The Asia and Pacific Region: Rural-Urban Impact on Disability

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Overview

This chapter will provide a view into the Asia and Pacific regional systems, policy changes, and socioeconomic development programs that are initiated to address disability issue as they relate to prevention, rehabilitation, and maintenance in the region. The following objectives are specific to discuss the demographical, social, political, and economical changes of this region and how these changes impact the quality of life in individuals with disabilities. Further, this chapter will also present the contributions from various entities from the United Nations, international organizations, national governments, and nongovernment organizations, including grassroots organizations with respect to working with persons with disabilities.

Learning Objectives

1. Define the Asia and Pacific region.
2. Understand the socioeconomic and cultural implications of the Asia and Pacific region.
3. Identify the demographical, social, political, and economical changes of the region and its implications to the populations of persons with disabilities.
4. Examine the ongoing efforts of community-based rehabilitation and disability-related policies, programs, and services.
5. Review national and international works and contributions.

Introduction: Overview of the Asia and Pacific Region

The Asia and the Pacific region is home to over 4.4 billion people or 60% of the global population, accounts for over 40% of the global economy, and is home to nearly 70% of the world's poor and most vulnerable populations including people with disabilities who are scattered throughout rural areas or crowded into towns and cities on a land area of almost 45 million km^2, roughly 17% of the world's surface. The region has a highly varied range of climatic and agro-ecological zones with large areas that have been affected by climate, natural disasters, and social degradation over the past 50 years including drier areas that are particularly vulnerable, and 39% of the region's population lives in areas prone to drought and desertification.

The Asia and Pacific region is divided into five subregional areas: East and Northeast Asia, North and Central Asia, Pacific, South and Southwest Asia, and Southeast Asia. It is a multicultural diverse region with seven of the world's ten most populous countries and also

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D.A. Harley et al. (eds.), *Disability and Vocational Rehabilitation in Rural Settings*,
DOI 10.1007/978-3-319-64786-9_17

some of the world's smallest island nations and territories in the Pacific. Geographically, it ranges from fragile Small Island Developing States in the Pacific to populous and vast plains of South and Southeast Asia, as well as the mountainous, landlocked countries of Central Asia (UN-ESCAP, 2015).

Poverty in Asia is a massive problem affecting all populations. Reducing poverty for large numbers of poor people was considered crucial to achieving the primary UN Millennium Development Goal of reducing poverty. Disability issues have increasingly become important factors in poverty reduction efforts, as there is a higher rate of disability among the poor. It is also noticeable that poverty reduction programs have become the major approach to resolve issues of persons with disabilities in rural areas as a high percentage of disabled persons in the rural area are among the poorest of the poor. More than two thirds of the world's poor people live in Asia, and nearly half of them are in Southern Asia. The same situation is evident among the population in the Pacific island nations. Poverty is basically a rural problem in Asia: in the major countries, 80–90% of poor people live in underdeveloped isolated rural areas. While Eastern Asia and Southeastern Asia have made impressive progress in reducing rural poverty over the past three decades, progress has been limited in Southern Asia. Natural disasters such as tsunamis and earthquakes that have struck the region will be taking a toll for years to come in Indonesia, Maldives, Sri Lanka, and Thailand among other regional and coastal areas.

Despite wide-ranging diversities in the region, many poor rural people in Asia share a number of economic, demographic, and social characteristics, the most common of which is landlessness or limited access to land. Poor rural households tend to have larger families, less education, and higher underemployment and unemployed. They also lack basic conveniences such as safe water supply, sanitation, and electricity. Their access to financial credit, equipment, and technology is severely limited. Other constraints, including the lack of market information, business and negotiating experience, and collective organizations, deprive them of the power to compete on equal terms in the marketplace. All of these factors severely affect quality of life of the regional population including people with disabilities.

In 2010, approximately 43% of the Asia and the Pacific population lived in urban areas, the second lowest urban proportion of a region in the world; however, in the last two decades, the Asia-Pacific urban proportion has risen by 29%, more than any other region. Between 2005 and 2010, the urbanized proportion of the world's population overtook the rural population (rising from 49% in 2005 to 51% in 2010); and the urban population continues to grow (the average annual growth between 2005 and 2010 was 1.9%) mostly of poor and close to poverty-level populations. As of 2010, Asia and the Pacific is the second least urbanized region of the world, with only 43% of the population living in urban areas; however, it has the second fastest urban population growth rate, at an average of 2.0% per year (2005–2010). Across the Asia-Pacific region, the urban proportion and urban population growth rates vary dramatically (UN World Population, 2015). The rural economy has become increasingly linked to a rapidly integrating world economy, and the rural society in Asia and the Pacific region faces new opportunities and challenges. The transformation of rural Asia and Pacific has been also combined by some troubling development and that is the significant gap between the rich and the poor. While large part of the region has prospered, Asia and most of the Pacific region remains home to the majority of the world's poor. Growing inequalities and rising expectations in many parts of rural Asia and the Pacific have increased the urgency of tackling the problems of rural extreme poverty. The rapid exploitation of natural resources is threatening the sustainability of the drive for higher productivity and incomes in some rural areas and in general is affecting the entire region.

The regional growing population and booming economies, in some area, exert considerable strain on the region's society and economic and environmental resources. Similar to other world

regions with developing nations and vast diverse populations, not enough has been done to equalize opportunities for those who want to contribute to their communities and want to participate in a growing society. As expected the most vulnerable groups (women, children, persons with disabilities, and the aging populations), in particular those living in rural and isolated areas, are at the bottom of the socioeconomic scales and continue to have multiple barriers to access and participation in all facets of society.

In countries undergoing a rapid transition from underdeveloped to developing and moving toward industrialized modernization such as the case of the People's Republic of China (PRC), we can still see evidence of poverty and disability. It is estimated that in China there were about 20 million impoverished disabled people in 1992. Among the disabled poor in rural areas, 30% lived in state-designated impoverished counties. One third of the total poor populations are persons with disabilities in China (ILO, 2002). Over the past two decades, a series of positive legislative and administrative action has been developed for the purpose of improving the living conditions and social status of people with disabilities in the country. The Constitution (enacted in 1982 and amended in 1988, 1993, 1999, and 2004) provides a general principle on the protection of people with disabilities. The Law on the Protection of Disabled Persons (enacted in 1991 and amended in 2008) is of significant importance to safeguard the rights of people with disabilities. It addresses issues of rehabilitation, education, employment, cultural life, welfare, access, and legal liability, among other social issues. The amendment added details about stable financial support, disability pensions, accessible medical care, and rehabilitation services for persons with disability, along with favorable job opportunities and tax policies.

The China Employment Regulation and the Education Regulation for people with disabilities were adopted in 1994 and reinforced by amendments in 2007, respectively, to promote equality, participation, and social inclusion, as well as to prohibit discrimination based on disability.

In addition, more than 50 PRC national laws contain specific provisions concerning people with disabilities, including the new Law on Employment Promotion. China is also advocating and supporting international standards to protect and promote the rights of people with disabilities in a comprehensive manner. The Chinese government has ratified the ILO Convention No. 159 on Vocational Training and Employment (of Disabled Persons) drafted in 1988 and the UN Convention on the Rights of People with Disabilities in 2008, to enable people with disabilities to secure, retain, and advance in suitable employment and to further enjoy integration or reintegration into society.

The organization and work of local nongovernmental organizations such as organizations of parents of children with disabilities at the local community level are more evident now than ever as they work in collaboration with the local entities responsible for disability-related work and other international partners such as WHO and ILO and academic institutions from different Western countries. The most recognizable government-based organization in China is the China Disabled Persons' Federation (CDPF). The CDPF was established in 1988, and it is a unified organization of and for the 83 million persons with various categories of disabilities in China. It has a nationwide umbrella network reaching every part of China with about 90,000 full-time workers and over 400,000 part-time workers who provide services, support, and advocate for persons with disabilities.

The CDPF performs three functions: (1) represent interests of people with disabilities in China and help protect their legitimate rights, (2) provide comprehensive and effective services to disabled people, and (3) commissioned by the Chinese government to supervise affairs relating to people with disabilities in China. The CDPF is committed to improving the lives of people with disabilities, protect the human rights of people with disabilities, and promote the integration of people with disabilities in all aspects of society in China. Much progress is being observed on these efforts and more is expected in years to come (CDPF, 2015).

International Partner Efforts in the Region

Among international partners working in the Asia and Pacific region is the United Nations Environment Programme (UNEP) organization which was established in 1972 to guide and coordinate environmental activities within the United Nations (UN) system for the region. UNEP promotes international cooperation on environmental issues, provides guidance to UN organizations in the field, and, through its advisory groups, encourages the international scientific community to participate in formulating policy for many of the UN's environmental projects spread throughout the region. The UNEP Headquarters is located in the African region in Nairobi, Kenya, from which all world region offices are reached and organize participation by the private sector to promote the sustainable use of the world's natural resources that will benefit the society. UNEP has been one of the UN system organizations that conduct significant work in the region, and it operates through its Regional Office for Asia and the Pacific based in Bangkok, Thailand, working in 41 countries in the region. UNEP works with governments, local authorities, civil society, other UN entities, regional and international institutions, as well as grassroots organizations and the private sector to develop and implement operational policies and strategies that transform efficient use of the region's natural assets and reduce degradation of the environment, communities, and risks to both populations and the socioeconomic development of the region. Despite expanding economies and an accelerated pace of change across the Asia and Pacific region, more than 700 million people continue living in multidimensional poverty in the region. Most recently, surge in urbanization has seen the region's slum population top more than 250 million people, where significant numbers of persons with disabilities are found to be living in substandard conditions (UNEP & UNEP Asia-Pacific, 2015).

By all indications of the region's present situation, it is obvious that another generation of regional children and youths in the Asia and Pacific region is experiencing a high risk of life hardship, lack of preventable disabling conditions, lack of accessible and affordable health care and rehabilitation services, and lack of education and is subject of different types of exploitation. These facts indicate the need for a deeper understanding of the issues faced by the poorest of the poor and most vulnerable people with disabilities in over 52 countries and related territories where there is also a dire need to implement socioeconomic development projects to improve the living conditions of vulnerable populations, among them, individuals with significant disabilities in Asia and the Pacific region.

Disability Statistics in Asia and Pacific Region

The prevalence of disability in the region is an important epidemiological activity to look into because it can provide a clear picture of disability statistics. According to the World Health Organization's (WHO) global estimation, one out of ten persons has some type of disability, and in the Asia and Pacific region, it is estimated that there are over 650 million people with disabilities, comprising two thirds of the world's disabled population who have a diagnosed disability. Among them, over 80% are estimated to live in the rural areas of developing countries of the region. However, these figures are not substantiated by any statistic methods, as collecting internationally comparable data on disability, in particular in rural isolated areas, is a challenging task for local governments and international partners (WHO, 2015).

In the majority of the countries and areas of East Asia and the Pacific region, similar to other countries in the developing world, it is difficult to ascertain the prevalence of disability. A major concern for policy makers and personnel working in the field of disability formulating policies and implementing programs to meet the needs of persons with disabilities is a deficiency of disability statistics and inaccuracy of whatever data is available. According to WHO (2011), in regional areas where disability data are seldom collected,

it is usually because of the low priority accorded to disability issues by the relevant national agencies compounded by the multiple barriers that may exist to locate and confirm disability cases among the population.

The existing reports and data indicate that disability issues represent a global burden, and it is estimated that there are over one billion people with disabilities in the world. This corresponds to about 15% of the world's population (WHO, 2012). In the Asia and Pacific region, disability is a significant burden due to the lack of resources to be allocated to deal with disability issues.

Disability is more common among children, women, young adults, and the elderly who are among the poorest populations. The WHO (2013) further indicated that people with disabilities face widespread barriers in accessing services in health care, rehabilitation services, education, and accessible transportation including employment opportunities.

The number of people with disability in the region is expected to rise over the next decades due to civil unrests and wars, population aging, natural disasters, chronic health conditions, road traffic injuries, poor working conditions, and other factors (WHO, 2012). People with disabilities generally have poorer health, lower education achievements or no access to education at all, fewer economic opportunities, and higher rates of poverty. This is largely due to the barriers they face and living situations, rather than their disability. Disability is not only a public health issue but also a human rights and socio-development issue. Disability issues in the region have been studied and analyzed by numerous international professionals and local civil and governmental organizations. The WHO, as part of the United Nations system, has made significant efforts to support regional UN member states to address disability. These multinational efforts are guided by the overarching principles and approaches reflected in the WHO global disability action plan 2014–2021 (2014), The *World Report on Disability* (2011), and the UN Convention on the Rights of Persons with Disabilities (2006).

According to the WHO global disability action plan 2014–2021, the *World Report on Disability*, and the Convention on the Rights of Persons with Disabilities, despite the constant increase in their numbers, persons with disabilities tend to be unseen, unheard, and uncounted. This situation is no different in the Asia and Pacific region with its diverse populations of persons with disabilities. They are often excluded from access to education, employment, social protection services, and legal support systems and are subject to disproportionately high rates of health issues and extreme poverty. Persons with disabilities continue to face both barriers in their participation as equal members of society and are violated of their most basic human rights (WHO, 2014).

An International Perspective of the Etiology of Disability

According to the World Health Organization (2011), "disability" can simply be defined as the umbrella term for impairments, activity limitations, and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors) (WHO, 2011).

Disability is part of the human condition, and it is perceived and treated differently in different parts of the world. Almost everyone will be temporarily or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulties in functioning. Most extended families have a family member with a disability, and many nondisabled people take responsibility for supporting and caring for their relatives and friends with disabilities (Ferguson, 2001; Mishra & Gupta, 2006; Zola, 1989). Every era has faced the moral and political issue of how best to include and support people with disabilities. The implications of disabilities will become more acute as the demographics of societies change and more people live beyond the expected life span to advance old age (Lee, 2003).

We are often challenged by the question: What is a disability? Based on numerous sources, while applying a global perspective, we can state that a disability is a condition or function judged to be significantly impaired relative to the usual standard of an individual or group. The term is used to refer to individual functioning, including physical impairment, sensory impairment, cognitive impairment, intellectual impairment, mental illness, and various types of chronic disabling diseases (Quinn & Degener, 2002).

Disability is conceptualized as being a multidimensional experience for the person involved. There may be effects on organs or body parts, and there may be effects on a person's participation in areas of everyday life. Correspondingly, three dimensions of disability are recognized by the International Classification of Functioning, Disability and Health, also known as ICF. The ICF is a classification of the health components of functioning and disability: *body structure and function* (and impairment thereof), *activity* (and activity restrictions), and *participation* (and participation restrictions) (WHO ICF, 2001). The World Health Organization's Assembly held on May 22, 2001, approved the International Classification of Functioning, Disability, and Health and its abbreviation of "ICF." The ICF classification also recognizes the role of physical and social environmental factors in affecting disability outcomes and defining what a disability is in different contexts such as individual and socioeconomic and social inclusion (WHO, 2011).

As indicated above, disability is complex, dynamic, multidimensional, and contested. Over recent decades, movement of persons with disabilities and their organizations together with numerous researchers from the social, rehabilitation, and health sciences (Barnes, 1991; Charlton, 1998; Driedger, 1989 and McConachie, 2006) have identified the role of social and physical barriers in disability. A positive outcome of the interpretation of the ICF, at the international level, has had a significant transition from an individual, medical perspective to a structural, social perspective which has been described as the shift from a "medical model" to a "social model" in which people are viewed as being disabled by society rather than by the condition of their bodies (Oliver, 1990).

While considering the etiology of disability, first we need to acknowledge the diversity and complexity of disability. The disability experience resulting from the interaction of health conditions, personal factors, and environmental factors varies greatly. Persons with disabilities are diverse and heterogeneous, while stereotypical views of disability emphasize wheelchair users and a few other "classic" or common groups such as people with visual impairment or blindness and people who are hearing impaired or deaf (Dalal, 2006). Disability encompasses the child born with a congenital condition such as cerebral palsy (CP) or the young soldier who loses his leg to a land mine or the middle-aged woman with severe arthritis or the older person with dementia, among many others. Looking into the etiology of disability, we come to understand that health conditions can be visible or invisible; temporary or long term; static, episodic, or degenerating; and painful or inconsequential. It is also important to note that many people with disabilities do not consider themselves to be unhealthy (Watson, 2002). For example, 40% of people with severe or profound disability who responded to the 2007–2008 Australian National Health Survey rated their health as good, very good, or excellent in spite of whatever disability they may have been diagnosed to have by the medical healthcare professional (National Health Survey, 2009). This demonstrated the continuation of life with a disability without major concerns of being "unhealthy" or perceived as being "sick."

Generalizations about "disability" or "people with disabilities" can be misleading. Persons with disabilities have diverse personal factors with differences in gender, age, socioeconomic status, sexuality, ethnicity, or cultural heritage. Each has his or her personal preferences and responses to disability (London Disability Rights Commission, 2007). Also while disability correlates with disadvantage, not all people with disabilities in all world regions are equally disadvantaged. A good example of disability-based experience is the unique interaction of the disability and the person worldwide. Women

with disabilities experience the combined women with disabilities experience and disadvantages associated with their gender as well as the disability and may be less likely to have a similar lifestyle as nondisabled women (Nagata, 2003; Rao, 2010). People who experience mental health conditions or intellectual impairments appear to be more disadvantaged in many settings than those who experience physical or sensory impairments (Roulstone & Barnes, 2005). People with more severe impairments often experience greater disadvantage, as shown by evidence ranging from the Asia and Pacific region and employment data from various countries in the region in rural and urban settings. Conversely, wealth and social status can help overcome activity limitations and participation restrictions for some but not for many across the region (Grammenos, 2003). The etiology of disability and its definition can give us information about the medically diagnosed type of disability, symptoms, prognosis, and health-related consequences affecting the life course of the person, but it cannot tell us much about other important factors of disability such as culturally based perceptions of disability, characteristics of the person, living conditions, and rehabilitation outcomes, if rehabilitation services were to be provided.

Cultural Implications of Disability and Rehabilitation Practice

Culture has been conceptualized and defined by scholars as the multiple historical, sociopolitical, and organizing systems of meaning, knowledge, and daily living that involve patterns of being, believing, bonding, belonging, behaving, and becoming which provide foundational frames for developing worldview, interpreting reality, and acting in the world for a group of people who share common ancestry, social location, group identity, or defining experiential context. All of these factors are very evident in the diversity of the Asia and Pacific region. This concept can be applied to individuals or intersectional subgroups, where particular elements of a cultural system may be embraced, internalized, and expressed differently. Cultural systems emerge and transform over time through cumulative and adaptation-oriented person-environment transactions and are maintained and transmitted through collective memory, narrative, and socialization processes. Cultural systems are dynamic while simultaneously being embedded in social and institutional contexts, internalized as patterns of meaning and identity, expressed through actions and relationships, and interactive with coexisting cultural systems that reflect the multiple dimensions of human diversity that carry culture (Chao & Kesebir, 2013).

Cultural factors influence attitudes toward everything that takes place around us, including our attitudes toward disability, persons with disabilities, and rehabilitation practices. The term "handicap" commonly applied to disability is defined in relation to contextual factors that are predominantly cultural. Though the influence of cultural factors is great, often rehabilitation practice and community-based rehabilitation (CBR) programs in the provision of rehabilitation services fail to recognize culture as a major characteristic of the individual or groups with disabilities. Western stereotypes of "community" are used in the planning of many rehabilitation service programs and CBR programs in developing countries whose communities have their own individuality. These programs expose themselves to a higher risk of failure because they tend to conflict, with the cultural factors of the host country or community. An illustration of the significant implications of cultural influences on disability and rehabilitation, in the context of CBR, can explain the importance of culture, disability, and rehabilitation. In many developing countries, "individual rights" as expressed in industrialized nations does not exist. Traditionally in these countries, an individual is born in a kinship group, with a network of relationships that involve mutual obligations with regard to religious and economic factors. People look toward their immediate family member for protection, welfare, and help, rather than at the traditional Western types of formal human or social services. Because of this kind of relationship, the process of "empowerment" of an individual in

this society is more complex, irrespective of whether he/she is a person with a disability or otherwise. Therefore, during planning of medical or vocational rehabilitation programs, one has to also consider the different aspects of cultural influences in these countries.

According to Yuenwah (2012), the Asia and Pacific region has a rich heritage of values and practices for community self-reliance and balanced resource use. "Gotong royong" (a concept of reciprocity or mutual help, common in Indonesia and Malaysia) and "Saemaul Undong" (an integrated rural development movement initiated in the Republic of Korea and based on the spirit of diligence, self-help, and cooperation) are just two examples.

These cultural resources lend themselves to CBR. They could give fresh impetus to a community-driven, self-help movement for change. This would take us one step closer to correcting a skewed development path that has left in its wake so much inequality and pain. In addressing development issues, be they chronic ones like poverty and inequality or dramatic, newer challenges such as urbanization and population aging, CBR could catalyze a new era of community action for inclusive growth and sustainability.

We also need to look back at previous studies and assessments of the region that set the path for the improvements of today. According to Rehman (1999), the influence of traditional values and religious beliefs on the practice of CBR in the North West Frontier Province of Pakistan illustrates this point very well. Rehman describes how cultural factors influence the outcome of CBR and explains how certain culturally based modifications were introduced in rural areas of Pakistan, to align to CBR services appropriately to the traditions and customs prevalent to the Pakistani rural areas. A review by Coleridge (1993), on the history of "negative attitude" toward people with disabilities, concludes that "attitude" toward people with disabilities was not always "negative" and that historically it had been a mixture of "tolerance" combined with "persecution." These attitudes, however, influence the perception of the causation of disability, reactions toward people with disabilities, disability-related child-rearing practices, education, and vocational rehabilitation of people with disabilities. In another review of cultural influences on planning and providing rehabilitation, Miles (1996) analyzed the reasons for Western misinterpretation of cultural variables and the effects of this misinterpretation on South Asian countries' disability planning.

Cultural factors are described in the broad sense as a set of variables related to tradition, ethnicity, and religion, grouped together into a single entity. This is not different when we describe the culture of people with disabilities in the world's regions. Even across the population of a single country, there are substantial differences in ethnicity, caste, religious practices, and so on, which are recognized by different social laws applying to different groups within the same nation. What seems to be ethically correct behavior in one group of people may not be recognized as such by a different cultural community. The recognition of these kinds of differences in the perception of "normalcy" and "disability" is very important in the case of rehabilitation, since what is considered a "handicap" in one cultural context may be considered normal in another context. For example, Benares, a place of worship in India, had most of its blind people living in their homes and begging in the streets of the town during the day. They could earn more money begging and living at home and preferred to do this, rather than stay in an asylum where begging was forbidden or receiving vocational rehabilitation with the goal of becoming employed. Unless someone who was truly destitute and disabled and unable to earn a living, a person with a disability would not want to seek shelter in an asylum (Miles, 1994). If the Western ideologies related to human rights and community-based rehabilitation are applied in the community of these people who are blind without due regard to the indigenous concepts of community-accepted behavior, this effort would more likely fail in any attempt to implement rehabilitation practice.

Rehabilitation Service Practice

During the past two decades, the World Health Organization (WHO), the International Labour Organization (ILO), and the United Nations

Development Programme (UNDP) have made great efforts to promote a more cost-effective, home-based, and culturally based rehabilitation services delivery system which is designed as a "community therapy program" also known as CBR, in developing countries in particular throughout the Asia and Pacific region. In the beginning, this model-practiced community-located interventions was nearly identical to that of the clinical setting in institutions, dealing primarily with disabling impairments. Gradually, it was recognized that these programs did not produce the desired impact unless the extrinsic cultural factors were recognized and incorporated and goals modified accordingly to each community. In 1994, the UN system organizations, jointly, reviewed CBR practices with a different perspective and emphasized the contributions from external contextual factors (disability, culture, and rehabilitation). The goal of the CBR programs was redefined as integration for persons with disabilities within their communities, rather than an attempt for relief of impairment or disability among disabled persons (ILO, UNESCO, & WHO, 1994). This broader view of CBR in the community development perspective reduces the importance of medical rehabilitation and medical model into a less significant peripheral activity within society.

In the Asia and Pacific region from developed to developing countries to island nations, the aim of this pattern of evolution and development of rehabilitation services has been to increase coverage and to gain access to the required resources from the community. However, there were insufficient efforts at promoting community ownership in these programs. As a result, they were most often practiced with a "top-down" management style and rarely did the practitioners take into account the relevance of sociocultural factors. The rural communities in developing countries are often exposed to severe economic pressures and daily living hardships. During this time, their primary focus shifts to survival and overcoming poverty rather than dealing with disability. This can also be better understood from the explanation of Ranganathananda (1995) about Indian democracy stating that "citizenship" as an identity entailing community responsibility is weak in much of South Asia. The members of the society expect the rulers such as governmental and community leaders to shoulder the entire responsibility of the society, while they consider themselves free of societal responsibilities. In these societies, participation and bottom-up management styles are not practiced and can only be brought about by preplanned strategies.

There are many other specific areas of cultural influences that affect disability and rehabilitation. Many of them have been recognized by different authors practicing CBR in different parts of the world. For example, the Afghan society views "empowerment" in a different light from the Western societies. In Afghanistan as in many Asian countries, "empowerment" of the individual, as seen in the Western context, is perceived as being selfish and undesirable. Being altruistic for the sake of the family and for the larger society has a higher value. The term "empowerment" can at best be interpreted only as a right to access provisions and services on an equal footing as others. Similarly, women in Afghan society remain segregated from men, and "integration" of disabled women into the "community" is perceived in a different context from the Western societies, as an integration into the subgroup of segregated women. Rehman (1999) has written about CBR programs that have been successfully practiced in these conditions, by adopting unusual strategies that were suitable for the cultural context of the country in which the programs operate. Another example is from the CBR program in Rupununi, a Guyanese village, as reported by Pierre (1995). The Rupununi villagers have a rudimentary style of living, which facilitates spontaneous rehabilitation of hearing-impaired people as farmers, fishermen, and cooks and where blind persons can go fishing sometimes. The Rupununi CBR program assimilated ideas from the spontaneous rehabilitation practices that had already existed in this community, to design training materials that were appropriate to their cultural requirements. There are also other reports of traditional "attitudes" which influence the outcome of rehabilitation positively as well as negatively (Khatleli et al., 1995; Thorburn, 1998).

The Asia and Pacific region is a good example of decentralization of rehabilitation services into

the community and integration of disabled persons into their society that calls for closer interactions with cultural factors. It is important to remember that rehabilitation is a gradual and long process that cannot escape the influences of local cultural factors, and therefore it is difficult to propose a universal theory for all aspects of rehabilitation, just as it is difficult to have a universal model for interventions in rehabilitation.

The System of Service Delivery in Rural Areas

Living in rural areas in the Asia and Pacific region poses particular challenges for people with disabilities in accessing education, vocational training, and employment opportunities. Dismantling the barriers that rural people with disability face enables them to improve their livelihoods and those of their families and take an active role in rural economic development. The removal of socioeconomic and environmental barrier is of vital importance for the empowering of people with disabilities in rural areas and for rural development (ILO, 2010).

People with disabilities, young and old, who live in rural areas where essential services are often limited or nonexistent face difficulties seldom encountered in urban areas. Access to housing, transportation, employment, educational programs, and specialized health care are some of the challenging issues found throughout the rural parts of the region. It is said that "where there is a will there is a way," but this can be difficult for people with disabilities in particular for those living in isolated rural areas. However, communities can help people with disabilities by looking for ways to partner and creatively use limited resources to provide basic needed services (UNESCAP, 2015).

The regional rehabilitation systems of service delivery are organized and provided by community-based rehabilitation agencies. Community-based rehabilitation (CBR) schemes have been in existence since the early 1960s in many developing countries (Miles, 1985). However, CBR received increased attention by being identified by WHO as an innovative new approach to replace the institution-based approach, alongside the trend of Primary Health Care (PHC) toward the realization of the goal of the Alma-Ata Declaration "health for all by the year 2000" (Lysack, 1992; Nakanishi & Kuno, 1997). At the same time, Tjandrakusuma et al. (1995) developed an approach which focused on the aspect of community participation and included consciousness raising and community organization in its program in Indonesia.

Community-Based Rehabilitation and Other Related Services for People with Disabilities

Community-based rehabilitation (CBR) is a developing concept and approach. Although the first definition of CBR in 1981 by WHO emphasized service delivery at the community level, the importance of the social development aspect was gradually recognized and explained as a "democratization of rehabilitation" in WHO's CBR manual (Helander, 1998). This trend has been developed further, and CBR is defined as follows: community-based rehabilitation is a strategy within community development for the rehabilitation, equalization of opportunities, and social integration of all people with disabilities. CBR is implemented through the combined efforts of persons with disabilities, their families, and communities and the appropriate health, education, vocational, and social services (ILO, UNESCO, & WHO, 1994). Likewise, many CBR practitioners define CBR by including two important characteristics: the appliance of community development approaches, not merely an expansion of rehabilitative service delivery at community level, hence focusing on participation and empowerment of the community including disabled people, and comprehensiveness in terms of programs and participants. There are three approaches to CBR. WHO divides approaches in rehabilitation into three types, institution-based (IB) approach, outreach (OR) approach, and community-based (CB) approach in its manual, and this distinction is accepted widely by CBR

practitioners. Nakanishi (1989) contrasts CB and IB/OR from a civil rights movement point of view and emphasizes this distinction in order to clarify who controls the resources, although she recognizes that the differences between these two approaches in practice are primarily a matter of degree rather than their being at either extreme (ESCAP, 1989). On the other hand, Tjandrakusuma (1995) indicated that it would fail to provide a true understanding of CBR to explain CBR as being in a dichotomy with IB, as CBR is neither in opposition to IB nor do they complement each other. CBR should be thought of as an entire continuum, or system, with many different aspects. Although these explanations of approaches seem different, they share the fundamental concept described in the definition of CBR and may be synthesized based on the type of services provided. Basically the services range from an at-home assessment, referral for medical services, physical therapy, and vocational services ranging from literacy to continuing education and skill development for employment. Employment can be found with private industries or with the type of shelter workshops similar to other Western countries.

Community-based rehabilitation (CBR), as mentioned above, is "a strategy that can address the needs of people with disabilities within their communities in all countries. This strategy promotes community leadership and the full participation of people with disabilities and their organizations. It promotes multi-sectoral collaboration to support community needs and activities, and collaboration between all groups that can contribute to meeting its goals" (WHO, ILO, UNESCO, and IDDC (2010). The following are some regional nations that have taken an active action in making improvement in favor of their population with disabilities:

- In the Asia and Pacific region, CBR focuses on enhancing the quality of life for people with disabilities and their families, meeting basic needs and ensuring inclusion and participation to empower people with disabilities to access and benefit from education, employment, and health and to have meaningful social roles and responsibilities and to be treated as equal members of society.
- In regional countries of Bhutan and Myanmar, CBR programs are implemented through the primary health-care system.
- In Nepal, CBR programs are implemented in 35 districts by local nongovernmental organizations (NGOs), with the central government providing funding, direction, advice, and monitoring at the national and district levels.
- In India and Sri Lanka, ministries of social welfare have national CBR programs.
- International migration and disability in the rural areas.
- Strategies to enhance services in the Asia and Pacific region.
- The National Trust Act of India has produced collaboration among a range of nongovernmental organizations (NGOs). In India different NGOs or agencies serve different disability groups, but the lack of coordination between them undermines their effectiveness.
- In Thailand, the national committee which comprises representatives from the department of People with Disabilities Development, medical services, local authority support, and disabled people organizations is the main mechanism of national-level CBR. However, at the community level, the main personnel who take care of people with disabilities are local authorities and community health workers, including international projects and partners (WHO, 2011).

It obvious that the region through its use of CBR has made a tremendous effort to provide the much needed services to persons with disabilities and their significant family members. CBR has made a lot of positive changes in the health, rehabilitation, and well-being of people with disabilities. However, like any program or initiative, adjustment and improvement are always needed, and in this case, it may be more of financial support and better training of personnel providing the services as well as different levels of training the consumers with disabilities and their significant family members in the community.

Barriers to Service Delivery for Persons with Disabilities in Rural Areas

Addressing barriers to service delivery in all regional areas is an ongoing effort of contributions on the part of government's entities and community key players all throughout the region's countries and communities. The challenge of barriers to services becomes greater when addressing the multiple implications to these barriers to service delivery in rural areas also considering costal isolated areas. Some of the efforts to address service delivery barrier issues are the work of disabled people's organizations (DPOs) and private- and government-funded service providers (human services, social protection, health care, and community-based rehabilitation). All regional nations continue to make an effort to put into best practice evidence-based service delivery that will provide positive outcomes for the people who need the services. Some of the guiding points to address barriers to service delivery are:

- All groups in society should have access to comprehensive, inclusive health care. Labeled as a major effort is the policy and programs identified by Development for All: Toward a disabilityinclusive Australian Aid Program 2009–2014, which identifies possible solutions (Canberra, 2009), including the following major key points.
- Targeted interventions can help reduce inequities in health and meet the specific needs of individuals with disabilities (Rauch, Cieza, & Stucki, 2008).
- Empowering people with disabilities to maximize their health by providing information, training, and peer support. Where appropriate, family members and care takers should be included.
- Groups who require alternative service delivery models should be identified, for example, targeted services and care coordination, to improve access to health care with significant effort to serve and care for rural populations.
- Community-based rehabilitation should be promoted to facilitate access for people with disabilities to existing services.

Addressing human resource barriers, such as qualified personnel and sensitivity training to work in the field of CBR, is also equally important as indicated by the UN Convention on the Rights of Persons with Disabilities (2006).

Human resource barriers can be overcome by:

- Educating, training, and preparing service delivery worker to work with people with disabilities and their immediate family members in whatever setting they may reside (rural, costal island, or urban)
- Integrating disability education into undergraduate and continuing education for all healthcare professionals
- Involving people with disabilities as providers of education and training wherever possible
- Providing evidence-based guidelines for assessment and treatment emphasizing patient/person-centered care
- Training of community workers so that they can play a role in screening and preventive healthcare services

Filling the existing gaps in data and research in the Asia and Pacific region is very important in order to provide and enhance service delivery to all regional populations of service providers and recipients of the services. According to Erie and Loeb (2006), this is an issue that has also been observed and managed to a certain extent in other world regions and provides a good example to duplicate service delivery practices.

Recommendations provided to address these issues are:

- Ensuring use of the ICF, to provide a consistent framework in health and disability-related research
- Encouraging research on the needs, barriers to general health care, and health outcomes for people with specific disabilities

- Establishing monitoring and evaluation systems to assess interventions and long-term health outcomes for people with disabilities
- Including people with disabilities in data gathering for research and research on general healthcare services

The above recommendations and the regional decade activities are promising to make more changes to benefit the regional population of people with disabilities.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) and the Asia and Pacific Region

Many years of work and collaboration of international organizations of people with disabilities and the collaboration of UN state members had the most significant outcome in the form of an international convention with a set of rules that countries can adapt to their regional public policies, laws, and regulations. The UN Convention on the Rights of Persons with Disabilities (CRPD) is the most rapidly approved United Nations human rights convention in history, a feat that demonstrates the global commitment to disability. The purpose of the CRPD is to promote, defend, and reinforce the human rights of all persons with disabilities. The Convention is intended as a human rights instrument with an explicit, social development dimension. It adopts a broad categorization of persons with disabilities and reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms. It clarifies and qualifies how all categories of rights apply to persons with disabilities and identifies areas where adaptations have to be made for persons with disabilities to effectively exercise their rights and areas where their rights have been violated and where protection of rights must be reinforced. Therefore, the Convention serves as the legal framework for policy making and advocacy (UNCRPD, 2006).

The Convention on the Rights of Persons with Disabilities and its Optional Protocol (A/RES/61/106) was adopted on 13 December 2006 at the United Nations Headquarters in New York and was opened for signature by the UN members states on 30 March 2007. The Convention follows decades of work by the United Nations and international nongovernmental organizations (INGOs) to change attitudes and approaches to persons with disabilities. It takes to a new height the movement from viewing persons with disabilities as "objects" of charity, medical treatment, and social protection toward viewing persons with disabilities as "subjects" with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members and contributors of society. The Convention as it is written and known focuses on the intention to have:

> A comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities will make a significant contribution to redressing the profound social disadvantage of persons with disabilities and promote their participation in the civil, political, economic, social and cultural spheres with equal opportunities, in both developing and developed countries. (United Nations Convention on the Rights of Persons with Disabilities. Preamble, 2006)

While many countries worldwide have begun to take action to improve the lives of people with disabilities, much remains to be done. The evidence in the *World Report on Disability* (2011) suggests that many of the barriers people with disabilities face are avoidable and correctable and that disadvantages associated with disability can be overcome. The report calls on governments to review and revise existing legislation and policies for consistency with the Convention on the Rights of Persons with Disabilities (CRPD) and to develop national disability strategies and action plans that will enhance the quality of life of persons with disabilities worldwide.

Policymakers at all levels have a responsibility to ensure that persons with disabilities enjoy all human rights and freedoms on an equal basis with other members of society. Worldwide efforts have been made by grassroots organizations such as disabled people's organizations (DPOs) and

governmental ministries' entities at the regional, local, and the United Nations international levels. With 166 country ratifications since the adoption of the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD) in 2006, the CRPD is the most valuable United Nations human rights convention in history, an accomplishment that demonstrates the global commitment to disability. It is notable to indicate that the Asia and Pacific region has been very involved from the very beginning of drafting the Convention in order to make sure that their regional countries will support and make the necessary changes for their communities. The contribution of the CRPD has also reinforced regional efforts like the extension of a decade to continue the work to raise awareness about disability and enhance the quality of life of persons with disabilities in the region.

The Asia and Pacific Decade of Persons with Disabilities (2013–2022)

In Asia and the Pacific, efforts to implement the rights of persons with disabilities have been strengthened by the *Incheon Strategy to "Make the Right Real" for Persons with Disabilities* in Asia and the Pacific countries. These are the world's first set of regionally agreed disability-inclusive development goals. The Incheon Strategy was the outcome of governments of the UN Economic and Social Commission for Asia and the Pacific (ESCAP) region gathered in Incheon, Republic of Korea, from 29 October to 2 November 2012 to chart the course of the new *Asian and Pacific Decade of Persons with Disabilities* for the period of 2013–2022. At this conference, they were joined by representatives of regional governments and civil society organizations, including organizations of and for persons with disabilities. Also in attendance were representatives of intergovernmental organizations, development cooperation agencies, and the United Nations system. The high-level intergovernmental meeting on the Final Review of the Implementation of the Asian and Pacific Decade of Disabled Persons, 2003–2012, was organized by ESCAP and hosted by the Government of the Republic of Korea. The meeting marked the conclusion of the Asian and Pacific Decade of Disabled Persons, 2003–2012, and launched the new Decade 2013–2022 (UNESCAP, 2012). The Decade 2013–2022 continues to work and has made some noticeable improvement in the way that countries enhance their local social policies and promote the contributions and abilities of persons with disabilities. More significant work is expected and final outcomes of this decade.

Challenges and Opportunities: Attitudinal, Social, Government, Familial

Where there are challenges, new opportunities can be created. The issue of attitudes toward disabilities depends greatly on the cultural believes of the social group. Society changes its views of disability becoming burdensome as they continue to see people with disabilities functioning and contributing to society even under the most hardship conditions. Governments have begun to adjust their resources and become more inclusive of people with disabilities in society. Consequently, families are also benefited by providing effective care and support to their family members with disabilities. They are also in agreement with new policies and programs in favor of people with disabilities. Disability-related activities in the region can demonstrate the changes taking place (ESCAP, 2016).

Activities on disability in the Asia and Pacific region:

- Ten countries in the region have national plans for disability prevention and rehabilitation.
- Since 2003, employment opportunities for people with disabilities have been reviewed among member states, representatives of private industry sectors, nongovernmental organizations (NGOs), the International Labour Organization (ILO), and WHO.
- Regional deafness prevention and alleviation activities have significantly progressed since

2005 and have moved forward for integration in community-based rehabilitation programs.
- The WHO Regional Office for Southeast Asia, as part of the WHO Task Force on Disability formed in 2008, has raised awareness on CRPD with country offices and Ministry of Health and Family Welfare and social protection through several briefings and seminars creating models for best practices.
- Major technical units have integrated disability in the work of the units creating an improved technological access by people with disabilities. The WHO Regional Office building is the first WHO building to have completed Disability Access Audit and is disability friendly.

Recommendations to the UN member states of the WHO Asia and Pacific region:

- Review and revise existing regional and national legislations and policies for consistency with the CRPD, and review and revise compliance and enforcement mechanisms.
- Review mainstream and disability specific policies, systems, and services that will identify gaps and barriers, and plan actions to overcome them.
- Develop a national disability strategy and action plan that are culturally based, establishing clear lines of responsibility and mechanisms for coordination, monitoring, and reporting across all societal sectors.
- Regulate service provision by introducing service standards and by monitoring and enforcing compliance.
- Allocate adequate resources to existing publicly funded services, and appropriately fund the implementation of the national disability strategy and plan of action.
- Adopt national accessibility standards and ensure compliance in new buildings, in transport, and in information and communication.
- Introduce measures to ensure that people with disabilities are protected from poverty and benefit adequately from mainstream poverty alleviation programs.
- Include disability in national data collection systems. Provide disability disaggregated data wherever possible, and consider the use of International Classification of Functioning, Disability, and Health (ICF) in the national data system.
- Implement communication campaigns to increase public knowledge and understanding of disability, and provide channels for people with disabilities and third parties to report and log complaints on human rights issues and laws that are not implemented or enforced.
- Adopt CRPD as a framework and CBR as main strategies for multisector activities to address disabilities (WHO, 2016).

These actions and opportunities to improve the delivery of services to people with disabilities and their family members are an ongoing effort that needs to be consistent and effective. As in any situation of human service provision, the major challenges are proper funding, administrative knowledge, and quality of services. Other challenges related to how society perceives disability and governmental support to the population in need can be overcome by enforcing laws and regulations that are already in place and that will make the case of disability a priority for social justice and socioeconomic development.

Summary

The results of the comprehensive research studies during the past years have clearly indicated the diverse experiences of people with disabilities in the Asia and Pacific region. There is a strong and consistent evidence to validate the association of disability with higher levels of poverty and deprivation and sufficient and vulnerable livelihoods from all age groups and cultural and ethnic backgrounds which resulted in findings of substandard living conditions of extreme poverty. The results of actions of research underscore the urgency of policy action to address the specific livelihood needs of people with disabilities, especially those living in poverty in rural and urban areas. There is also ample evidence that through the contribution of many international and regional entities, a lot of work has been done

which is still undergoing with the purpose to alleviate the situation of disability in the region. The Asia and Pacific Decade of People with Disabilities, 2013–2022, is a fresh opportunity for collective action to remove barriers to the participation of persons with disabilities in the everyday life of their communities. This collective action requires financial support and commitment from all government entities in the region and their international partners as well as their local community partners in order to provide comprehensive education, community-based rehabilitation, medical and vocational rehabilitation, and employment support opportunities to individuals with disabilities. Furthermore, the work, guidance, and participation of people with disabilities and their organizations should be an inclusive priority for the advancement of the region. This approach will bring all stakeholders closer to the goal of reaching equalization of opportunities for all its citizens in the region.

Learning Exercises

1. Compare and contrast the US Americans with Disabilities Act and the UN Convention on the Rights of Persons with Disabilities in reference to the protection of the civic and human rights of persons with disabilities and the promotion of the equalization of opportunities for individuals with disabilities.
   - What are the strengths of each?
   - What are the implications for policies and allocation of resources?
   - How can these two cornerstone documents make a definite change for people with disabilities and worldwide societies?
2. Discuss the cultural implications of the US American and Asia and Pacific region cultures regarding the perception of disability and attitudes toward disability.
   - Does culture affect how disability is perceived, understood, and treated?
   - Have these distinctive societies become more paternalistic?
   - What can they learn from each other?
3. CBR is perceived as an effective program for working with individuals with disabilities in the Asia and Pacific region.
   - Could this concept be applied in the USA?
   - What are the differences, if any, between the two systems?
   - How similar or different is rural rehabilitation in the US America?

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