indonesia	
	However, it still struggles with poverty and unemployment, inadequate infrastructure, corruption, a complex regulatory environment, and unequal resource distribution among regions. In late 2010, increasing inflation driven by higher and volatile food prices, posed an increasing challenge to economic policymakers and threatened to push millions of the near-poor below the poverty line. The government in 2011 faces the ongoing challenge of improving Indonesia's infrastructure to remove impediments to growth, while addressing climate change concerns, particularly with regard to conserving the country's forests and peat lands
GDP - Per Capita (2010 estimate in 2010 US dollars)	$4200
GDP - Composition by Sector	
Agriculture	16.5%
Industry	46.4%
Services (3rd quarter, 2010)	37.1%

Source: CIA World Factbook (2011 estimates)

Maldives	
Population	394 999 (100.0%)
Age Structure	
0-14 Years	84 974 (21.5%)
15-64 Years	293 917 (74.4%)
65 Years and Over	16 108 (4.1%)
Median Age (Years)	
Total Population	26.2
Male	26.8
Female	25.2

Maldives	
Life Expectancy at Birth (Years)	
Total Population	74.45
Male	72.22
Female	76.80
Ethnic Groups	South Indians, Sinhalese, Arabs
Religions	Sunni Muslim
Literacy (Age 15 and over can read and write)	
Total Population	93.8%
Male	93%
Female (2006 estimate)	94.7%
Government Type	Republic
Capital	Maale
Administrative Divisions	19 atolls and the capital city
Economy	Tourism is Maldives' largest economic activity, accounting for 28% of GDP and more than 60% of foreign exchange receipts. Fishing is the second leading sector, but the fish catch has dropped sharply in recent years. Constrained by limited availability of cultivable land and the shortage of domestic labour, agriculture and manufacturing play a lesser role in the economy. Due to falling tourist arrivals and fish exports, Maldives has had chronic budget deficits in recent years and the plans to cut expenditures have not progressed well. New goods and services tax on tourism and business profit tax have recently been introduced and are expected increase government revenue by about 25%. Diversifying the economy beyond tourism and fishing, reforming public finance, and increasing employment opportunities are major challenges facing the government. Over the longer term, Maldivian authorities worry about the impact of erosion and possible global warming on their low-lying country (i.e. 80% of the country is 1 meter or less above sea level.

Maldives	
GDP - Per Capita (2010 estimate in 2010 US dollars)	US$6900
GDP - Composition by Sector	
Agriculture	5.6%
Industry	16.9%
Services (2009 estimate)	77.5%

Source: CIA World Factbook (2011 estimates)

Myanmar	
Population*	53 999 804 (100.0%)
Age Structure	
0-14 Years	14 839 511 (27.5%)
15-64 Years	36 442 403 (67.5%)
65 Years and Over	2 717 890 (5.0%)
Median Age (Years)	
Total Population	26.9
Male	26.3
Female	27.5
Life Expectancy at Birth (Years)	
Total Population	64.88
Male	62.57
Female	67.33
Ethnic Groups (2000 census)	Burman 68%, Shan 9%, Karen 7%, Rakhine 4%, Chinese 3%, Indian 2%, Mon 2%, other 5%
Religions (2000 census)	Buddhist 89%, Christian 4% (Baptist 3%, Roman Catholic 1%), Muslin 4%, animist 1%
Literacy (Age 15 and over can read and write)	
Total Population	89.9%
Male	93.9%
Female (2006 estimate)	86.4%

Myanmar	
Government Type	Military regime
Capital	Rangoon (Yangon)
Administrative Divisions	7 divisions and 7 states
Economy	Myanmar is a resource-rich country. Despite its emergence as a natural gas exporter, socio-economic conditions have deteriorated due to mismanagement, leaving most of the public in poverty. The economy suffers from serious macroeconomics imbalances, including unpredictable inflation, fiscal deficits, multiple official exchange rates, a distorted interest rate regime, unreliable statistics, and an inability to reconcile national accounts. Its poor investment climate hampers the inflow of foreign investment. The exploitation of natural resources does not benefit the population at large. The business climate is widely perceived as opaque, corrupt, and highly inefficient. Over 60% of the FY 2009-10 budget was allocated to state owned enterprises - most operating at a deficit. The most productive sectors will continue to be in extractive industries. Other areas such as manufacturing, tourism, and services struggle due to inadequate infrastructure, unpredictable trade policies, and neglected health and education systems. A major banking crisis in 2003 has led to limited private sector's access to credit. The global crisis of 2008-09 has caused the country's exports to drop.
GDP - Per Capita (2010 estimate in 2010 US dollars)	US$1400
GDP - Composition by Sector	
Agriculture	43.2%
Industry	20.0%
Services (2009 estimate)	36.8%

Source: CIA World Factbook (2011 estimates)

*Taking into account the effects of excess mortality due to AIDS, which can result in lower life expectancy, higher infant mortality, higher death rates, lower population growth rates, and changes in the distribution of population by age and sex than would otherwise be expected

Nepal	
Population	29 391 883 (100.0%)
Age Structure	
0-14 Years	10 161 128 (34.6%)
15-64 Years	17 951 875 (61.1%)
65 Years and Over	1 278 880 (4.4%)
Median Age (Years)	
Total Population	21.6
Male	20.7
Female	22.5
Life Expectancy at Birth (Years)	
Total Population	66.16
Male	64.94
Female	67.44
Ethnic Groups (2001 census)	Chhettri 15.5%, Brahman-Hill 12.5%, Magar 7%, Tharu 6.6%, Tamang 5.5%, Newar 5.4%, Muslim 4.2%, Kami 3.9%, Yadav 3.9%, other 32.7%, unspecified 2.8%
Religions (2001 census)	Hindu 80.6%, Buddhist 10.7%, Muslim 4.2%, Kirant 3.6%, other 0.9%
Literacy (Age 15 and over can read and write)	
Total Population	48.6%
Male	62.7%
Female (2001 census)	34.9%
Government Type	Federal democratic republic
Capital	Kathmandu
Administrative Divisions	14 zones

Nepal	
Economy	Nepal is among the poorest and least developed countries in the world, with almost one-quarter of its population living below the poverty line. Agriculture is the mainstay of the economy, providing a livelihood for three-fourths of the population and accounting for about one-third of GDP. Industrial activity mainly involves the processing of agricultural products, including pulses, jute, sugarcane, tobacco, and grain. Political instability hampers foreign investment. Additional challenges to Nepal's growth include its landlocked geographic location, civil strife and labor unrest, and its susceptibility to natural disaster.
GDP - Per Capita (2010 estimate in 2010 US dollars)	US$1200
GDP - Composition by Sector	
Agriculture	33%
Industry	15%
Services (2009 estimate)	52%

Source: CIA World Factbook (2011 estimates)

Sri Lanka	
Population	21 283 913 (100.0%)
Age Structure	
0-14 Years	5 305 670 (24.9%)
15-64 Years	14 307 108 (67.2%)
65 Years and Over	1 671 135 (7.9%)
Median Age (Years)	
Total Population	30.8
Male	29.7
Female	31.8
Life Expectancy at Birth (Years)	
Total Population	75.73
Male	72.21
Female	79.38

Sri Lanka	
Ethnic Groups (2001 census)	Sinhalese 73.8%, Sri Lankan Moors 7.2%, Indian Tamil 4.6%, Sri Lankan Tamil 3.9%, other 0.5%, unspecified 10%
Religions (2001 census)	Buddhist 69.1%, Muslim 7.6%, Hindu 7.1%, Christian 6.2%, unspecified 10%
Literacy (Age 15 and over can read and write)	
Total Population	90.7%
Male	92.3%
Female (2001 census)	89.1%
Government Type	Republic
Capital	Colombo
Administrative Divisions	9 provinces
Economy	Sri Lanka is engaging in large-scale reconstruction and development projects following the end of civil war, including increasing electricity access and rebuilding its road and rail network. Additionally, it seeks to reduce poverty by using a combination of state directed policies and private investment promotion to spur growth in disadvantaged areas, develop SMEs, and promote increased agriculture. High level of government funding may be difficult, as the government already is faced with high debt interest payments, a bloated civil service, and historically high budget deficits. The 2008-09 global financial crisis and recession exposed Sri Lanka's economic vulnerabilities and nearly caused a balance of payments crisis, which was alleviated by IMF loan. The end of the civil war and the IMF loan have largely restored investors' confidence.
GDP - Per Capita (2010 estimate in 2010 US dollars)	US$5000
GDP - Composition by Sector	
Agriculture	12.6%
Industry	29.8%
Services (2010 estimate)	57.6%

Source: CIA World Factbook (2011 estimates)

Thailand	
Population	66 720 153 (100.0%)
Age Structure	
0-14 Years	13 246 348 (19.9%)
15-64 Years	47 323 590 (70.9%)
65 Years and Over	6 150 215 (9.2%)
Median Age (Years)	
Total Population	34.2
Male	33.3
Female	35.2
Age Structure	
0-14 Years	13 246 348 (19.9%)
15-64 Years	47 323 590 (70.9%)
65 Years and Over	6 150 215 (9.2%)
Median Age (Years)	
Total Population	34.2
Male	33.3
Female	35.2
Life Expectancy at Birth (Years)	
Total Population	73.6
Male	71.24
Female	76.08
Ethnic Groups	Thai 75%, Chinese 14%, other 11%
Religions (2000 census)	Buddhist 94.6%, Muslim 4.6%, Christian 0.7%, other 0.1%
Literacy (Age 15 and over can read and write)	
Total Population	92.6%
Male	94.9%
Female (2000 census)	90.5%
Government Type	Constitutional monarchy
Capital	Bangkok
Administrative Divisions	76 provinces

Thailand	
Economy	With a well-developed infrastructure, a free-enterprise economy, generally pro-investment policies, and strong export industries, Thailand enjoyed solid growth from 2000 to 2007, averaging more than 4% per year, as it recovered from the Asian financial crisis of 1997-98. Thai exports, mostly machinery and electronic components, agricultural commodities, and jewelry, continue to drive the economy, accounting for more than half of GDP. The global financial crisis of 2008-09 severely affected Thai exports, leading to the contraction of the economy in 2009. As exports rebounded from their depressed 2009 level, the economy expanded at 7.6% in 2010, the fastest rate since 1995. Antigovernment protests during March-May 2010 and the country's polarized political situation had a temporary impact on business and consumer confidence. Although tourism was hit hard during the protests, its quick recovery helped boost consumer confidence to new highs. Moreover, business and investor sentiment remained buoyant over the past year as Thailand's stock market continued to grow.
GDP - Per Capita (2010 estimate in 2010 US dollars)	US$8700
GDP - Composition by Sector	
Agriculture	10.4%
Industry	45.6%
Services (2010 estimate)	44%

Source: CIA World Factbook (2011 estimates)

Timor-Leste	
Population	1 177 834 (100.0%)
Age Structure	
0-14 Years	398 326 (33.8%)
15-64 Years	736 642 (62.5%)
65 Years and Over	42 866 (3.6%)

Timor-Leste	
Median Age (Years)	
Total Population	22.5
Male	22.5
Female	22.5
Life Expectancy at Birth (Years)	
Total Population	67.95
Male	65.54
Female	70.47
Ethnic Groups	Austronesian (Malayo-Polynesian), Papuan, small Chinese minority
Religions (2005 census)	Roman Catholic 98%, Muslim 1%, Protestant 1%
Literacy (Age 15 and over can read and write)	
Total Population	58.6%
Male	Not Available
Female	Not Available
Government Type	Republic
Capital	Dili
Administrative Divisions	13 administrative districts
Economy	In late 1999, about 70% of the economic infrastructure of Timor-Leste was destroyed by Indonesian troops and anti-independence militias. Over the next three years, a massive international program led to substantial reconstruction in both urban and rural areas. The country continues to face great challenges in rebuilding infrastructure, strengthening the civil administration, and generating jobs for young people entering the work force. The development of oil and gas resources in offshore waters has greatly supplemented government revenues, though has done little to create jobs for the unemployed because there are no production facilities in Timor-Leste.

Timor-Leste	
	In June 2005, the national parliament unanimously approved the creation of a petroleum fund to serve as a repository for all petroleum revenues and to preserve the value of Timor Leste's petroleum wealth for future generations. The fund held assets of US$ 6.6 billion as of October 2010. The economy continues to recover strongly from the mid-2006 outbreak of violence and civil unrest, which disrupted both private and public sector economic activities. Government spending increased markedly in 2009 and 2010, primarily on basic infrastructure, including electricity and roads. Limited experience in procurement and infrastructure building has hampered these projects. The underlying economic policy challenge the country faces remains how best to use oil-ang-gas wealth to lift the non-oil economy onto a higher growth path and to reduce poverty.
GDP - Per Capita (2010 estimate in 2010 US dollars)	US$2600
GDP - Composition by Sector	
Agriculture	32.2%
Industry	12.8%
Services (2010 estimate)	55%

Source: CIA World Factbook (2011 estimates)

Annex 2

Policies and programmes for persons with disabilities

Bangladesh

Constitutional provisions

- Part II, Section 15 of the 2004 Constitution of the People's Republic of Bangladesh stipulates that "it shall be a fundamental responsibility of the State to attain, through planned economic growth, a constant increase of productive forces and a steady improvement in the material and cultural standard of living of the people, with a view to securing to its citizens the right to social security, that is to say to public assistance in cases of undeserved want arising from unemployment, illness or disablement, or suffered by widows or orphans or in old age, or in other such cases."

Comprehensive disability-specific laws and regulations

- The 2001 Disability Welfare Act, the main legal instrument concerning disability in Bangladesh, covers definitions and identification related to disability welfare, as well as the organization, constitution, responsibilities, and functions of the National Coordination Committee on disability.

Sectoral disability-specific laws and regulations

- There are rules regulating the distribution of allowances for PWDs.

Disability-inclusive laws and regulations

- The 1993 National Building Code prescribes standards to ensure accessibility of PWDs.

Comprehensive disability-specific policies and plans

- The 1995 National Policy on Disability, based on the commitments made by the government in adopting the UN Standards Rules on the Equalization of Opportunities for PWDs, outlines guidelines for prevention, identification, education, rehabilitation, research and management of the national program.
- The 2006 National Action Plan on Disability, a comprehensive disability action plan involving fourteen different ministries and government departments, covers the areas projected in the Biwako Millennium Framework such as self-help organization, women with disability, early detection and intervention, education, training and employment, access to built environment and transport, access to communication, assistive technology, social security, and public awareness.

Disability-inclusive policies and plans

- The second phase of the national Primary Education Development Program also covers inclusive education.
- The Poverty Reduction Strategy Paper, a strategic direction for the overall comprehensive development of the country, has a special chapter on disability, acknowledging the interaction of poverty and disability.

Source: UNESCAP

Bhutan	**Constitutional provisions** According to the 2008 Constitution of the Kingdom of Bhutan, • "The State shall endeavor to provide legal aid to secure justice, which shall not be denied to any person by reason of economic or other disabilities." (Bhutan 2008a, art. 9, para. 6) • "The State shall endeavor to provide security in the event of sickness and disability…" (Bhutan 2008a, art. 9, para. 22) **Sectoral disability-specific laws and regulations** • Section 8 of the 2002 Bhutan Building Rules, administered by the Department of Urban Development and Housing, Ministry of Communications, covers "Access for the Disabled" to built environment. **Disability-inclusive laws and regulations** • The 2007 Labor and Employment Act, administered by the Ministry of Labor and Human Resources prohibits "discrimination against employees and job seekers" as stated in sections 11 through 14 of chapter II on Prohibitions. Section 96 directs employers to compensate employees against disablement (total permanent and temporary partial) due to work accident or occupational diseases. • The 2008 Election Bill includes provisions on "assistance to physically challenged voters." • The 2002 National Pension and Provident Fund Plan Rules and Regulations facilitate the management and administration of the National Pension and Provident Fund for providing post service retirement benefits to the members, income security in the event of permanent disability of member, social support to surviving members of family of the deceased member and compulsory savings plan for salaried employees. **Comprehensive disability-specific policies and plans** • The Disability Prevention and Rehabilitation (DPR) and Life Style Related Diseases (LSRD) Program aims at achieving a society where "all PWDs are able to attain fullest potentials, become self reliant within their limitations and be active contributors in nation building to the extent possible." The program emphasizes the importance of decentralized rehabilitation services and community-based model in achieving this ideal society. **Disability-inclusive policies and plans** • 10th Five Year Plan (2008 - 2013) specifically mentions issues confronting PWDs and provides plans to address disability concerns in the areas of women with disabilities, education, accessibility, and sports. • Vision 2020: A Vision for Peace, Prosperity, and Happiness includes health priorities such as a provision to "develop or strengthen response to the needs of special groups including the disabled, the elderly, and the emotionally disturbed and mentally ill." Source: UNESCAP

DPR Korea	**Constitutional provisions** • Article 72 in the Socialist Constitution of the DPR Korea states that "Citizens are entitled to free medical care, and all persons who are no longer able to work because of old age, illness, or a physical disability, the old and children who have no means of support are all entitled to material assistance." **Comprehensive disability-specific laws and regulations** • On June 18, 2002, the Law of Disability Protection was newly adopted in the Supreme People's Assembly, and thus the protection of the disabled is ensured by law. Source: UNESCAP
India	**Constitutional provisions** • Part IV, Article 41 of the 1996 Constitution of India states that "the state shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education, and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want." **Comprehensive disability-specific laws and regulations** • The 1995 PWDs Act is the main legal instrument concerning PWDs in India which provides for the establishment, composition, and functions of a Central Coordination Committee mainly to review and develop policies as well as coordinate disability-related activities by government and non-government organizations. It mandates early detection and prevention (research on disability causes, awareness raising on disability prevention, periodic screening of children at risk, and training of health staff among others); education (access to free education, integration of children with disabilities in regular schools, special education, and provision of vocational training facilities); employment (employment quota, employment promotion, and accessible workplaces); provision of aids, appliances, and accommodation; and provision of assistive devices and accessible transportation and buildings. • The 1996 PWDs Rules cover evaluation and assessment of various disabilities and identify authorities to give Disability Certificate. • The 1987 Mental Health Act protects the rights of mentally ill persons. **Sectoral disability-specific laws and regulations** • The 1992 Rehabilitation Council of India Act raised the status of the Rehabilitation Council of India into a statutory body. The act aims at standardizing training courses for professionals dealing with PWDs, prescribing minimum standards of education and training of various categories of professionals dealing with PWDs, regulating these standards in all training institutions uniformly throughout the country, promoting research in rehabilitation and special education, and maintaining central rehabilitation register for registration of professionals.

- The 1999 National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation, and Multiple Disabilities Act aims at enabling and empowering PWDs to have full and independent lives within or as close to the community where they belong. Among its provisions are legal guardianship, care and protection for PWDs.
- The 1998 Guidelines and Space Standards for Barrier Free Built Environment for Disabled and Elderly Persons
- Guidelines for issuance of disability certificate lay down that a Medical Board, duly constituted by the central and the state government shall issue a Disability Certificate. The certificate issued by the Medical Board makes a person eligible to apply for facilities, concessions, and benefits admissible under schemes of the government or non-governmental organizations, subject to such conditions as the central or the state governments may impose.
- Guidelines for evaluation of various disabilities and procedure for certification

Disability-inclusive laws and regulations

- The 2000 Juvenile Justice Care and Protection of Children Act mandates the government to provide services to children with mental or physical disabilities.
- The 1961 Income Tax Act provides for deductions, subject to rules defined in the act, on taxable incomes of PWDs. Income deductions also apply to persons who have dependents with disabilities in relation to maintenance and medical treatment.

Comprehensive disability-specific policies and plans

- The 2006 National Policy for PWDs recognizes that PWDs are valuable human resources and seeks to create an environment that provides for equal opportunities, protection of their rights, and full participation in society.

Disability-inclusive policies and plans

- The Approach to the 11th Five Year Plan 2007-2012 by the Planning Commission of the Government of India identifies specific strategies in dealing with disability and mental health issues, emphasizing mental health care, prevention of discrimination against PWDs, especially children with disabilities.

Source: UNESCAP

Indonesia	**Constitutional provisions** • Article 27, Chapter 10 of the 1945 National Constitution states that "Without any exception, all citizens shall have equal positions in law and government and shall be obliged to uphold that law and government. Every citizens shall have the right to work and to a living, befitting for human beings." **Comprehensive disability-specific laws and regulations** • The 1997 Act of the Republic of Indonesia Number 4 concerning disabled people is the legal foundation for social welfare of PWDs, reiterating the equal rights and opportunities of PWDs in all aspects of life (i.e. education, employment, participation, accessibility, rehabilitation, and social welfare. **Sectoral disability-specific laws and regulations** • Cover early detection, intervention, and education; training and employment; access to built environments and transportation; information and technology; social security and poverty alleviation; general election at national and provincial levels. **Comprehensive disability-specific policies and plans** • The National Plan of Action for PWDs 2004-2013 aims to steer political support from stakeholders; improve social services for and protection/ security of PWDs; and strengthen disability-related social organizations in accordance with the Biwako Millenium Framework to which Indonesia is a signatory. **Sectoral disability-specific policies and plans** • Social rehabilitation (i.e. institutional-based, mobility unit, and CBR), social assistance, and social security assurance are provided for PWDs. Sources: UNESCAP and JICA PED

Maldives	**Constitutional provisions** • Article 17 in the Constitution states that "Everyone is entitled to the rights and freedoms included in this Chapter without discrimination of any kind, including race, national origin, color, sex, age, mental or physical disability, political or other opinion, property, birth or other status, or native island." • Article 35 (b) of the Constitution states that elderly and disadvantaged persons are entitled to protection and special assistance from the family, the community, and the state. **Other policies and programs** • The general legislation applies to all different categories of PWDs with respect to education, employment, the right to marriage, the right to parenthood/family, political rights, access to court-of-law, right to privacy, property rights. • The following benefits are guaranteed by law to PWDs: health and medical care, training, rehabilitation and counseling, financial security, and participation in decisions affecting them. • There are laws and regulations ensuring accessibility of the built environment, requiring that public places, the outdoor environment, land, sea, and air transportation, and housing are made accessible. Sources: UNESCAP, HRCM, and ILI
Myanmar	**Constitutional provisions** • According to the 2008 Constitution of the Union of Myanmar, "the union shall: a) care for mothers and children, orphans, fallen defense services personnel's children, the aged, and the disabled; b). ensure disabled ex-servicemen a decent living and free occupational training." "Law shall be enacted to provide assistance and care for disabled defense services personnel and the families of deceased or fallen defense services personnel." **Disability-inclusive laws and regulations** • The 1993 Child Law has a section on children with disabilities that education and other assistances should be provided by the government. **Comprehensive disability-specific policies and plans** • The National Policy (since 1975) includes provisions for the rehabilitation of PWDs and their reintegration in productive activities after rehabilitation. Sources: UNESCAP and JICA PED

Nepal	**Constitutional provisions** The disability-related provisions of the 2007 Interim Constitution of Nepal are as follows: • Section 13 prohibits state discrimination against women, Dalit, indigenous ethnic tribes, Madeshi, peasants, laborers (i.e. those who belong to a class which is economically, socially, or culturally backward), children, the aged, and the disabled (i.e. those who are physically or mentally incapacitated). • Section 18 covers the right to employment and social security of PWDs. • Section 33 provides for the responsibilities of the state to arrange for appropriate relief, recognition, and rehabilitation for the family of the deceased persons, the disabled and helpless persons due to injury during the course of armed conflict. • Section 35 covers special provisions of social security for the protection and welfare of single women, orphans, children, the helpless, the aged, the disabled, incapacitated persons, and the disguising tribes. • Part 22 covers the formation of necessary commissions by the government to safeguard and promote the rights and interests of different sectors of the country, including women, Dalit, indigenous ethnic tribes, Madeshi, the disabled, laborers, or farmers. **Comprehensive disability-specific laws and regulations** • The Protection and Welfare of Disabled Persons Act and Rules aim to protect and promote political and civil rights and interests of PWDs in Nepal. **Disability inclusive laws and regulations** • The 1999 Local Self Governance Act provides guidelines for self-help organizations of PWDs. • The 1971 Education Act provides for the special education of children with visual, hearing, intellectual, or mental disabilities. • The 1992 Labor Act provides for safety measure and precaution in the factory and workplace for PWDs. • The 1992 Social Welfare Act provides for programs for the welfare of PWDs, among others. • The 1992 Children Act imposes duty on the government to establish homes for orphans with disabilities and educate them. • There are also other laws and regulations which cover poverty alleviation through capacity-building, social security, and sustainable livelihood programs.

	Comprehensive disability-specific policies and plans • The 2006 National Policy and Action Plan on Disability presents disability situation in Nepal and identifies the legal basis for respective programs, plans, and activities. The 17 priority areas include: national coordination, law making, information and research, awareness and advocacy, training and employment, access, communication, transportation, education, sports and cultural/recreational activities, prevention of disability, medical treatment, assistive devices, rehabilitation/empowerment and poverty alleviation, self-dependent organizations, women and disability, and international and regional assistance. • The 1996 Disabled Service National Policy aims to provide equal opportunities in all spheres of the society by empowerment. **Sectoral disability-specific policies and plans** • Include road map for improvement of governance, provision of reservation in civil service commission for inclusion, and special education policy. **Disability-inclusive policies and plans** • The 3-Year Interim Plan (2007/08 - 2009/10) and the 3-Year Interim Plan Approach Paper identify PWDs as one of the excluded groups which need interventions. Source: UNESCAP
Sri Lanka	**Constitutional provisions** The disability-related provisions under the 1978 Constitution of the Democratic Socialist Republic of Sri Lanka are as follows: • Clause 1, Chapter III states that "All persons are equal before the law and are entitled to equal protection of the law." • Clause 4, Chapter III states that "Nothing in this article shall prevent special provision being made, by law, subordinate legislation, or executive action, for the advancement of women, children, or disabled persons." **Comprehensive disability-specific laws and regulations** • The 1996 Protection of the Rights of PWDs Act provides for the establishment of a National Council for PWDs, National Secretariat for PWDs, and National Fund for PWDs, as well as for the registration of all non-governmental organizations working in the disability field and the protection of individual rights, emphasizing discrimination in employment, education, and access to public spaces. It also describes legal measures to be taken in instances where individuals have been discriminated against. • Disability Rights Bill includes rights for non-discrimination, participation in decision making, employment, vocational training and skill development, poverty alleviation, education, health, sports, transport, built environment, housing, social security, communication and information, assistive devices, family and community life, and rights of children, youth, women, and elders with disabilities.

- The 1999 Ranaviru Seva Act establishes the Ranaviru Seva Authority (RVSA) to provide for the after care and rehabilitation of members of the armed forces and police who have been disabled in action and the welfare of the families of those killed or missing in action. Among its activities is assisting ex-combatants with disabilities to secure gainful employment through vocational training, microfinance, and job placement.
- The 1992 Visually Handicapped Trust Fund Act deals with activities concerning persons with visual impairments, ranging from education, vocational training, financial assistance, guidance for the self-employed, housing facilities, welfare, marketing of products manufactured by persons with visual impairments, to equal rights and opportunities.
- The 2007 Sri Lanka Federation of the Visually Handicapped Act incorporates the Sri Lanka Federation of the Visually Handicapped.

Sectoral disability-specific laws and regulations

Cover training and employment, as well as access to built environment and public transportation

- 3% job quota in public sector for PWDs who have the requisite qualifications and whose disability would not hinder duty performance
- Compensation to workers who become disabled on the job
- Standards and guidelines to ensure accessibility to housing, building, public transport services, streets, and other outdoor environments

Disability-inclusive laws and regulations

Provide for poverty alleviation and social welfare improvement measures for PWDs

- A pension and social security benefit scheme for self-employed persons other than those employed in the fishery/agricultural sector in case of partial or total disablement and death allowance for persons over 18 and under 59 years of age
- Financial assistance for PWDs regardless of age

Comprehensive disability-specific policies and plans

- The 2003 National Policy on Disability provides information on disability in Sri Lanka (i.e. legal definition of disability, overview of disability issues in Sri Lanka, barriers to inclusion, and resources available for policy implementation) and sets the government's approach in addressing disability.

Sectoral disability-specific policies and plans

- Cover training and employment and call for the government to provide opportunities for PWDs to upgrade their knowledge and skills so they can secure a job and integrate into the community/society.

Sources: UNESCAP and JICA PED

Thailand	**Constitutional provisions** The disability-related provisions under the 2007 Constitution of the Kingdom of Thailand are as follows: • Section 30 prohibits unjust discrimination against a person on the grounds of the difference in origin, race, language, sex, age, disability, physical or health condition, personal status, economic or social standing, religious belief, education or constitutionally political view. • Section 40 provides for the rights of every child, youth, woman, aging, or disabled person to appropriate protection in judicial process and appropriate treatment in the case related to sexual offences. • Section 80 states that "the state shall act in compliance with the social, public health, education, and cultural policies in providing aides and welfare to the elderly, the indigent, the disabled or handicapped, and the destitute person for their better quality of life and ability to become self-reliance. • Section 49 provides for equal rights to free public education of the indigent, disabled or handicapped, or destitute person. • Section 54 provides for the right to accessible public facilities, welfare, and aids of the disabled or handicapped. • Section 152 provides for representation of PWDs when considering a bill concerning PWDs. **Comprehensive disability-specific laws and regulations** • The 2007 PWDs Empowerment Act provides for the establishment, organization, and regulations of the National Office for Empowerment of PWDs (NEP). The Act also provides for accessibility of public facilities for PWDs, promotion of employment (i.e. quota and tax incentives), and the establishment of a "fund for promotion and development of life quality of disabled person." **Disability-inclusive laws and regulations** • The 1999 National Education Act provides for the rights to education of PWDs, as well as access to services and assistive devices. PWDs are entitled to early intervention services, educational materials and facilities, and government-supported home schooling. • The 1979 Workers Compensation Act provides protection for employees who have become disabled at work so that they receive compensation for medical expenses, prosthetic devices and equipment, and physical and mental rehabilitation. • The 1994 Occupational Training and Promotion Act established occupational training among active workers to improve productivity. • The 1996 Vocational Training Promotion Act entitles registered private enterprises to a 50% tax reduction of training expenses and provides other incentives to encourage training.

	◦ The 1999 Social Security Act covers employees in private enterprises of 10 or more workers. Insured members are granted certain benefits (such as health care, rehabilitation services, and income replacement) in case of illness, disability, maternity, old age, and death, including a monthly living expense allowance of 500 Bahts for PWD. **Comprehensive disability-specific policies and plans** ◦ The National Plan on Life Quality Development for PWDs (volume 3: 2007-2011) is a guideline for disability development practice in Thailand which outlines strategies to promote accessibility of facilities for PWDs. **Sectoral disability-specific policies and plans** ◦ The 10th National Economic and Social Development Plan (2007-2011) articulates the development priorities for the country. One of the objectives of the plan is to provide social security for PWDs, focusing on people-centered development and equality for all. Source: UNESCAP
Timor-Leste	**Constitutional provisions** The disability-related provisions under the 2002 Constitution of Timor Leste are as follows: ◦ Section 6 on objectives of the state includes provisions to "ensure special protection to the war disabled, orphans, and other dependents of those who dedicated their lives to the struggle for independence and national sovereignty, and shall protect all those who participated in the resistance against the foreign occupation, in accordance with the law." ◦ Part II, Section 21 on disabled citizens states that a disabled citizen shall enjoy the same rights and shall be subject to the same duties as all other citizens, except for the rights and duties which he or she is unable to exercise or fulfill due to his or her disability; and that the state shall promote the protection of disabled citizens as may be practicable and in accordance with the law. ◦ Chapter II, Section 132 defines the responsibilities of public prosecutors to include ensuring the defense of PWDs. **Comprehensive disability-specific policies and plans** ◦ According to the Ministry of Social Solidarity, there is a draft disability policy that is being further developed through technical consultations and due to be approved as a decree law by the end of 2011. Source: UNESCAP

The World Health Assembly Resolution WHA 58.23 (May 2005), on "Disability, including prevention, management and rehabilitation", made particular reference to the need "to promote and strengthen community-based rehabilitation Programmes linked to primary health care and integrated into the health system".

WHO is committed to raising the profile of disability, and focusing its contribution on those areas where it can make the greatest difference, namely, in strengthening community-based rehabilitation and medical rehabilitation, and their links with primary health care, improving data collection, and supporting policy development in accordance with the principles of the United Nations Convention on the Rights of Persons with Disabilities (CRPD).

WHO, in partnership with ILO, UNESCO and International Disability and Development Consortium (IDDC), facilitated the development of CBR Guidelines (2010) to provide clear direction on how community-based development initiatives can work to ensure the rights of persons with disabilities, promote respect for their inherent dignity, and aim for an inclusive society, in accordance with the CRPD.

In line with its commitment to promoting CBR, the WHO Regional Office for South-East Asia (SEARO) is working towards developing a strategic framework for CBR for the Region. To prepare for this, WHO commissioned the Asia-Pacific Development Centre on Disability (APCD), Bangkok, Thailand, to carry out a situation analysis of CBR in 11 Member States in the Region - Bangladesh, Bhutan, DPR Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor- Leste.

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