Empowerment and CBR? Issues raised by the South Indian experience

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(Chapter 9 in Stone, E. (ed.) 1999: Disability and Development: Learning from action and research on disability in the majority world, Leeds: The Disability Press pp. 130–148).

INTRODUCTION

Community-Based Rehabilitation (CBR) and empowerment are critical issues in contemporary discourse within both development studies and disability studies. These issues have long been fraught with controversy, yet there remains little understanding of how CBR and empowerment interrelate, not only within programmes but also in a normative sense. There is even less understanding of what the outcomes would be were Non-governmental Organisations (NGOs), governments and the international development community to make empowerment a central tenet of practice in disability provision in developing countries.

In the first part of this paper, and by way of background, I review the main definitions and criticisms of CBR (CBR may have gained common currency in developing countries and international development agencies, but it is not a term that is frequently used in the industrialised countries of the North). Secondly, I examine the critical dimensions of the relationship between CBR and empowerment. Can CBR be empowering? Thirdly, I draw on some lessons learned from a CBR programme near Bangalore in South India. The case-study is based on data gathered as part of my doctoral research. It must be emphasised that this paper offers a preliminary and tentative analysis only, since my research is still in process. Even so, I believe that some interesting observations can be made that will help to move the empowerment/CBR debate forward.

COMMUNITY-BASED REHABILITATION: WHY?

The past two decades have witnessed the emergence and development of Community-Based Rehabilitation (CBR) as a strategy for disability-related service provision in countries of the developing world. The prime objective is to improve the quality of life of the majority of the world's disabled people: those who live in absolute and relative poverty in urban and, especially, rural areas in

developing countries. In effect, CBR was born out of a recognition that unless there was a substantial change in disability service provision in Asia, Africa and Latin America, the vast majority of disabled people would never benefit from any services whatsoever.

The services which did exist tended to emulate western models of healthcare provision: rehabilitation professionals, working in institutions with state-of-the-art medical technology. Services, as in the west, were rooted in a medical model of disability, prioritising diagnosis and therapy interventions. In addition, there was a fundamental mismatch in the allocation of human and financial resources devoted to disability service provision: most people lived in rural areas, yet the vast majority of services were located in large cities, for the benefit of the urban élites. Meanwhile, demand for services was rising.

CBR was held up as the best way forward. CBR would expand disability service provision through establishing working partnerships between local communities, disabled people and their families, governments and rehabilitation professionals. Such partnerships would use local (mostly human) resources to provide basic rehabilitation to a larger number of people than had ever been possible. It was felt to be better to provide basic rehabilitation to the many, than to provide high-tech services to the few.

DEFINITIONS OF CBR

As with many other fields within development work, there is a high degree of definitional controversy and lack of clarity as to what CBR actually is. As Wolffers and Finkenflügel have argued (1993), this may be explained by power conflicts between different interest groups, fostered by competition for financial resources from donor agencies. In order to give a flavour of the range of definitions that exist, a few examples are listed below.

> The goal of CBR is to demystify rehabilitation and to give responsibility back to the individual, the family and the community. It draws on existing organisations and infrastructure for the provision of services, by recruiting and training local supervisors from the community...Simple rehabilitation techniques are delegated to auxiliaries and volunteers...CBR attempts to involve the community in the planning, implementation and evaluation of the programme...The intention is that rehabilitation is perceived as an integral part of the community's own development efforts. Only when a community takes responsibility for the integration of its disabled people

can the process be truly called community-based rehabilitation (O'Toole & Maison-Halls 1994, p. 25).

Community-based rehabilitation (CBR) is a response, in both developed and developing countries, to the need for adequate and appropriate rehabilitation services, to be available to a greater proportion of the disabled population. It aims to rehabilitate and train disabled individuals, as well as to find ways to integrate them into the communities. In CBR, the disabled person, the family, the community, and health professionals collaborate to provide services in a non-institutionalised setting, and in an environment or community where services for disabled persons are seriously limited or totally absent. Its essential feature is its focus on partnership and community participation (Peat 1991).

Community-based rehabilitation (CBR) is a strategy for enhancing the quality of life of disabled people by improving service delivery, by providing more equitable opportunities and by promoting and protecting their human rights [...] It calls for the full and co-ordinated involvement of society: community, intermediate and national. It seeks the integration for the interventions of all relevant sectors - educational, health, legislative, social and vocational - and aims at the full representation and empowerment of disabled people. It also aims at promoting such interventions in the general systems of society, as well as adaptations of the physical and psychological environment that will facilitate the social integration and self-actualisation of disabled people (Helander 1993, p. 8).

CBR is a process to bring about a transformation in the community (change in. attitude, knowledge and skills), to enable community members to have a better understanding of disability services (medical, preventive, psychological, economic, socio-cultural, educational, etc.) and to improve the quality of life of persons with disability (Spastics Society of Tamil Nadu 1993, p. 7).

Community-Based Rehabilitation is a strategy within community development for the rehabilitation, equalisation of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and the appropriate health, education, vocational and social services (ILO, UNESCO & WHO 1994, p. 1).

As much as the emergence and development of CBR has been characterised by competing definitions, it has also been characterised by strong criticism.

CRITIQUES OF THE CBR CONCEPT

During the last 20 years, the majority of countries in the developing world have established CBR programmes, sometimes using the WHO approach, sometimes developing other versions of CBR. Many with experience of trying to "do" CBR at the grassroots, along with academics and other practitioners, have questioned its philosophy and efficacy. Some of the main criticisms are set out below.

CBR hasn't really involved disabled people and local communities

All the definitions cited above highlight the critical role of the local community, including local disabled people, in CBR. Yet it has to be admitted that many CBR projects have in fact been managed and directed with few real inputs from the community and disabled people. Instead, the pre-existing medical approach has been adapted and applied within community settings. While the rhetoric of CBR promotes community decision-making and a "bottom-up" approach, the reality of CBR is often (although not always) "top-down": rehabilitation professionals are still the decision-makers. In these cases, participation is seen as a long-term goal rather than a prerequisite for disability service provision.

CBR tends to be medical and technical, not social and political

Another key element in many visions of CBR is the understanding that disability is essentially a human rights issue. Yet CBR programmes based on the WHO model (and variations on the same theme) have generally advocated a medical, technocratic approach, and have completely excluded the social and political dimensions of disability. As Wolffers and Finkenflügel argue:

> One could summarise the WHO-CBR as dispersing basic rehabilitation techniques to communities and people with disabilities. The model is very much based on improvement of functions such as walking, cooking etc. The rehabilitation worker plans the training and the community facilitates and carries it out. ... Some professionals understand CBR as an outreach system in which they leave their institutions and come near to the community. They have not understood, or have not agreed, that the community's participation and decision-taking are at the heart of the

> concept (Wolffers & Finkenflügel 1993, pp.7, 9).

Or, in Susie Miles's words:

> CBR has been packaged and marketed from a western individualistic perspective and there tends to be a strong focus on correcting or minimising the impairments of individual disabled people. Focusing exclusively upon rehabilitation needs of individuals is likely to be counter-productive unless the informal support networks and the basic needs of the whole community are recognised and addressed (Miles 1996, p. 503).

The dominance of a medical focus has been compounded by the WHO's promotion of its training manual, which stressed the technical aspects of delivering rehabilitation (Helander et al 1989). If the manual is used uncritically, local services may develop in a way which ignores the surrounding social, economic and political contexts.

Fortunately, this narrow medical focus is starting to change, and more programmes now encompass employment, education and human rights as well. Even WHO has widened its perspective (ILO, UNESCO, WHO 1993).

CBR depends on a simplistic notion of "community"

CBR advocates have been criticised for an apparent assumption that local communities are benevolent, homogeneous, willing to get involved in meeting the needs of some of the most marginalised members of their community, and have adequate resources to do so. But in many communities in developing countries, people struggle for survival. In addition, negative social attitudes to impairment can act against effective community participation:

> The difficulty with the classic CBR approach is that it assumes a rather bland view of community action in which the entire community - family, neighbours, health service, social workers, local authorities, employers, etc. - all play their part in recognising the needs of disabled people (Coleridge 1993).

CBR doesn't leave room for appropriate institutional services

Another criticism of CBR is the stark dichotomy that has been drawn between institutional and community-based services. Miles has highlighted some of the

positive aspects of rehabilitation located in day-care centres, such as the visibility of the rehabilitation process and the need for respite care for family members (M. Miles 1985).

CBR is not a cheap option

Finally, several commentators have questioned the sustainability of CBR. CBR was conceived as a low-cost strategy, but many have found it to be high-cost. Good services (incorporating good follow-up and the necessary infrastructure in staff and transport) make considerable demands on resources (Finkenflügel 1993). An International Labour Organization review of 10 years experience in CBR revealed that the ILO could not name one programme that had been fully sustainable after external funding had been withdrawn (Momm & König 1989).

CAN CBR BECOME A TOOL FOR EMPOWERMENT?

Notwithstanding the criticisms described above, it is my contention that CBR has the potential to be an important instrument and catalyst for real social change ... change that gives rise to a new "social consciousness" in the community, and that ensures that disabled people attain full citizenship.

> Too often the tacit objective of rehabilitation - especially when approached from the top down - is to normalise disabled persons into the existing and discriminatory society. By contrast, the goal of the alternative, bottom-up approach is to empower disabled persons to join into an organised struggle of all disadvantaged and marginalised groups, to change our present society into one that is fairer, more truly democratic and more accepting of human differences (Werner 1995, pp. 24-25).

If this is to happen, there must be a quantum shift in how CBR is perceived and, crucially, in the roles of all professionals involved.

David Werner, a disabled activist who has spearheaded the establishment of community-based disability services that are run and managed by disabled people in Mexico, has outlined several key factors which can help make empowerment a reality in CBR (Werner 1995, pp. 26-27):

- CBR should be "based, planned, and managed within the community itself";
- CBR requires setting the "skills pyramid ... on its side so that disabled

persons and family members become front-line workers...mid-level rehabilitation workers become facilitators and back-up persons rather than 'supervisors'...rehabilitation professionals are on tap but not on top";
- Rehabilitation (and other) professionals need to "involve their disabled partners...in defining and resolving their needs"; and "encourage their participation and leadership in the planning, administration, delivery and evaluation of rehabilitation services" (Werner 1995, pp. 26-27).

CBR should be redefined to encompass "community development". CBR workers and health-care professionals should become enablers and facilitators - facilitating effective community participation by disabled people, their families and others. They should engage in genuine dialogue with disabled people and the community, to establish what their needs and aspirations are, and to support disabled people in the achievement of their aims. This way of working would have revolutionary implications for the structure and management of community disability services throughout the developing world, because it would completely transform the notion of "professionalism" within health-care management.

Historically, the culture of professionalism (especially in medical fields) has been based upon the acquisition and application of "expert knowledge" gained through formal training. This model places a high premium upon solving problems through the correct application of pre-determined rules governed by the scientific method. Such a model leaves little room for alternative methods of achieving specified aims; and seldom recognises that selection of solutions is socially determined. All of this reinforces hierarchical forms of decision-making and acts against the effective involvement of disabled people and their families in programmes such as CBR. Yet, as has already been stated several times, effective community participation (and thereby the empowerment of disabled people) will only be realised when disabled people become aware of their abilities to achieve within the social contexts of their local communities. The next question is: how? How can professionals promote empowerment within CBR?

CBR & EMPOWERMENT: LEARNING FROM PAULO FREIRE

Practitioners within CBR programmes, wishing to pursue policy and practice that genuinely empower disabled people may benefit from considering the work of the Brazilian educationist, Paulo Freire (see Freire 1970).

Freire maintained that social transformation and the liberation of oppressed,

marginalised groups in any society can only be realised when such groups come together to reflect on their situation (past and present) and collectively plan for change. This process can take place irrespective of the degree of oppression experienced, as long as an effective learning environment exists.

What makes an effective learning environment? The answer is "praxis". Here, it is helpful to distinguish between practice and praxis. Practice is about what people do. Praxis is the dynamic interaction between theory and practice, between knowledge and action, between reflection and doing. And reflection is as vital as action:

> Only by starting with the issues on which the community have strong feelings - hope, fear, worry, anger, joy, sorrow - and bringing these to the surface, will we break through the deadening sense of apathy and powerlessness which paralyses the poor [and disabled people] in many places (Hope & Timmell 1993, p. 17).

There are two prerequisites for grassroots social transformation. First, liberation (empowerment) can only be achieved through a collective (group) process, since: "Liberation is a social act" (Freire & Shor 1987, p. 109). It requires collective understanding of shared interests and the collective identification of a strategy for social change, realised through collective means. Furthermore, empowerment cannot be given to an oppressed group.

Secondly, the role of the facilitator (be s/he a disability activist, a rehabilitation professional, a CBR worker, a grassroots development worker, a social researcher, etc.) is radically different from other professional roles. The facilitator (Freire uses the terms "revolutionary educator" or "teacher-student") is a co-learner:

> In problem-posing education, people develop their power to perceive critically the way they exist in the world with which and in which they find themselves; they come to see the world not as a static reality, but as a reality in process, in transformation...Hence, the teacher-student and the student-teachers reflect simultaneously on themselves and then on themselves and the world without dichotomizing the reflection from action, and thus establish an authentic form of thought and action (Freire 1970, p. 64).

In CBR terms, disabled people, the local community and CBR professionals

would interact with each other. Through this interaction, the potential of disabled people becomes more fully recognised by themselves and their community. Thereby disabled people are enabled to empower themselves, secure their human rights, and make the decisions that directly affect their lives.

In current CBR practice, there are already some examples of this process underway. One important mechanism is the promotion of genuine partnerships between CBR programmes and disabled people's organisations. This strategy has been used in southern Africa by Save the Children (UK).

Susie Miles (1996) has described how, when disabled adults and parents have been centrally involved in the design and development of CBR, the programme priorities have shifted from medical rehabilitation to education, employment and poverty alleviation. Thereby, CBR programmes have become more consumer-focused, while disability has become recognised as a development issue, not a medical or technical individual problem. Miles goes on to make the powerful argument that:

> community-based rehabilitation is in danger of repeating the mistakes of institutional-based rehabilitation (IBR) if it does not enter into genuine consultation with disabled people's organisations (Miles 1996, p. 501).

Changing the process and management of CBR programmes along the lines suggested by David Werner, Paulo Freire and Susie Miles - which are clearly in keeping with a social model of disability (Oliver 1990) - could potentially improve the quality, and equality, of life of disabled people in developing countries significantly. Such changes would also entail the redefinition of indicators of "good CBR" from an empowerment perspective:

> The long-term value of any rehabilitation or development effort must be evaluated in terms of how much it empowers marginalised groups and moves us towards fairer, more fully democratic structures (Werner 1995, pp. 24-25).

A CASE STUDY FROM INDIA: SOURABHA CBR PROJECT, KANAKPURA

The previous section proposed a process for change for CBR's future development. But how feasible is that process in terms of its operationalisation?

One of the CBR projects I have linked with in the course of my fieldwork has

been attempting to undertake that crucial transition from a service-providing organisation dominated by a medical approach, to an organisation which acts as facilitator first, provider second. In this section, then, I outline the progress that has been made to date, indicating where there appear to be difficulties. Again, it must be emphasised that data analysis is still in its early stages.

BACKGROUND TO THE SOURABHA CBR PROJECT

The Sourabha CBR Project is managed and run by the Shree Ramana Maharishi Academy for the Blind in Bangalore. "Sourabha" is derived from the ancient Sanskrit word for "fragrance", since fragrance brings pleasure to all without discrimination. The project is located in Kanakpura, a medium-sized town some 54 kilometres south of Bangalore, in the largest taluk (or district) in the State of Karnataka. At the end of 1997, the project was providing services to approximately 1,700 disabled people in 147 villages (total population of 154,000).

The project started in July 1990 with funding from ActionAid (India) for 10 years. Initially, emphasis was placed upon providing services in the areas of health and medical rehabilitation, nutrition and awareness raising. However, two years after the project first started, education, vocational training and income generation programmes were also added.

In 1993, the Disability Division of ActionAid (India) conducted a mid-term evaluation. The findings showed that services were mostly provided in a very "top-down" manner. Rehabilitation professionals provided services that they thought met the needs of disabled people, without consulting local people themselves. As a result, local people were recipients not participants and contributors in the programmes (AAIDD 1997). In the light of these criticisms, and spurred on by prospect of complete financial withdrawal by ActionAid (India) in 2002, the project managers worked with ActionAid (India) to redraft the programme priorities and devise a strategy that would work towards project management and implementation by disabled people and the local community, supported by a much reduced team equipped to provide technical assistance.

The emphasis of the project shifted from being exclusively concerned with service provision to prioritising community development. It was hoped that these organisational changes would transform the role of disabled people from being passive recipients of services to "active stakeholders in most of its programmes" (AAIDD 1997, p. 9), as the revised aims and objectives illustrate.

Revised Aim

To empower persons with disabilities, enhance their quality of life, and integrate them into the societal mainstream.

Revised Objectives

To provide comprehensive medical, education and vocational rehabilitation services to 950 persons with a disability in the age group 0-50 years in 147 villages covering a radius of 40 kilometres, from the project office in Kanakpura.

To sustain CBR programmes in 5 hoblies in Kanakpura District by 2002 A.D. through formation and strengthening of local groups, providing training and sensitisation to local groups in disability rehabilitation, management and networking.

To generate income through income generation activities and raise funds from local and external sources for sustainability of CBR programmes in the community (AAIDD 1997, p. 7)

The aim of the project is "to empower persons with disabilities". This, however, is not possible from a Freirean perspective nor according to many disabled people and their organisations (see Campbell & Oliver 1996), on the basis that people can only empower themselves.

Sourabha's management team, in collaboration with ActionAid (India) and after an extended three-year period of consultation with the community, have now established a three-tiered hierarchy of self-supporting groups, predominantly made up of disabled people and their families, who will ultimately run the CBR project. These groups are: the Amarjyothi Disabled Persons' Association, the Hobli Rehabilitation Committees, and the Self-Help Groups (these are detailed below). A community organisation sector has also been established to spearhead this initiative. In addition to the three groups described above, the Sourabha management team has been making concerted efforts to make links within the local community. For example, representations have been made to the Lions and Rotary Clubs in Kanakpura, to local government departments and local youth clubs.

Amarjyothi Disabled Persons' Association (ADPA) is charged with overall

responsibility and project management (including planning, monitoring, resource mobilisation, networking and evaluation). It is envisaged that this group will ultimately take over the role currently played by the management team of Sourabha. ADPA also acts as a pressure group at the taluk (district) level, to influence policy on disability and rehabilitation services. ADPA's membership is elected by the Hobli Rehabilitation Committees and the Self-Help Groups.

There are five Hobli Rehabilitation Committees (HRCs) - a "hobli" is a group of villages. The HRCs are envisaged to comprise an informal group of key players/resource persons within the community who can develop the local CBR project. HRC members might be elected representatives of local panchayats (local councils), the medical officer of the local primary health-care centre, the headteacher of the local school, village leaders, and members of the Self Help Groups. HRCs co-ordinate the activities of the CBR programme, thereby taking on the responsibilities currently performed by Sourabha's CBR Sector Co-ordinators (e.g. networking, resource mobilisation, prevention and awareness programmes, supporting ADPA and the Self-Help Groups).

It is also planned to set up a Self-Help Group for every cluster of 20 villages involved in the CBR project. Ten groups have been established so far. The group are conceived as the first step in preparing disabled people to become actively involved in the management and running of the CBR programme, with the objective of securing long-term sustainability at the grassroots. Ideally, the groups will be entirely made up of local disabled people, but in cases where the disabled person is a child, or where disability is severe, then a family member may represent the interests of that individual. The Self-Help Groups will identify the rehabilitation and other needs of disabled people living within their vicinity, taking on the role previously done by the CBR worker. Each group democratically elects four office bearers (President, Secretary, Treasurer and Convener) who are then appointed as representatives on ADPA and the Tuluk Rehabilitation Committees. Each member of the Self-Help Group pays a monthly subscription fee, which is then put into a revolving loan-fund for rehabilitation. Loans are repaid on an agreed basis with a 1-3% monthly interest rate.

Financial resources have been injected by ActionAid (India) to sustain the Self-Help Groups during the initial start up phase. However, it is envisaged that the entire structure will be self-sustained by 2002, when ActionAid (India) and the Sourabha management plan to withdraw. Even after withdrawal, it is expected that a small technical team will remain to give expert advice ("on tap, not on

top") and support to ADPA to maintain the quality of services provided. The staff and running costs will, it is hoped, be met from the profits of income generation programmes.

SOURABHA: EMERGING ISSUES

In 1997 (March/April, and again in November), I conducted interviews with the officers of the Sourabha project teams as well as disabled people involved in the programme (some as staff, some as beneficiaries also). What follows is based on preliminary analysis of these interviews and personal observations. Most of the interviews took place approximately one year after the introduction of the new structure.

One intuitively feels uneasy when CBR programme managers suddenly start making pronouncements about the active involvement of disabled people in managing and running a project. One is left with the suspicion that the real driving force behind the Sourabha project's structural reorganisation is the need to ensure financial sustainability after 2002, when ActionAid (India) withdraws its financial support. Even if this is not so, it is important to question the many assumptions that underpin the planned involvement of disabled people.

Sourabha's revised plan assumes that, given the correct dosage of training from Sourabha staff, local disabled people will have the skills, capacity and inclination to manage and implement the CBR programme. Yet interviews revealed that many disabled adults had experienced a high degree of negative social attitudes from other community members, and so had very low expectations of their own capabilities. Many local disabled people expressed resignation to their own "fate" and that their needs would always be met through charity. Evidence also suggests that even the training provided to those disabled people in Self-Help Groups has been handled in a very "top-down" manner. Sourabha's Community Sector Co-ordinator, who is blind, stated in an interview that skills training involves himself telling trainees what their needs and priorities should be.

Other worrying signs emerged from focus-group interviews with Self-Help Groups. Even though these groups had been established for over one year, meeting fortnightly, disabled people were still unclear as to their role. It became clear that these groups mostly discussed how to get their own disability pensions and allowances. There was little comprehension of how they might develop into the front-line CBR workers envisaged by the Sourabha

management team. This was the case despite the fact that existing CBR workers attended every meeting.

A further area for concern is Sourabha's apparently over-optimistic view of the role that can be played by the community - especially local government officials - in providing community-based disability services. Indeed, one of the strongest messages to come out of focus-group interviews with disabled people was that corruption was rife among officials in the local panchayats. Instances were cited where disabled people had to bribe officials to receive their disability pension or allowance.

The Sourabha CBR programme is evidence that the operationalisation of empowerment in CBR is fraught with difficulties. This is perhaps to be expected. Several writers (Long & Long 1992, Hammersley 1995) have questioned how far the translation of theory into practice is possible in relation to social and economic policy. Also, the process of change is inherently political and will have a differential impact on different "stakeholders" who have different interests and agendas.

Recognising the politics of CBR is vital. For example, claims may be made about the advantages of a project which solely serve to buttress the position of a particular stakeholder. Is the clamour for grassroots involvement of disabled people in CBR always an accurate reflection of grassroots demands? Or might it sometimes be led by those, such as local officials and NGOs, who seek to pass the financial buck to local people in the name of long-term sustainability?

In summary, it seems that Sourabha has restructured the project in name only, and based the restructuring on an ill-conceived and limited understanding of the processes of social change and empowerment, and the nature of genuine partnership and involvement. There are few signs that the consultation process initiated by Sourabha has been effective in ascertaining the needs, aspirations of disabled people within the community. There is little evidence that local disabled people have felt supported to empower themselves (or even see self-empowerment as an objective) through the CBR programme.

ADDITIONAL BARRIERS TO EMPOWERMENT THROUGH CBR

Within the wider context of India, other barriers can also be identified which work against the genuine involvement of local disabled people and their organisations in development projects like the Sourabha CBR programme.

First, legislation has been passed by the Government of India which has been criticised by some local NGOs as stultifying a developmental approach to disability and rehabilitation. The Rehabilitation Council of India Act (1992) established a statutory body, the Rehabilitation Council of India (RCI), to monitor the training and activities of those working in the field. So, all rehabilitation training courses now have to be certified by the RCI. Yet this goes against the principle of building and using local (rather than outside and expert) resources. The Act also discourages a holistic approach and a focus on basic rehabilitation carried out by family members or workers without formal medical expertise. In setting the agenda for rehabilitation services, the Act works against disabled people defining their own needs. Instead, it promotes the continuation of medically-orientated rehabilitation services which exclude disabled people from decision-making and stifle local community initiative.

Secondly, until recently there has been no cross-disability organisation of disabled people in India. Disabled Peoples' International have now established an Indian chapter, but this is still in an embryonic stage of development. Historically, organisations of disabled people have existed, but these have been for single-disability groups, such as blind people, and deaf people. The Asia-Pacific Regional Seminar of Disabled Peoples' International, held in New Delhi in January 1997, advocated that all CBR programmes should be managed by disabled people. However, in the short to medium-term, this is unlikely to happen ... unless and until the capacity of the disability movement in India is strengthened. This clearly highlights the need for local and international NGOs and donor agencies to fund the development of organisations of disabled people (Miles 1996).

Finally, evidence gathered from interviews for this research indicate that many disabled people within South India have been so disempowered and socially excluded that it will take a very long time indeed, perhaps another generation, for significant numbers of disabled people to acquire the skills and confidence to become competent managers of CBR programmes. Where disabled people have these skills, there is no guarantee that they will want to get involved in CBR. Interestingly, ActionAid (India) has also voiced concern about making "unrealistic expectations" of disabled people, their families and communities (AAIDD 1997, p. 8).

For the time being, then, the best strategy might well lie in the establishment of more linkages and partnerships between fledgling disabled people's

organisations and CBR programmes.

CONCLUSION

This paper has suggested that CBR programmes, within India and within the broader international context, should look to the principles of social transformation set out by Paulo Freire. It has been argued that CBR needs to be conceived as an interactive (dialectical) process, whereby disabled people become aware of what they can achieve, the local community becomes confident in supporting disabled people's self-empowerment, and professionals become aware of the way in which their knowledge can best be used to support social transformation (on tap, not on top). There is much that can be learnt, and will need to be learnt, if CBR is ever to become an instrument and catalyst for social change and disabled people's self-empowerment. The role of disabled people and their organisations is central to this process, and therefore it has also argued that aid and development agencies could do much more in terms of supporting the development of these organisations; and that disability needs to be seen as a development issue - social and political, not just medical and technical.

These arguments have been made with reference to the Sourabha CBR project in South India and to existing literature on CBR, empowerment and disabled people's organisations in developing countries. The experience of Sourabha, especially the views of local disabled people, have highlighted several difficult questions relevant to implementing CBR which aims to empower. For example:

- Given that able-bodied professionals have "expertise" and "knowledge", based on several years training, is it realistic to expect them to adopt the role of a facilitator, as outlined in this paper? To be on tap, not on top?
- Given the politics that underpin development projects, and the social position of most disabled people in countries like India, is it realistic to expect local disabled people to assume managerial responsibility for delivering community-based services?
- Given that relative paucity of grassroots and national disabled people's organisations in developing countries, and the constraints they operate under, which disabled people should service planners and development workers consult with, when there is a genuine desire to meet the needs and aspirations of disabled people?

Clearly, there is a need for more research and more reflection on the potential

for empowerment within CBR development programmes.

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