

**DEVELOPMENTAL ARTICLES**

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**BACKBONE PRINCIPLES OF THE CBR GUIDELINES  
AND THEIR APPLICATION IN THE FIELD OF LEPROSY**

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**ABSTRACT**

*The thesis of the present paper is that CBR is not adequately defined by its activities but even more importantly, by the way these activities are carried out. It therefore aims to summarise the draft CBR guidelines of WHO/ILO/Unicef in three all-embracing principles: Inclusion of persons with disabilities in mainstream society, Empowerment of persons with disabilities to fully participate in society and to set their own life goals and Sustainability of CBR programmes so that these can provide basic disability services and work with disabled persons and society to break down barriers. Sound CBR principles have the potential to guide the development and application of CBR in different eco-social contexts.*

*Reviewing existing work with people affected by leprosy in the light of these CBR principles will make it easier to formulate new strategies in line with the vision contained in the CBR guidelines and in the UN Convention on the Rights of Persons with Disabilities. This means re-thinking the way in which existing interventions in the areas of health care, education, livelihood and social life are implemented and where necessary designing new ones. This paper gives pointers for issues to be addressed in such a process. New WHO policies seek to promote the integration of rehabilitation programmes for persons with disabilities and persons affected by leprosy. Some experiences from the field with inclusion of leprosy-affected persons in multi-disability self-help groups and disabled people's organisations are presented.*

## INTRODUCTION

Following on from their joint position paper (1), WHO, ILO and UNICEF agreed to develop guidelines, with full stakeholder participation which would provide a framework for CBR, and would highlight best practices in the field, so as to make CBR an effective multi-sectoral strategy (2, 3). An advanced draft of these guidelines was discussed at the first Asia-Pacific Community-Based Rehabilitation (CBR) Congress in Bangkok, in February 2009. The draft counted 374 printed A4 pages and was summarised in the CBR matrix. This matrix consists of five columns headed Health, Livelihood, Education, Social and Empowerment. Each column included five areas of activity which could legitimately be considered part of community based rehabilitation. The guidelines used six *principles* of CBR as a unifying concept (2): Inclusion, Participation, Sustainability, Empowerment, Self-advocacy and Barrier free environment.

This paper seeks to emphasise and unpack the principles of CBR. One could argue that the CBR matrix identifies activities which could or should be included in CBR, but that doing those activities does not make one's programme a CBR programme. It is not only about doing the right things but also about doing them in the right way. That latter aspect needs to be defined by principles. The draft guidelines themselves recognise that CBR needs to be expressed differently in different cultural and socio-economic contexts. This 'translation process' should in the authors' view be guided by sound principles which will help clarify whether the new expressions can be truly called CBR. In particular, the authors' quest is to understand the guidelines and their consequences for working with people affected by leprosy (4). Reviewing existing work in the leprosy field in the light of CBR principles will make it easier to formulate new strategies in line with the vision contained in the guidelines and in the UN Convention on the Rights of Persons with Disabilities (CRPD) (5). Thus, the purpose of this paper is to summarise the draft CBR guidelines in three all-embracing principles and suggest avenues for application of these principles in the field of leprosy.

## PRINCIPLES OF CBR

The first and most important principle underlying the CBR guidelines is *Inclusion* of persons with disabilities in mainstream society. This may be viewed as the overall development goal to which all efforts in CBR are directed. A complementing principle is *Empowerment*, which

aims at giving persons with disabilities the confidence to ask for and make full use of opportunities to be included. Thirdly, CBR programmes need *Sustainability* so that they can continue to influence both society and people who newly develop disabilities to abide by the principles of Inclusion and Empowerment.

In the authors' view, the three principles of Inclusion, Empowerment and Sustainability adequately summarise 90% of the information in the guidelines. More principles may be validly added, but this will only marginally increase one's understanding of what the guidelines are about.

### **Frame of reference: the ICF**

The most widely used definition of disability currently is the International Classification of Functioning, Disability and Health (ICF) (6), which serves as a frame of reference which not only explains disability as a social construct but also gives direction for the levels and types of interventions that are needed. The ICF describes the impact of a disease, disorder or disaster on an individual using three *levels* of disability: impairment, activity limitation and restriction in participation.

The ICF also acknowledges contextual factors, which vary from one specific situation (context) to another and are of immediate importance to the experience of disability. Contextual factors are commonly divided into personal factors and environmental factors. Some personal factors can be influenced e.g. fitness, education, beliefs, expectations and coping mechanisms while others cannot be influenced e.g. gender, race, age, social background. Environmental factors include physical aspects such as for example, the accessibility of buildings and roads, available equipment and adaptations as well as social aspects such as cultural values and belief systems, laws and regulations.

The ICF classification highlights that contextual factors will determine to a large extent how disabled a person will become. Contextual factors are critical to the experience of disability and can be both positive and negative. They thus act as *barriers* and as *facilitators* of rehabilitation interventions, and therefore cannot and should not be overlooked. In this article, it is argued that organisations involved in designing and implementing CBR programmes *can* and *should* influence contextual factors in order to achieve optimal inclusion of people with

disabilities in all spheres of life. In ICF terms, the principle of Inclusion refers to environmental factors while Empowerment refers to personal factors and Sustainability refers to the CBR programmes themselves.

### **Inclusion**

Inclusion of disabled persons in mainstream society is fundamentally an idea of emancipation (7). It means that persons with disabilities can and do participate in all sectors of society as equals. It assumes that where some persons are characterised by physical or psychological limitations, other members of society have other characteristics which equally are part of their identity, but do not fully define them and which do not preclude their having access to the same services as others. As all people are equal before the law regardless of ethnic, religious or gender characteristics, so persons with disabilities should have the same rights and duties as others in the society in which they live. This applies to all sectors of society such as the workplace, schools, hospitals, religious sanctuaries, theatres, banks, sports clubs and charitable organisations. A host of prejudices and stigmatising practices will have to be overcome for this ideal to be realised and barriers of all kinds (e.g. physical, social and legal) will need to be eliminated. As disabled persons mingle in society, play their role and make their contributions, people's perception of them will change and stigma will be broken down. In this struggle, people who speak out in favour of including persons with disabilities (advocacy) and disabled persons who themselves speak out for their emancipation (self-advocacy) will play a key role. The role of the media in this process of change cannot be overestimated. The way disabled persons are presented on the news, in quiz programmes, in movies, in soap operas and social marketing campaigns, deeply influences public perception and shapes attitudes towards them.

It is important to see that as human beings, persons with disabilities share many basic needs with all other members of society. All need drinking water and sanitation facilities. All need mobility, although an able-bodied person may have more options to satisfy that need than a person with a mobility limitation. All need social interaction. All need to belong. All need to find meaning in their lives and to fulfill dreams. Although persons with disabilities will have special needs, most of their needs are shared with everyone else. Consequently, by providing for those needs in an inclusive manner will result in those needs being met, and often more

appropriately and efficiently, both for people with and without limitations. Very simple adaptations to existing infrastructure may be enough to allow persons with a limitation to make use of it. This is true for computers, railway stations, water pumps, telephone booths etc.

Of course, persons with disabilities may have special needs as well and these will need to be met through special services or, better, special extensions of existing services. This is why a twin-track approach (8) is generally considered best: 'together where we can, separate where we cannot' meaning that we will include disabled persons in existing services to the maximum extent possible (and what is possible is often underestimated) while creating special services where this is not possible.

Even in an ideal society, where possibilities for inclusion are maximised, there is another condition that needs to be met before persons with disabilities can benefit from existing services. This concerns the attitude of persons with disabilities themselves. If a person has been conditioned to believe that it is not possible to participate in social gatherings, to travel or to open a bank account then changing the environmental factors alone will not be sufficient. The person needs to discover that new opportunities have opened up and to start believing in their reality. It is thus also the personal factors such as character, inner drive, coping mechanism etc which need to be challenged and/or influenced. In this sense, Inclusion and Empowerment are intrinsically related. They are two sides of the same coin.

**Example: Tribal Self Help Group in Andhra Pradesh, India**

A self help group in a tribal village with 400 inhabitants has 14 members aged 9 to 59 years. There are a number of youngsters - some with visual impairments, some with hearing and speech disorders. Two adult members have deformities due to leprosy. The village is very isolated but has electricity and a telephone booth. Two partially blind boys go to a local school in a village 5 km from their home. They have never been checked by an ophthalmologist or community eye technician. In a small school in another nearby village (not more than a shed) 7 pupils out of a class of 16 children were identified with early signs of trachoma during a recent visit of the eye health team.

The members of the self help group indicate that - besides their need for income generating activities - they face the following problems, which affect all members of this small community:

- the low payment they receive for the heavy work they do: they feel cheated and exploited.
- There is a borehole and pump in the village but the pump has been out of order for three years. The women have to walk approximately 5 km to get their water.
- Because of lack of water they cannot irrigate the fields anymore, seriously reducing their yield, which now depends entirely on rainfall.

By arranging for the pump to be repaired, the CBR programme will benefit the whole community, prevent blindness due to trachoma and generate trust and support for its work.

### **Empowerment**

Empowerment is about enabling a person with disabilities to join the main stream. To say: Yes, I can! and to participate more fully in society. This involves risk taking and this is an important reason why empowerment is best done together with others who will be there to share in victories as well as in disappointments and who provide the stimulus to not give up too quickly. Persons with disabilities learn more and more to claim what is rightfully their own. In particular, they learn to ask for the realisation of what by law has been accorded to them and to advocate for new legislation where the rights of the disabled are not secure. This also implies that gross violations of the rights of disabled persons are made known and perpetrators brought to justice. In many countries, disabled persons work together in Self-help groups and Disabled people's organisations to claim financial disability benefits or pensions. They work together to obtain bank loans or medical services. The success of the one is often the incentive for another to follow the example. Projecting positive images of disabled persons in the media is important – not only to change people's perception of them - but also to present role models for other persons with disabilities to follow. Special events such as the paralympic games or the Miss Disabled beauty contest (9) are such examples.

Empowerment is to show persons with disabilities that they can make choices for themselves and grow in autonomy. All people go through stages of personal development in their lives. They learn to walk, speak, play, charm their parents, relate to peers, become independent of their parents, marry, have children, become older, play a role in society... the concrete expression of these things vary, of course, from one culture to another. Similarly, persons with a disability develop and grow and journey a life path, though with some limitations which an able-bodied person will not experience. Empowerment is about helping people (with a disability) to become people in the full sense of the word, with equal opportunities, rights and responsibilities - living a life that is fulfilling and satisfying and contributing towards happiness, quality of life and community.

For this to happen, persons with disabilities need information about what is possible; about services they can use and about rights they can claim. This includes a phase of analysis to identify problems and to understand the root cause of a problem. Disabled persons also need skills and tools that will enable them to communicate effectively and to do what is needed to make use of available services. Providing information, skills and tools are important processes to achieve empowerment.

### **Sustainability**

When we speak of sustainability in CBR programmes, we do not mean that CBR programmes should generate enough funds to pay for their own expenses. This is virtually impossible to achieve in practice. Some funds can be generated through CBR programmes e.g. by charging fees for services to those who can afford it, by charging some interest on loans (10) or by selling food, drinks and other products in a shop. In practice, however, it is impossible to recover all the costs of a CBR programme in this way.

Even so, we can still work for the long-term future of a programme by ensuring that its organisational structures are sound. Many CBR programmes are started because of the vision of one or a very small group of pioneers. They start small and informally to organise activities and communication is easy since the numbers of people involved are few. However, as the programme grows and more resources are mobilised, it is important to consolidate the original successes by formalising organisational procedures. Decision-making processes have to be defined. The vision and mission of the programme need to be (re-)formulated. Policies

need to be agreed and written up. Transparent administrative processes need to be implemented. All this is necessary to ensure that as the original leaders fade away, others will know what to do when they take over. This includes a routine of training where vision is transferred and skills are learned. Participants in the programme, both staff and clients, need to internalise the ideas that drive it. Training should encourage people to think for themselves, enable them to identify and solve problems, foster communication skills. In other words, they should be empowered so that they can take initiatives and make use of the possibilities that are available. No sustainability can happen without empowerment. Creative, participatory training methods are most likely to achieve this.

Working for sustainability also includes building stable partnerships with organisations and programmes that help the CBR programme achieve its mission. Partnerships can be formalised by a written agreement and by creating a routine of regular meetings to discuss business. In some cases, this may take the form of an advisory group to the CBR programme or a regional committee on disability. Investing in networks and organisations that are all actors in the same domain has often proved worthwhile, though direct benefits are not always visible.

An important part of building organisational relationships concerns the relationships with donor organisations. It is important that CBR managers realise that funds may be accompanied by specific demands concerning the inclusion of target groups, the choice of interventions, the implementation of administrative processes, the conduct of evaluations etc (11). They need to be able to decide to what extent such demands are consistent with their own vision and whether or not they are willing to compromise.

It will be clear from the above that Inclusion, Empowerment and Sustainability, though separate concepts, are inter-connected and dependent on each other. Together they form the essence of what CBR is all about.

### **APPLICATION TO LEPROSY**

In its Enhanced Global Strategy for Reducing the Disease Burden due to Leprosy (2011-2015) (12), WHO endorses CBR as ‘a sustainable and cost-effective approach to address rehabilitation needs of persons affected by leprosy’. The operational guidelines that detail

the implementation of this strategy (13) is an encouragement to 'Promote community-based rehabilitation activities in collaboration with other stakeholders, both from the health and non-health sectors' as this will 'ensure equity and social justice'.

The latter half of this paper addresses the question of how CBR principles are currently reflected in the way leprosy work is usually done and/or how work with persons affected by leprosy should change if one wants to bring it in line with CBR principles. This paper is not exhaustive in the treatment of this question. Rather, the authors hope to inspire the leprosy practitioners, to develop their own thoughts on how their work might be transformed to achieve more freedom and equality for persons with (leprosy-related) disabilities in the different contexts of their work.

### **Basic Services**

Leprosy work covers a wide range of activities in the domains of health, education and livelihood. Basic services include the diagnosis and medical treatment of the disease, screening programmes to detect leprosy in people who may not be aware of having it and physical and occupational therapy for those who developed impairments. Therapy teaches skills and provides means to prevent further deterioration of disability status and to maximise autonomy. In some cases, assistive devices may be indicated. Such basic health care services are a necessary condition for participation of the leprosy-affected person in society and as such do have an element of empowerment in them. The way these services are delivered, however, can help or hinder the empowerment process and here is one area for further research and reflection.

The majority of leprosy-related hospital admissions are necessary for the management of complex ulcers, usually of the foot (14). An empowering approach to ulcer-care is to teach the affected person while in hospital how to care for his own ulcers with locally available materials. This is why The Leprosy Mission (TLM) has introduced the ulcer re-admission interval as an indicator of quality hospital care. Effective self-care teaching in the hospital ward should enable the affected person to have less and less complex ulcers and thus avoid or at least delay re-admission to hospital for recurrent ulceration. Thus the re-admission rate, operationalised as the percentage of ulcer admissions that concern persons who were discharged from the ulcer ward less than 12 months ago, should decline over time once

effective self-care teaching is in place. This is now being observed in some of the monitored hospitals.

After discharge, the person is encouraged to join a community-based self-care group. Ebenso et al.(14) present evidence for the effectiveness of this approach. There is no doubt that remaining ulcer-free for extended periods of time is an important pre-condition for empowerment i.e. for actively participating in society.

Many hospitals that were originally exclusive leprosy hospitals are now offering general medical services to low income populations. This is good from a sustainability point of view but, even more importantly, it is also a move in the direction of inclusion and de-stigmatisation. One implication of this approach is that the tradition of free medical care for persons affected by leprosy needs re-thinking; equality should mean that one's contribution is based on ability to pay, not on the medical condition. These discussions are taking place and different solutions are being experimented on the ground.

The principle of empowerment is also reflected in modern approaches to the provision of footwear. Rather than giving away shoes that nobody wants to wear because of their stigmatising effect, leprosy-affected persons are now taught how to select appropriate footwear that meets their needs from the open market. Another approach, common in Brazil, is to provide soft insoles to be used in commercially available shoes (15).

### **Socio-Economic Rehabilitation**

Many anti-leprosy organisations offer vocational training to young people personally affected by leprosy or to the children of leprosy-affected persons whose background is a hindrance to employment, because of the stigma attached to the disease. Similarly, there are programmes helping people to find work or to start a form of self-employment. This may involve the provision of grants or loans either in money or in kind. The majority of such programmes exclusively or almost exclusively, target persons affected by leprosy (16). Support is usually to individuals. In general, such forms of socio-economic rehabilitation do increase income (17) and contribute to empowerment as gaining an income is as such an empowering experience (18), leading to higher self-esteem, enhancing self-reliance and helping people to gain respect from the community (19). Nevertheless, the way such programmes are organised

and implemented may lead to other forms of dependence and, again, research and reflection is needed to evaluate how this type of work can be done in the most empowering way.

Thus, the process by which people are selected for this type of programme can be empowering if it emphasises people's abilities and prospects. The way in which clients participate in choosing an intervention that they feel they can manage and that they believe will meet their need, is all important. Income generating activities should ensure that economic, functional and social abilities of clients are well-matched with the realities of markets, available capital, and the competencies of supporting institutions or organisations. At the same time, the desires of the client are of prime importance. Thus proper counselling to help client and service provider to arrive at an unforced, shared decision is needed, often with input from relatives or other community members.

In supporting education of children, parents can be given more opportunity to participate in basic decisions such as the school their child will go to when sponsored and what he / she will study there. Parents can be involved in formulating the policies of an education-support programme e.g. concerning criteria for sponsorship, what expenses will be reimbursed and what parents have to pay themselves, how to deal with children who fail an exam etc.

When people are helped to set up a shop or learn marketable skills, the principle of empowerment suggests that the opportunity should be taken to teach them basic things about functioning in society, how to open a bank account, how to participate in elections or how to access government services. Ultimately, all interventions of this type must be temporary and come to an end point where the clients can manage on their own.

More and more, socio-economic rehabilitation programmes bring their clients together in groups, even if support is given on an individual basis. Selection of participants for support can then take place in the group setting, where everyone can give inputs into the decision making process. Although not every client can participate in a group, the exchange of experiences and the mutual encouragement are in many instances empowering in themselves, even apart from the interventions.

In terms of sustainability, the organisational structure of socio-economic rehabilitation programmes needs attention (16). A board or advisory group should be formed in which all stakeholders are represented i.e. the staff, the target group, the community, local authorities

and partner organisation; enough expertise about the type of work that is being done should be present.

### **From a Leprosy focus to inclusive CBR**

There is growing consensus among people working in leprosy rehabilitation that if one wants to realise the CBR principle of inclusion for persons affected by leprosy, it is necessary to move from programmes working exclusively with leprosy-affected people to multi-disability programmes i.e. programmes in which people with all kinds of disability due to a variety of causes participate (20). If the burden of leprosy-related stigma (21) has to be lifted, leprosy-affected persons need to join in the disability movement and advocate for their rights as defined in the UN Convention on the Rights of Persons with Disabilities (5). The future as outlined by the CRPD and the draft guidelines for CBR (2, 3) is one of gradual integration, mainstreaming, of persons with disabilities in society. If leprosy-affected people want to have a part in this movement, it is essential that they join in at the earliest opportunity. Thus this is a choice made on the basis of principle, not primarily based on considerations of economy or efficiency. Integration of leprosy into general disability rather than exclusive programmes is what ultimately offers the best future for people affected by leprosy. The WHO Global strategy for leprosy (12) states: 'It is not only pragmatic but beneficial for people affected by leprosy to be integrated into programmes that may already have been established for the rehabilitation of other disadvantaged people'.

WHO's operational guidelines for leprosy programmes (13) leave no doubt that this should be part of the practice: 'Persons affected by leprosy who are in need of rehabilitation should have access to any existing (general) rehabilitation services. Similarly, where leprosy-specific rehabilitation services are available, people with other disabilities should be given access. This facilitates integration, helps to break down stigma and promotes sustainability of rehabilitation services'. This view is shared by the international self-organisation of persons affected by leprosy, IDEA (22). Looked at it from another angle, leprosy rehabilitation programmes have a lot to contribute to general rehabilitation programmes in terms of leprosy-related skills and resources (e.g. wound care, self-care, footwear etc.), while the experience of more general CBR programmes can enrich the existing leprosy programmes. As an example, the potential for leprosy workers to contribute expertise to programmes for persons

disabled through diabetes is well-known though not much practised. Similarly, there is scope for self-care groups which include persons suffering from Buruli ulcer or lymphatic filariasis (15). By integrating disability care and rehabilitation for people who have become disabled through a range of causes but have similar impairments or activity limitations, it will be possible to achieve a wider coverage in contexts in which coverage has been traditionally low, which really means that many disabled persons there, will have been deprived of even the most basic rehabilitation services.

Research is needed to document different strategies to achieve integration and evaluate the relative effectiveness of each of them. Studies should be designed recognising that the way this integration is achieved will vary from one context to another. However, it is clear that needs-based planning, networking, resource sharing and multi-sectoral co-operation with governments will be key strategic approaches. It would appear that it is important to build up the strength and sense of identity of a leprosy rehabilitation programme or organisation and that this will aid in making the transition to a multi-disability programme easier - stronger leprosy organisations integrate more easily.

### **Barriers to Integration**

Given that current practice in most leprosy rehabilitation programmes is to exclusively target persons affected by leprosy, applying CBR principles is an important change and it is good to recognise the difficulties that such a transition would encounter.

First of all, then, there is the fact that most of the funds for leprosy rehabilitation come from charities who solicit donations from the general public. A lot of these donations are asked and received specifically for leprosy work and integration will require that people who give are helped to understand that their donations will be used in integrated settings benefiting both persons affected by leprosy and persons with disabilities due to other causes. For this to happen, it is important that leading professionals who are involved in shaping the policies of NGOs working in the field of leprosy, support the vision of integration of leprosy rehabilitation into multi-disability programmes. This is not self-evident and will require discussion and consensus building.

Where participants in rehabilitation programmes are encouraged to share resources or join in the same self-care or self-help group with persons affected by leprosy, stigma and self-

stigma will play a role. Aversion to people affected by leprosy is a behaviour often learned from early childhood that is shared by persons with disabilities and does not simply go away after a stimulating speech about solidarity. Leprosy affected persons themselves from their side have often become so used to rejection that they do not want to integrate with others (self-stigma) and prefer to manage by themselves. In addition, certain material benefits are available to them through exclusive leprosy programmes which they may be afraid to lose as a result of integration. Lastly, managers of rehabilitation programmes may well feel that integration leads to more confusion and that more sharing and networking will reduce their chances to distinguish themselves and show success. Clearly, much wisdom and persuasion is needed to bring about integration.

#### **Integration: some experiences**

Over the past five years, TLM gained experience with multi-disability programmes in India, where self-help groups were formed in which members were encouraged to apply for disability privileges, old-age pensions, assistive devices, medical care for disabled children etc. Group members contributed a fixed sum of money at each meeting and groups which could demonstrate an ability to manage these funds were given loans to fund income generating activities.

In the STEP programme in Nepal, groups of persons affected by leprosy met to encourage each other to practise self-care to prevent ulceration of hands and feet. These groups were transformed into self-help groups which were so successful at generating income, that people unaffected by leprosy asked to join and were gradually included (23, 25).

In Darfur in Sudan, the Nyala Society of the Disabled did not include people affected by leprosy. Once TLM had started to support the society, however, members agreed to open membership to persons affected by leprosy and accommodate a weekly clinic where multi-drug therapy was dispensed.

In the province of Cabo del Gado in Mozambique a disabled people's organisation ADEMO was created, which included persons affected by leprosy. However, after some time, the leprosy-affected members decided to break away and start their own organisation called ALEMO. The two organisations now exist side by side.

The Ethiopian National Association of People Affected by Leprosy (ENAPAL) is exclusively for persons affected by leprosy, but ENAPAL is a founding member of the Ethiopian Federation of Persons with Disabilities, EFPD, which brings together associations of the blind, the deaf, the physically handicapped and of mentally retarded children and Youth (26).

## **CONCLUSION**

So, if our vision is to integrate persons affected by leprosy with other disabled people, is there no longer a place for special leprosy programmes? The answer to that question needs a bit of reflection. What is the future or what do we want it to be?

For the time being, special programmes are the norm. The reality is that there is a multitude of leprosy organisations which support exclusive leprosy programmes and do not appear to need other disability organisations for their survival. This is the result of a long history of decades of isolation. To reverse that trend will take time. It is important to realise that some people have been affected by leprosy for most of their lives and are unlikely to make the step to integrated programmes.

This is why a twin-track approach (8) is recommended, which will integrate those who can but will provide for the specific needs of leprosy-affected persons who cannot. It is likely that expertise concerning leprosy will not be available in general disability programmes and this expertise will continue to be needed as new patients are diagnosed every year. Thus it will be important to diagnose, treat and rehabilitate new patients in such a way that they are prepared for joining the mainstream in the process.

In conclusion, the authors believe that leprosy organisations have a lot of re-thinking to do, reviewing their work in light of the three CBR principles of Inclusion, Empowerment and Sustainability. Operational research needs to be started up which will document the effects of the experiments and pilot programmes that are going to be developed as a result.

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