Community Based Inclusive Development Report 2021

cbm
christian blind mission

An inclusive community group meeting before the pandemic in Bahadur Bigha, India.

Contents

Title page: A community worker in Uganda shows children how to wear medical face masks.

1. Foreword

Community Based Inclusive Development (CBID) is a major pillar of CBM's programming, accounting for about half of the organisation's programmatic activity. As an approach to ensure that people with disabilities are respected and included in their communities on an equal basis in all areas of life, CBID is an essential contribution to CBM's Vision of an inclusive world in which all persons with disabilities enjoy their human rights and achieve their full potential.

CBM has a strong legacy in CBID, having influenced the continuous evolution of inclusive community development over decades and at a global scale. **Chapter 2** of this report will give you an overview of the history of CBID and CBM's contribution. In 2021, 189 programmes are being implemented with the technical and financial support of CBM in 33 countries all over the world (**chapter 3**).

CBID provides a key approach to realise the Convention on the Rights of Persons with Disabilities (CRPD) and to meet the Sustainable Development Goals (SDGs), in particular their 'Leave No One Behind' principle. In the current context and drive for localisation of the SDGs, CBID is becoming ever more relevant.

2020 and 2021 have been unusual years. With the unfolding pandemic, community programmes had to constantly adapt to continue their work within ever-changing rules and restrictions. **Chapter 7** gives the reader an insight into the support CBM provided to our partners to this end. The pandemic has laid bare how fragile the living conditions of many persons with disabilities are and how discriminating response mechanisms can become if organisations of persons with disabilities are not included in preparing the response from the outset. The pandemic has also displayed the power of local and inclusive community responses to ensure no one is left behind during a global crisis. This is encouraging to the worldwide community of CBID practitioners.

Thus, we are publishing this report at a critical period. And the journey of CBID is far from over. Indeed, CBM has released a new CBID Initiative plan: With our dedicated investment in innovation (**chapter 6**), capacity development (**chapter 5**) and Disability Inclusive Disaster Risk Reduction (**chapter 9**), CBM will continue to influence community development to ensure persons with disabilities are included and participate in their communities on an equal basis for the benefit of all. I wish you an insightful read of CBM's first CBID annual report.

Dominique Schlupkothen
Director
Community Based Inclusive Development

2. The evolving concept of Community Based Inclusive Development

This section provides a brief timeline to the evolution of the approach, highlighting key events that have shaped the work we do and CBM's involvement in the CBID movement.

1969

WHO publishes its 'Disability Prevention and Rehabilitation' report presenting CBR as a "novel, common sense approach to facilitate primary rehabilitation in developing countries".

1976

Killarney meeting, proposes an approach called Community-based Rehabilitation (CBR). CBR – as defined at this meeting – signifies a movement away from a predominantly urban-based, high-tech and costly approach towards simple rehabilitation which people with disabilities, family members and health personnel can perform.

1978

The Alma-Ata Declaration on Primary Health Care is adopted and provides the means to address the main health problems in the community, providing promotive, preventive, curative and rehabilitation services.

1983

CBM begins work in Community Based Rehabilitation (CBR) in the early 1980s. From its early days, this work engages in health, education and livelihood and quickly expands its cross-disability and multi-sectoral approach around the world.

1990

WHO, ILO, UNDP, UNICEF and UNESCO publish 'Training Disabled People in the Community'. This publication signifies the first active move by WHO, ILO, UNDP, UNICEF and UNESCO in branding and supporting CBR as a global strategy. CBR is introduced as part of Primary Health Care.

CBM forms its first technical advisory team for CBR in the early 1990s.

Since the 1990s, CBM thought leadership in CBR/CBID has provided essential technical support to WHO, producing CBR Guidelines, the CBR Indicators and the online INCLUDE course.

WHO, ILO, UNESCO and IDDC publish the CBR Guidelines based on the 2004 definition of CBR. The guidelines are introduced as a means of moving towards Community Based Inclusive Development and reinforce the principles of the CRPD. The co-editors of the CBR Guidelines are a CBM staff person and a WHO staff person.

Following an international consultation with the disability movement and CBR implementers, a 'CBR position paper' is published by WHO, ILO and UNESCO. The paper defines CBR as "a strategy within general community development".

2011 to 2021: non-government organisations and civil society networks debate a rebranding of the approach outlined in the CBR Guidelines to better reflect this move towards community based inclusive development (CBID). CBM, the International Disability and Development Consortium, and the Asia and the Pacific networks have embraced the terminology of CBID.

1994 2004 2006 2010 2011 2012 2015 2021

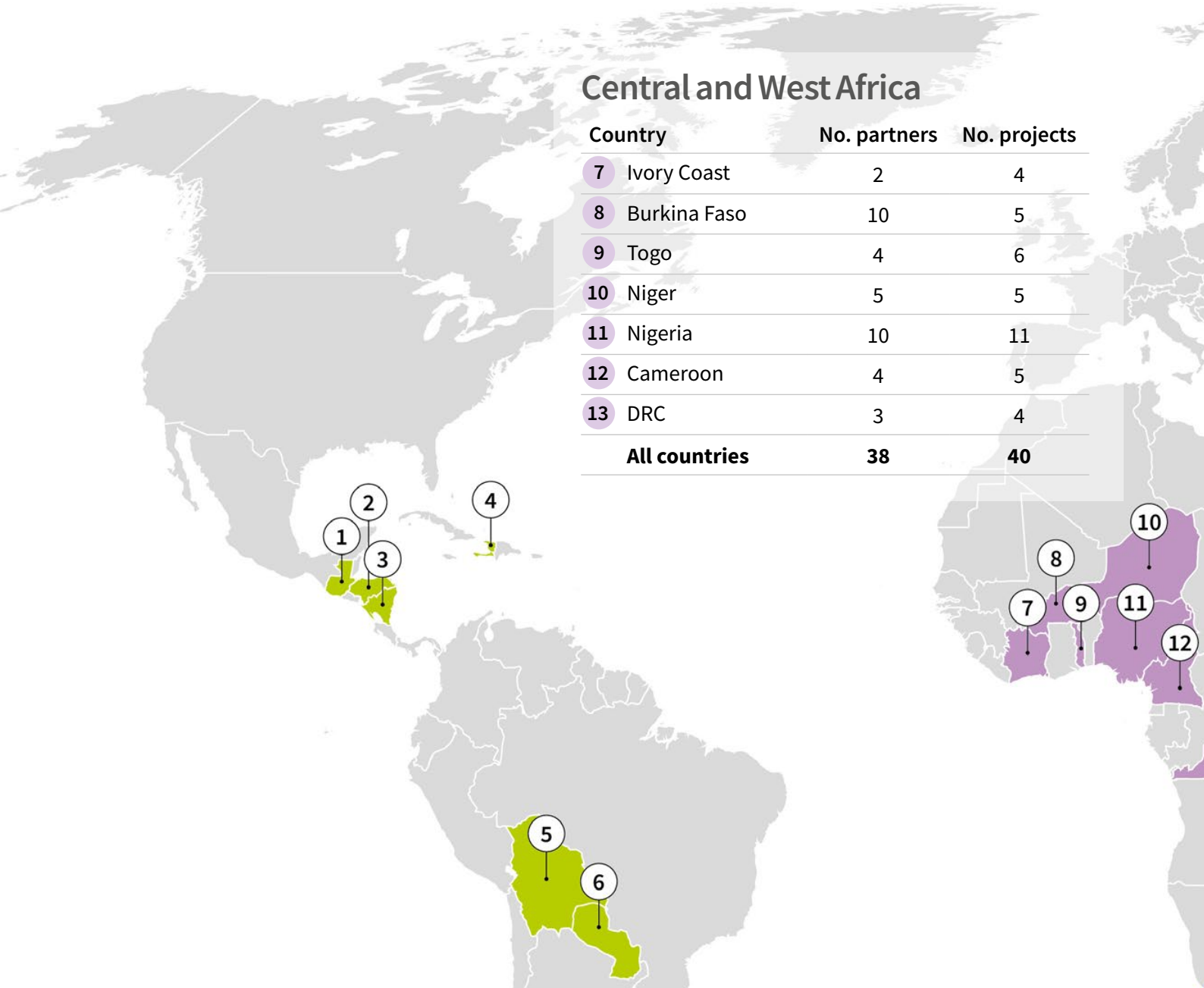
The UN Convention on the Rights of Persons with Disabilities (CRPD) is ratified.

First CBR World Congress in Agra, India (Unity in diversity – Strength in difference) supported by CBM.

The Sustainable Development Goals (SDGs), an inclusive development agenda, are adopted: No one, including persons with disabilities, must be left behind in achieving the SDGs.

WHO, ILO and UNICEF publish a Joint Position Paper on CBR. This paper lays out a new definition of CBR which includes concepts of community development, equalisation of opportunities and social integration as basic principles of CBR work.

3. CBID projects across the world



Central and West Africa

Country	No. partners	No. projects
7 Ivory Coast	2	4
8 Burkina Faso	10	5
9 Togo	4	6
10 Niger	5	5
11 Nigeria	10	11
12 Cameroon	4	5
13 DRC	3	4
All countries	**38**	**40**

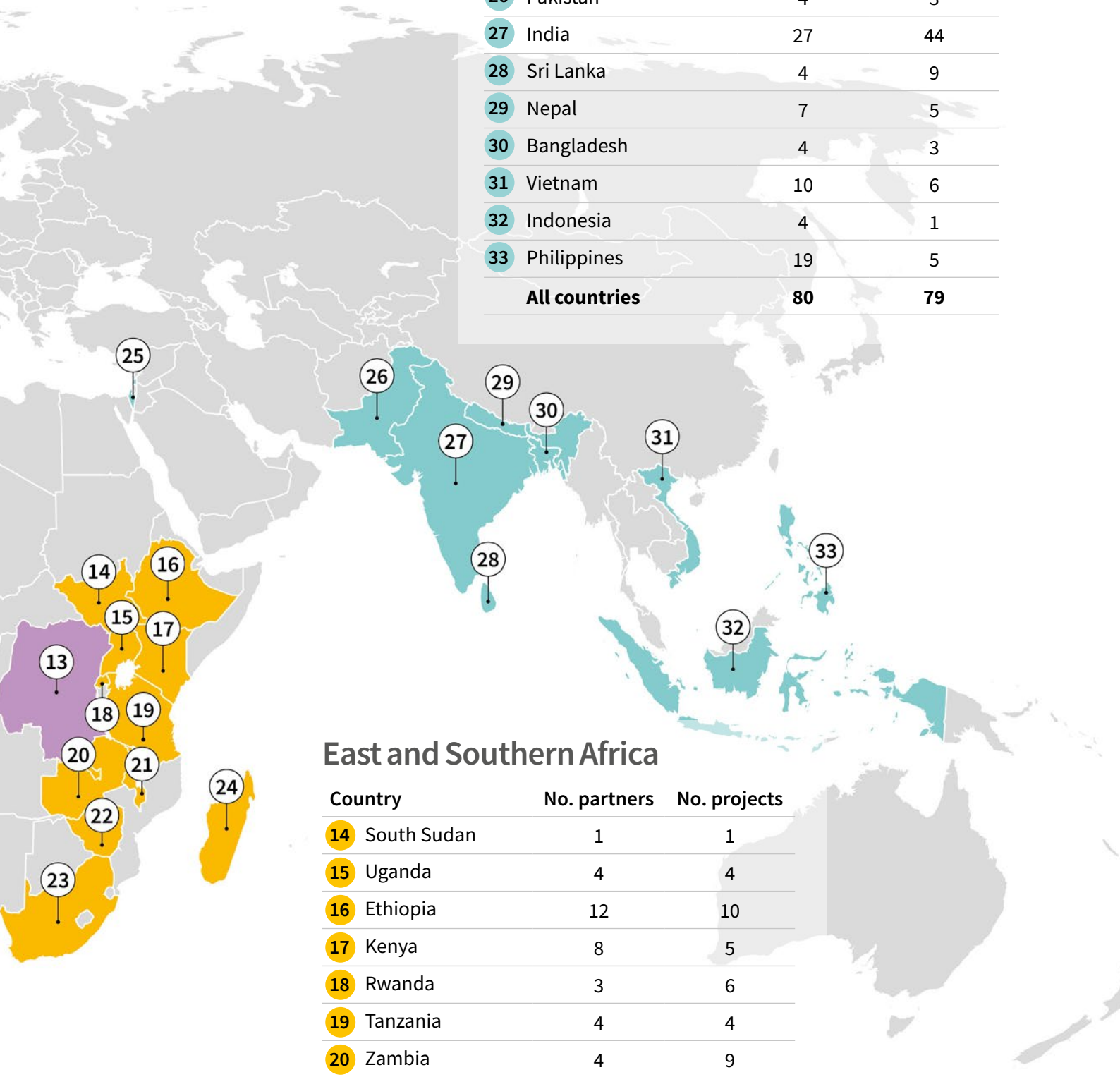
The Americas

Country	No. partners	No. projects
1 Guatemala	2	2
2 Honduras	2	3
3 Nicaragua	1	1
4 Haiti	1	2
5 Bolivia	11	1
6 Paraguay	1	1
All countries	**18**	**10**

Total	
No. partners	**193**
No. projects	**194**
No. countries	**33**

Asia and the Eastern Mediterranean

Country	No. partners	No. projects
25 Palestinian Territories	1	3
26 Pakistan	4	3
27 India	27	44
28 Sri Lanka	4	9
29 Nepal	7	5
30 Bangladesh	4	3
31 Vietnam	10	6
32 Indonesia	4	1
33 Philippines	19	5
All countries	**80**	**79**



East and Southern Africa

Country	No. partners	No. projects
14 South Sudan	1	1
15 Uganda	4	4
16 Ethiopia	12	10
17 Kenya	8	5
18 Rwanda	3	6
19 Tanzania	4	4
20 Zambia	4	9
21 Malawi	5	7
22 Zimbabwe	4	11
23 South Africa	3	2
24 Madagascar	9	6
All countries	**57**	**65**

Southern Leyte, Philippines:
Marietta Cadigal (left), producing face masks that allow lip reading.

4. Baseline study

In the context of CBM's new CBID Initiative plan, CBM worked closely together with the University of Cape Town (UCT), South Africa, to conduct a baseline study on CBID programmes in eight countries around the world (Zimbabwe, Rwanda, Ethiopia, Ghana, Togo, India, Pakistan and Honduras). The study will be repeated at regular intervals over the coming years. It will enable us to get an insight into the progress and improvement of CBM's CBID work.

The objectives of the baseline study were to:

- reflect an accurate picture of the status quo in selected CBID programmes in relation to the objectives provided in CBM's CBID Initiative plan,
- enrich our understanding of the communities in which CBM's project partners operate, including identifying problem areas in order to facilitate improvement in the implementation of CBID, and
- provide a baseline against which CBM's work in CBID can be evaluated.

The methodology used included a survey questionnaire conducted with a sample of 30 persons with disabilities from each of the 16 programmes and focus group discussions involving a range of stakeholders in the CBID programmes.

Survey participants were people with disabilities who are part of the local CBID projects, while the focus groups aimed to include people with disabilities, community leaders, leaders of Organisations of Persons with Disabilities (OPDs), parents of children with disabilities, and local project managers and staff.

The outcomes of this baseline data collection reflect on issues for persons with disabilities in the participating CBID programmes, particularly around discrimination, access to services, lack of participation in community activities and decision-making processes at community level, as well as poor representation of persons with disabilities in leadership roles. There is substantial divergence in the data across countries and also between programmes in a single country. The diverse outcomes indicate the need to address these programmatic issues and approaches in a targeted way and emphasise the need for consistent localisation of CBID programming.

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The findings also provide insight into the inherent interrelatedness between areas such as education, health, and livelihoods.

The study recommends that in the follow up studies to the baseline (2022 and 2024) analysis must be directed at how and to what effect interconnected areas in inclusive community development interact and connect.

Above: Focus group discussions during the pandemic

5. Capacity development & training

As highlighted in previous chapters, CBID is a key approach to realise the CRPD and the SDGs at community level. This huge task cannot be met by central government institutions alone. Active involvement of persons with disabilities, their families and communities, local government, community-based civil society groups and private sector stakeholders is pivotal. In this context, the need for adequately trained and certified CBID practitioners and managers is widely acknowledged. This is where CBM's CBID Capacity Development and Training Programme comes into play.

Over the past years, CBM's CBID advisors have developed and field tested a wide range of training modules, involving persons with disabilities and their representative organisations. We have now updated and consolidated this rich work to a Capacity Development and Training Programme consisting of basic, intermediate, and advanced levels. The basic level equips participants with a strong foundation covering the evolving approach and context of CBID, relevant international frameworks, as well as an introduction to gender & intersectionality, accessibility, and Disability Inclusive Disaster Risk Reduction. The intermediate level delves more deeply into the theoretical and practical skills that are needed to implement CBID whereas the advanced level explores the different topics in depth and from an academic perspective.

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Above: Community self-assessment and mapping are part of the training curriculum. **Picture on the right:** A community mapping exercise in Dosso, Niger.

In addition to these three levels, the programme offers elective modules on specific technical areas (see **chapter 8**), indicating and exploring how these are linked to CBID and how they can apply a CBID approach.

Throughout the course, participants are encouraged to reflect on their own experiences in CBID. They will be able to apply newly acquired skills directly to their own work. All trainings are delivered with strong involvement of persons with disabilities, as co-trainers or key resource persons.

The training programme also offers the opportunity for interested participants to become CBID trainers, enabling them to facilitate any of the modules themselves, using inclusive, interactive adult learning methods.

Prompted by the Corona pandemic, we are moving the content of our trainings to a virtual setting and have started to offer a mix of face-to-face (where the situation allows) and online trainings. The overall feedback from the first online trainings carried out was very encouraging. People felt very engaged and we experienced how an interactive group and workshop atmosphere can be created in an online environment, when the trainings and methods are well adapted.

The coming year will keep us busy with:

- finalising the consolidation of all training levels;
- continuing the transformation in to an online training and, most importantly;
- delivering trainings to our staff and partners in order to strengthen CBID capacities and further develop CBID programmes supported by CBM.

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6. Innovation Fund

CBM's CBID Initiative aims to be innovative and contribute to CBM's thought leadership in the field of disability inclusive development. Fostering and highlighting innovative ideas is one of the ways to achieve this. In 2020, CBM staff undertook research, consultations, and designed the CBID Innovation Fund, which was launched in early 2021. This fund provides a space for creative thinking about social innovation with practical impact on the lives of persons with disabilities in their communities.

One of the things staff and partners most value about CBM is the long-standing relationships we build and invest in. In today's philanthropic world, a new approach called Trust Based Philanthropy is emerging. Trust Based Philanthropy holds power sharing, equity, humility, transparency, curiosity, and collaboration as core values. CBM's partnership approach, which values ongoing relationships, provides a solid basis for applying this approach in the operation of the CBID Innovation Fund. The fund honours CBM's founder, Ernst Jakob Christoffel, through the sentiment that it is by walking alongside each other that we embody God's will of a loving and just world.

Through the fund, we aim to support innovative sparks and work collaboratively as we 'learn by doing'. Our vision is of a space for creative thinking and investment in ideas which can be replicated or scaled up sustainably.

The parameters for applications to the fund are in line with the priorities of CBM's CBID Initiative. Within these parameters an annual theme is selected. The theme selected for 2021 is: Innovations in community supports enhancing the participation of people with disabilities in family and community life.

Through the fund, we aim to support innovative sparks and work collaboratively as we 'learn by doing'. Our vision is of a space for creative thinking and investment in ideas which can be replicated or scaled up sustainably.

7. Covid-19 Community Action Matrix

It is well documented that people with disabilities are amongst the most vulnerable populations in a pandemic, as they often may not be able to fully implement the required self-protection and hygiene measures or might end up in inappropriate health care environments. In the context of the COVID-19 crisis, it became obvious that many people with disabilities have an increased risk of contracting COVID-19 (e.g. difficulty of accessing handwashing facilities, need to touch their face more often) and may have more difficulty with social distancing or self-isolation (e.g. because they need to remain in close contact with other people who support them). In addition, many people with disabilities have an increased risk of developing a severe case due to underlying health conditions and barriers they experience in accessing appropriate health care and support once they have contracted COVID-19.

CBM was one of the first organisations to come out with a tool to support COVID-19 response and programme adaptations at community level when the pandemic hit. In order to support our community-based partners, we designed and distributed a 'Disability inclusive COVID-19 community action matrix' with the aim to provide guidance to community programmes in relation to COVID-19 preparedness and response. The matrix provides brief and clear action points that can be easily adapted to the local context. It gives CBID programme managers anchors for engaging with local governments and service providers and for holding them accountable. The action points of the matrix emphasise the importance of proactive community development responses and encourage community stakeholders to work collaboratively in response to the COVID-19 challenge.

The 'Disability inclusive COVID-19 community action matrix' has been promoted by other organisations, academic institutions and UN bodies and is used by many CBID practitioners across the world. It was translated into numerous languages.

The Disability Inclusive Community Action Covid-19 Matrix

Compassion

- Promote and protect well-being
- Encourage hope, safety and calmness
- Be considerate (social distancing)

Communication

- Share your contacts and stay connected
- Ensure messages are clear and truthful
- Ensure messages are accessible to all

Networks

- Ensure Organisations of Persons with Disabilities play a key role in awareness raising
- Coordinate with other community groups
- Support and exchange good practices

Participation

- Be part of community conversations
- Ensure persons with disabilities contribute to the outbreak response
- Ensure inclusive community based organisations lead in communication

Access

- Ensure accessible and alternative communication is available to all
- Secure access to necessities (water, food, medicine etc.)
- Ensure access to services and financial support

8. CBID: specialist technical areas in times of COVID-19

Within our Community Based Inclusive Development (CBID) division, a team of specialist technical advisors supports CBM's programme work in the fields of Ear and Hearing Care, Physical Rehabilitation, Inclusive Education, Livelihood and Disability Inclusive Disaster Risk Reduction. In all these technical areas, we witnessed challenges resulting from the COVID-19 pandemic: significant morbidity, mortality and stress on support systems. We witnessed how health and social systems were redirected, prioritising direct health threats arising from the spread of COVID-19 – often leading to weakening in other areas of social and health services.

Public resources in health were redirected from specialist medical areas (such as Ear and Hearing Care and Physical Rehabilitation) to the COVID-19 response. Global supply chains for medical supplies were interrupted and services had to stop temporarily. Schools were closed or education was transferred from face-to-face to distance learning while people and communities lost their sources of income as economic activities were restricted. This led to CBM further developing and adjusting its programming in Ear and Hearing Care, Inclusive Education, Physical Rehabilitation and Livelihoods by applying a lens of **Disability Inclusive Disaster Risk Reduction**, which will have a long-term and positive impact well beyond the response to the COVID-19 pandemic.

The need for face masks and physical distancing and the absence of sign language interpretation and closed captioning in official briefings often led to the exclusion of persons with hearing impairment. Prolonged closure of schools widened the existing education gap between hearing and hearing-impaired children. Reprioritisation of health and social services and interruptions in

The need for face masks and physical distancing and the absence of sign language interpretation and closed captioning in official briefings often led to the exclusion of persons with hearing disabilities.

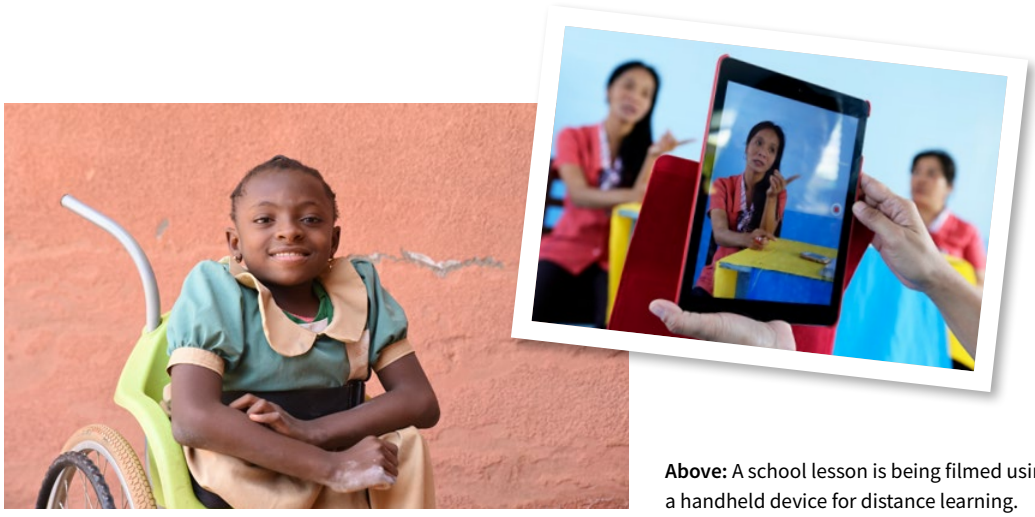
supply chains, led to disruptions in services for provision, maintenance and programming of hearing devices, increasing the isolation and vulnerability of children and adults with hearing loss. Ear health services have been impacted by reprioritisations of health services, which has led to many untreated ear problems. The COVID-19 situation aggravated existing challenges, leading to additional measures to promote **Ear and Hearing Care** being put in place to ensure persons with hearing impairments were heard. CBM – in line with WHO and others – reinforced a drive to promote the 'CRISP' strategy:

- **C**larity (easy to understand messaging),
- **R**each (broad dissemination of messaging),
- **I**ntensity (increase in high-level advocacy),
- **S**olidity (consistency of messaging) and
- **P**ower (effectiveness of messaging)

These key messages were developed to ensure Ear and Hearing Care is adequately addressed by public policies, social and health services even in times of a pandemic.

In the field of **Physical Rehabilitation**, we witnessed the interruption of rehabilitative services due to them either closing or persons with disabilities being asked to stay at home. Congenital conditions requiring early rehabilitative attention remained untreated leading to an increased risk of long-term impairments and the need for long-term treatment.

Above: A teacher in Bolivia communicating with hearing impaired children.



Above: A school lesson is being filmed using a handheld device for distance learning.

In the field of Physical Rehabilitation, we witnessed the interruption of rehabilitative services due to them either closing or persons with disabilities being asked to stay at home.

Services are now faced with backlogs while, at the same time, resources remain limited and are often interrupted by lockdowns, quarantine requirements, travel restrictions, etc.

Successful measures taken by CBM and our partners included:

- provision of Personal Protective Equipment to staff, clients and caretakers
- obtaining special permission from local authorities to continue community outreaches or to offer transport of clients to their facilities were made available
- use of wards or hostels to accommodate clients and family temporarily to reduce the need for travel
- use of communication technology to accompany clients and professionals within their communities, and
- use of motorcycle taxis to deliver assistive devices.

In the field of **Inclusive Education**, the pandemic aggravated the exclusion of children with disabilities. Those with limited or inadequate access to schools experienced a fragmented learning biography and were most affected by school closures. Learners depending on assistive devices to access education experienced additional barriers due to interruptions in rehabilitative services. Suspension of transport services created additional barriers to reach schools. In many countries, technology-based distance learning was identified as an alternative to face-to-face teaching. However, learners with disabilities are the least likely to benefit from distance learning solutions. Without accessible means of learning, many learners are being left behind. In addition, the risk of abuse and domestic violence especially for girls with disabilities has increased and is more likely to remain undetected due to limited interaction with communities, teachers and support services. CBM and partners have responded to those challenges by working with others to:

In many countries, technology-based distance learning was identified as an alternative to face-to-face teaching. However, learners with disabilities are the least likely to benefit from distance learning solutions.

- ensure inclusive, accessible messaging around the pandemic and hygiene including upgrading accessible WASH facilities
- provide accessible on/offline educational resources
- provide home-based learning
- develop emotional wellbeing services, and
- ensure and strengthen safeguarding measures (including online protection considerations).

COVID-19 restrictions have had a significant impact on the economy from local to global level. This socio-economic crisis is especially threatening the **livelihoods** of persons in low-income countries where social safety nets hardly exist. Persons with disabilities are less likely than others to be employed and when employed, they are more likely to be employed in the informal sector, often without social security or health insurance covers.

This resulted in weaker economic resilience in the COVID-19 context. Those employed or self-employed have often experienced new barriers preventing them from participating fully in economic activities and have subsequently faced increased risks of losing income and work. The lack or loss of income is a disproportionate burden on persons with disabilities and their households which typically face extra costs and expenditures related to disability including transportation, medication, accessible housing and assistive devices, increasing the risk of sliding further into poverty.

To overcome the socio-economic challenges triggered by the pandemic, CBM has supported partners through:

- life-sustaining food packages
- cash transfers to meet needs for food and other basic needs such as payment of rent, or restocking materials to revive stalled businesses
- revival of or transition to online meetings of Village Savings and Loan groups
- advice to savings groups on how to access savings or loans through mobile fund transfers to avoid travelling and physical meetings.

The lack or loss of income is a disproportionate burden on persons with disabilities and their households which typically face extra costs and expenditures related to disability.

9. Enhancing community resilience through Disability Inclusive Disaster Risk Reduction (DIDRR)

In the context of CBM's new CBID plan, CBM embarked upon a bold initiative to drive Disability Inclusive Disaster Risk Reduction and increase the resilience of persons with disabilities and their communities. To do so, we are following a three-dimensional approach focusing on a) Mainstreaming DIDRR into programmes across CBM's portfolio b) Designing programmes that mainly focus on DIDRR and c) Knowledge development for DIDRR.

The first dimension focuses on priority areas one and three of the Sendai Framework for Disaster Risk Reduction (**SFDRR**) and aims to ensure that DIDRR is mainstreamed through our partners in high-risk priority countries. The second and third dimensions focus on priority areas two and four of the SFDRR, ensuring that DRR frameworks are influenced through learning and driving the disability inclusion agenda across relevant national, regional, and global alliances.

To make optimum use of available resources, a multi-dimensional risk profiling of countries, based on internationally established indexes was conducted. Five high risk countries (Niger, Nigeria, Ethiopia, Zimbabwe, and Haiti) were identified for primary action. An additional 10 at-risk countries are kick-starting DIDRR interventions. By the end of 2024, we envision to have increased capacities in DIDRR programming, stronger representation across strategic alliances, and proactive representation of persons with disabilities across the DIDRR portfolio in these 15 countries. And CBM aims to be recognised as a DIDRR-sensitive thought-leader in the five high risk countries.

To enhance resilience of our programmes in at-risk communities, CBM has prioritised the use of Disability Inclusive Crisis Modifiers (DICM)[1] as a preferred strategy. DICM are resilience-building mechanisms that add value to development programming by protecting development gains.

These mechanisms support development projects in risk-prone contexts to become sensitive to small-scale emergencies in local communities by adjusting current project activities and quickly reallocating pre-agreed resources to meet needs. In practice, an effective crisis modifier quickly reallocates resources from development budgets to respond to a crisis. At the same time, it supports a crisis response to scale down or adapt when the situation on the ground changes, by allowing for funds to be reallocated back into development activities.

1. A crisis modifier is one of many risk-financing tools. Its purpose is to create a predictable, coordinated, timely and cost-effective response to shocks and stresses. Taking early action allows organizations, governments, communities, and households to act before or right after a shock occurs and helps affected communities avoid negative coping strategies.

CBM's DICM Toolkit

CBM developed a Disability Inclusive Crisis Modifier (DICM) toolkit to support its country offices and partners in reducing the disconnect between humanitarian and development interventions.

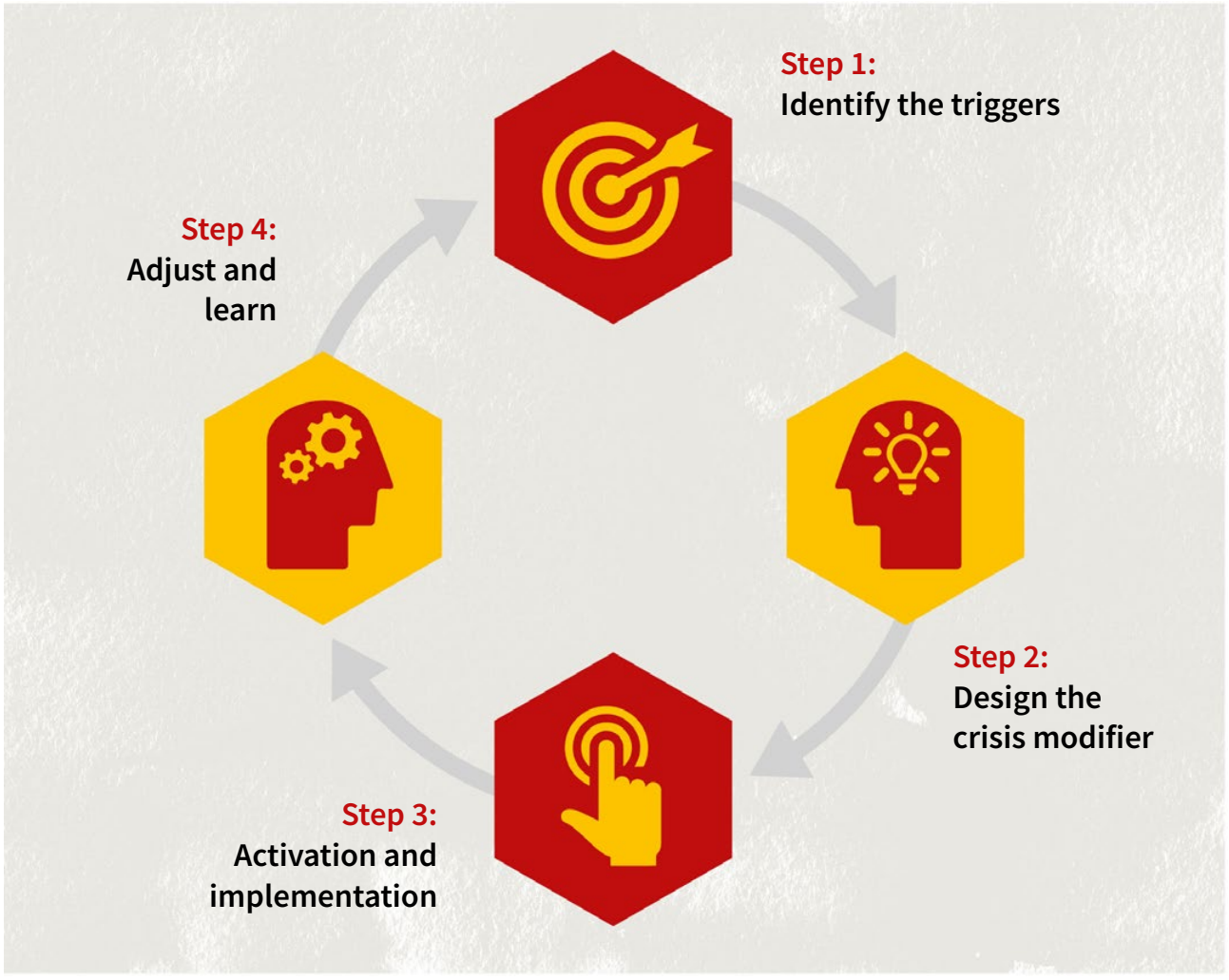
Above: Community workers in the Philippines organising delivery of relief goods during Covid-19.

The DICM toolkit was pilot-tested in Niger, with the aim to support CBM and its partners in the relief – recovery – development continuum, by allowing for an easier and more organic transition between phases.

How It Works

This toolkit does not reinvent the wheel – it builds on and enhances pre-existing programme processes and tools to ensure practical use. It contains guidance and tools to support CBM and partner staff to undertake the process of designing, budgeting, activating and deploying resources, whilst learning from the implementation of a crisis modifier mechanism at the same time.

Project planning teams (including representatives from CBM, its partners, and communities) embed DICM in programmes at the design stage so they can be activated in response to small scale crises. The process overview is as follows:



Roman Hossain (left) is providing hand sanitizer to a local seller in Savar Municipality, Bangladesh.

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christian blind mission

CBM Christoffel-Blindenmission
Christian Blind Mission e.V.
Stubenwald-Allee 5 • 64625 Bensheim
www.cbm.org