

DEVELOPMENT PROGRAMMING  
FOR PERSONS WITH DISABILITIES  
IN GULU, UGANDA IN THE CONTEXT  
OF A DISABILITY – POVERTY –  
CONFLICT NEXUS

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## **Abstract**

This thesis research explores the influence of the community-based rehabilitation approach on development programming in Gulu, Uganda. This CBR approach, originally designed to address the multidimensional needs of persons with disabilities living in rural, low-income regions, has been endorsed by many development actors, including the Government of Uganda and the United Nations. It also holds the potential to address the complex intersection of disability, poverty and conflict that resulted from two decades of violent conflict in Northern Uganda. An environmental scan and interviews with development professionals from the local government and non-government organizations was conducted to identify the ways in which this international policy idea has influenced development programming, and the obstacles to implementing community-based rehabilitation in Gulu. This research contributes to the literature on policy transfer, and illustrates how local development actors often lack the capacity to fully implement and sustain international “best practices.” While community-based rehabilitation may be a way to address the nexus of disability, poverty and conflict in places like Gulu, too few resources have been committed to fully implementing it and supporting persons with disabilities.

**Keywords:** disability, poverty, conflict, community-based rehabilitation, policy transfer, Uganda

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## Chapter 1: Introduction

International development programming has done a poor job of addressing the needs of persons with disabilities. It has been estimated that only three to four percent of the world's persons with disabilities benefit from development efforts (UNDESA, 2013). Disability can be a cause and consequence of poverty: persons with disabilities are more likely to experience poverty, and in turn are more susceptible to the conditions that can cause impairments (Yeo & Moore, 2003). While increasing attention is being paid to disability and development, including in Canadian policies on development assistance, in practice this remains wholly inadequate (Stienstra & Estey, 2016).

While the relationship between disability and poverty is well known, less attention has been paid to the intersection of disability, development and conflict. Persons with disabilities are often more vulnerable during conflict due to mobility impairments and targeted violence, and conflict can directly cause physical impairments and mental health conditions through injury, illness or trauma (Mitchell & Karr, 2014). Given that disability prevalence is higher in low-income countries, the intersection of conflict, disability and poverty is especially relevant for development practitioners (World Health Organization & World Bank, 2011).

One solution that has been proposed to address the multidimensional needs of persons with disabilities is community-based rehabilitation (CBR). CBR is a set of strategies developed by the World Health Organization (WHO), the United Nations Educational, Scientific and Cultural Organization (UNESCO) and the International Labour Organization (ILO). Developed for resource-poor settings, CBR is an approach to providing services through capacity building and decentralized services, intended to promote community economic and social development (WHO, UNESCO, & ILO, 1994). This multidimensional CBR approach may also be a meaningful way to engage with persons with disabilities in conflict and post-conflict settings (Boyce, Koros, & Hodgson, 2002).

This research will examine the influence of CBR on development practice in Gulu, a district in Northern Uganda that experienced conflict and mass displacement from 1986 to 2008. As a post-conflict region, Gulu is host to a large number of international non-governmental organizations (NGOs), multilateral organizations, and local NGOs. This research will determine the extent to which development projects and programs that serve persons with disabilities in Gulu are being planned and implemented in keeping with the CBR guidelines, prepared by the WHO and other United Nations (UN) actors. This research will also consider which thematic areas of the multidimensional CBR matrix are being emphasized by development actors in Gulu.

The research consists of an environmental scan, conducted using an online questionnaire to identify patterns and trends in development practice related to persons with disabilities in Gulu. This is supplemented by semi-structured interviews with international development professionals to explore their understanding of CBR, and how the intersection of disability, poverty and conflict affects their organizations' work in Gulu.

This findings of this study are situated within two analytical frameworks. First, the study develops the idea of a disability – poverty – conflict nexus, which underlines the multidimensional threats and barriers faced by persons with disabilities in settings such as Gulu. Present and historical events and trends in Gulu District are interpreted through this nexus to illustrate the extensive challenges faced by persons with disabilities in the conflict and post-conflict eras, and the complexity that this poses for development actors.

The study will also rely on the policy transfer literature, and theoretical work on the localization and translation of international policy ideas, to determine how and to what extent CBR as an international policy idea has influenced development practice in Gulu, Uganda. Policy transfer literature has examined how states in the Global North identify and emulate policy ideas from abroad to address local concerns, or in some cases how states in the Global South have policy ideas thrust upon them through direct or indirect coercion. This study considers how CBR has been positioned as an international best practice, and how this has influenced development actors in Gulu to adopt the approach.

CBR is an important international policy idea, which has been promoted by multiple UN organs (WHO, UNESCO, & ILO, 2004) and incorporated into Uganda's National Policy on Disability (Government of Uganda, 2006). The study of how a policy like CBR is transferred and translated in Gulu, and the challenges and gaps that may forestall implementation, can help to provide a better understanding of the role of international policy ideas in local development practice. This research also highlights some of the issues with the CBR approach that may limit its usefulness in low-income countries, and especially those recovering from conflict.

This paper begins by outlining the theoretical framework drawn from the policy transfer literature, emphasizing the role of ideas and influence in the international policy sphere. The paper then proceeds to explore theoretical understandings of disability, followed by a literature review of the origins and debates around CBR. The paper will then present the disability – poverty – conflict nexus as an analytical framework, undertaking a conceptual literature review to illustrate how these three factors, combined with gender and the diversity of disability, can impact the lives of persons with disabilities. Finally, a historical overview of the conflict in Northern Uganda, and the current state of affairs for persons with disabilities in Uganda, is presented to contextualize the research.

Having established these analytical and contextual foundations, the paper proceeds to outline the methodology, and then the findings. First, the evidence for a nexus of disability, poverty and conflict in Gulu is presented, drawing on secondary literature and primary data gathered from development practitioners. The research findings on policy transfer are then presented, beginning with an environmental scan, followed by an exploration of CBR's influence on development planning and practice in Gulu. A discussion follows which situates the findings within the literature on policy transfer.

## **Chapter 2: Theoretical Framework**

This paper will primarily draw its theoretical framework from the literature on policy transfer. Since the paper's objectives are exploratory rather than explanatory, the policy transfer literature provides a useful set of variables to examine how an international policy idea like CBR has come to influence development practice in Gulu, Uganda. Dolowitz and Marsh's (2000) framework for analyzing policy transfer provides a useful tool for interpreting the results of this particular study.

Policy transfer has been called a model and a variable, but it is generally viewed as lacking the explanatory power necessary to constitute a theory. As such, to complement and enhance the policy transfer framework, this paper will employ contributions from discursive institutionalism, as well scholarship on norm diffusion and localization. The study of policy transfer is itself a heuristic technique, and as such this paper will draw its theoretical framework from a number of different scholarly traditions.

This section will begin with a discussion of the origins and key contributions in the field of policy transfer, with a specific focus on the role of international organizations and other non-state actors. Dolowitz and Marsh's (2000) framework will be presented as a tool for understanding the various mechanisms of policy transfer. After briefly assessing the limitations of policy transfer, this section will identify complementary approaches that can enhance the analysis, including relevant contributions from the discursive institutionalist school.

### ***Policy transfer***

Dolowitz and Marsh's (1996) article serves as the starting point for most studies of policy transfer, which they define as "a process in which knowledge about policies, administrative arrangements, institutions etc. in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place" (344). Their review highlighted the actors, objects, and processes of policy transfer, which encompassed both voluntary and coercive forms of transfer. They later revisited their framework, identifying new actors, research questions and degrees of transfer (Dolowitz & Marsh, 2000).

The policy transfer approach, which is primarily employed in the field of public policy, has several similarities with the study of diffusion in international relations, which looks at how ideas inevitably spread through social systems. Diffusion underplays the intentionality of policy transfer, describing it as a natural, incremental process, and posits that there is a tendency towards policy convergence across states (Stone, 2012). In contrast, the policy transfer literature gives greater emphasis to agency in the process, be it coercive or voluntary (Marsh & Sharman, 2009).

Policy transfer can take on many different forms, depending on the nature and motivations of the actors involved. Dolowitz and Marsh (1996) categorize policy transfer as either being voluntary, directly coercive or indirectly coercive. A voluntary transfer results from dissatisfaction with the status quo, and leads to a selective process of identifying evidence and possible solutions to problems in a given state. Coercive transfers can be direct, as with the

imposition of structural adjustment policies by the World Bank and International Monetary Fund, or indirect, possibly as a result of negative externalities or a need to keep up with rapidly changing international norms.

Policy transfer analysis has become especially popular with the increasing attention paid to globalization, a process which, according to some definitions, is itself about the spread of ideas (Evans, 2009a). While initially fixated on government to government transfer, policy transfer analysis has increasingly focused on the role played by other international actors. There has also been a greater emphasis on the spread of ideas and concepts, rather than just focusing on the transfer of policy instruments (Marsh & Sharman, 2009).

### ***International Organizations and Non-state Actors in Policy Transfer***

Dolowitz and Marsh (2000) identified nine main categories of political actors who engage in the policy transfer process: elected officials, political parties, civil servants, pressure groups, policy entrepreneurs and experts, transnational corporations, think tanks, supra-national governmental and nongovernmental institutions and consultants (10). They argue that international actors can play a role in coercive or voluntary transfer; for example, international organizations can have a direct influence through policies and loan conditions, or indirectly through the production of information.

Stone (2012) argues that it is important to look at policy transfer as more than a simple bilateral exchange, and international actors are a crucial player in this process, either as a direct participant or a facilitator. Stone (2004) places particular emphasis on the role that international actors can play in disseminating and validating ideas. For example, international organizations have research departments that engage in a variety of activities to emphasize the scientific validity of their findings, which in turn can translate into policy advice and change within member states. Similarly, networks of non-state actors can draw attention to certain issues and lend a degree of “normative resonance” that compels policy actors to respond (Stone, 2004, 556). In this way, certain states may feel compelled to adopt the policies and practices of social leaders, be they states or international organizations, in order to present themselves as advanced and morally praiseworthy (Marsh & Sharman, 2009).

The increasing role of non-state actors in the development and dissemination of policy has been dubbed the “transnationalization of policy,” and presents a host of questions for scholars of policy transfer and diffusion (Stone, 2004). International organizations are an especially interesting actor to consider, as their relative lack of coercive power has necessitated a more indirect means of instigating policy change and transfer in member states. Even an organization like the World Bank, whose structural adjustment policies were one of the most illustrative examples of coercive transfer, now draws much of its influence in the policy transfer process from research and data collection (Stone, 2012).

***Dolowitz and Marsh’s Framework***

Arguably, the strength of the policy transfer field is “its ability to identify the complexities of a highly pluralized field” (Ellison, 2017, 10). Indeed, much of the policy transfer literature is merely the identification of complexity, rather than causal explanation. Given the multitude of actors, forms and degrees of transfer highlighted in the literature, Dolowitz and Marsh’s (2000) framework provides a useful tool for analysis.

This framework is structured around the authors’ key research questions for policy transfer, encompassing the degree of coercion, the actors engaging in transfer, and the site of the transfer. Their “how to demonstrate” column is an attempt to identify data sources that can be used to show that a transfer actually occurred. While this framework is useful, it does not necessarily engage with the question of “why” a policy transfer occurred. In the case of a purely coercive transfer, the answer may be self-evident, but in the many cases where policies were not imposed, the motivation behind the transfer is not captured in this framework.

**A Policy Transfer Framework**

Why Transfer? Continuum			Who Is Involved in Transfer?	What Is Transferred?	From Where			Degrees of Transfer	Constraints on Transfer	How To Demonstrate Policy Transfer	How Transfer leads to Policy Failure
Want To.....	.....	Have To			Past	Within-a Nation	Cross-National				
Voluntary	Mixtures	Coercive	Elected Officials	Policies (Goals) (content) (instruments)	Internal	State Governments	International Organizations	Copying	Policy Complexity (Newspaper) (Magazine) (TV) (Radio)	Media Reports	Uniformed Transfer
Lesson Drawing (Perfect Rationality)	Lesson Drawing (Bounded Rationality)	Direct Imposition	Bureaucrats Civil Servants	Programs	Global	City Governments	Regional State Local Governments	Emulation	Past Policies	Reports	Incomplete Transfer
	International Pressures		Institutions			Local Authorities		Mixtures	Structural Institutional Feasibility	Conferences Meetings/ Visits	Inappropriate Transfer
	(Image) (Consensus) (Perceptions) Externalities	Pressure Groups	Ideologies					Inspiration	(Ideology) (cultural proximity) (technology) (economic) (bureaucratic) Language	(Commissioned) (uncommissioned)	
	Conditionalities	Political Parties	Attitudes/ Cultural Values	Negative Lessons			Past Relations			Statements (written) (verbal)	
	(Loans) (Conditions Attached to Business Activity)		Consultants Think Tanks Transnational Corporations Supranational Institutions								
	Obligations	Policy Entrepreneurs/ Experts									

Figure 1: A Policy Transfer Framework (Dolowitz and Marsh, 2000, 9)

***Weaknesses of the Policy Transfer Literature***

The fact that the Dolowitz and Marsh framework, despite its usefulness, does not engage with questions of causality is reflected throughout the majority of the policy transfer literature.

Some authors [for example, Evans (2009b)] describe policy transfer analysis as “a theory of policy development” (243). However, other authors have cautioned against such a classification. While acknowledging its strengths, Ellison (2017) argues that the weakness of the policy transfer literature is its “inability to push beyond this exploration of parameters and content to accounts of transfer that are theoretically coherent, methodologically sound and consequently able to inform the conduct of transfer events” (10).

Even Dolowitz and Marsh (2000) concede that policy transfer is a useful variable, but not an explanatory factor behind policy development. Ellison (2017) notes that policy transfer has typically been used as a dependent variable, but not as a means of explanation. Evans and Davies (1999) describe policy transfer as an “analogical model,” which is useful for examining processes and relations but lacks a causal model.

The geographic scope of policy transfer inquiry may also be questioned. While Benson and Jordan (2011) argue that the policy transfer literature has managed to expand beyond its earlier state-centricity to encompass non-state international actors, Marsh and Sharman (2009) argue that the Global South is usually ignored, and much of the literature has focused on policy transfer between developed countries. This has obscured the important dynamics of asymmetrical power relations inherent to donor-recipient policy interactions.

These weaknesses of the policy transfer literature mean that it cannot constitute a coherent theoretical framework for this particular study. While, like much of the policy transfer literature, this study will not engage with questions of causality, there is still a need for a stronger theoretical foundation upon which to situate the analysis. Stone (2012) argues that, while policy transfer in itself cannot provide an explanatory theory, it can be combined with other approaches to support a more rigorous analysis. The following section will consider several related approaches which place a strong focus on ideas and the way they move between different cultural and political spaces.

### ***Translation, Localization, and Norm Diffusion***

There are a number of approaches that focus specifically on the transfer of international norms. According to True and Krook (2012), international norms are “ideas... with respect to fundamental values, organizing principles or standardized procedures that resonate across many states and global actors, having gained support in multiple forums” (103). The analysis of the development of international norms, and how they come to be accepted across diverse states and societies, is of great interest given the role that international organizations play in modern policy development.

Nay (2012) identifies three main forms of influence that international organizations can wield to affect policy change. *Prescriptive* influence implies the ability to develop rules and norms that other parties must abide by. This is quite difficult, given that most international organizations cannot make binding decisions or compel state parties to follow their “rules.” In contrast, *technical* influence can be wielded more readily, especially against countries receiving

international assistance. This form of influence is achieved through coordination of members (eg. donors), the delivery of programming and the way programs are staffed, and means of funding. Finally, the subtlest and yet possibly most powerful form of influence is *cognitive*, which is the capacity to define problems, selectively gather information and propose solutions that appeal to wide audiences.

Nay (2012) argues that technical and cognitive influence are especially important for the UN system; these organizations cannot enforce regulations, so they engage in advocacy and the development of international norms. International organizations also carry out a variety of knowledge activities which can give resonance to new and evolving norms. They serve as policy forums for debate, they employ expert “norm entrepreneurs” who define policy prescriptions, and they attempt to enforce ideas through activities like evaluation, country reviews, and progress monitoring (Nay, 2014). This is especially true of the World Bank, which dedicates considerable resources to research and knowledge dissemination. In doing so, the Bank and other international organizations seek to define norms of conduct and consciously engage in the production of hegemonic knowledge (Nay, 2014).

The production of norms by international organizations can subsequently translate into policy change at the national level. Finnemore, (1993) explores how “state policies and structures are influenced by intersubjective systemic factors, specifically by norms promulgated within the international system” (593). States are part of an international system, and international organizations can leverage communities of experts to promote, design and support certain policies at the state level.

Of course, international norms are not always perfectly replicated at the national level. Béland (2009) argues that such policies “are implemented at the national level through processes of symbolic and institutional translation” (710). States may take symbolic steps to align with international policy norms with very little substantive impact on national institutions. For example, True and Krook (2012) argue that norms that prescribe behaviour, such as gender mainstreaming, leave room for local reinvention. Such norms can have a limited impact on the identity and structure of the state, and therefore the adoption of norms like gender mainstreaming has been very inconsistent and taken on diverse forms, some with far less impact than others.

The ways in which states reinvent international policy ideas has received attention from a number of authors, and has been described in different terms. Park, Wilding and Chung (2014) describe this as policy translation, and explore how international policy ideas may look very different when implemented in a given state. Similarly, indigenization looks at how ideas are transmitted and reinterpreted, and considers the process that takes place beyond the adoption of a policy idea. As Stone (2012) argues, “Even if there are cases of linear transmission of a policy from one jurisdiction to another, the transfer does not create a cryogenically preserved policy forever more” (489). After a policy instrument is transferred, the endogenous forces of indigenization take hold, and analysis of this phenomena considers the political acceptance of an idea, which may be contested.

Acharya's (2004) analysis of localization offers similar insights. Localization is defined as "the active construction (through discourse, framing, grafting, and cultural selection) of foreign ideas by local actors, which results in the former developing significant congruence with local beliefs and practices" (245). Localization emphasizes the agency of local actors, who are not simply passive recipients of international norms. Foreign norms can be incorporated into local norms, or elements can be borrowed and modified to meet existing normative beliefs in a given state.

Localization, indigenization and policy translation are complementary approaches for looking at the spread of international norms, and demonstrate that all international actors have a role to play. International organizations will engage in various activities to create knowledge and contribute to the production of new norms of thought and conduct. In turn, member states will engage with these norms and alter them according to their own normative convictions. Indeed, Nay (2014) argues that, once a norm is created, there is likely to be a process of fragmentation for those very reasons. Increasingly complex concepts, and the disparate and sometimes contradictory interpretations held by local actors, may erode the internal consistency of a norm or concept. International organizations, or other actors who support a given norm, may leverage their influence and knowledge to forestall fragmentation, but norms can certainly fade from relevance in the international system.

### ***Discursive Institutionalism***

While the study of norms is important for understanding international policy transfer, the role of institutions and discourse must also be taken into consideration. Finnemore and Sikkink (1998) argue that, while norms consider single standards of behaviour, an institution is an interrelated collection of behavioral practices and rules. Institutions lend a form of structure to ideas, and the discursive institutionalist school, also known as constructivist institutionalism, considers how ideas and discourse shape institutional change.

According to Carstensen and Schmidt (2015) the discursive institutionalist approach is "concerned with the substantive content of ideas and the interactive processes of discourse in an institutional context" (121). Schmidt (2010) argues that institutions can constrain actors, but also be changed by those same actors. For Hay (2006), this process of institutional change is dynamic and allows for innovation and new ideas; however, it can also take a great deal of time.

While institutional change is the focus of this approach, change largely occurs due to the power of ideas and discourse. Schmidt (2010) argues that ideas allow actors to conceptualize the world, but also to reconceptualize it through an exchange of ideas known as discourse. This discursive process is how an individual idea can be translated into collective action or institutional change. This process is also normative in nature, since actors seek to employ discourse strategically to achieve their goals (Hay, 2006).

Carstensen and Schmidt (2015) identify three types of ideational power, which is the capacity to influence other actors' normative and cognitive beliefs in the pursuit of certain goals

(321). Power can be achieved *through* ideas, *over* ideas and *in* ideas. Power through ideas is the ability to persuade other actors to adopt a certain view, similar to Nay's idea of cognitive influence. Power over ideas is the coercive ability to control and dominate the meaning of ideas, while power in ideas is the subtle ability to shape which ideas have authority and are considered valid. This is akin to Stone's idea of normative resonance, which can be achieved through discourse and knowledge systems. Power in ideas might be achieved when

agents seek to depoliticize ideas to the degree where they recede into the background, meaning that they become so accepted that their very existence may be forgotten, even as they may come to structure peoples' thoughts about the economy, polity and society (Carstensen & Schmidt, 2015, 329).

Actors who employ discourse to pursue institutional change look to demonstrate the value of an idea for a given community, rather than its validity or internal coherence. In doing so, actors "may intersperse technical and scientific arguments with more generally-accessible narratives to generate compelling stories about the causes of current problems, what needs to be done to remedy them, and how they fit with the underlying values of the society" (Schmidt, 2011, 110).

As the name suggests, discursive institutionalism brings together the power of discourse and ideas, the actors who employ them, and the institutions that structure discourse and in turn are reshaped by it (Schmidt, 2011). The dynamic interaction of these actors can give rise to institutional change.

### ***A Framework for Analysis***

Ideas, norms, institutions, and policies shape the way our world is organized and the way we interact with it. This study will consider the ways in which CBR is shaping the work that development actors undertake in Gulu, Uganda. A theoretical framework drawing insights from policy transfer, international norms and translation, and discursive institutionalism can help to illustrate how an international policy idea like CBR can move from the offices of the WHO to development organizations in Northern Uganda. This paper will use Dolowitz and Marsh's (2000) analytical framework to explore the influence of CBR, and supplement it with the theoretical ideas discussed in this section to further understand to what extent CBR is influencing development practice in Gulu.

## **Chapter 3: Theoretical Perspectives on Disability**

In many societies, people with disabilities are faced with derision and neglect, and may be seen as carrying contagions or curses (Brydges & Mkandawire, 2017; Eide, Khupe, & Mannan, 2014). In the face of this marginalization, disability theorists have sought to understand

the nature and origins of disability, and whether it is an individual characteristic or a product of social phenomena.

Theoretical perspectives on disability are often reduced to a simple dichotomy: the medical model vs. the social model (Oliver, 1990). The medical model is one of deficit, whereby a person's disability is a deviation from normality that requires correction through medical treatment (Devlin & Pothier, 2006). From this perspective, disability is inability, such as a physical inability to walk, hear or see properly. This inability results from a medical condition which requires treatment to regain normal functioning.

Several theoretical perspectives have been put forth to counter the deficit-based medical model. These perspectives are grounded in a belief in social justice, and the power of theory to overcome the marginalization facing persons with disabilities. For example, the rights-based approach, which positions persons with disabilities as a minority facing oppression, has become popular, especially in the United States. The goal of such an approach is self-sufficiency and independence for persons with disabilities (Bickenbach, Chatterji, Badley, & Üstün, 1999).

While the rights-based approach has been effective at securing legal remedies to discrimination, especially in the Global North, on a theoretical level it presents some challenges. Deal (2003) argues that there is no unified culture of disability that would qualify it as a minority group, nor is there a sense of cohesive identity. Rather, different impairment groups are more likely to view each other as a separate entity, rather than possessing a common identity as "disabled." Bickenbach et al. (1999) also dispute the validity of the minority approach, noting that not all of the challenges faced by persons with disabilities are a result of discrimination, and the inequitable distribution of resources (which is admittedly due to power imbalances) plays a crucial role in the conditions facing persons with disabilities.

The most prominent theories of disability look at how individuals, and groups, of people interact with their social and physical environment, and how certain conditions can cause disability. The Nordic relational model looks at disability as a situational mismatch between person and environment. For example, a person who can only communicate through sign language is at no disadvantage when they are spending time with other sign language speakers, but this is not the case when they are in a social situation where no sign language speakers are present (Shakespeare, 2006).

This interaction between individual and environment is at the core of the social model, the most commonly cited theoretical perspective of disability. The social model conceives of disability as a form of social exclusion, and differentiates between impairments and disability. Disability, as per the social model, is not a functional limitation, but rather the restriction of activity due to social barriers, such as negative attitudes, discrimination, and ignorance (Shakespeare, 2013). Barriers can also take on more concrete form such as the built environment, the availability of aids and personal assistance, and financial and material factors (Shakespeare and Watson, 1997).

Freund (2001) argues that the starting point for the social model is not the body of a given person, but rather the "structural elements that organise space, time and motion" (702).

Given that the origins of exclusion lie in social systems, this model encourages us to reform and remove the barriers that prevent the full participation of persons with disabilities in social and economic life (Shakespeare, 2012). The social model acknowledges that disablement is a result of an interaction between an individual and their environment. For example, Zola (2005) notes how an impairment that affects one's ability to read and write would only constitute a disability in an environment where literacy is essential.

This distinction between impairment and disability is crucial for the social model and related perspectives. Bickenbach et al. (1999), drawing from the WHO, describe impairments as temporary or permanent differences of structure or function in human body that are readily, objectively identifiable. An impairment is not the same as a disability, and its impact on an individual's participation can vary based on the social environment (Vehmas & Shakespeare, 2014). If, due to social factors like inaccessible buildings or workplace discrimination, this impairment limits the participation of a person in socio-economic life, it constitutes a disability.

Given that this model presents disability as a social construct, there is also a need to understand the overlapping social identities that affect a person's ability to participate in society. An intersectional approach to understanding disability, as advocated by Manning et al. (2016), pushes us to recognize the multiple relationships of power and exclusion that impact people's lives. This can include gender identity, both in terms of societal roles and sexual expression. For example, Shuttleworth et al. (2012) note the tension between the perceived dependency of persons with disabilities and the contrast with norms of power and autonomy that are associated with masculinity. The authors note that much of the existing theory on disability and masculinity has been fixated on physical disability, leaving room for a more nuanced intersectional analysis.

Increasingly, research that focuses on gender and disability is taking a more explicit focus on the sexuality of persons with disabilities. This includes research highlighting the challenges facing women in countries like South Africa (Naidu, 2015) and Nigeria (Afolayan, 2015), where the sexuality of people with disabilities is often derided, condemned or ignored. Men also face unique challenges in expressing their sexuality; Cambridge and Mellan's (2000) findings from India note that existing research and practice emphasize the pathological, almost predatory nature of the sexual behaviour of men with learning disabilities, highlighting the need to understand the needs and desires of men to express themselves sexually. Understanding these interactions of gender, race, sexual orientation, and other identities with disability (and different types of impairments) is necessary for identifying and eliminating the barriers to the full participation of people with disabilities in social life.

Shakespeare (2012) acknowledges that the social model has allowed for important instrumental victories in social policy, and the push-back against the deficit-focused medical perspective has been a source of personal liberation and self-worth for many people with disabilities. The simplicity of the social model, and its clear message for change based on eliminating barriers, has made it a powerful tool for social justice (Shakespeare, 2013).

That said, the social model has not been without its criticisms. Most notably, Tom Shakespeare, once a vocal proponent of the social model (see Shakespeare & Watson, 1997) has

emerged as a high-profile critic (Shakespeare, 2006, 2012, 2013). Shakespeare (2013) argues that the pushback against the medical model has served to underplay the nature and impact of impairment, from a health perspective, on the lives of persons with disabilities.

Arguably, the neglect of the medical aspects of disability stems from the fact that many authors in disability studies are relatively privileged white males with physical disabilities (Bickenbach et al., 1999; Shakespeare, 2013). Herein lies the importance of an intersectional approach that understands that people with disabilities are not a homogenous group, and differences in identity and power exist within the “disabled community.” For example, Deal (2003) notes that people with hearing impairments often prefer not to identify as disabled. Shakespeare (2006) notes that his own impairment leads to chronic pain, and can make him a target for insults due to his appearance. If we understand that impairments are a manifestation of human diversity, we must also consider that diverse impairments come with diverse experiences, some of which present different or greater challenges. Many impairments come with additional medical expenses, and for these people disability is indeed a part of their individual experience, and is not solely the result of societal barriers (Shakespeare, 2006).

Shakespeare (2006) has put forth a model of critical realism, which acknowledges that not all of the disadvantages experienced by persons with disabilities are solely the result of social barriers. This approach “attends to the independent existence of bodies which sometimes hurt, regardless of what we may think or say about those bodies” (Shakespeare, 2006, 54). Building upon the strengths of the social model, critical realism calls for understanding that the “experience of a disabled person results from the relationship between factors intrinsic to the individual, and extrinsic factors arising from the wider context in which she finds herself” (Shakespeare, 2006, 55). Disability is certainly far more than a health issue, but people with disabilities do have unique needs that, if they are not attended to, will limit their ability to fully enjoy social life and the realization of their rights (Shakespeare, 2012).

This perspective is very evident in the World Report on Disability, for which Shakespeare was a key contributor (World Health Organization & World Bank, 2011). The report cautions against a dichotomous medical vs. social model understanding of disability, and attempts to bridge this divide with the International Classification of Functioning (ICF). The ICF as a conceptual framework “understands functioning and disability as a dynamic interaction between health conditions and contextual factors, both personal and environmental” (World Health Organization & World Bank, 2011, 4). This bio-psycho-social model identifies disability as a product of impairments, participation limitations and activity limitations. Disability is not an individual attribute, but in line with the UN Convention on the Rights of Persons with Disabilities, it is an “interaction” (World Health Organization & World Bank, 2011).

The move from a medical model, to a social model, to alternative theories of disability has seen a greater emphasis on the dynamic interactions that affect the lives of persons with disabilities. The social model remains a dominant theoretical perspective, both within academia and in social justice movements. The social model of disability draws our attention to the many factors that contribute to exclusion, while perspectives from the health field force us to keep in

mind the daily needs of those living with impairments. The WHO’s approach, which represents a compromise between the medical and social models that are so often presented as being antithetical, is especially relevant given that it is the basis for the community-based rehabilitation approach (Sally Hartley et al., 2009).

## Chapter 4: The Community-Based Rehabilitation Approach

Community-based rehabilitation is an approach to meeting the needs of persons with disabilities, with an emphasis on low-cost solutions that engage with beneficiaries in their communities. It is a response to the acute need in many developing countries, where persons with disabilities often live in poverty, and where many impairments are preventable and treatable. Conventional rehabilitation services are typically expensive and difficult to access, especially for the rural poor (Lightfoot, 2004).

The CBR approach traces its origins to the 1978 International Conference on Primary Health Care, and is derived from the WHO’s primary health care approach, which also sought to move medical care out of institutions and put it closer to the end user (Khasnabis & Heinicke-Motsch, 2010). In 1980 the WHO began distributing a set of guidelines entitled “Training Disabled People in the Community,” with the understanding that rehabilitation and other services for persons with disabilities could be simplified and delivered by non-professionals in resource-poor environments (Finkenflügel et al., 2005).

While CBR was rooted in a health perspective, it eventually took on a more multi-dimensional character, and was further articulated through two important joint position papers by the WHO, UNESCO, and ILO (1999, 2004). In these papers, CBR is defined as a “strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities” which sought to promote access to services and promote the human rights of persons with disabilities (WHO et al., 2004, 2). The emphasis on

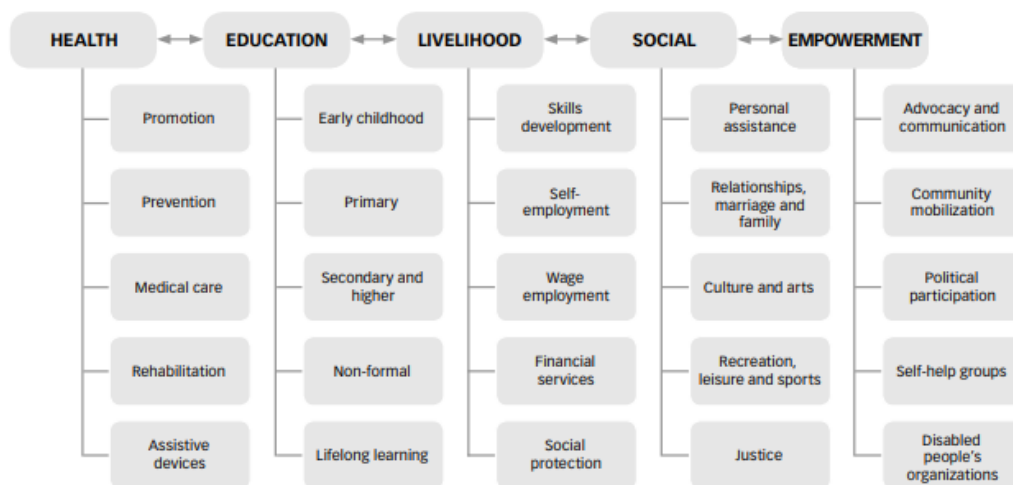


Figure 2: The CBR Matrix (WHO, 2010)

removing barriers to participation is explicitly aligned with the social model of disability, which greatly influenced the move beyond a purely medical

approach.

While these position papers played an important role in promoting the potential benefits of the CBR approach, they provided little practical guidance on how to design and implement a CBR program. This gap was addressed with the launch of the CBR guidelines in Abuja in 2010 (Wickenden et al., 2012). The WHO and its partners undertook an extensive consultation process to develop the guidelines: 120 people contributed content and 300 stakeholders provided feedback on the draft guidelines following field validation in 29 countries (Khasnabis & Heinicke-Motsch, 2010). The result was a series of guidelines which encompassed the five thematic areas of CBR, as well as a supplementary booklet which addressed CBR in relation to mental health, HIV/AIDS, leprosy, and humanitarian crises.

The five thematic areas for CBR are health, education, social development, livelihoods and empowerment, and these are represented in the CBR matrix seen in Figure 2, which provided the organizational structure for the guidelines (Khasnabis & Heinicke-Motsch, 2010). The matrix is intended to show that CBR is indeed a multidimensional approach, with health having the same importance as education or empowerment.

The most common feature of a CBR program is a reliance on local CBR workers, who typically work as volunteers. They are given sufficient training to allow them to provide basic rehabilitation, special education or other services in the homes of persons with disabilities or in the local community. (WHO et al., 2004). These volunteers are usually recruited and then deployed in their home community, with the goal of tapping into their knowledge of the local context and their desire to affect positive change in the lives of their fellow community members (Lightfoot, 2004).

A CBR program is meant to operate at three levels: the local community level, the intermediate level and the national level. The majority of service delivery occurs at the local level through CBR workers, with the participation of persons with disabilities in the planning and implementation. Professionals at the intermediate level train, supervise and provide support. The national level is responsible for coordination and planning, and may involve key stakeholders like the national disabled persons' organization (DPO) (Lightfoot, 2004). The parallels with primary healthcare and the chain of referral are very evident here. Arguably, this structure requires strong government support in order to provide adequate referrals and to ensure sustainable outcomes, which may not be the case with smaller, NGO-led projects (WHO et al., 2004).

According to the WHO (2010), CBR programs have been implemented in over 90 countries. Hartley et al. (2009) state that, at the time of their research, there were nearly 300 CBR programs in 25 African countries, half of which were run by NGOs and DPOs and the other half by governments. It is an approach that is continuing to grow and evolve, with an increasing attention to gender as a cross-cutting theme. There are also efforts to move beyond the original focus on rural areas to consider the needs of persons with disabilities living in informal settlements and other low-income urban areas (World Health Organization, 2002).

The CBR approach can encompass a wide variety of activities, from vocational training, to inclusive schooling, to constructing and distributing assistive devices (Khasnabis & Heinicke-Motsch, 2010). The five thematic areas in the matrix, as well as the numerous examples and suggestions in the CBR guidelines, have resulted in a multitude of different projects and programs bearing the name CBR. For example, van Pletzen et al. (2014) found that community volunteers in South Africa, Botswana and Malawi were engaged in a wide variety of activities in support of persons with disabilities and their families, including helping parents enroll their children in mainstream schools, providing vocational training, and supporting advocacy efforts. Luruli et al. (2016) highlight the crucial role that CBR plays in the social wellbeing of persons with disabilities in Limpopo province in South Africa, as community workers were a source of encouragement and trusting relationships, an important resource given that persons with disabilities are often socially isolated.

CBR has also been seen in some less traditional settings. Wee (2010) notes that CBR was implemented in Dadaab refugee camp in Kenya, where refugees with disabilities were provided with basic therapy and assistive devices like wheelchairs and artificial limbs. Alheresh et al. (2013) also noted that CBR is being implemented in refugee camps in Jordan.

CBR has also been implemented in Uganda, a notable example being the Uganda Children's Orthopaedic Rehabilitation Project, a Christian Blind Mission project which began in 1996. This project sought to create awareness of the causes of disability and to provide reconstructive surgery and physical rehabilitation. The project was also integrated into the government's primary health system and sought to complement pre-existing programs that addressed the needs of people with visual and auditory impairments (Penny et al., 2007).

Another notable example of CBR in Uganda was the program in Tororo District in Eastern Uganda. An evaluation by Claussen et al. (2005) deemed it a successful program, which managed to create a high degree of awareness in the local community and benefitted from the involvement of DPOs and government stakeholders. That said, this program did have issues with reaching beneficiaries in isolated villages; Adeoye et al. (2011) found that in the 15 years of implementation, the Tororo CBR program reached approximately 6,500 beneficiaries, or 21% of the estimated population of persons with disabilities.

CBR forms a key component of Uganda's National Policy on Disability, which is aligned with the CBR approach and related policy documents. The Policy notes the importance of the active participation of persons with disabilities and the need for multidimensional solutions, with explicit mention of decentralization and community-based care (Government of Uganda, 2006).

One of the areas where CBR may increasingly be seen is conflict zones. Boyce (2000, 2008; Boyce et al., 2002) has argued that CBR can be a useful strategy for meeting the needs of persons with disabilities both during and after conflict, and that is consistent with the objectives of peacebuilding. The flexibility of the approach, and its responsiveness to local needs, can account for the fact that people experience different impairments at different stages of conflict. During the conflict the most common issues may be the result of injuries from bullets, shrapnel, or explosions, but after the conflict more chronic conditions may be prevalent. In either case, the

breakdown of formal health services may necessitate local solutions that attend to the abundant and diverse health and social development needs (Boyce et al., 2002).

CBR has in fact been implemented in a number of post-conflict zones, according to Boyce (2008). In Sri Lanka, CBR has been implemented in a variety of ways, including facilitating access to schools for refugee children with disabilities, and giving training to former combatants on the treatment of war-related conditions. CBR has also been used as a livelihoods strategy; for example, in El Salvador and Angola local craftspeople have been trained to make assistive devices for people with mobility impairments.

Clearly CBR has attracted a great deal of attention from international policy makers and academics, as well as governments and donors around the world. In spite of the positivity surrounding the CBR approach, there has been a dearth of conclusive evidence that CBR is indeed effective at meeting the needs of persons with disabilities.

A number of case studies and other qualitative studies have looked at the impacts of CBR on the lives of beneficiaries. Hartley et al. (2009) collected data from a convenience sample of beneficiaries in Mpigi, Iganga and Tororo districts in Uganda, where respondents reported “increased independence, enhanced mobility, and greater communication skills... [as well as] positive social outcomes, enhanced social inclusion, and greater adjustment of people with disabilities” (1803). The livelihood components of these programs apparently contributed to increased income for persons with disabilities and their families, and there were efforts to help integrate children with disabilities into schools.

A WHO report looking at Ghana, Nepal and Guyana found a number of important outcomes from CBR. These included increased self-esteem for persons with disabilities and caregivers of children with disabilities, and enhanced visibility and respect for persons with disabilities in the community. Increased self-care and life skills have also contributed to greater self-reliance for beneficiaries (WHO and Swedish Organizations of Disabled Persons International Aid Association, 2002).

A more rigorous case study was developed by Mauro et al. (2015), using the capabilities approach to frame a study of the CBR program in Karnataka State, India. They found that the program resulted in positive effects in the areas of health and feeling free from prejudice, with considerable short term benefits but fairly sustainable results over time.

A number of literature reviews have attempted to evaluate and develop the evidence base for CBR, with varying levels of sophistication. Cleaver and Nixon (2014) conducted a scoping review on CBR to identify patterns in the literature. While the authors draw no conclusions about the quality or rigour of research into CBR, they do note some intriguing patterns. The authors looked at 114 articles; of these articles, 52 presented empirical research, while the rest were commentaries or reviews of CBR. A similar review by Finkenflügel et al. (2005) found that the literature on CBR is fragmented and mostly consists of theory papers which do not provide adequate information to judge effectiveness.

Velema et al. (2008) examine studies from 1987 to 2007, and claim that CBR programs have been able to enhance school attendance for children with disabilities, increase beneficiaries’

income, enhance autonomy through home-based training, and improve community attitudes. Grandisson (2015) questions the validity of these findings, given that the authors are unable to provide baselines for any of these results.

A review by Robertson et al. (2012) found that the evidence base for CBR is limited because few studies have looked at effectiveness, and the heterogeneity of their samples makes it difficult to generalize findings. The authors argue that these findings are not an indictment of CBR, but rather a testament to the need to invest more into evaluation (Robertson et al., 2012).

The lack of evidence is a key concern for authors like Grandisson (2015) and Iemmi et al. (2016). The evaluations of CBR that have been conducted are quite heterogeneous, though they typically lack baseline data and data on cost-effectiveness. Iemmi et al. (2016) also note that the rigorous studies they were able to review were almost exclusively in the field of health, with little attention paid to the other elements of the approach. Grandisson (2015) argues the CBR matrix gives a broad, visual representation of what activities might fall under the approach rather than clear information on what principles define CBR. This may lead to confusion, and

It may imply that any program delivering community services to people with disabilities, in one or more of the CBR Matrix cells, can call itself CBR. In addition, rehabilitation services provided in the community by health professionals are often referred to as community-based rehabilitation in the literature (Grandisson, 2015, 5).

Grandisson (2015) and Iemmi et al. (2016) conclude that the evidence base for CBR is fragmented and insufficient, and in need of clearer guidance on rigorous evaluation procedures.

A number of other issues have come out of CBR programs around the world. Despite aspiring to be a low-cost solution, securing funding has been a major issue for CBR programs. For example, Alheresh et al. (2013) note that CBR programming in Jordan's refugee camps has been inadequately funded. A study by Kuyini et al. (2011) of CBR in Northern Ghana found that the programs there had largely collapsed in the absence of donor funds. Local supervisors and DPOs, which had relied on donors to implement the programs, were not receiving adequate support from the government or local community. This is a concern in Uganda as well, given the National Policy on Disability provides no guidance on how services will be financed (Government of Uganda, 2006).

CBR has been promoted as a cost-effective approach, with the potential to reach far more beneficiaries than conventional rehabilitation services delivered in an institution (Lightfoot, 2004). However, while CBR may be cost-effective for the government, Dawad and Jobson (2011) argue that this may be due to the fact that many of the costs are downloaded onto the local community, or passed on to NGOs who are unlikely to have the resources to ensure long-term programming.

Indeed, while the supposed cost-effectiveness of CBR is certainly attractive, the burden of care typically falls on voluntary CBR workers. In some cases, international volunteers or interns may play a key role in setting up and coordinating a program; however, most

professionals, be they local or international, cannot afford to volunteer on a long-term basis. A short-term deployment may lead to less emphasis on capacity-building and local participation (Pollard & Sakellariou, 2008).

The reliance on voluntarism may also have some unintended, gendered impacts. Giacaman (2001) notes that in Palestine, CBR workers were almost always women, which added to their domestic burden while reinforcing the stereotype that women are exclusively responsible for caregiving. There may also be tensions between the informal CBR workers and the professionals at the intermediate level tasked with offering support: these professionals may distrust the informal workers or withhold information because they do not view them as being capable (Dawad & Jobson, 2011; Lightfoot, 2004).

Ultimately, the reliance on voluntary labour poses serious concerns for the sustainability of many CBR programs. The lack of remuneration for CBR workers makes it difficult to retain them, leading to attrition and the need to recruit and train more workers (Lightfoot, 2004; WHO and Swedish Organizations of Disabled Persons International Aid Association, 2002).

Some CBR programs have also struggled to reach the most vulnerable, and to meet the diverse needs of all persons with disabilities. Hartley et al. (2005) found that the CBR programs in the three districts of Uganda they visited were not well-known among the target population, perhaps due to the size of the districts or the fact that activities did not align with local needs. In South Africa, Luruli et al. (2016) encountered a variety of issues, from poor quality assistive devices to infrequent home-based care. There were also institutional barriers, with a lack of options for skills upgrading for CBR workers, poor management, and inadequate integration into the primary healthcare system (Luruli et al., 2016).

While CBR workers make many important contributions to the lives of persons with disabilities, it is beyond their means to truly affect many of the barriers to socio-economic participation that persons with disabilities encounter (Chappell & Johannsmeier, 2009). Sometimes, the nature of the impairments may be too severe for minimally-trained CBR workers to address at the local level, as was the case in Kayunga District, Uganda, where Hamid et al. (2017) found that most of the beneficiaries of a CBR program had severe disabilities.

The benefits of CBR have also not accrued equally to all persons with disabilities. Claussen et al. (2005) note that the CBR program in Tororo, Uganda struggled to accommodate the needs of visually and hearing-impaired beneficiaries, given that this would require specialized services in sign language and Braille that are beyond the capacity of local CBR workers. Similarly, Mauro et al. (2015) found that people with intellectual impairments were far less likely to benefit from the CBR program in Karnataka, India.

The WHO's (2002) report on beneficiaries' experiences in Ghana, Guyana and Nepal identified several major issues with the CBR programs in those countries. First, the reach of the programs have been limited to only a few thousand people. Second, the reach has been uneven across impairment groups; people with physical disabilities were more likely to benefit, while those with intellectual or other communication impairments were often neglected. Third, there was a lack of participation by DPOs and beneficiaries, which is contrary to the basic principles

of CBR. Finally, there were sustainability issues related to the reliance on voluntarism and the lack of support from the government.

Clearly there are major concerns with how CBR has been implemented in various countries. The reliance on voluntarism, the lack of sustainable funding, and the fragmented evidence base are worrying and certainly worthy of attention. That being said, CBR has also made some important contributions to the lives of persons with disabilities around the world. The CBR guidelines, which draw on best practices and experiences around the world, highlight many innovative and meaningful examples of how CBR has benefited people with disabilities, from skills training and job placement services to inclusive schooling (WHO, 2010a; WHO, 2010b). Efforts to develop evaluation guidelines (Grandisson et al., 2014; Grandisson et al., 2016) will hopefully promote more rigorous work to demonstrate the effectiveness and impact of CBR. Despite its flaws, the widespread adoption of the CBR approach, and its incorporation into national policies in countries like Uganda, attests to its influence of CBR on how governments, NGOs and other actors engage with the needs of persons with disabilities.

## **Chapter 5: The Disability – Poverty – Conflict Nexus**

CBR is a response to the multidimensional needs of persons with disabilities, which can be the result of complex patterns of marginalization. Building on Yeo and Moore's (2003) disability/poverty cycle, this review illustrates the linkages between disability, poverty development and conflict, including the intersection of gender, in order to identify the "disability – poverty – conflict nexus." This nexus serves as a context for implementing a policy like CBR, and a challenge that such approaches must contend with.

### ***Disability and Poverty***

The linkages between poverty and disability are widely acknowledged. Many of the common impairments in low-income countries are a direct result of poverty. For example, maternal malnutrition can lead to developmental impairments in a fetus (Groce et al. 2014). Environmental hazards due to poor housing and sanitation can often lead to otherwise preventable impairments (Lightfoot 2004). Yeo and Moore (2003) discuss how social, political and economic exclusion contribute to the marginalization of persons with disabilities. People with disabilities facing discrimination in schools and the labour market are more likely to have lower incomes, which can contribute to further exclusion. Similarly, people with lower incomes have less access to healthcare and education, which can put them at a greater risk of developing an impairment that leads to disability. Thus poverty can be a cause and consequence of poverty (Yeo and Moore 2003).

While poverty and disability are linked, the experiences of persons with disabilities are diverse. Moodley and Graham (2015) found that South African women with disabilities often

have lower educational attainment, and their traditional responsibility for household care limits their ability to participate in the labour market. Gender can also be an obstacle to accessing health services; Mavuso and Maharaj (2015) find that women with disabilities faced a number of obstacles in trying to access sexual and reproductive health services in Durban, South Africa. This can result in disparities in health outcomes; for example, Warner and Brown (2011) found that in the United States, disability prevalence rates are highest for black and Hispanic women and lowest for white men.

Just as there can be gendered dimensions of disability and poverty, disparities often exist within countries. Specialized rehabilitation services are typically offered in urban hospitals, making them inaccessible for persons with disabilities in rural areas (Lightfoot, 2004). This is evident in Northern Uganda, where predominantly rural victims of war are more likely to use inferior government health services or forgo certain treatments due to poverty (Mazurana et al. 2016).

### ***Poverty and Conflict***

While it is not a specific focus of this paper, it is worth noting the clear linkages between poverty and conflict which underpin the nexus. This is relevant for persons with disabilities, who are more likely to live in low-income countries (WHO and World Bank, 2011). The OECD has concluded that various factors contribute to violence in a country, including extreme economic fragility. This is a situation consisting of the absence of long-term drivers of growth (e.g. education, proximity to world markets), the absence of individual economic opportunity (including female, youth and general labour force participation), and high levels of resource and aid dependence (OECD 2016). This economic fragility is one significant risk factor for violence and conflict.

While poverty can exacerbate the risk of conflict, it is widely understood that conflict can result in poverty. Gates et al (2012) find that conflict has negative implications for poverty, hunger, primary education, child mortality, and access to water. These factors could all contribute to impairments, as well as exacerbating the challenges for persons with disabilities. The 2011 World Development Report highlighted how conflict can delay progress on poverty reduction and negatively impact social indicators ranging from school enrollment to under-5 mortality (World Bank 2011).

Gender also influences the impacts of violent conflict. There is a substantial body of literature on gender-based violence in African conflicts (see, for example, Blay-Tofey & Lee, 2015, Ferrales et al., 2016; Freedman, 2015) which often targets women and girls but also men and boys. Conflict can disproportionately harm women and girls, as well as exacerbating their vulnerability in post-conflict situations (Coomaraswamy 2015). The breakdown of institutions and economies may harm women's livelihoods, pushing them into informal employment where there is a greater risk of abuse and exploitation. The absence of the rule of law also raises the

risks of gender-based violence in countries experiencing conflict, and contributes to a culture of impunity.

### *Disability and Conflict*

There is an increasing focus on how conflict can cause disability and exacerbate the vulnerability of persons with disabilities. Conflict can directly cause impairments, especially since the majority of modern conflicts are fought within states and disproportionately affect civilians (Sidel and Levy 2008). Boyce (2000) illustrates the link between landmines and disability, as injury and amputation create impairments that can affect the whole body, leading to issues with self-care and attending work or school. Other impairments might include nerve injuries from bullets or shrapnel, hand, foot, and facial injuries, blindness from explosions or torture, and other injuries from building collapse (Boyce, Koros, and Hodgson 2002).

The general breakdown of institutions as a result of conflict can also indirectly lead to impairments and disability. Sidel and Levy (2008) argue that much of the morbidity and mortality in war is due to the destruction of societal infrastructure (eg. food and water supplies, healthcare, sewage systems) often resulting in malnutrition and food and water-borne diseases. These conditions can cause preventable impairments, especially amongst children. Sidel and Levy also note that war diverts funds from essential services, such as healthcare, further affecting those who are disabled or are vulnerable to new impairments. This is evident in crisis situations like Zimbabwe from 1990-2008, where health clinics and schools shut down, resulting in major increases in infant mortality and a dramatically lower average life expectancy (Munro 2015).

While conflict can clearly cause physical impairments, there is also the psychological trauma of violence. Smith-Khan et al. (2015) found that humanitarian relief agencies in refugee camps primarily identified disability among refugees by noting physical impairment, underlining the widespread assumptions among practitioners that equate disability with physical impairment. On the contrary, there are many forms of disability that may be invisible, or may manifest themselves only in social situations. For children, conflict can cause a wide range of mental health issues, including “fear and anxiety, depression, anger, blame and guilt...” (Nilsson, 2013, 499). Ertl et al. (2011) highlighted that children recruited as child soldiers in Northern Uganda were highly susceptible to physical impairments, but also post-traumatic stress disorder (PTSD) and other mental health conditions.

The impact of conflict on mental health extends beyond children, as well. While most people are well-equipped to deal with even extreme emotional trauma, such as the violence of war, “daily stressors” can be a major factor in mental illness. Miller and Rasmussen (2010) present a model whereby

armed conflict results in exposure to violence and loss, which in turn directly affect mental health and psychosocial functioning. Exposure to armed conflict also gives rise to a constellation of daily stressors [eg. poverty, inadequate

housing, changes in family structure], which in turn affect psychological wellbeing (8).

This model highlights the complex intersection of conflict, poverty and mental illness. Ongoing and pervasive daily stressors can affect the mental health of people in conflict or post-conflict settings, potentially leading to impairments like PTSD or other anxiety disorders (Miller and Rasmussen, 2010).

A word of caution is necessary when drawing a causal link between trauma and mental disorder. A number of authors (notably Kleinman, 1977 and Young, 1995) have argued that Western conceptions of mental illness do not fully account for the ways in which culture mediates an individual's response to trauma. Categorizations of mental illness based on Western psychiatry may not reflect the ways in which people perceive and experience trauma in a different cultural context. Parker (1996) argues that the diagnosis of PTSD relies on conceptions of deviance and normality that are not entirely objective or readily translated across borders. While Kirmayer and Ryder (2016) argue that modern diagnosis manuals account for these challenges, there is an ongoing debate regarding the links between trauma, culture and mental health.

While conflict can result in impairment and disability, people's experiences in conflict settings can also be influenced by their impairment. Rohwerder (2013) notes that persons with intellectual disabilities are highly vulnerable during conflict situations, especially due to mobility and communication impairments that make it harder to flee violence or to know when to flee. Myerscough et al. (2010) note that people with intellectual disabilities are more prone to suffering psychological, physical or sexual abuse, and find it harder to identify or disclose this abuse. This is especially problematic given that people with intellectual disabilities have become targets for physical and sexual violence (Myerscough et al., 2010).

Given the relationship between conflict and poverty, governments in countries undergoing or recovering from conflict are likely to lack resources. Considering the marginalization of persons with disabilities, specialized health services are a likely candidate to be cut when resources are scarce (Myerscough et al., 2010). Given the stigmatization and marginalization of persons with intellectual disabilities, these individuals are considered a low priority for resettlement (in the case of refugees or internally displaced people) and for post-conflict reconstruction or health efforts (Rohwerder, 2013). This may be especially true of the urban displaced; during the conflict in Northern Uganda many persons with disabilities relocated to the urban centre of Gulu Town to be able to access services, but as a result they were ineligible for resettlement and found themselves living in informal settlements (Muyinda and Whyte 2011).

Intersectional considerations also must be taken into account when discussing the experiences of persons with disabilities in conflict and post-conflict settings. Sexual and gender based violence (SGBV) in particular can be cause or a consequence of disability. Sherry's (2013) discussion of disability hate crimes demonstrates that persons with disabilities in the Global North are often targeted for hyper-violent and, especially for women, hyper-sexual forms of

attacks. This may be especially true of women or men with intellectual impairments, as Meer and Combrinck (2015) note how the myths and attitudes that devalue these individuals make them more vulnerable to being targeted for sexual violence. These risks are often exacerbated during times of conflict. High rates of SGBV, both as a result of organized violence and due to general societal breakdown, are typical of many conflicts around the world. While the direct casualties of most wars are predominantly men, women are far more likely to experience SGBV (Buvinic et al. 2013).

Fistula and other injuries resulting from sexual violence can create impairments with long-lasting consequences, as has occurred during the conflict in the Eastern Congo (Longombe, Claude, & Ruminjo 2008). Just as the physical injuries associated with sexual violence can be a source of impairment, the trauma of SGBV can also put victims at risk of experiencing mental health conditions. Rees et al. (2011) found that in Australia, SGBV may either predispose women to mental disorders, or mental disorders may increase the vulnerability of women to experiencing SGBV. Fergusson et al. (2002), drawing on longitudinal data from New Zealand, find that women are more likely to experience sexual violence and, as a result, are more likely than men to develop anxiety disorders or clinical depression.

### ***Disability – Poverty – Conflict Nexus***

This review has highlighted the intersections of disability, conflict and poverty, which are further complicated by the intersection of gender. Figure 3 provides a graphical summary of the literature review. The main implication to be drawn from this nexus is that the needs of persons with disabilities in conflict or post-conflict settings are highly complex. Disability is an experience of socio-economic exclusion grounded in society's perceptions of and reaction to a person's functional impairments. In countries or regions experiencing conflict, this exclusion and vulnerability is heightened, as the social structures that exclude persons with disabilities are weakened and may ultimately disintegrate. The few protective institutions, be they formal or informal, that supported persons with disabilities in times of peace may cease to exist in times of conflict. The complex interplay between disability, poverty and conflict calls attention to the urgent need to ensure that persons with disabilities are a priority for post-conflict development.

An exploration of this nexus also illustrates the diversity of experiences for persons with disabilities living in conflict-affected settings. In particular, this analysis demonstrates the impact of one's gender identity. While it cannot be definitively stated that women with disabilities are inherently more vulnerable than men, there are different threats and obstacles which disproportionately affect women in times of conflict. In particular, the threat of sexual violence is heightened for women and women with disabilities, with the potential to severely impact their future reproductive and mental health.

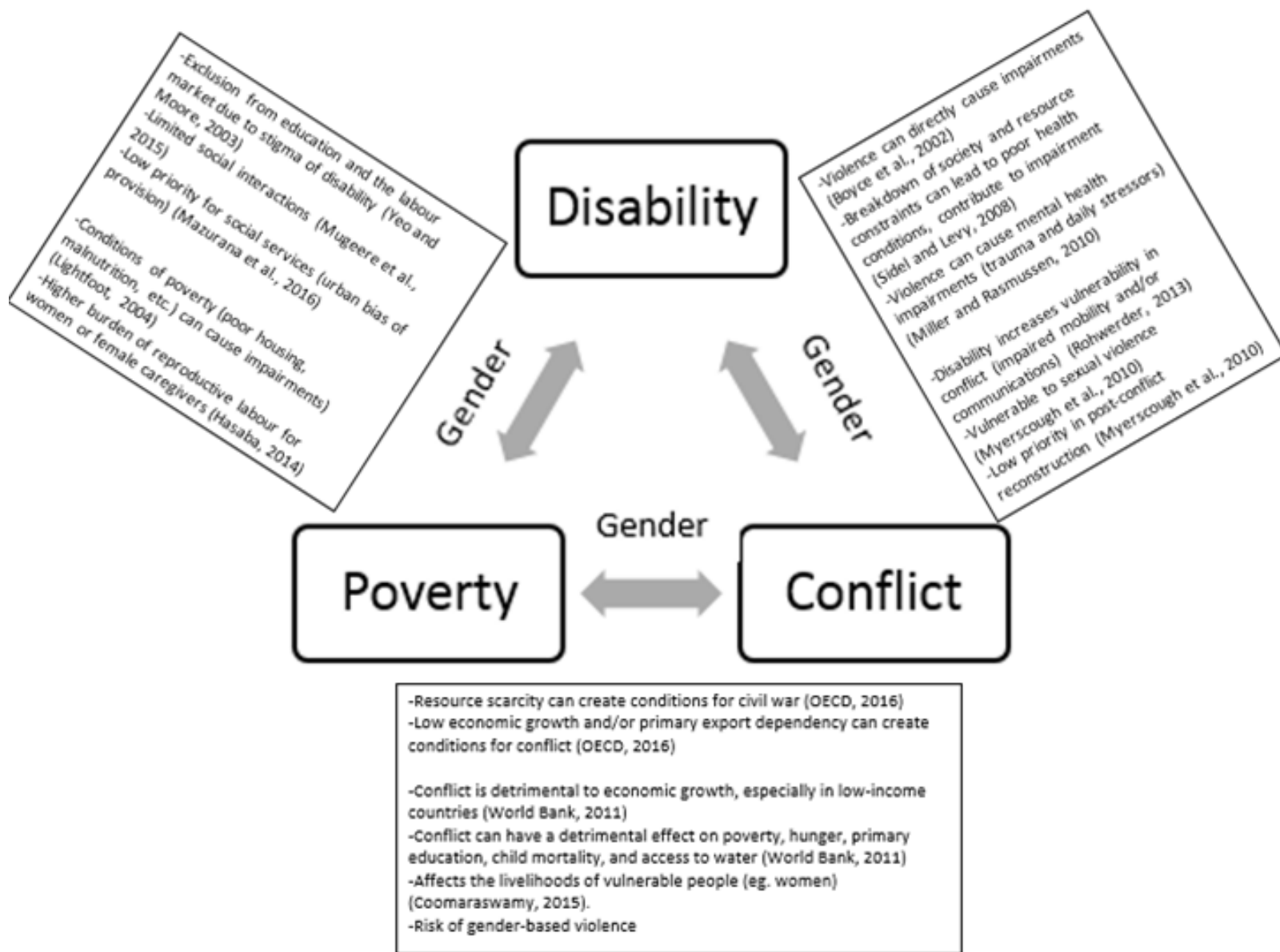


Figure 3: The Disability - Poverty - Conflict Nexus

In addition to functional differences in the lives of persons with disabilities with different impairments, differing attitudes towards impairment groups also have social or policy implications. Deal (2003) illustrates that, even within the disabled community, different impairment groups can be perceived within a hierarchy, whereby people with intellectual, developmental or mental health impairments are often disproportionately marginalized. This has important implications, given that service provision across impairments groups is highly uneven (Bickenbach et al. 1999). For example, Berghs (2015) describes the “valorization of the male veteran” in post-conflict settings, which may lead to a bias towards providing services that support this particular group of men with physical disabilities.

The nexus of disability, conflict and poverty draws our attention to how various socio-economic factors, and their interaction with a person’s impairment, can create a lived experience of exclusion and marginalization. Policymakers and development professionals must be conscious of these dynamics in order to design and implement interventions that positively impact the lives of persons with disabilities in conflict or post-conflict settings.

## Chapter 6: Disability and Conflict in the Ugandan Context

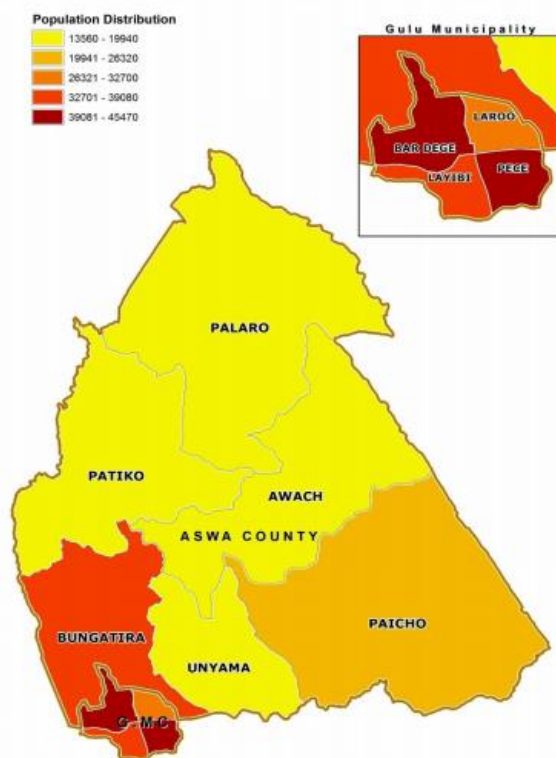


Figure 4: Map of Gulu District showing population distribution, (Uganda Bureau of Statistics 2017)

This section provides a contextual overview of conflict and disability in Gulu District and the Northern Uganda region. The overview of key issues and historical events in this section is intended to inform the subsequent discussion of the study findings, especially those around the disability – poverty – conflict nexus.

The setting for this research study was Gulu District, one of the 121 administrative districts in Uganda. Geographically, Gulu is primarily a lightly wooded savannah, which experiences a long dry season, with an economy that has traditionally been dominated by agriculture and pastoralism. The Acholi, a Luo-speaking ethno-cultural group, constitute the majority of the District’s population (Atkinson, 1994). Three quarters of the Ugandan population live in rural areas, and similar trends hold true in Gulu (Uganda Bureau of Statistics, 2017).

The Acholi region, which contains Gulu District, is economically impoverished in comparison to the rest of Uganda. Only 35.8% of

Acholi region's population are in formal employment, and 53.9% of its people rely on subsistence agriculture for their livelihood (Uganda Bureau of Statistics, 2017). Poverty rates in Gulu District exceed 60% in some sub-counties, and even in Gulu Town, the major municipality in the District, they stand at approximately 40% (Gulu District Local Government, 2013).

This section will begin with an overview of the conflict with the Lord’s Resistance Army, a period that greatly impacted the region and remains relevant for development practitioners today. This will be followed by an overview of disability in the Ugandan context, encompassing relevant laws, statistics and contextual information.



Figure 5: Map of Uganda's Districts (UNICEF, 2010)

**The War in Northern Uganda**

The town and district of Gulu have become, in the minds of outsiders, inextricably linked with violence, tragedy and poverty, and indeed the insurgency of the Joseph Kony and the Lord’s Resistance Army (LRA) was undoubtedly one of great brutality and an immense human cost. An examination of the region’s history of conflict is important for understanding the current socio-

economic and political conditions that have excluded the North from the economic development experienced elsewhere in Uganda. Furthermore, examining the humanitarian crisis brought about the LRA insurgency, and the heavy-handed response by the Government of Uganda, is crucial for understanding how poverty and conflict have contributed to a heightened prevalence of disability in the Northern region.

Media and NGO narratives about the conflict have often emphasized the horrific and sensationalist aspects, such as child abduction, mutilation and religious fanaticism (Finnstrom, 2010). These accounts have obscured the root causes of the conflict that lie in the political, social and economic realities of Gulu and Northern Uganda. This section will provide an overview of the historical roots of the conflict, as well as an overview of key events during the LRA insurgency. Particular attention will be paid to the resulting humanitarian crises which gave rise to many development challenges that persist today, especially for persons with disabilities.

The LRA conflict has its origins in the politicization of Acholi ethnic identity and the rise and fall of their fortunes in post-independence Uganda. The Acholi are primarily found in Northern Uganda, including modern-day Gulu District (Amone, 2015). Amone (2015) cautions against the use of a primordialist understanding of ethnic identity, whereby a group's origins are fixed in the distant past. This is especially true of the Acholi; while a vague sense of ethnic identity did exist prior to colonization, it was truly fixed and institutionalized by the British for administrative convenience (Allen & Vlassenroot, 2010). Indeed, Vlassenroot and Doom (1999) argue that the use of the term "Acholi" to describe a group of people only dates back about 100 years.

While the British found a capable and centralized state in Buganda in Southern Uganda that facilitated colonial administration, the Acholi did not have a paramount chief, and the local leaders did not have the capacity or willingness to execute the functions of taxation and administration demanded by the British (Branch, 2011). The system of divide and rule that was subsequently instituted by the British set the stage for ethnic competition in Uganda. As Branch (2011) argues, the "British reified and essentialized an Acholi identity along with other tribal identities, rendering the tribe the dominant political category in national politics" (pg. 48). While ethnic identity in Uganda is, as in any other country, socially constructed, these markers of identity have greatly influenced the political discourse in the post-independence era.

As in other British colonies, Uganda experienced very marked regional disparities in investment. Cash cropping was promoted in the South, while the North saw very little investment or private sector development, and primarily served as a labour reserve for the civil service and, crucially, the police and military (Jackson, 2002). The decentralized nature of Acholi society, filtered through a racist lens, led many missionaries and colonial officials to portray the Acholi as a warlike race fit only for military service. Elsewhere in Uganda, the events of the post-independence era further reinforced the generalized perception of the Acholi as a "violent people" (Finnstrom, 2006).

Ethnic divisions and competition were ongoing concerns throughout the post-independence era in Uganda. The political dominance of the Baganda was contrasted with the

prominent role of the Acholi in the military; under President Milton Obote, the military expanded from 700 troops at the time of independence to 9,000 in 1971, one third of whom were Acholi (Branch, 2010). Idi Amin’s coup in 1971 led to massive purges of the Acholi from the civil service and the military, and in 1977 alone, Amin’s death squads killed 10,000 people in Acholiland and Lango (Branch, 2011).

The Acholi resumed their prominent role in the armed forces following the expulsion of Amin and the disputed return to power of Milton Obote in 1980. Obote’s return prompted the formation of several rebel groups, most notably the National Resistance Army (NRA), led by Uganda’s current president Yoweri Museveni (Finnstrom, 2006). As Branch (2010) explains, the NRA framed Uganda’s problems as stemming from a North vs. South dynamic, allowing them to draw support from the Baganda as well as the Banyankole of Southwestern Uganda and Banyarwanda refugees from neighbouring Rwanda (Branch, 2010). This North/South animosity was further stoked by the atrocities committed by mostly Acholi government forces in the Luwero Triangle region in 1983, where 300,000 civilians were killed (Jackson, 2002).

Following a brief coup which installed an Acholi officer named Tito Okello as President, the NRA succeeded in consolidating power by March 1986 (Allen & Vlassenroot, 2010). The Acholi remnants of the armed forces formed a number of rebel groups, including the Uganda People's Democratic Army (UPDA) and the eccentric Holy Spirit Movement (HSM) (Vinci, 2006). These Northern resistance groups were driven by an existential fear of reprisals following the atrocities committed in Luwero , and indeed the NRA were guilty of indiscriminate killing, forced evictions and sexual violence in the late 1980’s, including around the major towns of Gulu and Kitgum (Dolan, 2009).

- |   |
|---|
| <ol style="list-style-type: none"> <li>1. August 1986 - May 1988: LRA as a minor group</li> <li>2. June 1988 to March 1994: Beginning of LRA insurgency</li> <li>3. April 1994 to December 1999: High profile massacres</li> <li>4. December 1999 to March 2002: Renewed activity in Northern Uganda</li> <li>5. April 2002 to November 2003: Operation Iron Fist</li> <li>6. 2004 to 2006: Temporary ceasefire</li> <li>7. June 2006 to April 2008: Juba Peace Talks</li> <li>8. 2008 to 2011: Post-talks revival of LRA</li> <li>9. 2011 to 2017: US Special Forces involvement</li> <li>10. 2017 onwards: LRA no longer pursued</li> </ol> |
|---|

Figure 6: Phases of the LRA Conflict (adapted from Dolan, 2009)

While the UPDA and HSM insurgencies ultimately failed, some former members chose to continue their rebellion against Museveni’s new government, and joined the organization that would become known as the Lord’s Resistance Army. Drawing from the unique tactics employed by the HSM, the LRA’s leader Joseph Kony claimed to be able to speak to spirits and receive instructions from God, and perpetuated the idea that the Acholi needed to be purified by violence (Allen & Vlassenroot, 2010). As Jackson (2009) argues, this apocalyptic vision was grounded in rational grievances and security fears, including the attacks by the NRA and the limited political space allocated to the Acholi or other Luo-speaking groups under the

renamed National Resistance Movement (NRM) government. Kony sought to address this by “transcending political institutions and representing a new moral identity, acting as the mouthpiece of God through the Holy Spirit” (Jackson, 2002, pg. 41).

While the LRA rebellion was rooted in internal Acholi grievances and historical factors, popular support for Kony’s group quickly waned, and they were nearly destroyed by 1991 during Operation North, a counter-insurgency carried out by the newly christened Uganda People’s Defence Force (UPDF) (Jackson, 2002). During these early years, the LRA relied heavily on the support of the Sudanese government, who provided weapons and a safe haven in return for support in their fight against the Sudan People’s Liberation Army (SPLA), a rebel group operating in South Sudan (Vinci, 2006).

The mid to late 1990’s saw the LRA carry out a series of high profile massacres across Northern Uganda. These included massacres in Atiak, Acholpi refugee camp, and Lokung/Palabek, each of which claimed hundreds of lives. October 1996 also saw the abduction of over 100 school girls from St. Mary’s College in Aboke, an incident which attracted international attention to the conflict. Other trends during this period included the practice of “night commuting,” whereby people (especially children) would move to the major towns of Gulu and Kitgum during the night to sleep and avoid abduction, often seeking shelter in public spaces, NGO offices or the doorsteps of shops (Dolan, 2009). The LRA also cemented their reputation for brutality during this period. Jackson (2002) states that

...the nature of the violence consist[ed] of a code that is clearly decipherable by the Acholi. For example, informers have lips and ears cut off, women are raped to subvert family, men are publicly raped as a means of humiliation and those possessing bicycles (the main form of communication) have their legs chopped off (pg. 45).

Not surprisingly, these atrocities eroded what little popular support the LRA had once had. As a result, abducting children for use as child soldiers, porters and sex slaves became the main form of recruitment into the LRA (Vinci, 2006). Research into child abduction in Northern Uganda (Annan & Blattman, 2010; Annan, Blattman, & Horton, 2006) illustrates that, while the length of time spent with the LRA varied from years to a few days, tens of thousands of children and youth were kidnapped and forcibly recruited.

While the violence perpetrated by the LRA was extensive, the response from the Government of Uganda arguably took a greater toll on the people of Northern Uganda. The mid-1990s also saw the creation of the “protected villages,” a policy of forced displacement carried out by the UPDF in Northern Uganda. Ostensibly to protect the civilian population from LRA attack, the creation of these villages resulted in displacement, social dislocation, disease and death on a massive scale, such that Dolan (2009) typifies the protected villages as a conscious policy of “social torture.” In 1996, the Ugandan government and the UPDF gave the rural population of Northern Uganda, and primarily those living in Gulu and Kitgum Districts, 48

hours to vacate their homes and report to the “protected villages.” Those who resisted were faced with violence, and people’s former homes were burned and possessions looted. Branch (2013) describes how

Within days, the region was violently transformed from being characterised by widely dispersed homesteads and small trading centres to a space of ‘slums without cities’, an archipelago of a couple of dozen desperately congested agglomerations of squalid mud huts with no sanitation or services, containing up to tens of thousands of people (pg. 3153).

Far from being protected, these internally displaced persons (IDP) camps were a humanitarian disaster by every possible measure. Hastily erected mud huts were tightly packed, often with only a metre between them, leading to a serious risk of fire. Latrine facilities were very limited, leading to regular outbreaks of disease. In spite of the stated goal of protecting the population, the UPDF barracks were usually at the centre of the village, and soldiers were slow to respond to attacks by the LRA (Dolan, 2009). This meant the villages, more accurately referred to as IDP camps, were often targets for LRA massacres (Cline, 2013). By the spring of 2002, 79% of Gulu District’s 469,700 people were living in 33 IDP camps. Primary school enrollment in the camps was extremely low; for example, in Pabbo camp in 1998, only 25% of primary-age children were enrolled in school (Dolan, 2009).

By 2005 nearly 90% of the population of Kitgum, Gulu and Pader Districts were displaced, and excess mortality among this population due to violence, disease and malnutrition was equal to 1,000 deaths per week (The Republic of Uganda Ministry of Health, 2005). Leaving the camps to farm was extremely dangerous, and as a result by 1999 less than 10% of arable land was being cultivated, contributing to food insecurity and overall economic decline (Dolan, 2009). By 2007, the peak of displacement, the World Food Programme (WFP) was providing food aid to 1.9 million people (FAO, IFAD, UNICEF, WFP, and WHO, 2017).

The destructiveness of the protected villages policy cannot be overstated, and when Jan Egeland, then the UN Secretary General's Special Representative on Humanitarian Affairs, visited Northern Uganda in November 2003, he dubbed it “the biggest neglected humanitarian emergency in the world” (Dolan, 2009, pg. 56). This led to a significant influx of humanitarian agencies, both multilateral and NGOs, to provide relief (Dolan, 2009).

There were efforts beyond the battlefield to bring the conflict to the end. An internationally-brokered peace deal between Sudan and Uganda eventually deprived the LRA of their safe haven in South Sudan (Dolan, 2009). In December 1999, the Parliament of Uganda passed the landmark Amnesty Act, which was specifically targeted at encouraging defection from the LRA. While slow to gain traction, amnesty has been issued for over 13,000 former LRA combatants to date (Bradfield, 2017). The amnesty situation became far more complicated in 2003, when Uganda referred the LRA conflict to the nascent International Criminal Court (ICC). On October 13<sup>th</sup> 2005, the ICC issued arrest warrants for five prominent LRA

commanders, including Joseph Kony, for multiple crimes against humanity and war crimes (Mcknight, 2015).

This ICC indictment proved to be an obstacle during the peace talks held in Juba, South Sudan from 2006-2008. These negotiations faced numerous obstacles, as schisms within the LRA and the Government of Uganda were very apparent. Vincent Otti, the LRA's second in command, was the lead figure pushing for peace, while Kony did not attend and remained a distant, skeptical onlooker (Quinn, 2009). On the Government of Uganda side, political figures were seeking a negotiated peace while UPDF commanders were committed to a military victory against the LRA (Macdonald, 2017). Otti, seen by many as the key force beyond the LRA's participation in the talks, was subsequently killed in a power struggle with Joseph Kony in 2007 (Allen & Vlassenroot, 2010). The talks ultimately fell apart in 2008, and fighting resumed.

The failure of the Juba Peace Talks marked the end of the LRA's insurgency in Northern Uganda, since by 2008 they were primarily operating across the border in the Democratic Republic of Congo (DRC) (Cline, 2013). Instability and insecurity in the DRC and Central African Republic (CAR), especially after the coup against CAR President Francois Bozize in 2013 ("CENTRAL AFRICAN REPUBLIC," 2013; "United Nations Security Council Resolution 2127," 2013) has allowed the LRA free reign to operate in these forest regions.

Operating in foreign territory, the LRA have continued to carry out massacres and abductions of considerable brutality, and primarily rely on abduction and coercive violence to extract resources from the local population (Titeca & Costeur, 2015). The LRA of today are not a cohesive military force, but rather an array of armed groups operating in isolation with a common allegiance to Joseph Kony. Far from fighting for Acholi liberation, after thirty years of operation, the LRA of today have been reduced to looting for survival (Cline, 2013). An offensive led by the UPDF, with the support of the Congolese Armed Forces (FARDC) and the United States, has supposedly reduced the LRA to a mere 100 fighters. As a result, the LRA are no longer deemed a threat to Uganda, and the mission to pursue them was brought to an end (Cooper, 2017).

While the ultimate outcome of the insurgency remains somewhat unclear, the humanitarian crisis in Northern Uganda eventually ended. The IDP camps began to empty in 2007, and the UN High Commissioner for Refugees (UNHCR) closed its Gulu office in 2012 as the process of return was nearly complete (Spindler, 2012). Rather than returning to their destroyed homesteads, many people chose to relocate to Gulu Town, and the trend towards urbanization in the region continues apace. The majority of these new residents of Gulu Town made their homes in unplanned settlements (Branch, 2013).

The twenty year conflict in the region cannot be disassociated from the political, economic and social grievances resulting from decades of colonial and post-colonial ethnopolitics. While the LRA was only briefly a popular movement, Kony's talk of cleansing and impending doom for the Acholi drew from political exclusion under the NRM, memories of atrocities in Luwero, the purges under Amin, and the fear and reality of NRA reprisals. Subsequently, the LRA conflict has given rise to new grievances and unresolved issues,

combined with the exclusion of the conflict-affected regions from the economic growth experienced in the rest of Uganda (UNDP Uganda, 2015).

In the aftermath of the conflict, transitional justice practices have been reinterpreted and gained new meaning as a form of social healing, while questions of UPDF culpability<sup>1</sup> remain unresolved (Baines, 2007). The conflict cost the region over \$800 million USD in lost agricultural production and productivity (Civil Society Organisations for Peace in Northern Uganda, 2006), with a social cost that is difficult to express. Attention has now shifted from recovery to development, as illustrated by Uganda's 2015 Human Development Report, which is subtitled "Unlocking the Development Potential of Northern Uganda" (UNDP Uganda, 2015).

Undoubtedly, the decade since the end of the insurgency in Northern Uganda has seen a great deal of positive change, and the story of this region, and of Gulu District in particular, should not begin and end with conflict. However, this section has provided a basis for understanding the conflict that took place in the region, the resulting costs borne by its people, and the origins of development challenges encountered today. In particular, as will be seen in Chapter 8, the humanitarian crisis brought about the LRA and the mass displacement played an important role in contributing to a heightened prevalence of disability in the region, and exacerbating the challenges experienced by persons with disabilities contending with poverty in Northern Uganda.

### *Disability in Uganda*

As with many developing countries, there is a dearth of reliable and comparable disability statistics in Uganda, as a result of limited statistical capacity, changes in census methodology, and varied definitions of "disability" (Abimanyi-Ochom & Mannan, 2014; Lang & Murangira, 2009). The most recent and authoritative statistics come from the 2014 census, which states that disability prevalence for the population above 5 years old was nearly 14%, with a higher rate of prevalence among women and among people living in rural areas (Uganda Bureau of Statistics, 2016). The census also provides district-level data, indicating that 53,791 people in Gulu District had a disability (26,621 seeing, 15,114 hearing, 19,330 remembering, and 17,218 walking) (Uganda Bureau of Statistics, 2016). There is evidence here of the changes in methodology, as data drawn from the 2002 census had indicated a much lower prevalence rate in Gulu of 5.6%, with physical disabilities constituting 37% of impairments (Gulu District Local Government, 2013).

Setting aside the matter of statistics, it is clear that Uganda is, in policy terms, a leader in disability inclusion in Africa and the world (Abimanyi-Ochom & Mannan, 2014). Uganda has an extensive set of institutions to provide for the representation of persons with disabilities at all levels of government, from local village councils all the way to Parliament. The 1996

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<sup>1</sup> Grievances over violence perpetrated by the UPDF remain a topic of debate today. During my fieldwork in Gulu, I attended a number of events concerning transitional justice. Even in 2017, the question of accountability for the actions of government actors has not been resolved to the satisfaction of the people of Northern Uganda.

Parliamentary Elections statute designated five seats in parliament for persons with disabilities, at least one of which is to be a woman's seat (Owens & Torrance, 2016). The Local Government Act of 1997, which laid out Uganda's extensive decentralization policy, also established the position of elected persons with disabilities representative at each level of government (Francis & James, 2003). Furthermore, a National Council for Disability was established in 2003 to monitor government programs that pertain to persons with disabilities (Aniyamuzaala, 2012).

Uganda is a signatory to all major international conventions on disability, most notably the UN Convention on the Rights of Persons with Disabilities (2007). The country has also taken steps to translate these international commitments into domestic law. The most prominent example is the Persons with Disabilities Act of 2006 (Ministry of Gender, Labour and Social Development, 2006), which upholds the fundamental rights of persons with disabilities and provides a legal basis for implementing the country's National Policy on Disability (Lang & Murangira, 2009). The constitution also positioned Uganda as only the second country in the world to recognize sign language as an official language (Owens & Torrance, 2016).

In terms of service delivery, the Government of Uganda adopted community-based rehabilitation as their official policy of supporting persons with disabilities in 1992. This policy was to be delivered by the Ministry of Gender, Labour and Social Development with donor support from Norway (Abimanyi-Ochom & Mannan, 2014). An evaluation conducted in the early 2000's highlighted the broad implementation of CBR, with services offered in ten of the country's fifty-six districts (the number of districts has since doubled). A further eleven programs were being run by NGOs in eight other districts (S. Hartley et al., 2005). A National CBR Strategic Plan was instituted from 2002 to 2007, and CBR has also been supplemented by a cash transfer program for persons with disabilities called the Social Assistance Grants for Empowerment (SAGE) (Abimanyi-Ochom & Mannan, 2014). As of 2016, CBR programs are in place in 26 districts of Uganda (Committee on the Rights of Persons with Disabilities, 2016).

Uganda's impressive range of policies and institutions supporting persons with disabilities is largely the result of concerted advocacy efforts by domestic civil society. The lead actor, the National Union of Disabled Persons of Uganda (NUDIPU), was founded in 1987, and has also been supported by groups like the National Union of Women with Disabilities of Uganda (NUWODU) (Abimanyi-Ochom & Mannan, 2014). NUPIDU and other disabled person's organizations have successfully lobbied for laws and policies that account for the needs of persons with disabilities. Local branches, like the Gulu Disabled Person's Union (GDPU), have magnified the voices of persons with disabilities across Uganda.

Despite an impressive policy framework, there is a gap between policy and practice around disability in Uganda. Persons with disabilities in Uganda continue to face discrimination and poverty, and many of the institutions set up to support them are ineffective or lack capacity. The National Council on Disability, for example, is underfunded, and there is a lack of clarity on their role with regards to electing persons with disabilities representatives, which traditionally was the role of NUPDIU (Aniyamuzaala, 2012). Mazurana et al. (2016) also critique the Persons

with Disabilities Act for its emphasis on the medical dimensions of disability, failing to recognize the role of social and cultural attitudes that contribute to exclusion.

In addition to gaps in policy, civil society has its own limitations. Aniyamuzaala (2012) highlights NUDIPU's strong legalistic focus on human rights, rather than addressing the livelihood concerns facing persons with disabilities, resulting in a strong set of laws and policies but limited substantive change in their lives. Activists and DPOs spend a great deal of time advocating for human rights and participating in "capacity building," leading to considerable duplication. This is consistent with Andrews' (2013) finding that Ugandan NGOs typically focus on advocacy and lobbying rather than service delivery. Lang and Murangira (2009) also highlighted concerns from some members of civil society that NUDIPU may not be fully representative of all impairment groups, leading to a proliferation of NGOs focused on more narrowly defined membership (eg. groups for people with visual or hearing impairments).

The implementation of CBR has also had limited reach in some areas of Uganda. Hartley et al. (2005) found that, "in the year 2000 [CBR] programmes offered services to 85,712 people. This gave a coverage level of around 8.5% of the estimated number of disabled people for the whole country" (168). The authors also found that, in the three districts chosen for their study, most of their respondents (caregivers of children with disabilities) did not mention the existence of a CBR program, indicating that they were either unaware of it or did not deem it relevant to their needs. The gaps in the provision of CBR are most evident in Northern Uganda, where a study found that 70% of persons with disabilities had received no rehabilitation services in the previous year (Uganda Bureau of Statistics, 2004). That said, an evaluation of the SAGE program highlighted the positive effect of cash transfers to marginalized households (Merttens & Jones, 2014).

The gap between policy and practice with regards to disability inclusion in Uganda is most evident in the area of education. While Uganda has adopted a policy of inclusive education, children with disabilities are less likely to enroll in and attend school, and those who do enroll are very unlikely to advance beyond the early primary levels. The outcomes also vary across impairment groups, as "vision and some forms of physical disabilities carry less stigma and require fewer extra resources in school... Other disabilities, such as difficulty with selfcare, require more resources and carry greater stigma" (Moyi, 2012, 12).

Many rural Ugandan schools in particular suffer with serious physical and human resource constraints, which can prove to be a barrier for all students, and especially those with disabilities. As a result of these institutional deficiencies, combined with household poverty and other barriers, access to education for children with disabilities is very limited. According to Aniyamuzaala and Riche (2014) only about 9% of children with disabilities attend primary school (compared with a national average of 92%) and only 6% continue on to secondary level. While the authors concede that these data are imperfect, it is evident that inclusion is not being achieved in the realm of education in Uganda.

As a result of institutional deficiencies, negative social attitudes and other barriers in society, persons with disabilities are, on average, more likely to be poor than other Ugandans.

The most recent Uganda Poverty Status Report found that “In 2009/10, 92.3 percent of households with a severely disabled member were poor or insecure nonpoor compared with the national average of 67.4 percent” (Ministry of Finance, Planning and Economic Development, 2014, 79). Hoogeveen (2005) found that households with a disabled head were more likely to be poor, and experience a greater depth of poverty. Poverty among persons with disabilities in Uganda manifests itself in terms of lower consumption, lower literacy levels, worse quality of dwellings, and less access to clean water and sanitation, among other issues (Hoogeveen, 2005).

The challenges facing persons with disabilities are more evident in Northern Uganda as a result of decades of conflict and displacement. Northern Uganda has a higher prevalence of disability than any other region in the country (Aniyamuzaala & Riche, 2014). This can be attributed to violence perpetrated by the LRA, as well as malnutrition and disease resulting from displacement and the collapse of health systems in the region during the conflict (Bird et al., 2010; Dolan, 2009; Ogwang D M, 2007; Owens & Torrance, 2016). Lang and Murangira (2009) note that many persons with disabilities lost their land and livestock during the conflict, severely limiting their ability to earn an income, and the social networks they relied on for support were disrupted. Lang and Murangira (2009) also criticize official resettlement initiatives that merely listed persons with disabilities as a vulnerable group, but made no substantive effort to support them. Even a decade after the end of the conflict, the impact can still be felt by persons with disabilities in Northern Uganda. Echoing the criticism that recovery programs are not disability-inclusive, Mazurana et al. (2016) found an increased vulnerability to poverty and food insecurity among those with war-related disabilities, as well as worse mental health outcomes.

Persons with disabilities continue to face a higher incidence of poverty compared to their fellow Ugandans. While promising initiatives like the SAGE program and CBR initiatives have made an impact in the lives of persons with disabilities, their coverage and impact remain limited. The current situation of persons with disabilities in Uganda is not one of hopelessness, but much remains to be done to ensure that laws and policies are translated into substantive changes in the lives of people’s lives.

This section has provided a broad overview of two contextual issues of great relevance to this study: the history of conflict in Northern Uganda, and the status of persons with disabilities. These two issues converge in Northern Uganda, where a legacy of conflict and displacement has resulted in a greater prevalence of disability, as well as heightened rates of poverty.

## **Chapter 7: Methodology**

The preceding literature review demonstrated how the intersection of disability, poverty, conflict and gender can create complex challenges in the lives of persons with disabilities. This nexus is quite evident in the historical and contemporary challenges facing post-conflict Northern Uganda, and presents an opportunity for multi-dimensional interventions like CBR. This study identifies the unique challenges facing people with disabilities in post-conflict Gulu,

and within this context, identifies the ways that CBR has influenced the work of development actors in Gulu. The methods described in this chapter are intended to describe the policy transfer of CBR within a context where the impacts of disability, poverty and conflict are evident.

### ***Overview: Qualitative Multi-Method Case Study, Including Site Visit***

This research project consisted of three stages of data collection. It began with the establishment of a sample frame of development actors in Gulu. Subsequently, a web-based questionnaire was distributed, and finally, semi-structured follow-up interviews were conducted. These methods were chosen in order to provide insights into how organizations are engaging with persons with disabilities, and permit inquiry into the intersectional challenges of development in the context of disability and conflict. The qualitative mixed methods approach was intended to allow for triangulation and validation of results.

It was necessary to identify development organizations serving persons with disabilities, either as an explicit focus or incidentally. Organizations were classified as government, multilateral, international NGO or local NGO. The sample frame was developed through a combination of purposive and snowball sampling, including internet searches of organizational websites, especially for international organizations. For locally-based organizations, including NGOs and government, snowball sampling was crucial to identifying relevant organizations, as many did not have a web presence. During the field research period, the primary researcher was completing an internship with ACORD Uganda at their field office in Gulu. This was invaluable in gaining access to networks of practitioners and making the necessary introductions. The Gulu Disabled Persons Union, as the local branch of NUDIPU, was also an important source of information on the landscape of disability-focused initiatives in Gulu. Approximately 70 organizations were identified for participation, though upon follow-up it was discovered that approximately 15 of these were defunct or ineligible for participation. The final response rate was approximately 45% (25 out of 55).

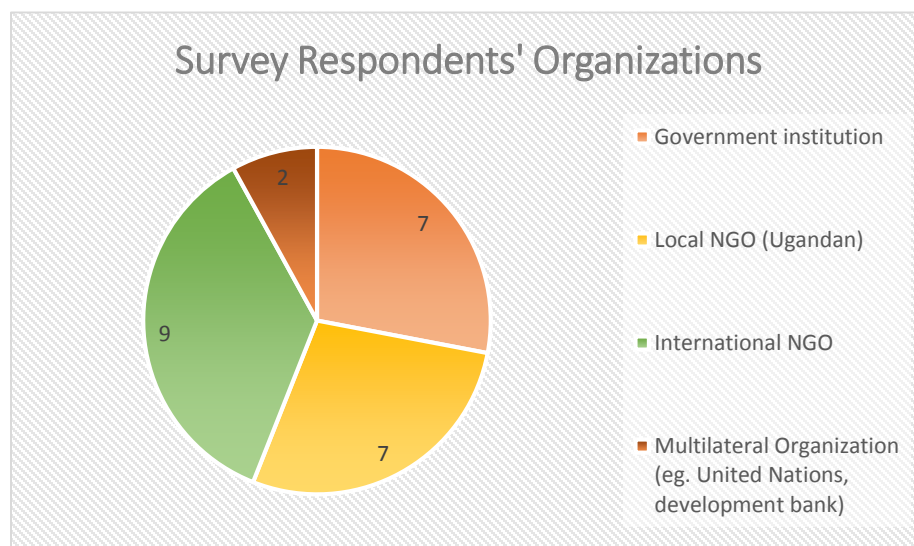


Figure 7: Distribution of Survey Respondents by Organization Type

Once the sample frame was completed, a questionnaire was distributed by email. The introductory email explained the research project, and was accompanied by a letter of information and a letter of consent. The inclusion criteria stated that participants must

have programming that directly or indirectly benefits persons with disabilities in Gulu District. Only one participant per organization was sought, to ensure a clear narrative. For participants who lacked reliable internet access, or preferred to complete their survey with the primary researcher, an appointment was made to complete the survey in person. For these participants, informed consent was sought using a printed form, and the survey was completed using a smartphone application.

The final distribution of survey respondents is presented in figure 7. A total of 25 respondents completed the survey. Local and international NGOs, as well as government institutions, were well-represented in this survey.



Figure 8: Distribution of Interview Participants by organization type

The final stage of this research consisted of follow-up interviews with questionnaire respondents. As seen in figure 8, a total of eight people agreed to participate in follow-up interviews, with half of them representing local NGOs. The purpose of the interviews was to validate the survey data and to provide further insights into the challenges organizations face when working with persons with disabilities. The interviews were also an opportunity to identify the ways in which the disability – poverty – conflict nexus manifests itself. The audio of the interviews was recorded and transcribed manually. Participants were given the

opportunity to review their transcript once it was completed and could request any alterations they deemed necessary.

### **Research Validity**

The validity of qualitative research is derived primarily from “the ‘appropriateness’ of the tools, processes and data” (Leung, 2015, 325). The question of validity in qualitative research is often contrasted with norms associated with quantitative studies. Whether described as appropriateness, or in other terms like “trustworthiness” (Guba, 1981; Miles & Huberman, 1994), the qualitative researcher aspires to conduct research that is honest and demonstrates a commitment to quality (Whittemore et al., 2001).

According to Patton (1999), the credibility of research depends on three main factors. The first factor is the application of rigorous techniques and methods, such as triangulation. The other two factors relate to the researcher themselves, specifically their suitability for the research (derived from experience and training) and their belief in the value of qualitative inquiry.

Triangulation is based on the premise that no single method is perfect. Triangulation is therefore a means to overcome the weakness of certain methods, and in doing so strengthening

the credibility of the research (Krefting, 1991). Patton (1999) defines triangulation in four ways: in terms of methods, data sources, analysts, and theoretical perspectives.

This research project employed triangulation to enhance the validity of the findings. This was primarily done through employing multiple research methods, and through a diversity of theoretical perspectives. As argued by Whitemore et al. (2001) a researcher must determine the validity ideals of a study and choose the corresponding methods. This study was intended to describe the range of development interventions for persons with disabilities being undertaken in Gulu District, and to evaluate the extent to which these are influenced by the CBR approach and complicated by the intersection of disability, poverty and conflict. The methods employed in this study were selected in order to meet these objectives.

The use of an online questionnaire and in-person interviews was intended to enhance the validity of the results. The questionnaire provided a broad overview of the types of interventions taking place in Gulu, and allowed for straightforward and efficient collection of data from a number of respondents that would be difficult to achieve with interviews or a physical questionnaire. That said, on its own the questionnaire results may overstate the scope of interventions taking place in Gulu, since data is anonymously self-reported and no probing was possible. Interviews provided an opportunity to understand the constraints facing practitioners, and to understand the different types of activities that organizations undertake.

The interviews were useful for gaining in-depth information on the intersection of disability, poverty and conflict, since a questionnaire would not allow for the researcher to probe and explore emerging themes. Responses to interview questions were also usually longer than those provided in the questionnaire. This may be due to the benefits of human interaction versus an online form, or the ease of typing a response versus simply speaking.

Multiple theoretical perspectives were also drawn upon in this study. The analytical framework developed in this study encompasses perspectives from public health, international development, political science, microeconomics, gender and sexuality studies, and critical disability studies. This multidisciplinary approach enhanced the analysis, as multiple explanations for phenomena could be drawn from these diverse perspectives. There was also a diversity of respondents involved in this study. Medical practitioners, government administrators, and NGO program managers working in education, social development and health all contributed their perspectives to this study. This allows for a more nuanced understanding of the topic, and represents a form of triangulation via analysts.

These methods were appropriate for gaining insights into the issues being explored in this study. They did not always provide a clear and singular narrative; indeed, as Patton (1999) suggests, the contrasts and even inconsistencies between accounts were themselves very informative. However, the methods chosen and the manner in which they were applied contributes to the validity of the findings. This study provides a credible understanding of the influence of CBR on development practice in Gulu, Uganda.

## ***Data Collection Instruments***

Two data collection instruments were used for this research project: a web-based questionnaire and an interview guide. The questionnaire was developed using the WHO's CBR guidelines (Khasnabis & Heinicke-Motsch, 2010), and was divided into two main sections. The first, and most extensive, section constituted a profile of the organization's work. This section was intended as an environmental scan, and was broken down into five sub-sections corresponding to the elements of the CBR matrix. The questionnaire asked organizations which thematic area they worked in, and then used open and closed ended questions to collect further detail on the scope of the organization's activities. This data was intended to help to answer both research questions: are the development programs consistent with the guidelines, and which dimension of the matrix is being emphasized?

The questionnaire was developed and deployed using Kobo Toolbox, a free survey platform developed by the Harvard Humanitarian Initiative and designed for use in challenging environments. The majority of participants completed this survey anonymously using the link that was emailed to them. Several completed theirs in person, in which case the KoboCollect smartphone application was used for offline data collection before uploading to the secure cloud server. Data was only accessible to the primary researcher through a password-protected account.

The other data collection tool was a guide used for the semi-structured interviews. This guide contained three main sections. The first, brief section included questions regarding the organization that the interview participant represented, including the type of organization and the scope of their work. The second section focused on the disability – poverty – conflict nexus, and contained questions relating to the intersection of these three variables in Gulu. The final section was related to community-based rehabilitation, including the participant's knowledge of the approach and whether they felt it to be viable in a post-conflict setting like Gulu. The data collection instruments can be found in Appendix A.

## ***Researcher Positionality***

Discussions of validity in qualitative research often focus upon the nature and role of the researcher themselves, given that they constitute the main research instrument. Miles and Huberman (1994) identify four parameters for assessing the trustworthiness of the researcher: their familiarity with the topic and setting, a strong interest and ability to work with voluminous qualitative data, the ability to take a multidisciplinary approach, and good investigative skills developed through training and experience. Patton (1999) also argues that information on the researchers' track record, skills, education and training are crucial to evaluating their credibility.

The ability of the researcher to reflect critically on their own role in the research process is also essential. For example, Guba (1981) notes that credibility can be derived from an extended engagement with the research setting, as this allows for building rapport and accessing

hidden truths. At the same time, excessively deep engagement can also undermine credibility, given that the researcher is implicated in the findings and develops close relationships with the informants.

Considerations of reflexivity and positionality are also crucial when the researcher is foreign to the research setting. As Milner (2008) notes, researchers must be conscious of the deep cultural differences which affect our perception. A researcher working in a foreign setting, especially one where the majority of people are of a different race or culture than the researcher, must dedicate time to reflecting on their positionality in relation to their researcher participants.

My credibility as a researcher in this case derives from a number of sources. This research topic ties together disparate themes and areas of inquiry, from disability to conflict studies. My experience with conducting primary research dates back to my undergraduate studies, when I conducted research with students with disabilities and their families in Lagos, Nigeria. This experience allowed me to develop a greater familiarity with qualitative research methods, which was further developed in subsequent jobs as a research assistant. Furthermore, the process of publishing my research from Nigeria drew my attention to the need for clear and transparent procedures for ensuring validity, and informed how I designed this work in Uganda.

My investigative skills were honed in the classroom and in the field, both in Ottawa and abroad. My interest in disability dates back to middle school, when I first began volunteering with students with intellectual impairments. This continued into high school, and in 2017 as a volunteer soccer coach with Special Olympics Ontario. The attention I pay to the diversity of disabled experiences in this thesis project is derived from my own history of seeing peers and friends with intellectual impairments struggling to fully integrate with society.

My engagement with this research setting consisted of four months living and working in Gulu, Uganda. This prolonged period of time in the field allowed me to gain a greater understanding of the development sector, and my work term with ACORD exposed me to the constraints and peculiarities of working in an NGO in Gulu. This enabled me to better understand the issues raised by the research participants. I was also able to develop a personal rapport with the research participants, as it was clear I was committed to learning more about this topic and setting.

My internship with ACORD was crucial to the success of this research. Four months of work experience in Uganda was beneficial to my professional development, but it also facilitated access to the target population of development practitioners. Working with ACORD, an African organization with thirty years of history in Uganda, gave a degree of legitimacy to my research. My co-workers' personal and professional networks, and their knowledge of the development landscape in Gulu, allowed me to identify and contact relevant organizations. This potentially introduces an element of bias in the sampling process; however, I also identified and pursued my own contacts through snowballing, rather than relying solely on ACORD contacts. I introduced myself first and foremost as a student at the University of Ottawa when conducting research activities, rather than emphasizing my ACORD connection.

My position as a white, male Canadian in Gulu is worthy of attention. These markers of identity can lend the researcher a heightened degree of privilege in an impoverished setting like Gulu, especially when interacting with marginalized groups like persons with disabilities. One challenge identified by other researchers in Gulu (such as Victor, 2011) is the tendency of Acholi people, and especially women, to agree with statements put forth by foreigners rather than offending them by offering correction. My privilege as a white foreigner was certainly evident in the field activities I participated in as a staff member of ACORD.

However, I believe that my positionality in relation to my research subjects did not have a detrimental impact upon the results. This is primarily due to my age and relative lack of professional experience. While I was functionally a staff member of ACORD, I was technically an unpaid intern. The majority of the research participants I interacted with were much older than me, with more extensive professional experience and a corresponding position within their organization. As a 25 year old intern I was in a subordinate position to my research subjects, and in a town like Gulu which is home to numerous foreign development professionals, my race did not afford me special status. My race certainly helped to gain access to certain organizations; undoubtedly most local people would not be able to easily walk into an office and ask for an interview with a government official or the head of an organization, as I did. However, while my race certainly made it easier to gain access to respondents, my positionality in relation to the research participants in the study had little impact upon the results, as a result of my age and relative inexperience.

### ***Ethical Approval***

This research project received ethical approval from the University of Ottawa's Office of Research Ethics and Integrity (file number 04-17-11). Data collection and other primary research activities began after receiving ethical approval on May 8<sup>th</sup>, 2017. As this research was conducted as a staff member of ACORD Uganda, an international NGO registered with the Government of Uganda under the NGO Act, additional approval was not requested. The research was of a minimal risk to participants, and was conducted within a professional context. The approval document can be found in Annex C.

### ***Data Analysis***

Traditional quantitative understandings of research reliability are centered on the need for research to be reproducible, offering the same results each time. This allows for results to be generalizable. However, the highly context-specific nature of qualitative research does not lend itself to such considerations; rather, the reliability of qualitative research is derived from a clear and consistent approach to analysis (Leung, 2015).

The data analysis for this project was conducted manually, with different approaches taken for the survey data and the interview data. The survey data itself required multiple approaches since it contained different types of information.

The first half of the survey, which served as an environmental scan, consisted primarily of quantitative data, and so the analysis focused on identifying patterns in the frequency of responses in relation to the research questions. For example, the distribution of activities across thematic areas was one area of consideration. To facilitate the analysis, the data were transformed into graphs, which allowed for a more clear understanding of various patterns. Attention was paid to where certain activities were very common or uncommon, with possible explanations generated inductively based on secondary research and observations from the field.

The latter portion of the survey contained open-ended questions across three main categories: policies on disability, experience with CBR, and the role of CBR in conflict. The text-based responses were divided into these three categories, and were colour-coded by organization type to ascertain if any patterns arose. Within the three categories, responses were reviewed and were coded based on themes that were identified inductively. While the coding was primarily inductive, the identification of themes was informed by the principles of community-based rehabilitation, as described in the CBR guidelines and other academic literature. These codes were subsequently refined and key quotations were identified for use in the thesis write-up.

A similar thematic content analysis approach was used to analyze the interview data, though the volume of qualitative data was greater than in the survey. Three main categories were identified that corresponded to the sections of the interview guide. The interview transcripts were reviewed to identify recurring themes. After an initial list of themes was generated, the coding was refined, and key quotations were grouped together by theme. A brief summary of each code or theme was prepared by the researcher to facilitate the thesis write-up.

The analysis of this data relied primarily on an inductive review of the survey and interview data, though the theoretical and analytical frameworks also informed the process. In particular, the disability – poverty – conflict nexus framework was used to structure interview data regarding the Gulu context. As noted by Brannen (2005), triangulation will not necessarily produce the same results across data sources. Analysis can help to elaborate, complement or contradict other sources. In this case, the themes and data derived from the interview data was used to complement and elaborate upon the information derived from the questionnaire. Subsequently, the theoretical frame of policy transfer and its related approaches was employed after the majority of analysis was completed, and served to guide the discussion and conclusions regarding the influence of CBR.

### ***Limitations***

This research project has two main limitations that arose during the course of the fieldwork. The first is the lack of participation by multilateral organizations, and the second is the failure to complete the document analysis.

Given that CBR is an approach developed and promoted by a number of United Nations organs, the intention was to solicit survey responses from at least five multilateral organizations, in addition to two follow-up interviews. Ultimately, only two multilateral organizations completed the survey, and none agreed to participate in interviews. As a result, the perspectives of the originators of CBR were not included, and the environmental scan is incomplete.

While ten multilateral organizations were invited to participate in this study, their low response rate can be attributed to two main factors. First, several organizations deemed themselves to be ineligible for participation, as they either did not have programming that supported persons with disabilities, or they did not have such programming in Gulu District. The other possible reasons for the low response rate could be bureaucratic inefficiencies, or a lack of time. Many of the Gulu field offices requested that contact be made with their country office in Kampala, perhaps due to a lack of time to participate or a reluctance to provide information on record. Emails and phone calls to country offices often went unanswered, and despite repeated attempts at following up, no response was forthcoming.

While the lack of participation from multilateral organizations is disappointing, it does not invalidate the results. This study focused on the influence of CBR on development practice in Gulu. Arguably, the CBR guidelines are intended to support NGO and government practitioners more than fellow UN practitioners. While the fact that many multilateral organizations claimed to have no programming with persons with disabilities is surprising, the findings of this study remain relevant and informative despite the absence of perspectives from these organizations.

The second limitation is the failure to conduct a thorough document analysis, in line with the initial research proposal. The document analysis was meant to supplement the interviews and surveys and enhance the validity of the results through triangulation. When follow-up interview requests were sent to the survey participants, these respondents were also requested to share relevant documents like concept notes or work plans for projects. This document analysis relied upon voluntary participation, and unfortunately respondents stated they did not have any documents that they were authorized to share.

Attempts were made to correct this problem. Particular effort was made to account for the lack of multilateral participation by seeking out publically available documents from online databases. These included the UN Official Document System, the World Bank eLibrary, WHO's Institutional Repository for Information Sharing, and the websites of multilateral organizations' country programs in Uganda. The current country strategies of four key multilateral organizations were reviewed. Purposive searches of seven key international NGO websites were undertaken as well, and their annual reports and other publications were scanned to locate references to CBR or other activities with persons with disabilities.

Where documents were located, the few references to CBR were at the country level and were not in relation to the Northern region or Gulu District specifically. For example, reports to

the UN's Committee on the Rights of Persons with Disabilities make broad references to CBR programs in Uganda, but do not provide specifics on activities or outcomes. The most recent country strategies for the various multilateral organizations, including the WHO, UNDP, and ILO, do not mention CBR. People with disabilities were mentioned as "vulnerable groups" in need of attention, but no specific activities were described. These efforts to supplement the document did provide some useful context about disability in Uganda, but little data that could be used to respond to the research questions.

There are a number of reasons that may explain the respondents' lack of participation in document analysis. The most innocuous explanation is that internal policies may indeed prohibit the sharing of project documents. There may have been increased reluctance because the primary researcher was also an NGO practitioner, and sharing project documents may be risky in an environment where there is competition for funding opportunities. Burger and Owens (2010) find a stark difference between Ugandan NGOs claims of transparency and their actual practices, and one could argue that this might have contributed to the failure to access project documents. However, the most likely explanation is that the internal approvals required to share such documents would be troublesome to obtain.

The lack of document analysis in this project does somewhat undermine the validity of the results, since the environmental scan in particular relies on self-reported data on project activities. That said, it would have been impossible to use project documents to verify the results of an anonymous survey. These documents would have been useful for validating the responses of interview respondents, but the purpose of the interviews was to explore the ways in which CBR is influencing the thinking and practice around interventions with PWD's in Gulu. While documentation would have been useful for identifying how the principles of CBR are translated into practice, the knowledge and opinions of practitioners identified through interviews are equally valid for determining the influence of the CBR approach.

## **Chapter 8: Research Findings - A Nexus in Gulu?**

This study is intended to evaluate the influence of the community-based rehabilitation approach in Gulu, and incorporates an analysis of the disability – poverty – conflict nexus approach to identify the multiple barriers to the full participation of persons with disabilities in socio-economic life. This nexus of multiple deprivations is a challenge that may be addressed through the CBR approach "so that people with disabilities and their families become empowered, contributing to an inclusive society or 'society for all'" (Khasnabis & Heinicke-Motsch, 2010, 26).

This section is intended to explore how the nexus of disability, conflict and poverty manifests itself in the lives of persons with disabilities in Gulu, Uganda, serving as the context in which community-based rehabilitation's influence will be assessed. This discussion is drawn from published literature and from interviews with practitioners who have worked with persons

with disabilities in Gulu. The interview subjects quoted in this paper have been given pseudonyms to protect their identities.

### *Poverty and Conflict*

<b>Brian</b> - Male - International NGO
<b>Stella</b> - Female - International NGO
<b>Akenna</b> - Male - Government
<b>Betty</b> - Female - Government
<b>Beatrice</b> - Female - Local NGO
<b>Charles</b> - Male - Local NGO
<b>Isaac</b> - Male - Local NGO
<b>Joshua</b> - Male - Local NGO

Figure 9: Interview participants' pseudonyms

Poverty can be causal factor behind the outbreak of conflict, as a lack of economic prospects may cultivate a frustrated population seeking access to resources and a way to address perceived grievances. This does not appear to be the case in Gulu District. Jackson (2002) argues that the greed/grievance dichotomy is not useful for studying the LRA conflict. He notes that Acholi recruits to the LRA were not seeking control of any natural resources, and only participated in looting to ensure their own survival. Ethnic grievances, or more accurately fear of retribution for past atrocities, certainly contributed to Acholi support for the forerunners of the LRA: the UPDA and the Holy Spirit Movement (Vlassenroot & Doom, 1999). Opposition to Museveni's NRM, which primarily

drew its support from Southern ethnic groups, did indeed constitute the original political ideology for the LRA. However, Kony's apocalyptic vision and belief in the need to cleanse the Acholi of their sins means that, if anything, the LRA has subsequently been focused inwards on the Acholi themselves, and any grievances it may have had with the NRM gave way to preying upon the movement's original support base (Jackson, 2002).

While the Acholi and other Northern ethnic groups do hold some historical grievances concerning the region's underdevelopment, poverty was not a significant factor in the formation of the LRA. While Collier and Hoeffler (2002) argue that poverty may make the local population more amenable to participating in civil war, this trend is not especially evident in Gulu. As Vlassenroot and Doom (1999) note, the LRA has lacked popular support since the early 1990's, and its recruitment strategy is primarily based on abduction and indoctrination rather than eliciting support from the Acholi people.

However, it can be argued that the relationship between poverty and conflict may become increasingly relevant in the near future, with the return of relative stability to the region. Betty, an interview respondent working with the local government, related how

There are issues of land wrangles, there is a high rate of selling the land. You find maybe one brother wants to sell part of the land, the others disagree and so you have conflict, fighting, killing...

While lacking natural resources, Gulu District has abundant and potentially valuable agricultural land. Jackson (2009) noted that, at the time of writing, the vast majority of Gulu’s land was not “effectively owned” due to overlapping tenure systems, leading to fear of expropriation by the government. Branch (2013) draws attention to the increasing frequency of corporate land grabs in Gulu, as well as smaller local conflicts. While poverty may not have been a factor in past conflicts in the region, exclusion from land ownership as a result of poverty and displacement may be a factor in future issues in the region.

Even though poverty may not have contributed to the conflict in Gulu, decades of fighting and displacement have had a negative impact upon the region’s economic development.

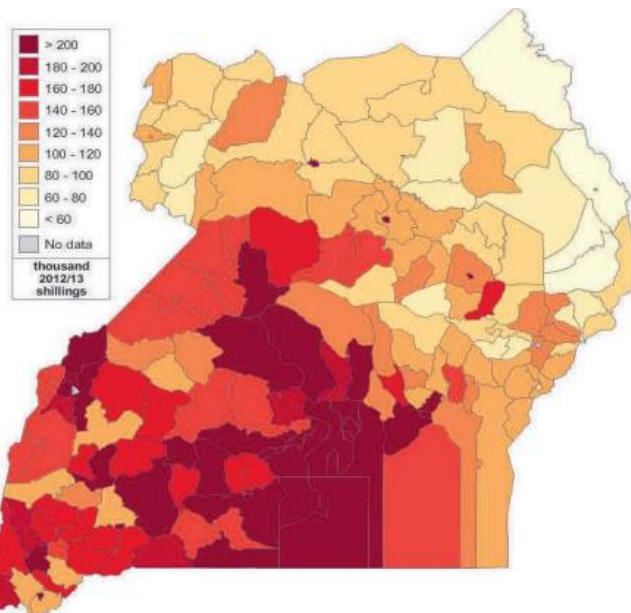


Figure 10: Monthly consumption per adult equivalent, as of 2012/2013 (Ugandan Ministry of Finance, Planning and Economic Development, 2014)

In 1992-1993, during the early years of the LRA insurgency and when the current poverty line was set, 73.5% of the population of the Northern region was classified as “poor,” with a further 21.6% classified as “insecure non-poor.” By 2005/6, towards the end of the LRA conflict, the percentage of the population classified as “poor” had actually fallen to 60.7%, though this reduction was dwarfed by the progress made in the rest of the country. For example, Central region managed a 64% reduction in poverty during this time, from 45.6% of the population to only 16.4% in 2005-2006 (Ministry of Finance, Planning and Economic Development, 2014). Gulu District

specifically has a poverty rate in excess of 60%, with 57% of the population engaged in subsistence agriculture (Gulu District Local Government, 2013).

Arguably the most devastating aspect of the conflict with the LRA was the forced displacement of nearly 2 million people across Northern Uganda from 1996 to 2008. According to Dolan (2009), by spring 2002, 79% of Gulu District’s 469,700 people were living in 33 IDP camps. By 2006, the conflict had cost Northern Uganda approximately \$846 million USD, as a result of direct expenditures on conflict, the loss of economic infrastructure, opportunity costs of foregone agriculture production and lost labour productivity due to mortality and morbidity (Civil Society Organisations for Peace in Northern Uganda, 2006).

The experience of living in IDP camps for a prolonged period of time was socially and economically destructive for people in Northern Uganda. Boas and Bjorkhaug (2014) liken this experience to living in a “prison economy,” whereby all economic activities and even freedom of movement were controlled and curtailed. For a population that was, and still is, dependent on

subsistence agriculture, this period was incredibly detrimental. Dolan (2009) notes that in 1991 subsistence farming constituted 77% of economic activity in the region and employed 95% of the population. By 1999, after years of forced displacement, less than 10% of arable land was being cultivated due to insecurity and the resulting inability to access land.

The impact of forced displacement was mentioned by all but one of the interview participants. Charles relates how people in IDP camps

...couldn't do business, transport, these things were all on hold. And for a long time people stayed in restricted places. They couldn't raise anything for themselves to earn a living. That started a cycle of poverty that is still continuing. Even though people have gone home, they are still trying to begin reviving, erecting makeshift buildings that are not permanent and are very weak.

Brian further elaborates that

...the war cut off their opportunity to participate in their life in terms of production. As I said, this is an agricultural region, so people were not able to cultivate. They relied on provisions from WFP and other stakeholders who could provide humanitarian assistance. The war destroyed the economic infrastructure of the people... The economic infrastructure of the people was destroyed, animals were looted. Farmland was devastated, landmines were planted into farmland. People were denied the right to reach their farmland. And the long term crops that were planted were destroyed.

Forced displacement in this region undoubtedly had a major economic and social impact. In the Northern region, a clear link can be identified between persistent poverty, far

exceeding the national rate, and the destruction brought on by forced displacement. As seen in figure 11, the poverty rate from 1999 to 2006, when internal displacement was at its worst, saw very little change. While the region has subsequently seen considerable reductions in poverty, there remains a generation of young, poor and landless individuals who remain trapped in the poverty cycle (Branch, 2013).

Interestingly, segments of the population in Gulu Town itself may have actually benefitted economically from the region's conflict. Branch (2013) draws attention the role of the humanitarian economy in Gulu Town's relative prosperity. He describes how "by 2003, over 100 relief organisations were working in northern Uganda and,

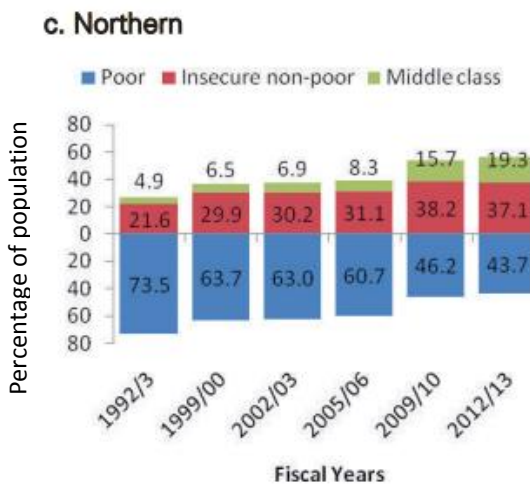


Figure 11: Distribution of Poverty in Uganda's Northern Region (Ministry of Finance, Planning and Economic Development, 2014)

by 2007, US\$200 million was being spent annually on the camps. Gulu was the primary beneficiary of this humanitarian industry” (Branch, 2013. 3156). In a town with very few formal sector jobs, the humanitarian economy was, and largely still is, a key economic driver. While the poverty rate in the surrounding district remains in excess of 60%, Gulu municipality is relatively more prosperous, with a poverty rate of approximately 40%. While Gulu Town has benefitted considerably from the humanitarian economy, the steady departure in recent years of NGOs and other development organizations has negatively impacted the supply of formal job opportunities (Branch, 2013).

This discussion demonstrates that the link between poverty and conflict can, at times, be non-existent or contradictory. There is little evidence that latent poverty contributed to the outbreak of the LRA insurgency, and the municipality of Gulu appears to have benefitted somewhat from the humanitarian economy that arose during the height of the conflict. However, Gulu District and the Northern Region have higher poverty rates than the rest of the country, and with a fair degree of certainty this can be attributed to the conflict and forced displacement that destroyed so much of the region’s already limited economic infrastructure.

### ***Disability and Conflict***

Violent conflict can often result in injuries and impairments that contribute to disability, and the impact of war on mental health can also result in disability if the impairment impacts an individual’s functioning. In addition to these direct effects of war on disability, Sidel and Levy (2008) also draw attention to the indirect effects of war on disability, as the destruction of war affects the provision of basic health and sanitation services, potentially resulting in a variety of impairments. Both indirect and direct effects of conflict in Gulu are evident in the lives of persons with disabilities, with implications for their wellbeing as the region continues along its post-conflict development journey.

As Bird et al. describe, “The LRA conflict in particular [was] characterised by the brutality of the violence, which included killings, maimings and rape” (Bird et al., 2010, 1190). This infamous brutality has certainly contributed to the prevalence of disability in the region, as amputations and mutilations produced physical impairments. Stella related how all manner of body parts, from lips to ears to legs, might have been lost at the hands of the LRA, and as a result

you can’t fully do what you used to do before the war. You used to provide for your family members, but now because you are disabled your energy has gone down, you can’t really be a breadwinner in the family to that extent.

Other direct effects of war that caused impairments included gunshot wounds and landmines. Ogwang (2007) noted that wounds from gunshots and bombs were seen relatively frequently at Gulu Town’s Lacor Hospital during the conflict, and Dolan (2009) estimates that approximately 100 people a year died from landmines. Akenna noted that “If you look at gunshots, cases of

spinal injuries are very common in Gulu. Issues of unexploded ordinances, landmines, and many people with disabilities are amputees without limbs because of conflict.” Injuries like this, without proper treatment, can result in functional impairments that render a person disabled.

In addition to the physical impact of war on a person’s body, the trauma of conflict has had a very real impact upon the lives of people in Gulu. Vinck et al.’s (2007) work in Gulu and the surrounding districts of Kitgum, Lira and Soroti found a very high prevalence of conflict-related mental health conditions, concluding that “About three quarters of the respondents (74.3%) met PTSD symptom criteria and almost half (44.5%) met depression criteria” (551). Children in Gulu also suffered greatly due to the widespread abduction of child soldiers by the LRA, resulting in many cases of PTSD and very serious challenges with reintegrating into society (Ertl et al., 2011).

Despite this evidence, Mergelsberg (2010) urges caution when using language that emphasizes victimization and traumatic events. PTSD, for example, relies on drawing connections between events and the resulting symptoms, but with former LRA abductees, the timeline between the trauma of abduction and depressive symptoms was not so clear. Many former abductees spoke of the sense of purpose and agency that came with life in the LRA, a stark contrast to the typical narrative of brutalized and powerless children (Mergelsberg, 2010). Given these complications, a contextualized understanding of trauma and mental health is necessary.

The impact of the conflict on mental health in Gulu was readily acknowledged by interview participants. Beatrice, who works on issues of mental health, described how “I still see some impact of post-traumatic stress disorder as a result [of the conflict]. This is mostly those ones who stayed so long in the bush, and their trauma was not addressed.” Stella noted similar concerns, as “people live with the scar of trauma in their mind. People feel devastated, you are not important, you feel hopeless, you have suicidal ideas, you feel depressed. Some of them take to drinking and drug abuse.”

While many respondents were conscious of the impact of conflict on mental health, some interview participants used terms like “mentally-challenged,” “retarded,” “deranged,” and “mad” to describe people with mental health conditions. This should not be overanalyzed, as language is always evolving and terminology can carry different meanings in different social contexts. The interviews were also conducted in English, which was the second or third language for the respondents. However, the use of these problematic terms, in contrast to the near universal use of the term “people with disabilities” among respondents, is worth considering. Attitudes towards people with mental health conditions, as well as intellectual and developmental disabilities, can differ from attitudes towards physical disability. Beatrice notes that, before the war, there was no dedicated ward at Gulu Regional Referral Hospital for mental health, and services to support these individuals remain very underdeveloped across the region.

In addition to these direct effects of war on the mental and physical wellbeing of people in Gulu, the physical and social displacement caused by the conflict has had implications for disability. A breakdown in the quality and availability of health services can be detrimental to the

entire population, not only those directly affected by conflict. Accorsi et al. (2005), who reviewed hospital discharge records from Lacor Hospital from 1992-2002, found that, while the escalation of the conflict led to an increase in war related injuries, diseases conventionally associated with poverty remained the most common reason for hospital admission. The top cause of admission to Lacor during this time was malaria, followed by pneumonia, tuberculosis, malnutrition and diarrhea (Accorsi et al., 2005). These conditions are not unique to conflict-affected regions and exist elsewhere in Uganda, and this may speak more to the relationship between disability and poverty than anything related to conflict.

Outside of Gulu Town, the forced displacement was a humanitarian disaster, with camp populations suffering attacks from outside and difficult conditions within. A WHO health and mortality survey in 2005, conducted in IDP camps in Gulu, Pader and Kitgum, reported extremely high rates of adult and child mortality among these populations. They estimated a total excess mortality of nearly 1,000 deaths a week from January to July 2005. Malaria, AIDS and violence were the most common causes of death, followed by diarrhea and other complications due to malnutrition (The Republic of Uganda Ministry of Health, 2005).

Malnutrition was one of the most significant issues facing IDPs in Northern Uganda. Reports from IDP camps in Gulu show that malnutrition and the associated problems with stunting and wasting in children peaked in the late 1990s, but remained elevated into the mid-2000s (Action Against Hunger, 2005). Subsequent research by Olwedo et al. (2008) found a 6% rate of global acute malnutrition in Gulu's IDP camps. 78% of their respondents relied on WFP rations, which were limited in variety and quantity. IDPs also experienced delays of up to a year in accessing these rations (Olwedo et al., 2008). Dolan (2009) notes that WFP reports from 1999 acknowledged high levels of corneal ulceration and childhood blindness from Vitamin A deficiency, in addition to widespread Vitamin B and iron deficiencies. The result was delayed mental and physical growth, especially for girls.

Interview participants also spoke of the challenges of malnutrition in the IDP camps. Echoing reports of corruption gathered by Dolan (2009), Isaac described how "I remember even me, myself... sometimes even [to access] relief you have to pay to receive it. You have to pay money to someone who is distributing..." He went on to say that "I believe we have a number of young people who got disabilities because of malnutrition. And that was rampant." In her interview, Beatrice elaborated that

From the camp, there are people with 8 or 10 children in the house, but you are maybe given a basin of beans and a basin of rice. And you need to wait until the next month comes, that's when you get more food from the World Food Programme.

Clearly the experience of malnutrition was a difficult one for IDPs, and maternal and childhood malnutrition can be a cause of developmental and other disabilities, in addition to stunting and wasting in children.

There is less data available on how the experience of disability itself was shaped by conflict. Most of the interviews for this study focused on how conflict contributed to disability, and there is less academic research highlighting the experiences of persons with disabilities during the LRA conflict. A notable exception is a collection of testimonies collected by the Gulu Disabled Person's Union (2010). Many of these stories highlight the challenges facing persons with disabilities who tried to return home from the IDP camps, but lack the resources and support to do so. This issue was also mentioned in an interview with Akenna, who described how "Many people can't build their grass-thatched hut on their own, they need help from relatives and well-wishers. So for them they return last."

Other issues raised in the GDPU testimonies include targeted violence and exploitation of persons with disabilities. One such testimony comes from a woman with a visual impairment who lamented how

I might sit outside, and other people might see the rebels coming from far, run and leave me, whereas I cannot see them. This happened to me. [The rebels] gave me millet to grind and chicken so I prepared food for them. When they were finished they locked me in a hut so I could not hear which direction they were going and they left me there (Gulu Disabled Persons Union, 2010, 16).

Another testimonial puts forward the notion that persons with disabilities may have been actively targeted for violence during the LRA conflict. A woman describes how

We [the disabled community] lost many lives. .... In the rural areas it was [the] worst for persons with disabilities. They could be tortured. The rebels would say that persons with disabilities were the mothers and fathers of the UPDF. If they did not find any other people [while raiding a village] they would target persons with disabilities (Gulu Disabled Persons Union, 2010, 18).

These testimonials speak to the heightened vulnerability of persons with disabilities during times of war. Armed groups may prey upon vulnerable members of the community, acting upon latent distrust or negativity towards persons with disabilities, and the breakdown of security and social norms may permit targeted violence.

Muyinda and Whyte (2011) also provide valuable insights into the challenges of displacement for people with mobility impairments in Northern Uganda. The economic challenges facing the region's displaced population were exacerbated for those with mobility impairments. Farming was very difficult, and the few other economic activities that were possible (such as reselling goods or rations) were poorly remunerated. The few latrine facilities that were available in the IDP camps were hastily constructed and often poorly maintained, rendering them inaccessible for those with mobility constraints.

Even when relief services are provided in times of conflict, they may be largely inaccessible to persons with disabilities, with disastrous consequences. Another testimony spoke of how "One of our [Gulu United Deaf Blind Association] members died because of

communication problems. The medical team did not understand his condition so he died” (Gulu Disabled Persons Union, 2010, 17). Other challenges might include mobility for visually or physically impaired people in crowded IDP camps, and accessing food and water resources where communication barriers exist (Gulu Disabled Persons Union, 2010). Muyinda and Whyte (2011) highlight the shortage of mobility aids that were available to persons with disabilities in IDP camps; rural insecurity meant that, at the height of the conflict in mid-2000's, mobility appliances were only available at the office of AVSI, an Italian NGO, in Gulu Town. The challenges of camp living induced many persons with disabilities to move to Gulu Town, where aid and support was more readily accessible; however, many found themselves living in “urban IDP camps” that, despite having the same issues with congestion and sanitation, were not eligible for the same emergency support as the protected villages (Muyinda & Whyte, 2011).

These stories support the notion that an individual’s disability affects their ability to navigate physical and social spaces that are being degraded by conflict. It is evident that the relationship between disability and conflict in Gulu resulted in an increased prevalence of disability, and increased vulnerability for those living in the region during and after the conflict. Their vulnerability in the midst of post-conflict development is inherently connected to the relationship between poverty and disability.

### ***Disability and Poverty***

Like in other regions around the world, the relationship between poverty and disability is evident in Gulu. In a region where the population remains largely reliant on subsistence agriculture, persons with disabilities face many difficulties when participating in the formal and informal economy. These include discriminatory attitudes, inaccessibility, and their lack of credentials due to exclusion from education. Unfortunately, the fact that disability can result in poverty has implications for the extended family support system. Furthermore, malnutrition, lack of medical knowledge and certain dangerous activities associated with poverty can increase the likelihood that impoverished individuals or their children will develop an impairment, resulting in disability.

Over 50% of the people in Gulu District are engaged in subsistence agriculture, representing the most common livelihood activity in the district (Gulu District Local Government, 2013). Brian stated that the majority of Gulu’s population derives their income from the informal sector, and this is true of persons with disabilities as well. Reflecting on her organization’s beneficiaries, Stella estimates that

[the] majority, over 90% of the beneficiaries are dependent on peasant farming. Subsistence even. You dig, whatever you get you eat. Or maybe if you need some paraffin, some soap, you sell and get some small money. That is the lifestyle the majority are involved in.

Unfortunately, there are barriers to participating in these economic activities for persons with disabilities. While mobility impairments certainly might impact one's ability to farm, they become especially problematic when attempting to sell one's produce. Joshua notes that produce sellers "should be moving to the market every day to transport your goods," but this is challenging when mobility is limited. Approximately 2% of people in Gulu own a motor vehicle, and only 3% own a motorcycle (Gulu District Local Government, 2013). This implies that persons with disabilities attempting to transport their goods often rely on public transportation, most forms of which can be physically inaccessible.

Akenna also raises the issue that "many of the markets are not accessible... some markets exploit persons with disabilities, especially the deaf. You may have your goods to sell in the market, but you may not have the communication means to communicate with your customers." This draws attention to the many components of accessibility. While Gulu Town's newly renovated central market is well-equipped with ramps, other markets in Town and throughout the District are less physically accessible. Furthermore, communication barriers exist for those with visual or hearing impairments which may limit their ability to participate in the market economy.

Barriers also exist for those who may wish to move beyond agriculture. Skills training for small-scale trades is a common activity undertaken by development actors in Gulu. For example, Akenna's organization has provided training in electronics repair and garment production, while Charles' organization has trained beneficiaries in shoe repair. While these trades provide a useful source of income for persons with disabilities, starting a business can be challenging. As Joshua rightly points out, "let's say you want to start a business, how will you move and inquire, if you want to do market research? It's not easy for [people with mobility constraints], hence many of them are not in business for that reason."

The financial considerations associated with disability may also pose a barrier to entry in certain occupations. Akenna notes that many persons with disabilities bear additional costs due to their impairment: "maybe you need mobility devices, like maybe a wheelchair, maybe you need a white cane. So that means to participate in income generating activities you need additional support... So because of your disability you are likely to incur more costs to generate income." In addition to these direct costs, there is also the issue of the additional time that may be required to travel as a result of a mobility impairment. In spite of the flexibility of the informal sector, there are clearly some barriers to entry for persons with disabilities that may limit their ability to access income.

The formal sector, unfortunately, offers even fewer prospects for persons with disabilities. Formal employment is very limited in Gulu District, and beyond Gulu Town opportunities are virtually non-existent. Like in the informal sector, communication may be a challenge for persons with disabilities seeking formal sector employment. While persons with disabilities in the informal sector may be expected to bear the costs of adaptive technology themselves, in the formal sector the employer would legally bear some or most of the costs of accommodation. Brian notes that

We have many [people] with hearing problems, but hearing kits here, we only hear about them. We have very few interpreters. This is where organizations fear. When you employ a person with a disability, say one with a hearing difficulty, you need to cater to the interpreter.

Even those organizations that are willing to accommodate someone with a hearing impairment may face challenges in doing so. Joshua highlights the dire lack of professional support for people with hearing impairments, lamenting that "...they lack the interpreters. In the whole of Gulu we have only 10 interpreters." The same issues are present for people with visual impairments, as Braille materials are very difficult to access in Uganda (Abimanyi-Ochom & Mannan, 2014). This means that even an organization that strives to be inclusive may struggle to adequately accommodate someone with different communication needs.

Unfortunately, discrimination and stigma continue to pose a barrier to formal employment for persons with disabilities as well. Beatrice highlights the challenges for people with mental health conditions, describing how

If someone with mental illness comes to the office, they say "you can't manage." And maybe if you develop mental illness, you are chased away because they say "you are mentally ill, you can't work in this type of setting."

Despite progressive policies and advocacy from civil society, attitudes towards disability are still negative in Gulu. Brian argues that "here in Gulu and in Uganda generally, persons with disabilities were never considered as very viable community members. They were seen as a burden." These attitudes pose a continuing obstacle to the full economic participation of persons with disabilities.

Another barrier to formal employment, and a contributor to poverty in general, is limited access to formal education. Brian notes that "Many [people with disabilities] miss formal education, and their ability and capability is not enough to meet the growing market demand." Isaac spoke at length about the challenges that children with disabilities face when attempting to access the education system. He clearly demonstrates the circular nature of the poverty trap facing children with disabilities, since in poor families "You find parents prioritize which child goes to school and which does not, and in most cases the child with a disability does not go." The limited availability of adaptive technology may also be a barrier to accessing education,

because a child can be recommended for hearing aids, but the parents may not be able to afford them. Sometimes some children are recommended for reading glasses, and because of the price [they can't get them]. And then some children with physical impairments may not be able to move to school because there is no wheelchair, unless maybe a well-wisher gives one.

Even for those children with disabilities who do attend school, Isaac admits that "they may not get adequate support, especially if the teacher does not know what [their impairment] is,

and this child may be stigmatized all the time.” Placement options are limited in Gulu for children with disabilities. According to Isaac, there is an official policy of inclusive education in the District, but many children with disabilities learn in special units at mainstream schools. Most of the units Isaac described are in Gulu Town, and it is unclear what options are available to rural children with disabilities. Isaac noted that children with disabilities are often out of school, and this especially true for certain impairment groups, like those that Isaac described as “mentally impaired.”

Ultimately, access to education for children with disabilities is limited in Gulu District. This is driven by variables within the family, such as poverty and negative attitudes, as well as institutional barriers, including the lack of placement options and the lack of adequate teacher training. This means that children with disabilities are less likely to access education, with implications for their potential to earn income in the future.

The intergenerational transfer of poverty is another element of the poverty – disability cycle in Gulu District. This issue was clearly described by Brian, who first noted the issue of discrimination facing persons with disabilities and their families, “because they suffer also stigmatization, and labelling which is a terrible thing. Their own family members suffer the same. When their children go to school, they are stigmatized by their colleagues.” Brian went on to note the transfer of poverty, especially in times of conflict:

And to compound it further, to think this is a person with a family, and this has affected the breadwinner. It means everybody there is going to be affected. Many persons with disabilities were under care of some other people. Now if this able person around is abducted or killed, you see how it compounds for this [person with a disability] here?

Similar concerns were raised by Betty, who also drew attention to the intergenerational transfer of poverty. She described how

If I’m the breadwinner, and I’m sick, I’ve failed to get this [medical] attention, the little resources there will be exhausted. At the end of the day the family will go into abject poverty and a lot of things will go on around that. It will bring psychosocial issues...

The intergenerational transfer of poverty described here, whereby the families of persons with disabilities bear the additional costs of an impairment while having a reduced access to income, speaks to the challenges posed by the poverty trap (Sachs, 2005), and the disability – poverty cycle (Yeo & Moore, 2003). Just as disability is a product of social and economic relations, the impact of disability will not be solely felt by an individual with an impairment.

While it is clear that disability may increase the likelihood that a person is living in poverty due to challenges accessing income, poverty itself also contributes to the prevalence of disability in Gulu. This occurs through three main channels: malnutrition, practices associated with poverty (especially transportation), and poor health practices.

Malnutrition has been mentioned as one of the means by which conflict can contribute to disability, but malnutrition is fundamentally an issue of poverty. According to Isaac, when considering the prevalence of disability in Gulu, "...poverty is a big contributing factor, because some of these disabilities are caused by malnutrition. And sometimes parents cannot afford certain foods, or because of ignorance, you find this child is becoming blind because they lack Vitamin A." Stella identified similar trends in her work, noting that:

We find that most of our beneficiaries that come here [with developmental disabilities] are from low income families. I would say that directly poverty can influence chances of a child or someone being born with a disability, because access to support and basic health care is very difficult.

With so many people in Gulu relying upon subsistence agriculture or living on a low income, it is not surprising that many children and pregnant mothers are malnourished. This contributes to a variety of different impairments associated with disability.

The previous quote from Stella also alludes to the issue of poor health practices or inadequate access to health services. Betty argues that the health-seeking behaviour (that is, their ability and willingness to access medical care) of low-income individuals in Gulu is impaired by poverty, and this can lead to poor health and disability. She states that

...as much as [poverty] affects our health seeking behaviour, even if your health seeking behavior is good, if there should be a call for more advanced medication, you will not get it... And from the health facility, if my condition is quite above the facility's ability to handle, and I'm moved farther than that facility, that will require more resources, I won't be able to access the services.

This quote draws attention to the fact that rural health clinics offer a limited range of services and medications, and certain conditions will require a patient to visit a better equipped clinic, perhaps even going all the way to Gulu Town. The Uganda Household Survey (2017) states that 34% of people in Acholi region must travel 5 km or more to reach a health facility. The cost of transportation would usually be borne by the patient or his or her family, which can discourage them from seeking care. The time and cost involved, especially for people in rural villages, is a disincentive to seeking treatment. According to Joshua, "you find out that there are these people in the village... and they fail to maybe vaccinate their children. At times they will be at a high risk of getting a disease like polio."

Not seeking medical care at the proper time can lead to preventable impairments worsening, contributing to a disability. Isaac describes how, in his experience,

...sometimes some children are recommended for some type of intervention; in some cases we get children with club feet, and we have very few referral hospitals, and we find parents can't take children for this type of intervention. So this child may remain with club feet and face difficulties in walking.

The effects of conditions like clubfoot can be mitigated with early and consistent access to treatment, but poverty may inhibit the ability of poorer families to do so. This has lifelong implications for their children, who may face substantial functional limitations due to painfully deformed feet (McElroy et al., 2007). Beatrice mentioned similar issues for individuals who needed medication to treat mental health conditions: they could not afford to purchase the medication they needed to manage their condition effectively, and had to be readmitted to the mental health ward as a result.

There are also quite a few impairments that are the result of avoidable injuries. Unfortunately, poverty and the need to save money or earn an income may lead people to make dangerous choices. The most common example is with transportation. The *boda boda*, or motorcycle taxi, is a common form of transportation throughout Uganda which carries a high risk of preventable head injuries (Kamulegeya et al., 2015). The *boda boda* is very common in Gulu, but these small motorcycles are often overloaded with passengers and cargo. Kitara (2011) recorded 410 injuries from *boda boda* at Gulu Regional Referral Hospital over a two year time period. Joshua noted that "...because of poverty you might squeeze yourself in town on a *boda* with five people, where you will get in an accident." Betty also indicated that in her line of work she treated many patients who were involved in *boda boda* accidents, either as drivers or passengers.

In addition to accidents on the road, the day to day rigour of a subsistence lifestyle may expose low-income individuals to a range of different hazards. According to Akenna,

Poverty is one of the contributors to disability in Gulu because most of our population rely on quite a number of subsistence farming activities, like digging using hand hoes. And then also looking for firewood and other things for their survival. Meaning that, while doing these activities one can easily become disabled.

Poverty means that people may have to undertake certain activities or make choices that endanger their health and safety. Whether this involves unsafe modes of transportation, hazardous forms of work, or foregoing medical care, the result is that these people are exposed to greater risks of impairment that can create disability. In doing so, they are more likely to succumb to the disability – poverty trap, further reducing their ability to earn an income and potentially impacting the family as a whole.

### ***Gender Dynamics***

Certain elements of the disability – poverty – conflict nexus manifest themselves differently depending on an individual's gender identity. Certain injuries, for example, may be more common among men. Kitara (2011) found that the majority of *boda boda* injuries were

suffered by men, since the majority of drivers are male. During the LRA conflict, Ogwang (2007) also observed a higher incidence of abdominal injuries among men since they were more actively involved in violent conflict.

The main gender issues identified during the interviews pertained to gender-based violence and the division of labour during and after the conflict era. Isaac also noted disparities in school enrollment for poor families, given that “In case a family has no child with a disability, the girl is asked to remain and the priority is the boy child.” Undoubtedly this effect would be far more pronounced for school-age girls with disabilities.

Joshua made the important point that “conflict,” as discussed in this study, should not only consider a typical violent conflict like a war. He argued that gender-based and intimate partner violence, and the role that poverty plays in these forms of domestic conflict, are equally worthy of attention. Gender-based violence is an especially important issue for women with disabilities, who may be more vulnerable due to social isolation and a lack of legal recourse. Interviews conducted by Human Rights Watch (2010) noted that many women with disabilities experienced gender-based violence before and after the war in Northern Uganda. This issue was taken up in detail by Beatrice during her interview, as she described shifts in the allocation of domestic labour as a result of conflict:

You note that during that period [of forced displacement], men started becoming irresponsible people. Because a man would just come out of his house from the camp, go next door to a drinking joint, and drink the whole day. And a woman is hustling and thinking of what my children will eat today. So that woman has to struggle, look for food the whole day, the children are starving... So when the people returned back home, the men continued drinking instead of being productive, digging and helping their wives. Instead when the wives dig, during harvest time, the man would pocket some of the harvest and goes to a drinking joint and sells it. Drinks the money, and comes back empty handed.

Beatrice’s quote illustrates how conflict and displacement have led to an increase in the share of household labour born by women. The quote from Beatrice also speaks to the problem of alcoholism in Uganda, and the North in particular. Kabwama et al. (2016) found that medium to high alcohol abuse was most prevalent in Northern Uganda, and men were more likely to be heavy drinkers. This is confirmed by the most recent National Household Survey (2017), which puts alcohol use in Acholi region at 24% of the population, the fourth highest rate in the country. Betty also speculated that alcoholism in Gulu has roots in the era of displacement:

Because during the camp situation, you wake up in the morning and there is nothing to do, and you can’t even go anywhere because you are being guarded. Also drinking became the order of the day, substance abuse. People have gone to that drinking. That was in the camp, now they are out and what is happening?

Roberts et al. (2011) did not find evidence that rates of alcohol abuse were higher in the IDP camps than in the rest of Uganda; however, they do note that alcohol abuse was correlated with cumulative exposure to traumatic events. This indicates that alcohol abuse among adult men may be a form of coping strategy to address mental health conditions, since trauma support services were very limited (Roberts et al., 2011).

Indeed, Ovuga et al. (2008), who assessed former LRA abductees at a reintegration school in Gulu, found that “boys reported more exposure to war-related traumatic events [and] were more likely to experience war-related injuries and complications though they were less likely to be hospitalized or referred to mental health professionals” (140). Dolan (2009), drawing on interviews with local health care providers, also argues that mental health outcomes were gendered. Women increasingly developed anxiety disorders, and quite a few attempted suicide as a result of possible domestic violence. At the same time, men and women were also impacted by the effects of war on the economy. Women struggled to fulfill their role as caregiver, while young men could not live up to their traditional role as breadwinner.

While alcohol may have been an income source for women and a coping strategy for men, the ubiquity of alcohol may expose women to gender-based violence. Research elsewhere in Uganda has shown a correlation between alcohol abuse and intimate partner violence (Zablotska et al., 2009), and Annan and Brier (2010) observed a high risk of intimate partner violence among female LRA returnees. Kitara et al. (2012) made similar observations at Gulu Regional Referral Hospital. Their analysis of hospital admissions from January 2008 to December 2009 accounted for 454 cases of domestic violence, one fifth of which involved alcohol abuse.

The prevalence of alcohol abuse and gender-based violence in Gulu speaks to the gendered impacts of conflict and displacement upon a population. Given that trauma, mental illness and addiction can constitute disabilities, these trends are important to consider. Adult men, who have received very little support in overcoming trauma, may even end up victimizing or rejecting a partner who is also a victim. Beatrice described how

[In] those days the Lord’s Resistance Army would sometimes cut the arms, the legs, the lips... And most times the men would withdraw from their wives, thinking “I brought you when you were normal, and now you are disabled; I don’t want you anymore.” The women would end up going back to their homes because they are no longer wanted.

Stories like this draw attention to the intersection of attitudes towards disability and attitudes towards gender. A woman who has been disfigured may no longer be deemed attractive enough for marriage. Poverty in Uganda remains markedly gendered, and in such a context, dismissal from marriage may only deepen a woman’s poverty (Hasaba, 2014).

While this research did not provide extensive detail on the unique challenges that women encountered during the LRA conflict,<sup>2</sup> it does demonstrate that displacement and post-conflict recovery have resulted in certain issues that are inherently gendered. The reallocation of labour in the household, as well as alcohol abuse and domestic violence, can be linked to the history of conflict in the region, and these issues further complicate life for impoverished individuals, particularly women, in Gulu District.

### *A Hierarchy of Impairment*

The term “disability” describes a diverse range of impairments that may affect someone’s mobility, intellectual capacity or ability to interact in social situations. As such, any assessment of the challenges facing people with disabilities must be cognizant of the fact that different impairment groups may experience marginalization differently. It may well be that, as argued by Deal (2003), there is a hierarchy of impairment whereby certain groups experience a disproportionate share of the discrimination and marginalization associated with disability.

Research by the Ugandan Ministry of Finance, Planning and Economic Development (2008) found marked differences in the lives of different impairment groups. People with visual impairments were among the poorest of persons with disabilities, while people with intellectual disabilities are often dismissed as “stupid” and hidden away at home. People with physical impairments were often seen as lacking the strength and mobility for employment, and relied on light manual work for income. People with hearing impairments were fairly competitive in the Ugandan labour market, which is perhaps not surprising given the special status afforded to sign language in the Ugandan Constitution. This study demonstrated the differing prospects for persons with disabilities seeking to earn an income.

Muyinda and Whyte (2011) found that, during the height of the LRA conflict, there was uneven support for people with mobility impairments. They argue that

Most NGOs and government departments supported mainly people with war-related impairments, leaving out those who were impaired due to other causes. In particular polio and leprosy survivors and those with a visual impairment were hardly targeted... Attention was given mainly to those whose impairments were a direct result of the war: landmine, bullet and bomb blast survivors (Muyinda & Whyte, 2011, 130).

This is consistent with patterns in other conflicts, as discussed by Berghs (2015), where war-related impairments are prioritized by relief agencies.

In Gulu, this hierarchy of impairment was most evident in discussions around education. Gulu District has a policy of inclusive education for children with disabilities, but like in other settings (see, for example, Brydges & Mkandawire, 2018) the extent of inclusion is, in practice,

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<sup>2</sup> For more information, see Gustavsson, Oruut, & Rubenson, 2017 and Victor, 2011

limited by the functional capability of the student in relation to the available educational resources. For example, Isaac notes that

Children with physical impairments have better opportunities than the rest. Most go to school, either on a wheelchair, or a walking stick or crutches. Children who are blind have better opportunities than the deaf. When you look in terms of the number of people who got more education, they are the blind people.

In the case of children with physical impairments, a few environmental modifications are all that is needed to include them in a mainstream school. Similarly, there are typically resources in place to include children with visual impairments, meaning they are able to access mainstream classrooms.

This is in contrast to other impairment groups, whose functional limitations are less easily accommodated given the available resources. As Isaac describes,

...there may be specific skills like Braille, sign language, or children who have very severe mental retardation like cerebral palsy; those kind of learners, they are not easy to put in an inclusive setting because we do not have teachers who are trained on working with them. Let alone the teachers, but also the facilities. So we don't have them all in inclusive schools, but we have them in units.

As previously noted, Gulu has a severe shortage of sign language interpreters. Contrasting the options available to children with visual and hearing impairments, Isaac feels that "... the education for the deaf remains a challenge in our country."

These challenges are exacerbated for children with intellectual or developmental impairments, for whom more complex pedagogical accommodations would have to be made. The ability to integrate students with special education needs is also limited by high student to teacher ratios, which were reported at 50:1 in 2010 but are likely much higher in rural areas (Gulu District Local Government, 2013). Isaac concedes that

Support for children who have mental impairments is very, very limited. Well it depends; if it is mild, this child is likely to go to school, ordinarily... you find the majority of [children with intellectual impairments] may not [go to school], unless they are in an area where we have a unit for children with mental retardation...

Unfortunately, the units for children with intellectual impairments are almost exclusively found in Gulu Town, leaving few options for rural children.

The gaps in service provision for children with developmental and intellectual disabilities speaks to broader issues in the provision of services to persons with disabilities. In Gulu's education sector, services are most readily extended to those children whose impairments are "mild," and as such require very minimal effort for accommodation. Children whose needs are

more pronounced and therefore require greater effort to accommodate are more likely to be excluded.

This may also be the case for other development actors who work with people with disabilities. Describing the link between disability and poverty, Beatrice argued that “It’s even worse with mental illness, nobody thinks of them.” As will be discussed in the next section, medical interventions like physical rehabilitation are common ways of working with persons with disabilities, as are skills training and livelihood initiatives. It is unclear to what extent these initiatives are inclusive of people with mental health or intellectual impairments.

Even Beatrice, who highlighted the neglect of people with mental health issues, indicated her own tendency to work around people with intellectual impairments by engaging with their parents or caregivers rather than person themselves. There is evidence of a tendency to work with those who require fewer accommodations, like those with “mild retardation.” In other cases, a person with an intellectual or developmental disability may be regarded as a dependent of their family, and not directly involved as an active participant in a development intervention.

These patterns may hold true in other development organizations as well, though no interview participants explicitly stated the existence of such a hierarchy of impairment. As previously discussed, the use of words like “deranged” and “mad” may be indicative of a hierarchy of impairment in the minds of practitioners, consciously or otherwise. People with physical, visual and hearing impairments may be grouped together as “people with disabilities,” as their situation is more readily understood and remedied with traditional development initiatives, in contrast to those with intellectual or developmental impairments or other mental health conditions who may require more complex support.

Isaac provided clear evidence that the prospects for children with disabilities are certainly influenced by the nature of their disability, and Beatrice alluded to a general neglect of people with mental health issues. Whether or not this is indicative of trends in practice, it is clear that, when considering the impact of poverty and conflict on people in Gulu, attention must be paid to the diversity of experiences for those who are classified as persons with disabilities. The nature of one’s impairment, as well as their gender and even where they live, can result in a considerable diversity of experiences.

### ***Identifying a Nexus in Gulu***

This section has demonstrated the various ways in which disability, poverty and conflict interact and impact the lives of people living in Gulu District. While the link between poverty and conflict was dismissed in this context (though land conflict and gender-based violence may be current manifestations), the other elements of the nexus can be clearly identified in Gulu’s history of conflict and current development experience.

These connections are highlighted in figure 12 .

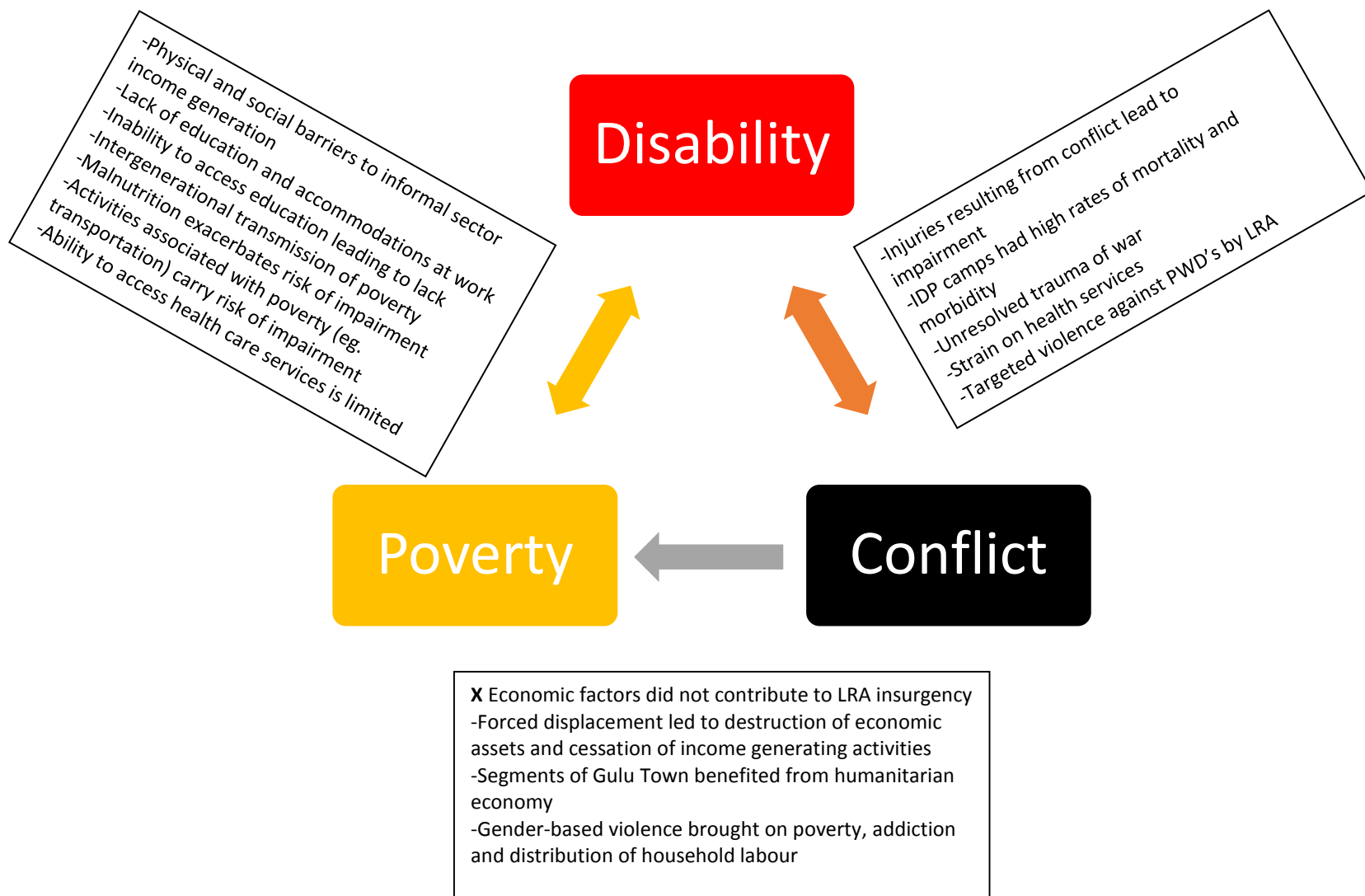


Figure 12: The Disability - Poverty - Conflict Nexus in Gulu

## Chapter 9: Research Findings - The Influence of CBR in Gulu

This study sought to understand if and how CBR is influencing development practice in Gulu, Uganda. The research findings in this section are organized thematically. The first section constitutes an environmental scan, outlining the range of programming currently involving persons with disabilities in Gulu. The second section pertains to the influence of CBR on the thinking around and planning of development interventions with persons with disabilities in Gulu. The final section looks at how CBR is actually influencing the delivery of development interventions. This research indicates that, while interventions with persons with disabilities occur across thematic areas, the thinking and indeed the practice around development practice remains grounded in the health sector.

### *An Environmental Scan of Programming for PWD's in Gulu*

This section will focus on the questionnaire results, which describe the development sector in Gulu and the range of programming involving persons with disabilities. The results indicate a recognition of the importance of disability and a willingness to address the multi-dimensional challenges facing persons with disabilities in Gulu.

That said, a word of caution is necessary when interpreting these results. First of all, the sample is non-exhaustive and non-random, so the result cannot necessarily be generalized. Furthermore, the data are self-reported, and likely overstates the scope of work that these organizations are undertaking. While the survey instructions stated that organizations should only refer to current programming, several responses made reference to past initiatives. The results should be interpreted with caution, but nonetheless provide a useful overview of the programming with persons with disabilities in Gulu.

Survey and questionnaire respondents were asked to indicate in which thematic areas they worked, with five options drawn from the CBR matrix. Most organizations indicated that they were working across multiple thematic areas, and there was a fairly even distribution across the five areas, with “social” activities standing out as the most common and

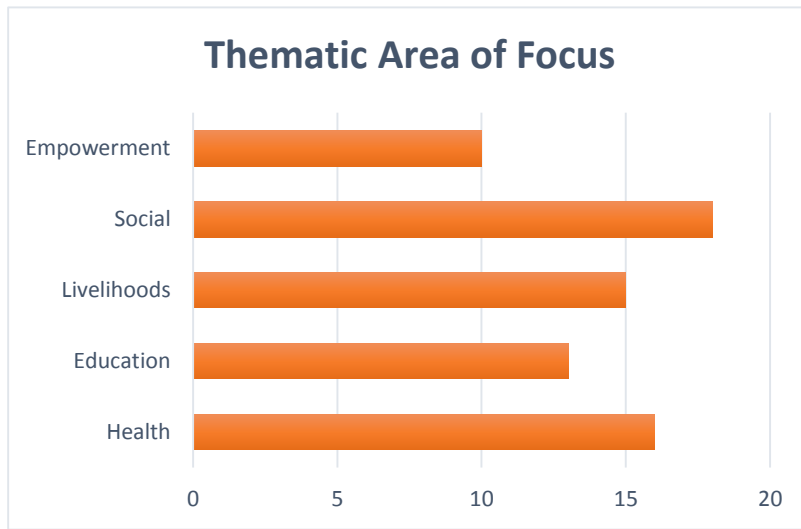


Figure 13: Thematic areas of focus among surveyed organizations

“empowerment” activities the least common. The following sections will provide greater detail on what activities are occurring across thematic areas.

### Health

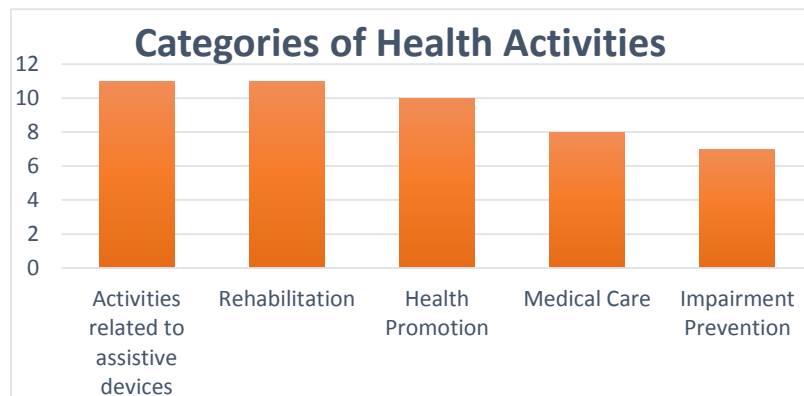


Figure 14: Categories of health activities implemented among survey respondents

Under the category of health, rehabilitation and assistive devices are the most common areas where programming is taking place. Medical care and impairment prevention saw fewer responses, perhaps due to the large number of NGOs surveyed who primarily carry out referrals

rather than direct provision of care. Specific activities are primarily in the realm of training (eg. in the use of devices, for family members to support persons with disabilities) as well as referrals to other health facilities.

### Education

Education activities are predominantly in non-formal education. Again, the number of NGOs surveyed contributes to these findings, as they are far less likely to be direct providers of education services. That said, the emphasis on supporting persons with disabilities in non-formal education may also reflect the fact that they remain less likely to access formal schooling due to poverty, discrimination and other barriers. The most common education activities were skills training, as well as advocacy and environmental modifications to improve the accessibility of existing facilities.

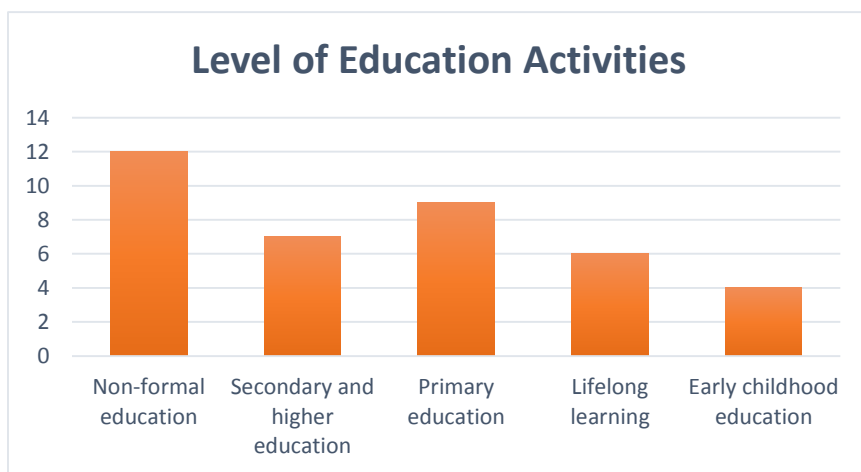


Figure 15: Level of education activities implemented by surveyed organizations

The low number of respondents working on early childhood education is somewhat of a concern, as early intervention in cognitive development can pay huge dividends in future

wellbeing. The lack of public early childhood education programming for children with disabilities reflects broader trends in Uganda, where access to pre-schools is extremely limited, especially outside of major urban centres (Kisitu, 2009).

### Livelihoods

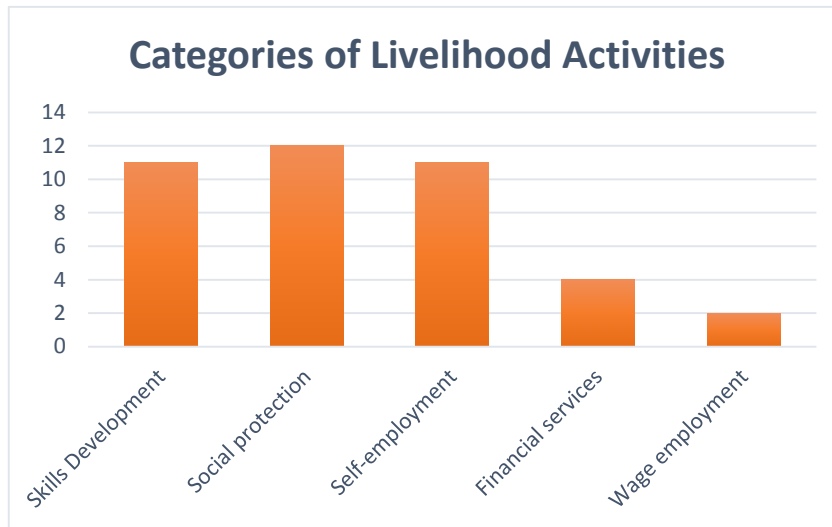


Figure 16: Categories of livelihood activities implemented by surveyed organizations

Livelihood activities primarily relate to skills development and social protection for participating in self-employment and entrepreneurship. This is not surprising, given that most Ugandans work in the informal sector (Uganda Bureau of Statistics, 2003). Only two organizations stated that their activities supported waged employment for persons with disabilities; this

is perhaps reflective of general trends in society, but undoubtedly the exclusion of persons with disabilities from formal employment is a relevant consideration.

Training in business skills and general vocational training was quite common. This is typically done in a group setting, to allow persons with disabilities to access “special grants” from the government, which are only available on a group basis.

### Social

Social development was the most common thematic area of focus for the organizations that were surveyed, with personal assistance standing out as a priority. Beyond this, the distribution of activities was fairly uniform in the remaining categories. The emphasis on personal assistance is consistent with the aims of community-

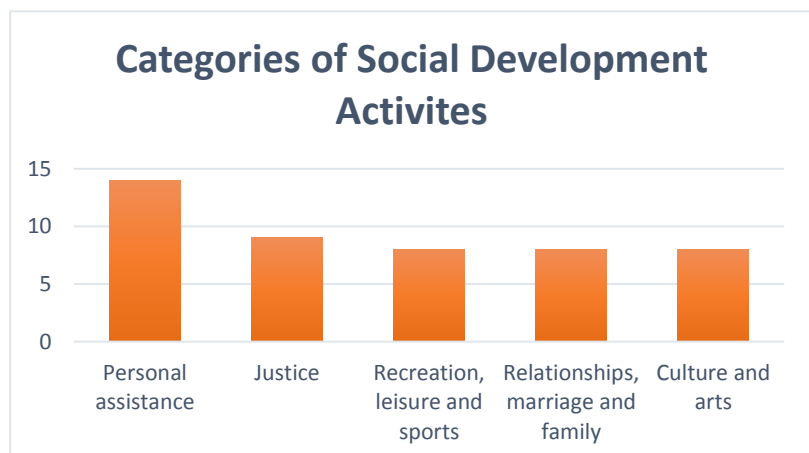


Figure 17: Categories of Social Development Activities implemented by surveyed organizations

based rehabilitation: promoting functional independence with the support of family members is a key aspect of CBR.

Common activities included developing plans for personal care to promote independence and family participation, as well as encouraging participation in community events. There was also an emphasis on getting persons with disabilities to participate in existing provisions, be they social activities or development programs.

### *Empowerment*

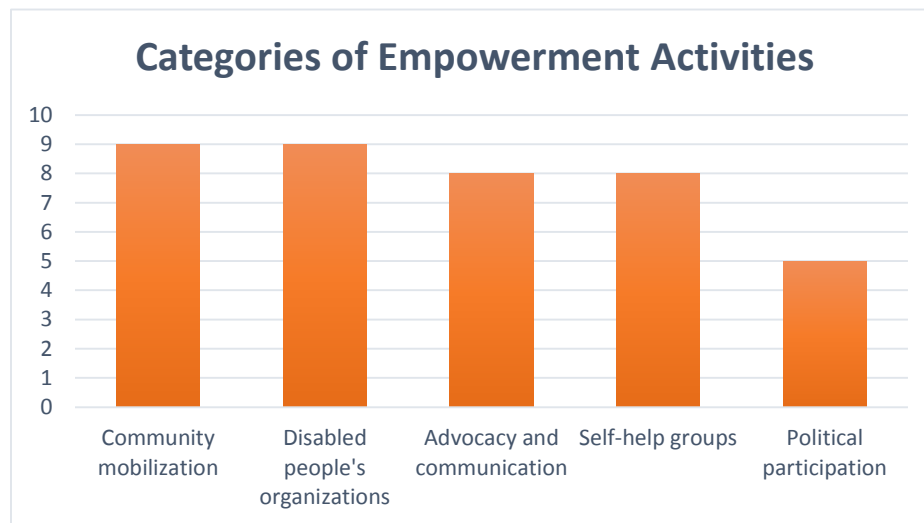


Figure 18: Categories of empowerment activities implemented by surveyed organizations

Empowerment was the least common area of focus for the organizations that were surveyed. The low emphasis on political participation is somewhat surprising, given Uganda's progressive system of representation for persons with disabilities (Abimanyi-

Ochom & Mannan, 2014).

Common activities included raising awareness about the rights of persons with disabilities, empowering them to become advocates for their own interests, and promoting inclusion in mainstream institutions. Radio talk shows were also mentioned by a number of respondents, where issues pertaining to disability and the rights of persons with disabilities were discussed.

### ***CBR's Influence on Thinking and Planning***

Having examined the range of programming in Gulu for persons with disabilities, this section now considers practitioners' perceptions and understanding of CBR. In both the questionnaire and interviews, respondents were asked whether they were familiar with CBR, and whether they felt this approach would be useful in post-conflict settings. 88% of survey respondents (22 of 25) indicated that they were familiar with CBR, while seven of the eight interview participants stated they were familiar with the approach. All of the participants, both in

the surveys and interviews, agreed that the approach would be useful in a post-conflict setting like Gulu. Research participants readily identified several key principles of CBR, both explicitly when asked to evaluate the approach, and implicitly when discussing other aspects of their work.

The CBR approach suffers from some definitional ambiguity, but key elements include sustainability (in terms of cost and long-term impact), community ownership, and multi-dimensional solutions. These principles were readily identified by research participants as being crucial to effective development interventions with persons with disabilities. The fact that respondents highlighted these particular principles when discussing CBR and working with persons with disabilities indicates that the central tenets of the approach have been influential among development professionals in Gulu.

Sustainability was mentioned in both interviews and survey responses as a key consideration when designing interventions to work with persons with disabilities, and was regarded as a major advantage of the CBR approach. Discussions of sustainability centred around two issues: affordability and long-term impact. Affordability was considered an advantage of the CBR approach, which emphasizes the use of local resources, especially for producing assistive devices. This is a key consideration in Gulu, as Akenna, a representative of a local NGO, noted that

Many [persons with disabilities] are in need of assistive devices like wheelchairs, and white canes. These are very expensive, we cannot afford them. And these things cannot last for many years; they need to be replaced, especially for children.

The need for affordable local solutions, built with resources and ideas found in the community, was mentioned by numerous respondents. One survey respondent from a government institution remarked that with CBR, “working in the community allows for more resources that are locally available, making it more cost effective.” One of the activities most readily associated with CBR is the production of assistive devices in local communities; the fact that this was repeatedly mentioned by respondents indicates a degree of familiarity with CBR.

Long-term impact was also a reason that several respondents were in favour of CBR. Donor-funded projects are notoriously short-term in nature, and as Isaac noted, “Even if you have money and you want to support me now, what about after? When you leave, how will I continue to survive?” Given these concerns, respondents felt it was important to ensure that the local community is given the tools and skills necessary to support themselves beyond the life cycle of a project.

This concern with long-term sustainability also points to the importance of community ownership, as emphasized by the CBR approach and numerous research participants. As Brian, who works for an international NGO, argued:

We implement projects, but you know some people, they do good work but they want to own the people. When they leave, the project collapses. Why? Because, they were doing it themselves, you were just using the people to do it.

The lack of community ownership identified here is seen as a major obstacle to successful development interventions, especially with persons with disabilities. In response, CBR is intended to be locally-driven and implemented. As one survey respondent stated, CBR “enables the community to access services, this allows for participation and involvement of the local community. There is ownership.”

Ownership was deemed to be a particularly important aspect of CBR in Gulu as a post-conflict region. Many respondents, in both surveys and interviews, spoke of the prevalence of “dependency syndrome,” a legacy of the years of forced displacement. As Isaac described

...during the war, people were not engaged in economic activities because the majority of the population were put in camps. People were depending on relief for a long time, over thirty years. They were surviving on the mercy of people who came to support us. And that really affected the lives of people.

Many respondents felt that this dependency syndrome was a major obstacle to promoting development in the region. This is especially true for persons with disabilities, as Stella noted that “Normally what happens is that if someone is living with a disability... they are stigmatized, they are side-lined, they are dependent, and they are looked at as a burden to the community.” In such a social context, CBR was deemed to be a beneficial approach because it engaged people to take ownership of the design, implementation and long-term trajectory of a development intervention.

Another element of CBR that was apparent in the responses from practitioners was the importance of multi-dimensional strategies to working with persons with disabilities. The environmental scan indicated a range of programming across thematic areas, and very few organizations identified themselves as working in a single thematic area. Among survey respondents, the average number of thematic areas of focus was three per organization, and only two respondents (both from government organizations) stated that they were working in just one thematic area. This indicates that development organizations recognize the importance of working across thematic areas and offering multi-dimensional solutions.

This concept was highlighted by many respondents. They recognized that working on a single issue would be unlikely to create transformative change in the life of a person with a disability. This idea was clearly captured by Charles, who argued that

When we try to tackle livelihoods only, and we leave them in poor health and their education is not provided for, nearly no work is done. Whole sum interventions would do much, and when you provide education, health, livelihoods, knowledge is expanding, people are learning more about themselves

and their environment, then people can gain more skills and start working on themselves.

Even those organizations that were working in a single thematic area understood that collaboration was necessary to truly support persons with disabilities. Isaac and Betty, both of whom worked in government institutions, highlighted the importance of working with other ministries to offer holistic solutions. Betty argued that

[if] my organization... or the health sector, is made to do something, other sectors like education are also made to do something. And then the ministry of gender, social development and whatnot is supposed to do something. There is supposed to be a multi-sectoral approach to all these issues.

The need for holistic solutions that address the complexity of a person's situation was also recognized by survey respondents. One survey respondent wrote that "Disability and war go hand in hand. Understanding this forces us to look at the community broadly, and approach them with a holistic approach." The interrelated nature of post-conflict challenges was deemed to require solutions that encompass multiple thematic areas, in keeping with the CBR approach.

The results indicate that CBR is understood and supported by development practitioners in Gulu. All participants who claimed to be familiar with the approach agreed it was suitable for working in post-conflict settings. Of course, the nebulous definition of CBR makes it somewhat difficult to "disagree with," and the principles associated with CBR like community ownership, affordability and using local resources are already widely accepted in general practice.

It is also necessary to critically examine the true extent of respondents' awareness of CBR. Interview participants demonstrated a very clear understanding of the approach: six of eight were able to offer definitions that were consistent with the CBR guidelines. One participant claimed to be familiar with the approach but defined it as institutional care, and the final participant stated that he was unfamiliar with the approach but nonetheless proceeded to identify the importance of sustainability, local ownership and holistic solutions. Of course, the familiarity with CBR among the interview participants, as a sub-sample of the survey respondents, may be a result of selection bias, as individuals who were more familiar or interested in the approach would be more likely to respond to the invitation to participate.

It is especially important

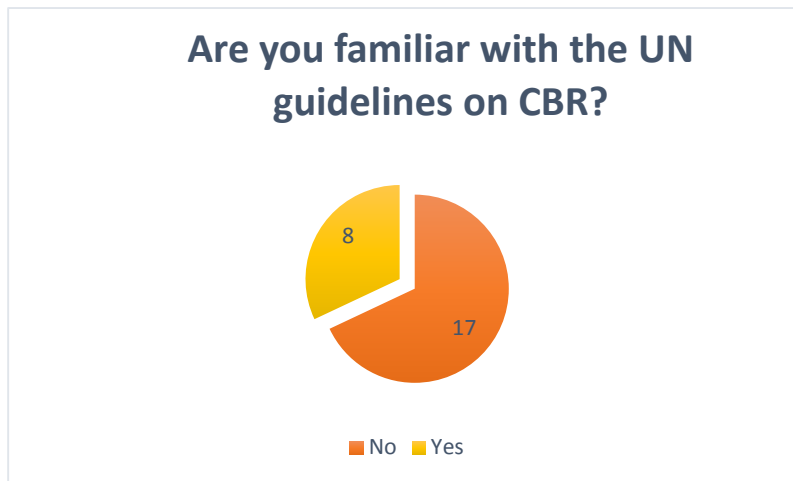


Figure 19: Number of respondents familiar with the UN's CBR Guidelines

to be cautious when interpreting the survey results. Though 88% (n= 22) of survey respondents claimed to be familiar with CBR itself, 70% of respondents said they were unfamiliar with the United Nations guidelines on CBR. Among those who were familiar with the guidelines, two respondents consulted them frequently, five respondents consulted them occasionally, and one rarely consulted them. The fact that many respondents stated that they were familiar with the concept of CBR, and yet had not consulted these formative guidelines, calls into question the extent to which CBR is making an impact among practitioners. This could indicate that the approach is having an influence but in a very indirect manner, through a general emphasis on low-cost initiatives “in the community” that support persons with disabilities.

Furthermore, most of the interview respondents argued that other organizations and community members lacked knowledge of CBR. For example, Isaac felt that “It is a concept that is understood, but I don’t think the entire community of this region understands. You know the way we have been brought up, especially persons with disabilities who are a bit older now, they have not been brought up on the concept of CBR.” Joshua echoed these sentiments, stating that while some practitioners may be familiar with CBR, “we may say it is well suited when our people don’t even know it.”

Similarly, Betty reflected on the understanding of CBR within the local government, asking whether “all the sectors understand what community rehabilitation is? Do they also understand where they can play a role?” These observations by interview respondents may indicate that the level of knowledge on CBR may be greatest in a select group of practitioners who are more closely engaged with disability and development, and less so in other organizations or indeed in the broader community.

This lack of clear understanding was evident when research participants were asked to describe CBR initiatives they had participated in, of which sixteen organizations in the survey claimed to have had experience. A few provided examples of CBR programs that were in keeping with the typical definition of CBR, with local CBR workers trained at the main regional hospitals to provide rehabilitation services at the local level. Other responses included awareness raising and funding public events on disability.

It would be easy to look at some of the activities highlighted by respondents as CBR programs/projects and dismiss them as not truly being genuine examples of CBR. Something as simple as giving a livelihood grant, or referring someone to services, does not immediately seem to fit the CBR model, and rather appears to be a case of an organization merely highlighting projects that are tangentially related to disability. Arguably, a true “CBR program” should encompass multiple dimensions, such as health and education, but these activities do contain some elements and principles of CBR. This is a challenge brought forth by the nebulous definition of CBR: perhaps respondents are not truly familiar with the approach and merely highlighted disability-related projects; however, it is not possible to completely dismiss their contributions given the extent of what can be considered CBR.

Setting aside the confusion, it is clear that some principles of CBR are influencing the way development practitioners in Gulu think about working with persons with disabilities.

Whether they fully understood the approach or not, there was unanimous support for applying CBR to post-conflict settings like Gulu. The CBR approach has been lauded for its low cost, sustainable model that is based upon multi-dimensional solutions at a local community level. Responses to surveys and interviews echoed these sentiments in favour of CBR. Arguably this approach, or at least its core principles, have attracted support among donors as well, as Stella described how “I’ve been working with a few partners who also embrace community-based rehabilitation so much... With some of our partners that we work with, they say that is what their donors advise them to do, and they also find that it is working.” While the depth of understanding may be somewhat limited, CBR appears to be an influential approach in this context.

### ***CBR’s Influence on Development Practice***

Having considered the scope of programming for persons with disabilities and the perspectives of practitioners, this section will analyze the extent to which CBR has impacted actual development practice in Gulu. While it would appear that the principles of CBR are influencing the thinking around development interventions with persons with disabilities, the impact upon practice is less evident. While some examples of CBR-inspired programming have been mentioned, it is clear that the model of CBR put forth by the UN guidelines is not being fully implemented in Gulu at this time, though there have been notable examples in recent years. This section will also reflect on the factors that have limited the influence of CBR, specifically the current funding trends in the region and the shifting role of the UN organs in Gulu. Finally, this section will consider whether perceptions of CBR are concentrated on one or more thematic areas.

At the time this research was conducted, no respondent had an ongoing project or program explicitly titled as CBR. Isaac described an initiative that had existed in previous years whereby

We used to go to the community, sensitizing people. We were a team, we used to have physiotherapists going with us, we used to have quite a number of professionals in the hospital, then the teachers. We used to go the community to identify children with disabilities, working with the parents. And then supporting even the young ones who needed some devices like crutches, or how to make a walking stick from ordinary materials in the setting.

Akenna described a CBR program his organization had participated in, which involved

Making things like corner seats using the local materials. All the facilities they are trained on are locally made, from materials that can be found locally in the community. We did that but most of them have left the work. Some of them were

linked to Lacor Hospital, so if there are cases they can just refer directly if they need medical intervention.

These two examples fit very closely with the traditional model of CBR, with a hospital as the key partner and community-based volunteers disseminating information on proper care of people with disabilities. Two NGOs, one local and one international, also described the following CBR initiatives in their questionnaire responses:

- “Mobilisation of war victims for physical and psychosocial [sic] support services, responding to women with disability that suffered sexual violence for redress, conducting outreaches and follow up of war victims, home visits and follow-ups, including group therapy [sic]”
- “Training of community based rehabilitation workers (CBR) to support in early identification and referral of (cases of neural tube defect, hydrocephalus and any form of physical disability), continence management, production of mobility appliances using the available local resources and follow ups”

Again, these are examples of typical CBR programs, drawing from the approach’s origins in primary health care. The first example is intriguing as a direct response to the unique challenges encountered in a post-conflict setting. In both cases there are efforts to ensure services are provided in a home or community-based setting. It must be noted though that these examples remain almost entirely within the thematic area of health.

In addition to these examples of typical CBR programs, other respondents noted initiatives that were inspired by CBR. For example, Betty’s organization undertook medical outreach activities, and described how

Our outreaches, we really try to make it CBR. How do we do it? We say for community rehabilitation we should use the available resources on the ground. When we go to the community, we use the available community participation of clients; like follow-up we pick on the clients who are leaders and work with them. And then we also, in the community when it comes to mobilization, we use the structures on the ground for their participation and sustainability and all that. And when it comes to being affordable, we really do things which we feel will be affordable within the context in which we are working.

While Betty stated that these medical outreach activities may not be a perfect application of CBR, her description is consistent with the goals and principles of the approach. Perhaps the only missing elements are activities in complementary thematic areas like education or livelihoods. Another interview participant, Stella, highlighted similar programming, in which

we have children who were born with neural tube defects. So because this centre is at regional level, and our beneficiaries are scattered all over the districts, at times it is difficult for them to come all the way here to get the support they need.

So, we take the service nearer to them, and then we don't end there because involve other actors and stakeholders. And then we train others who can provide similar services that these people would have gotten from here.

Again, there is a clear parallel with primary healthcare and the notion that interventions should be oriented towards reaching all beneficiaries in their homes, rather than forcing them to travel to regional health centres. This is consistent with CBR, but the approach has not been fully implemented, as Stella stated that “We do community-based rehabilitation on a small scale, like health. But we don't look at the wider things, maybe economic and other things, but very specific on health.”

While a number of practitioners noted that they have primarily remained focused on a specific thematic area like health, others have managed to approach their work with persons with disabilities in a multi-dimensional fashion. While Charles, who worked with a local NGO, felt that his organization's work was “not perfectly following all the protocols of reaching the person's home,” he did highlight how they had incorporated some skills training and small scale trades and agriculture for their beneficiaries, which indicates a commitment to multidimensional solutions. That said, Charles also described how

we have only limited capacity to reach homes. That is why we have centres and expect persons with disabilities to come and gather in one place. Then we talk with them, maybe provide some services to them. But if we had the capacity to reach homes, our services would be more effective. Because here we do that work in clinics and do work in outreach activities. But the outreach we do does not reach homes.

While interview and survey participants clearly expressed their familiarity with CBR, their support for the approach, and in some cases their experience with implementing it, there also appeared to be a lack of capacity for formulating programs for persons with disabilities that were fully consistent with the CBR approach. It would appear that the major obstacle to fully adopting the CBR approach is funding.

Not surprisingly, funding was a major concern raised by almost all respondents, but especially local NGOs. Now that it has been approximately ten years since the LRA left Uganda, donors are shifting their attention in two ways. First, they are focusing on surrounding districts; Gulu is the regional urban centre and is soon to be designated a city, so perhaps there is a perception that it has relatively more extensive resources to address development problems. Second, there is a shift away from meeting basic needs towards building the capacity of local government and local organizations to provide services. For example, Joshua, a local NGO staff member, maligned that “‘capacity building, capacity building...’ That's what most projects are all about.” An overemphasis on capacity building ignores the fact that many organizations, especially at the local level, have a very weak financial base to put their training into practice.

Since most NGOs, especially local ones, are totally reliant on donor funds, the scope of their activities has been reduced as donor priorities shift. Projects end, and local initiatives fall

apart due to a lack of funding. Long term, reliable funding is next to impossible to secure, forcing organizations to chase funds through calls for proposals.

The lack of reliable funding surely has impacted the ability of development organizations to support persons with disabilities and to adopt the CBR approach. As much as CBR is intended to be a sustainable approach that relies on the ownership of the local community, this is not always the case in practice. Isaac, who was involved in a CBR program in Gulu at the end of the conflict, stated that “CBR was doing very well because of donor funding. Now when donor funding is removed... Nothing is going on.” The collapse of this program with the withdrawal of donor funds appears to be the very situation that CBR, with its emphasis on ownership and sustainability, is intended to avoid.

Akenna, who had also participated in a CBR program, raised a similar issue which calls into question some of the underlying assumptions of the CBR approach. Having described how his organization recruited and sponsored some individuals to receive training and become CBR volunteers, he noted that “when we were training them, [the challenge] was that some of them thought they would be getting regular monthly income. So they sort of left the work.” This is only understandable on the part of the volunteers: in a region where many people are living in poverty, dedicating time and effort to working as a CBR volunteer without any stipend would mean forgoing potential income. The fact that no provisions were made to support the volunteers, either during or after the project life cycle, is a major concern.

With the increased emphasis on capacity building as opposed to meeting basic needs, support for persons with disabilities seems to be lacking. Isaac related how

the donors that were supporting people with disabilities have scaled down their activities. So getting reliable funding throughout is not easy. That’s why if you look at our organization now, we are limping. We don’t have adequate funding to support a number of activities.

Isaac, who represents a local NGO, was not the only respondent to complain of gaps in funding to support persons with disabilities. Even Stella, who works with a well-known international NGO, noted that “here we are also limping, we can provide this but the other one we can’t provide. We can refer there but the person may find a dead end.” Her mention of incomplete referrals is especially concerning, given that many of the activities mentioned in the environmental scan were referrals. Being able to refer persons with disabilities to services requires that those services are functional and adequately funded, but according to Charles “the scope of services is still insufficient. And worst of all, in this region and Uganda in general, rehabilitation services are very poor. Physiotherapy is not there...” Given these gaps in service provision, and a lack of donor support for direct provision of services, an emphasis on referrals may not be especially beneficial. Unfortunately, the CBR approach relies on having multiple levels of related services available for all parties to access.

Another possible obstacle to implementing CBR in Gulu is the limited presence of multilateral organizations. As previously mentioned, the response rate from these organizations

was notably low. One of the reasons that few multilaterals participated in this study is that they deemed themselves ineligible for participation since they did not have programming with persons with disabilities, or the programming they had was not in Gulu District. Some have shifted their emphasis towards capacity building, while others are engaged elsewhere in the country, especially in response to the influx of South Sudanese refugees (UNCHR, 2017). For these organizations, Gulu is a logistical base for programming in the surrounding region, but not an area of direct implementation. Others no longer maintain a presence in Gulu. For example, UNHCR's operations in Gulu ended in 2012 with the closure of the IDP camps (Spindler, 2012), and WHO's Gulu office had apparently closed not long before this research was undertaken.

The absence of a presence or programming by multilateral organizations, primarily the UN organs that defined CBR, cannot be discounted as an obstacle to full adoption of this approach. The fact that so many of these organizations claimed to have no programming that even tangentially addressed disability is also somewhat surprising given the efforts made to mainstream disability in the Sustainable Development Goals. Some participants were skeptical of the commitment of multilateral organizations to supporting CBR, such as Akenna who claimed that "I don't see their impact. I don't see any kind of work in that area, so I do think it is in paper, but practically on the ground, no." Even if work is being done by multilateral organizations in the area of disability, there seems to be a lack of credibility in the eyes of other practitioners.

### *Determining the Influence of CBR in Gulu*

Having explored the range of programming available in Gulu, as well as the perceptions and understanding of CBR among practitioners, this section will offer a response to the research questions. This study sought to answer two research questions, the first regarding the influence of the CBR approach, and specifically the guidelines, on development practice in Gulu. The second question concerned the CBR matrix, and whether one or more dimensions were most prominent in development practice in the region. The results lead to the conclusion that, while the CBR approach has been influential, the guidelines themselves have not. Furthermore, CBR's impact on practice is most evident in the field of health.

### *Consistency with the CBR Guidelines*

The central research question this study set out to answer is "To what extent are the development projects and programs that serve persons with disabilities in Gulu being planned and implemented in keeping with the CBR guidelines?" The results indicate that there is an awareness of the CBR approach, and especially the principles of sustainability and community ownership that the approach emphasizes. There also appears to be a clear understanding of the need for multi-dimensional solutions when working with persons with disabilities, since the marginalization they experience occurs in social, economic and other spheres of life.

Although the central principles of CBR are well-understood and accepted in this context, the impact of the approach is less evident in practice. Development organizations are attempting to formulate interventions with persons with disabilities that emphasize sustainability, ownership and holistic solutions; however, their capacity to fully adopt the CBR approach is limited by gaps in financial and logistical capacity. As a result, there are few current examples of programming that are truly consistent with the ideal model of CBR. The impact of CBR on development practice is most evident among organizations involved in health activities, who attempt to ensure that services are provided at the local level through field outreach and linkages to regional health facilities.

The final element of the research question is whether planning and implementation is being done in keeping with the CBR guidelines. The influence of the CBR approach itself, and whether programming in Gulu is consistent with the approach laid out by the United Nations, is debatable, as elements of the approach are clearly evident in various development initiatives. That said, the results lead to a fairly straightforward conclusion regarding the impact of the CBR guidelines themselves as a set of documents. Of the twenty-five survey respondents, only two stated that they frequently consulted the CBR guidelines. 70% of survey respondents said they were unfamiliar with these guidelines. From the interviews, four participants claimed to be familiar with the guidelines. One stated that he had read them once but forgotten most of the content, another said that she consults them fairly infrequently and has not read them fully, while the other two seemed fairly familiar with the content.

Responding to the research question, it can be argued that the CBR approach and the principles behind it may be influencing development practice in Gulu. However, the fact that the overwhelming majority of respondents were unfamiliar with the guidelines leads to the conclusion that these documents are not influencing the planning or implementation of development projects in Gulu. This does not necessarily mean that development initiatives for persons with disabilities in Gulu are flawed, but rather indicates that the impact of the CBR approach on practice is limited. As a result, organizations are not adequately exposed to an approach that arguably holds great potential for benefiting persons with disabilities living in post-conflict regions.

### *Dimensions of CBR*

The second research question considered “which dimensions of the CBR matrix do development projects in Gulu emphasize, and why?” While CBR itself is intended to be a multi-dimensional approach, its origins are in primary health care. The environmental scan appears to show a balanced range of programming for persons with disabilities across multiple thematic areas, which is reflective of the desire of development-oriented organizations to take a multi-dimensional approach to support persons with disabilities.

That being said, this environmental scan was not explicitly focused on “CBR activities.” When turning to the initiatives that organizations themselves classified as CBR, there appeared

to be more of an emphasis on the health sector. The most common activity referred to as CBR was the provision of mobility aids such as wheelchairs. Direct provision of medical care and rehabilitation, and community outreach activities related to health, were also common responses. Organizations carrying out capacity building initiatives also typically targeted health workers, or focused on helping communities to manage impairments locally. The examples of CBR that fit with the traditional understanding of the approach clearly had health as their foundation, with hospitals as the key partners.

Interestingly, and again in contrast to the environmental scan, empowerment initiatives were also commonly identified as firsthand examples of CBR. Several organizations described advocacy activities around the rights of persons with disabilities to health and employment.

The clear emphasis on health and, to a lesser extent, empowerment interventions in this section contrasts with general trends in the survey, where the thematic focus was more balanced. Given that CBR evolved from primary health care, perhaps this emphasis on health care and health promotion is not surprising. Furthermore, while perceptions of disability were not investigated in this study, the persistence of the medical model of disability may also be a factor here, with disability understood as a health problem necessitating medical solutions.

Regardless of the reason, the fact remains that the majority of survey respondents provided examples of CBR initiatives that pertained to health. Despite the widespread recognition of how important multi-dimensional programming is when working with persons with disabilities, the health perspective remains foundational to practitioners' understanding of the needs of persons with disabilities and, in turn, the CBR approach.

Again, this is not to say that the work of development organizations in Gulu is flawed. As several respondents noted, there is a great need for rehabilitation services, both physical and psycho-social, in this region. It also aligns with Shakespeare's (2012) critical realism model, acknowledging the social dimensions of disability while not neglecting the medical needs of persons with disabilities. In spite of its origins in the field of health, CBR aspires to be an approach that positively impacts the lives of persons with disabilities across all five dimensions of the CBR matrix. Graphically, the matrix depicts the health dimension as being at the same level as all others, with no hierarchy of importance. The fact that the health perspective on CBR appears to dominate, at least in Gulu, calls us to consider our conceptual definitions of "impairment" and "disability," and whether this has any practical impact when working with persons with disabilities around the world.

## **Chapter 10: The Policy Transfer of CBR**

While the literature on policy transfer initially focused on state to state transfers, increasing attention has been paid to other actors in the international policy sphere and the roles that they can play in creating and transmitting policy ideas. This study of CBR in Gulu provides insights into how policy transfer can influence the work of development actors like NGOs and local governments. This study also draws attention to the practical obstacles to policy transfer in

resource-poor settings, and how this can constrain the adoption of supposed “best practices.” A policy transfer analysis of CBR also points to some of the weaknesses of the approach, which present opportunities to improve CBR for use in resource-poor settings, including those recovering from conflict.

Dolowitz and Marsh (2000) provide a framework for looking at the various elements of policy transfer (see figure 1). In the case of Gulu and CBR, a variety of different actors are involved in the process. First are international organizations, most notably those in the UN system who helped to define and promote the CBR approach. These actors have initiated the transfer of CBR as a policy idea to many countries around the world. In this case, the recipients are development actors in Uganda, and specifically in Gulu.

The CBR approach and the principles of inclusive participation and service decentralization are very evident in Uganda’s National Policy on Disability (Government of Uganda, 2006), which translates into the provision of services in Gulu District. The preamble to the National Policy on Disability states that it is aligned with key international statutes, including the “Alma Ata Declaration of 1978, which emphasizes inclusion of the rehabilitation approach into the primary health care system” (Government of Uganda, 2006, 11). Uganda’s submissions to the UN Committee on the Rights of Persons with Disabilities states that, when operationalizing the national policy, the Government of Uganda has made use of the CBR guidelines (Committee on the Rights of Persons with Disabilities, 2013).

Degrees of coercion are an important element of Dolowitz and Marsh’s (2000) framework, and in the case of Gulu and CBR, this provides an opportunity to consider insights from theories of norm diffusion and Nay’s (2012) discussion of the forms of influence employed by international organizations. It would appear that the transfer of CBR to development actors in Gulu is an example of international organizations wielding their technical and cognitive influence. The creation of the CBR guidelines provides a clear example of this: by drawing together many stakeholders in consultations and field testing, these guidelines present CBR as an approach derived from widespread consensus, positioning it as a best practice. Therefore, while there is no means to force member states to adopt CBR, the extensive literature and evidence base gives normative resonance and the prestige of “best practice” to the approach, which can compel members states (and non-governmental actors) to promote and adopt it.

Alignment with international norms is important for Uganda, a country that remains heavily dependent on foreign aid (World Bank, 2016) and hosts numerous international and local NGOs that are reliant on international donors (Andrews, 2013). It is clear that there has not been any overt coercion in the transfer of CBR to development practitioners in Uganda, but there is an implicit need for development actors to align with international best practices in order to continue attracting funding. This is especially true for NGOs, who must constantly readjust their programming and respond to shifting donor priorities (Abouassi, 2013; Reith, 2010). Therefore, while the transfer of CBR to development actors in Gulu was not coercive, it was not entirely voluntary either. To some extent their efforts to adopt CBR may be motivated by the intrinsic value of the approach, as was emphasized by the many research participants who argued that it

was a meaningful way to engage with the needs of persons with disabilities. That said, the adoption of CBR is likely also motivated by the need to remain consistent with current norms of practice in international development.

Given the diversity of actors considered by this study, it is worth noting that there are likely multiple channels of policy transfer. International organizations have played a role in defining national level priorities in regards to CBR, but their influence is less evident at the local level in Gulu. As previously noted, most of the key multilateral organizations in Gulu stated that they were not involved in disability programming or provision of CBR services in the district. Therefore, the transfer of a policy idea like CBR may be occurring in different ways. District and local government actors in Gulu stated that they design programs and policies in line with the National Policy on Disability. Given that this Policy is itself aligned with CBR and international norms of participation and inclusion of persons with disabilities, there may well be an indirect transfer of CBR from international organizations to the local government in Gulu. There may also be a direct transfer through technical assistance and policy dialogue at the national level by international organizations in Uganda, but there is insufficient data to draw such conclusions.

For NGOs, the transfer process is less clear. Some respondents stated that they had learned of CBR from international policy documents and other publications, while others learned about it during their own post-secondary studies. That said, most of the respondents were completely unfamiliar with the CBR guidelines themselves. There was a general lack of awareness about the details of the CBR approach, even among those who claimed to be familiar with it. This is arguably indicative of incomplete, or perhaps even failed, policy transfer.

That being said, there are some important exceptions that should be considered before labelling this case as a failed transfer. There is, of course, the notable exception of the health sector. Research participants who were working in health showed the greatest awareness and understanding of the CBR approach, indicating that the WHO's work on primary health care and CBR have had an impact on establishing norms of practice. The need for decentralization and moving medical care outside of institutions was an important message that came from discussions with practitioners. The emphasis on the rehabilitation aspect of CBR, including the production of assistive devices, was very evident in the research findings. Participants working in education also showed a high degree of knowledge of principles related to CBR, perhaps due to the consistency between CBR and inclusive education. Finally, and perhaps not surprisingly, respondents who were working with a disabled persons organization or other disability-focused organizations showed a high degree of familiarity with CBR and the underlying principles.

However, for actors whose work focused on other thematic areas of the CBR matrix beyond health and education, there was not the same degree of knowledge. While international organizations have dedicated a great deal of effort to developing CBR as a norm of best practice through methods of technical and cognitive influence, this does not appear to have had a great deal of impact in this particular context, except among those development actors who have a specific focus on disability and rehabilitation.

A number of authors (Acharya, 2004; Park et al., 2014) have focused on the processes by which international policy ideas are adopted and changed to fit local needs and values. While localization is an important part of the policy transfer process, it is unclear to what extent it has taken place in Gulu with regard to CBR. Several respondents noted that they did not fully implement CBR, but rather adopted “elements” of the approach and incorporated them into their work. The literature argues that localization can be a means to simplify a complex idea, or align it with local values, but in this case the localization appears to be a response to limited resources. The respondents who said they were incorporating elements of CBR also stated that they wanted to do more, but given their reliance on limited donor funds, were unable to fully implement the approach.

Herein lies a useful contribution of this research to the literature on policy transfer. A criticism has been that policy transfer focuses too heavily on cases from the Global North, and this case shows that there are indeed gaps in the analytical framework when looking at states or regions in the Global South, or when looking at non-governmental actors (Marsh & Sharman, 2009). While the Dolowitz and Marsh framework does mention that failed transfer can occur due to feasibility or structural issues, the fundamental reality is that in many cases, there is simply not enough money available to put good ideas into practice. Most NGOs can only really do what they are funded to do, either by an institutional donor or through fundraising campaigns. Local governments, which, depending on revenue streams and institutional arrangements, are often underfunded, may lack the means to implement national level policies like Uganda’s National Policy on Disability.

Whether the CBR approach is viewed as a meaningful way to support persons with disabilities, or simply as a means to access funding, development actors cannot implement the approach if they do not have a sufficient and reliable source of funding, and this is arguably the most significant obstacle in Gulu. Nearly all of the development actors who participated in this study rely on some external source of funding, whether it is project-based funding or transfers from the national government. In the cases where CBR was actually implemented, at the end of the project funding cycle the activities stopped, with no means to provide for CBR workers or to otherwise support the initiative. In the cases where actors wanted to implement CBR or incorporate it into their work, the funds were not available. And, given that the international organizations that created and promoted the approach, as well as major international donors, were not funding disability-focused programming in Gulu, there were limited opportunities to implement CBR.

This forces us to expand our understanding of policy transfer when looking at non-governmental organizations, and when considering cases in the Global South. While in an ideal world these actors would perhaps engage in lesson drawing by identifying and incorporating best practices into their work, they often lack the means to do so. Rather than localizing a policy idea based on needs or values, development actors in the Global South will localize ideas based on the resources available to them. In some cases, where the available funds are inadequate, this may lead to a failed policy transfer. These findings are summarized in figure 20.

Of course, it is perhaps too simplistic to say that the incomplete transfer of the CBR approach to Gulu is a result of a lack of funds. To what extent is this partial failure the result of flaws with the CBR approach itself? There was universal support for the CBR approach among research participants, who emphasized its relevance for Gulu as a post-conflict region with a high prevalence of poverty and disability. CBR also aligns well with Uganda's decentralization policy, and makes sense in Gulu where the population is predominantly rural and widely dispersed. A holistic, multidimensional approach to disability programming appears to be sensible given the complex needs associated with the disability – poverty – conflict nexus.

However, the ideal model of CBR has not been realized in Gulu; where it has been implemented, it is mostly in the form of rehabilitation outreach activities and the provision of assistive devices. These are very important activities, but they admittedly fall short of the goal of an integrated approach inspired by the CBR matrix.

Where CBR has been implemented in Gulu, the leadership has come from government and non-governmental actors in health and education, as well as DPOs. While the CBR guidelines were the product of a broad-based consultation process, there may be a need for more effort to engage with major international donors and other actors that do not specifically work with persons with disabilities. While DPOs and disability-focused organizations, as well as traditional partners in the health sector, have an important role to play in implementing CBR, other partners are necessary to broaden the implementation of the approach. The case of CBR in Gulu points to perhaps the greatest flaw of the approach, and here there is a need to again consider issues of funding. While authors like Lightfoot (2004) argue that CBR provides a sustainable, low-cost alternative to traditional rehabilitation, in many cases sustainability has been a major weakness of CBR programs around the world (Dawad & Jobson, 2011; Kuyini et al., 2011; WHO, 2002). This is immediately evident in Gulu, where several programs which received donor funding near the end of the conflict ceased to exist when the project ended.

This is an important cautionary tale when applying CBR to post-conflict settings. The needs of persons with disabilities in such contexts are especially great, and CBR can be one possible means of supporting them (Eide, 2010). However, while funds to support such initiatives may be fairly easy to come by in the immediate post-conflict phase, that is unlikely to be the case in the long run as donors shift their attention elsewhere. This is why the WHO and its partners emphasize the need to secure government buy-in and support to truly make CBR sustainable, since the government will be responsible for maintaining such a program in the long run (WHO, UNESCO and ILO, 2004). Unfortunately, the results of this and other studies (in particular Kuyini et al., 2011) have shown that governments often lack the funds, capacity, or political will to take over and sustain CBR in the absence of donor funding.

A closely related issue with CBR is the reliance on voluntarism at the local level, which has been identified in other studies as well (Pollard & Sakellariou, 2008; WHO, 2002). Research participants stated that CBR workers were reluctant to carry out their tasks without some form of remuneration, and this should not come as a surprise. In a region where poverty is widespread,

Why transfer?	Who is involved	What is transferred	From where	Degrees of transfer	Constraints on transfer	How to demonstrate policy transfer	How transfer leads to policy failure
Mixture			Cross-national				
<ul style="list-style-type: none"> <li>-Technical and cognitive influence wielded by international organizations</li> <li>-Growing international policy consensus on inclusion of persons with disabilities (consensus, image, donor funds)</li> <li>-Need to align with donor priorities and seek out funding</li> </ul>	<ul style="list-style-type: none"> <li>-International organizations as “norm entrepreneurs” who promote CBR</li> <li>-Ugandan government who sets national policies in line with international priorities</li> <li>-International and local NGO’s who promote CBR, and are recipients of the policy idea</li> </ul>	<ul style="list-style-type: none"> <li>-Principles (inclusion, participation, decentralization of services)</li> <li>-The CBR approach as a programming model</li> </ul>	<ul style="list-style-type: none"> <li>-International organizations developed the CBR approach and promoted it through knowledge mobilization and consensus generating activities</li> <li>-Government of Uganda, who have aligned the National Policy on Disability with international norms</li> </ul>	<ul style="list-style-type: none"> <li>-Distorted or localized transfer, due to insufficient funds for complete implementation</li> <li>-CBR has provided the inspiration to take services for persons with disabilities out of institutions and closer to the end user, and to involve their family and community</li> </ul>	<ul style="list-style-type: none"> <li>-Lack of funds and sustainability strategy for CBR to continue beyond initial project cycle</li> <li>-Lack of funds to support new CBR programming</li> <li>-Lack of organizational and technical capacity among local actors to fully implement CBR without external support</li> </ul>	<ul style="list-style-type: none"> <li>-The influence of international norms and CBR are evidence in the National Policy on Disability</li> <li>-Development actors report that CBR has influenced the way they approach their work</li> <li>-Outreach activities demonstrate the belief that that programming should respond to needs of persons with disabilities</li> </ul>	<ul style="list-style-type: none"> <li>-Incomplete transfer due to insufficient funds for long-term sustainability and lack of handover strategy</li> <li>-Inappropriate transfer, because reliance on voluntarism is not sensible in a setting where people struggle to earn a sufficient income</li> </ul>

Figure 20: The Policy Transfer of CBR to Gulu

expecting ordinary people to dedicate time and effort to CBR work on a purely voluntary basis is unrealistic, as this time could be dedicated to other income-generating activities. Any approach that is largely reliant on unpaid labour and altruism, especially in a resource-poor setting where people are struggling to meet their own essential needs, is unlikely to succeed or be in any way sustainable.

The incomplete transfer of the CBR approach to Gulu can serve as a useful case for understanding how policy transfer analysis can be applied to international development, especially in post-conflict settings. International development actors are important players in the creation, promotion and transfer of international policy ideas through their advocacy and knowledge mobilization work (Stone, 2004). However, they are also expected to reflect changing priorities and ideas in international development practice, and here it is important to differentiate between international NGOs with bases in the Global North and local NGOs.

NGOs are very important actors to consider when looking at policy transfer in Uganda. Branch (2013) describes how many international relief agencies flocked to Gulu from the early 2000's onwards to respond to the humanitarian crisis in Northern Uganda, and Andrews (2013) highlights how NGOs provide one of the most important sources of formal sector employment in Uganda. As Gulu grows in terms of population and economic activity, and other priorities (most notably the influx of refugees from South Sudan) take precedence in the minds of donor organizations, local NGOs face existential challenges to continue attracting funding. They must respond to shifting priorities that are largely beyond their control.

Therefore, when looking at policy transfer in international development, there is a need to differentiate between NGOs, and indeed levels of government, by considering capacity to identify, transfer and implement international policy ideas. NGOs certainly play a role in setting the policy agenda through their advocacy work, but their continued existence relies upon securing a source of funds. While actors at the local level, be they NGOs or governments, may be aware of international policy ideas, they may well lack the organizational capacity to identify and secure funding, or the technical capacity to implement them effectively. Taking capacity into account provides insights into the constraints on transfer and the ensuing degree of transfer, as well as why transfer may fail. Understanding capacity is also necessary for identifying indirect forms of coercion, since there is an imperative for local actors who are dependent on donor funds to these adopt international policy ideas.

CBR is a promising policy idea. It is responsive to the multidimensional needs of persons with disabilities, and emphasizes their participation and inclusion in all aspects of social and political life. However, examining the transfer of this international policy idea to Gulu, Uganda has illustrated some of the flaws with the approach, most notably its reliance on voluntarism and frequent lack of planning for sustainability. This analysis of policy transfer has also illustrated the need for the literature on policy transfer to take a more critical look at the constraints on policy transfer faced by development actors, most notably funding and capacity.

## Chapter 11: Conclusion

Community-based rehabilitation is one strategy that has been proposed to support persons with disabilities and address the multidimensional barriers they face to full participation in economic, social and political life. These barriers are very real, as there can be a cyclical relationship between disability and poverty, especially in the Global South. These challenges are especially detrimental to the wellbeing of persons with disabilities living in regions experiencing or recovering from conflict.

Conflict can create impairments that result in disability through injury or illness, and persons with disabilities are often more vulnerable to violence and injury or illness during and after conflict, when social systems and services are in a state of decline. In Gulu, Northern Uganda, there is clear evidence of a nexus of disability, poverty and conflict. The forced displacement of over a million people, coupled with violence, malnutrition and poor health led to an increased incidence of disability, and the collapse and stagnation of the region's economy and the degradation of social networks increased the vulnerability of those people living with a disability. These impacts are diverse, influenced by gender as well as the nature of one's impairment.

In such a setting, community-based rehabilitation represents a possible approach to meeting the needs of persons with disabilities in terms of health, education, livelihoods, social development and empowerment. This approach has been well-received by development actors, many of whom believe it is suited to the unique development challenges in post-conflict Gulu. They feel that the emphasis on the active participation of persons with disabilities, their families and communities in designing and implementing programming holds the possibilities for meaningful and sustainable development outcomes. This has translated into a variety of targeted interventions with the intention of influencing the overall, multidimensional wellbeing of beneficiaries.

Unfortunately, CBR's influence on development practice in Gulu is limited outside of the field of health. Drawing upon the policy transfer literature, it is evident that there are a number of constraints facing development actors, which means that this international policy idea is not being fully adopted in Gulu. A lack of sustainable funding is the most critical factor, as local development actors lack the means to put CBR into practice without external support. The CBR approach itself also has flaws, since the promises of sustainability beyond the project cycle have not been borne out in reality. A heavy reliance on voluntary CBR workers is a major weakness of the CBR approach that has limited its long-term viability in Gulu.

This study set out to determine the extent to which development programming in Gulu is being planned and implemented in keeping with the CBR guidelines, and whether one thematic area of the CBR matrix was being disproportionately represented in practice. Ultimately, it can be concluded the CBR guidelines themselves have had very limited influence on development programming Gulu, since most development actors are unaware of them or unfamiliar with their contents. Given that these guidelines were a major product intended to promote the technical and

cognitive influence of the CBR approach, this finding will disappoint the many contributors and the international organizations that led the development of the approach.

That said, the CBR approach itself and the principles it embodies have gained traction among development actors in Gulu. There is a recognition that persons with disabilities are important stakeholders in the development process, and that their marginalization is a product of several interdependent factors. While the depth of knowledge about what CBR is and how to implement it is limited, the increasing understanding that persons with disabilities must be better served by development programming holds some promise for the future.

## ***Recommendations***

This research informs a number of recommendations for development organizations seeking to support persons with disabilities in Gulu. First, it would be beneficial for development organizations to adopt an intersectional approach to understanding the needs of persons with disabilities, taking into account the challenges posed by the disability – poverty – conflict nexus. While an individual organization will not be able to address all of the challenges facing persons with disabilities in post-conflict settings, this holistic understanding is necessary for identifying entry points, realistically scoping project outcomes, and providing referrals to complementary services.

While ideally all development interventions should be informed by a needs assessment drawing on this manner of intersectional analysis, local NGOs and local government likely lack the time and resources to do so. Larger international NGOs which have the funds available, and multilateral organizations that engage in research and knowledge dissemination, should carry out this type of analysis to inform their programming. This information should be publically available to support organizations which may lack the means to carry out such research. While most disability-focused organizations demonstrated an understanding of the need for an intersectional approach, all development organizations need to move towards developing a holistic understanding of disability in post-conflict settings.

Second, the Gulu District government should take a lead role to ensure that existing services for persons with disabilities are coordinated and aligned. The departments of education, social affairs and health all support persons with disabilities with their programming, and systems should be in place to allow for service referrals. A coordinating body or council should be established to bring together all District government departments that support persons with disabilities. In the absence of funding from the national government to fully implement CBR in keeping with the National Policy on Disability, such a council could ensure that existing efforts are aligned and complementary, and identify possible areas for joint action across sectors and between the public sector and civil society.

Such a body should also draw upon the multitude of DPOs which are active in Gulu District, as well as the elected disability representatives at the various levels of government. In keeping with the principle of ownership that is foundational to CBR, persons with disabilities

and the organizations that represent them should play a central role in directing interventions in Gulu.

Finally, multilateral organizations should investigate the reasons why important documents like the CBR guidelines have not been accessed by local development actors in Gulu. While multilateral organizations may not be able to directly fund interventions for persons with disabilities, they should take a more active role in promoting the benefits of the CBR approach. While the CBR guidelines went through an extensive field testing process to ensure they were accessible and useful, they appear to have not been widely accessed by practitioners in Gulu. Whether further refinements to the guidelines are needed, or simply more effort to promote the benefits of the approach, these multilateral organizations should ensure that CBR remains part of the discussions around disability and development in this region.

The development needs of persons with disabilities in Gulu and around the world are extensive, and much remains to be done to ensure that they actually benefit from the programs and policies of national governments, international organizations and NGOs. Especially in post-conflict settings like Gulu, the nexus of disability, poverty and conflict poses an immense challenge. That said, this research serves to provide a better understanding of how international policy ideas can be transferred to address these needs, and the capacity gaps among development actors that must be overcome in order to do so. Approaches like CBR may hold the key to putting disability firmly at the forefront of the development agenda, and ensuring that persons with disabilities, from Geneva to Gulu, are better able to realize their full social, political, and economic potential.

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## Appendix A: Data Collection Instruments

### *Interview Guide*

Topic	Main Questions	Probing Questions
Organizational Characteristics	<p>-How would you classify your organization:</p> <ul style="list-style-type: none"> <li>a) International NGO</li> <li>b) Ugandan NGO</li> <li>c) Multilateral Organization</li> <li>d) Government</li> </ul> <p>-Are persons with disabilities your main population of focus?</p>	<p><i>-If international:</i> Where are your organization's headquarters?</p>
Projects and Programs	<p>-How many projects do you have that serve persons with disabilities?</p> <p>-Approximately how many participants do you have in these projects?</p> <p>-In which of the following categories would you say your organization works:</p> <ul style="list-style-type: none"> <li>a) Health</li> <li>b) Education</li> <li>c) Livelihood</li> <li>d) Social</li> <li>e) Empowerment</li> </ul>	
Disability and Poverty	<p>-How does poverty contribute to disability in Gulu?</p> <p>-How does disability affect the livelihoods of people in Gulu?</p> <p>-Does your organization attempt to address the link between poverty and disability?</p> <p>-How has the war contributed to poverty in Gulu?</p>	<p>-How do you address this link?</p> <p>-How has the war contributed to poverty for persons with disabilities?</p>
Disability and Conflict	<p>-How has the conflict in Gulu contributed to disability?</p>	

	<p>-Are people with disabilities more vulnerable in the post-conflict era compared to people without disabilities?</p> <p>-How does the legacy of conflict affect/complicate your work with persons with disabilities?</p>	
Dealing with Complexity	<p>-Disability, poverty and conflict appear to be interlinked. How is this evident in your organization's work?</p> <p>-How does your organization try to address this complexity?</p> <p>-Is it better to address the linkages holistically, or try to address specific links (eg. poverty and disability)?</p>	
Community Based Rehabilitation	<p>-Are you familiar with community based rehabilitation?</p> <p>-How would you define CBR?</p> <p>-Do you think it is a relevant approach for your organization?</p> <p>-Has this approach influenced any of the work your organization undertakes?</p> <p>-Are CBR strategies applicable in post-conflict settings?</p> <p>-Do you try to incorporate local disabled persons organizations into your planning or programming?</p>	<p>-Have you consulted the UN's guidelines on CBR?</p> <p>-Do you feel it is well defined?</p> <p>-What aspects are relevant?</p> <p>-How has it influenced your organization (eg activities, principles)?</p> <p>-Do you feel that donors support this approach?</p> <p>-Why/why not?</p>

# Questionnaire

2/24/2017

Development Programming for Persons with Disabilities in Gulu, Uganda | KoboToolbox

Development Programming for Persons with Disabilities in Gulu, Uganda
SAVE ✕

👁️
☰
🗑️ Layout
☰

Search Library

🔵
▼ What type of organization do you represent?
⚙️

<input type="checkbox"/> International NGO	Value: international_
<input type="checkbox"/> Local NGO (Ugandan)	Value: local_ngo_uga
<input type="checkbox"/> Multilateral Organization (eg. United Nations, development bank)	Value: multilateral_o
<input type="checkbox"/> Government institution	Value: government_inst
<input type="text" value="+ Click to add another response..."/>	Value: AUTOMATIC

🔵
▼ Does your organization serve persons with disabilities with your programs/projects?
⚙️

<input type="checkbox"/> Yes	Value: yes
<input type="checkbox"/> No	Value: no
<input type="text" value="+ Click to add another response..."/>	Value: AUTOMATIC

☑️
Thank you for your time. This study focuses on organizations that serve persons with disabilities. Since you have indicated that your organization does not serve persons with disabilities, you are not eligible for participation in this study. If you have made an error, please contact the researcher.
⚙️

☑️
Thank you for agreeing to participate in this study. The following questions will ask you to reflect on your organization's work with persons with disabilities in Gulu. Please respond to the questions based on whether they apply to your organization's work with persons with disabilities in Gulu.
⚙️

🔵
▼ Are persons with disabilities your primary target population?
⚙️

<input type="checkbox"/> Yes	Value: yes
<input type="checkbox"/> No	Value: no
<input type="text" value="+ Click to add another response..."/>	Value: AUTOMATIC

☰
▼ In which of the following thematic areas are your programs for persons with disabilities? (check all that apply)
⚙️

<input type="checkbox"/> Health	Value: health
<input type="checkbox"/> Education	Value: education
<input type="checkbox"/> Livelihood/employment	Value: livelihood_emp
<input type="checkbox"/> Social (eg. community engagement, personal development)	Value: social_eng_co
<input type="checkbox"/> Empowerment (eg. political participation)	Value: empowerment_e
<input type="text" value="+ Click to add another response..."/>	Value: AUTOMATIC

☰
▼ Which of the following types of health activities does your organization undertake? (select all that apply)
⚙️

<input type="checkbox"/> Health Promotion	Value: health_promotion
<input type="checkbox"/> Impairment Prevention	Value: impairment_prevention
<input type="checkbox"/> Medical Care	Value: medical_care
<input type="checkbox"/> Rehabilitation	Value: rehabilitation

<https://kobo.humanitarianresponse.info/forms/##/forms/avH9kdddpxaKG6Rs5ebdSC/edit>

1/12

<input type="text"/>		
<input type="checkbox"/> Activities related to assistive devices	Value:	activities_related_to_assistiv
<input type="text"/> + Click to add another response...	Value:	AUTOMATIC
<hr/>		
<input type="checkbox"/> Which of the following health promotion activities does your organization undertake?		
<input type="checkbox"/> Community health promotion campaigns	Value:	community_heal
<input type="checkbox"/> Strengthening individuals personal knowledge and skills	Value:	strengthening_
<input type="checkbox"/> Promoting and providing referrals to self-help groups	Value:	promoting_and_
<input type="checkbox"/> Educating health care providers	Value:	educating_heal
<input type="checkbox"/> Promoting healthy and accessible environments	Value:	promoting_heal
<input type="checkbox"/> Providing health training and education to staff	Value:	providing_heal
<input type="checkbox"/> None of the above	Value:	none_of_the_ab
<input type="text"/> + Click to add another response...	Value:	AUTOMATIC
<hr/>		
<input type="checkbox"/> Does your organization undertake any other health promotion activities? (please specify)		
<hr/>		
<input type="checkbox"/> Which of the following impairment prevention activities does your organization undertake? (select all that apply)		
<input type="checkbox"/> Facilitating access to existing prevention services	Value:	facilitating_a
<input type="checkbox"/> Promoting healthy behaviour and lifestyles	Value:	promoting_heal
<input type="checkbox"/> Encouraging immunization	Value:	encouraging_im
<input type="checkbox"/> Promoting proper nutrition	Value:	promoting_nut
<input type="checkbox"/> Facilitating access to maternal and child health care	Value:	facilitating_a_1
<input type="checkbox"/> Promoting clean water and sanitation	Value:	promoting_clea
<input type="checkbox"/> Helping to prevent injuries	Value:	helping_to_pre
<input type="checkbox"/> Helping to prevent secondary conditions	Value:	helping_to_pre_1
<input type="checkbox"/> None of the above	Value:	none_of_the_ab
<input type="text"/> + Click to add another response...	Value:	AUTOMATIC
<hr/>		
<input type="checkbox"/> Does your organization undertake any other impairment prevention activities? (please specify)		
<hr/>		
<input type="checkbox"/> Which of the following medical care activities does your organization undertake? (select all that apply)		
<input type="checkbox"/> Gathering and sharing information about medical services	Value:	gathering_and_
<input type="checkbox"/> Assisting with early identification of impairments	Value:	assisting_with
<input type="checkbox"/> Ensuring access to timely treatment	Value:	ensuring_acces
<input type="checkbox"/> Facilitating access to surgical care	Value:	facilitating_a
<input type="checkbox"/> Promoting self-management of chronic conditions	Value:	promoting_self
<input type="checkbox"/> Building relationships with medical care providers	Value:	building_relat
<input type="checkbox"/> None of the above	Value:	none_of_the_ab
<input type="text"/> + Click to add another response...	Value:	AUTOMATIC
<hr/>		
<input type="checkbox"/> Does your organization undertake any other medical care activities? (please specify)		

**☰** Which of the following rehabilitation activities does your organization undertake? (select all that apply)

<input type="checkbox"/> Supporting needs assessments for persons with disabilities	Value:	supporting_nee
<input type="checkbox"/> Facilitating referral and providing follow-up	Value:	facilitating_r
<input type="checkbox"/> Providing early intervention for child development	Value:	providing_earl
<input type="checkbox"/> Encouraging and supporting functional independence	Value:	encouraging_an
<input type="checkbox"/> Facilitating environmental modifications	Value:	facilitating_e
<input type="checkbox"/> Referring persons with disabilities to self-help groups	Value:	referring_pers
<input type="checkbox"/> Developing and distributing rehabilitation resource materials	Value:	developing_and
<input type="checkbox"/> Training community health providers	Value:	training_commu
<input type="checkbox"/> None of the above	Value:	none_of_the_ab
<input type="button" value="+ Click to add another response..."/>	Value:	AUTOMATIC

**abc** Does your organization undertake any other rehabilitation activities? (please specify)

**☰** Which of the following activities related to assistive devices does your organization undertake? (please select all that apply)

<input type="checkbox"/> Training community health professionals about the use of assistive devices	Value:	training_commu
<input type="checkbox"/> Building the capacity of individuals and families to use assistive devices	Value:	building_the_c
<input type="checkbox"/> Training local artisans to produce assistive devices	Value:	training_local
<input type="checkbox"/> Facilitating access to assistive devices	Value:	facilitating_a
<input type="checkbox"/> Addressing environmental barriers to the use of assistive devices	Value:	addressing_env
<input type="checkbox"/> None of the above	Value:	none_of_the_ab
<input type="button" value="+ Click to add another response..."/>	Value:	AUTOMATIC

**abc** Does your organization undertake any other activities related to assistive devices? (please specify)

**☰** At what level are your organization's education activities? (select all that apply)

<input type="checkbox"/> Early childhood education	Value:	early_childhood_education
<input type="checkbox"/> Primary education	Value:	primary_education
<input type="checkbox"/> Secondary and higher education	Value:	secondary_and_higher_educ
<input type="checkbox"/> Non-formal education	Value:	non_formal_education
<input type="checkbox"/> Lifelong learning	Value:	lifelong_learning
<input type="button" value="+ Click to add another response..."/>	Value:	AUTOMATIC

**☰** Which of the following early childhood education activities does your organization undertake? (select all that apply)

<input type="checkbox"/> Identifying early childhood needs	Value:	identifying_ea
<input type="checkbox"/> Supporting early learning in the home	Value:	supporting_ear
<input type="checkbox"/> Supporting learning in the community	Value:	supporting_lea
<input type="checkbox"/> Helping to develop inclusive preschools	Value:	helping_to_dev
<input type="checkbox"/> Ensuring the availability and accessibility of specialist services	Value:	ensuring_the_a
<input type="checkbox"/> Involving people with disabilities in planning and providing early childhood education	Value:	involving_peop

	<input type="checkbox"/> Carrying out training and awareness raising	Value:	carrying_out_t
	<input type="checkbox"/> Address the complexity of poverty at school and at home	Value:	address_the_co
	<input type="checkbox"/> Lobbying and advocating for inclusion	Value:	lobbying_and_a
	<input type="checkbox"/> Preparing for emergency, conflict, or refugee situations	Value:	preparing_for_
	<input type="checkbox"/> None of the above	Value:	none_of_the_ab
	<input data-bbox="365 451 852 472" type="button" value="+ Click to add another response..."/>	Value:	AUTOMATIC
.abc	Does your organization undertake any other early childhood education activities (please specify)		
	<input type="checkbox"/> Which of the following primary education activities does your organization undertake? (select all that apply)		
	<input type="checkbox"/> Raising awareness about inclusive education in the community	Value:	raising_aware
	<input type="checkbox"/> Supporting and involving parents in the school's operations	Value:	supporting_and
	<input type="checkbox"/> Supporting children with disabilities to access medical services	Value:	supporting_chi
	<input type="checkbox"/> Ensuring schools are welcoming and accessible	Value:	ensuring_schoo
	<input type="checkbox"/> Training and supporting teachers to create an accessible learning environment	Value:	training_and_v
	<input type="checkbox"/> Altering curricula to accommodate students with disabilities	Value:	altering_curri
	<input type="checkbox"/> Encouraging flexibility in examinations and assessments	Value:	encouraging_fl
	<input type="checkbox"/> Developing and using local resources for the classroom	Value:	developing_and
	<input type="checkbox"/> Facilitating access to specialist services	Value:	facilitating_a
	<input type="checkbox"/> Address the complexity of poverty at school and at home	Value:	address_the_co
	<input type="checkbox"/> Advocating for inclusion	Value:	advocating_for
	<input type="checkbox"/> None of the above	Value:	none_of_the_ab
	<input data-bbox="365 1081 852 1102" type="button" value="+ Click to add another response..."/>	Value:	AUTOMATIC
.abc	Does your organization undertake any other primary education activities? (please specify)		
	<input type="checkbox"/> Which of the following secondary and higher education activities does your organization undertake? (select all that apply)		
	<input type="checkbox"/> Involving the community in helping students with disabilities to access secondary or higher education	Value:	involving_the_
	<input type="checkbox"/> Supporting the family in helping students with disabilities to access secondary or higher education	Value:	supporting_the
	<input type="checkbox"/> Making school environments more accessible for students with disabilities	Value:	making_school_
	<input type="checkbox"/> Adapting curricula and teaching methods to students with disabilities	Value:	adapting_curri
	<input type="checkbox"/> Adapting assessment methods to students with disabilities	Value:	adapting_asses
	<input type="checkbox"/> Integrating information and communities technologies into schools	Value:	integrating_in
	<input type="checkbox"/> Promoting peer support and mentoring	Value:	promoting_peer
	<input type="checkbox"/> Promoting the use of specialist resources and support	Value:	promoting_the_
	<input type="checkbox"/> Supporting students through their transition to secondary or higher education	Value:	supporting_stu
	<input type="checkbox"/> None of the above	Value:	none_of_the_ab
	<input data-bbox="365 1680 852 1701" type="button" value="+ Click to add another response..."/>	Value:	AUTOMATIC
.abc	Does your organization undertake any other secondary or higher education activities? (please specify)		

☰ ▼ Which of the following non-formal education activities does your organization undertake? (select all that apply) ⚙️

<input type="checkbox"/> Helping to make existing non-formal education programs disability-inclusive	Value:	helping_to_mak
<input type="checkbox"/> Promoting practical and relevant curricula in non-formal education	Value:	promoting_prac
<input type="checkbox"/> Supporting home-based learning programs	Value:	supporting_hom
<input type="checkbox"/> Sustaining specific learning groups (eg. sign language classes)	Value:	sustaining_spe
<input type="checkbox"/> Ensuring the quality of community-based daycentres	Value:	ensuring_the_q
<input type="checkbox"/> Facilitating links with formal schooling	Value:	facilitating_l
<input type="checkbox"/> None of the above	Value:	none_of_the_ab
<input data-bbox="365 567 852 588" type="button" value="+ Click to add another response..."/>	Value:	AUTOMATIC

abc Does your organization undertake any other non-formal education activities? (please specify) ⚙️

☰ ▼ Which of the following lifelong learning activities does your organization undertake? (select all that apply) ⚙️

<input type="checkbox"/> Facilitating support for transitions (eg. school to work)	Value:	facilitating_s
<input type="checkbox"/> Identifying opportunities for adult literacy and adult education	Value:	identifying_op
<input type="checkbox"/> Identifying opportunities for continuing education	Value:	identifying_op_1
<input type="checkbox"/> Facilitating learning for individuals and groups with particular needs	Value:	facilitating_l
<input type="checkbox"/> Ensuring opportunities for learning life and survival skills	Value:	ensuring_oppor
<input type="checkbox"/> Working with educators in the community to promote social inclusion	Value:	working_with_e
<input type="checkbox"/> None of the above	Value:	none_of_the_ab
<input data-bbox="365 1039 852 1060" type="button" value="+ Click to add another response..."/>	Value:	AUTOMATIC

abc Does your organization undertake any other lifelong learning activities? (please specify) ⚙️

☰ ▼ Which of the following types of livelihood activities does your organization undertake? (select all that apply) ⚙️

<input type="checkbox"/> Skills Development	Value:	skills_development
<input type="checkbox"/> Self-employment	Value:	self_employment
<input type="checkbox"/> Wage employment	Value:	wage_employment
<input type="checkbox"/> Financial services	Value:	financial_services
<input type="checkbox"/> Social protection	Value:	social_protection
<input data-bbox="365 1428 852 1449" type="button" value="+ Click to add another response..."/>	Value:	AUTOMATIC

☰ ▼ Which of the following skills development activities does your organization undertake? (select all that apply) ⚙️

<input type="checkbox"/> Promoting home-based training in traditional skills	Value:	promoting_home
<input type="checkbox"/> Enabling access to basic education opportunities	Value:	enabling_acces
<input type="checkbox"/> Facilitating participation in vocational training	Value:	facilitating_p
<input type="checkbox"/> Encouraging training the community	Value:	encouraging_tr
<input type="checkbox"/> Assisting with the development of business skills	Value:	assisting_with
<input type="checkbox"/> Facilitating inclusive training in mainstream institutions	Value:	facilitating_i
<input type="checkbox"/> Facilitating training in specialized institutions for persons with disabilities	Value:	facilitating_t
<input type="checkbox"/> None of the above	Value:	none_of_the_ab

	<input type="text" value="+ Click to add another response..."/>	Value:	AUTOMATIC
abc	Does your organization undertake any other skills development activities? (please specify)		
	▼ Which of the following self-employment activities does your organization undertake? (select all that apply)		
	<input type="checkbox"/> Identifying appropriate opportunities through market analysis	Value:	identifying_ap
	<input type="checkbox"/> Assisting persons with disabilities in choosing business activities	Value:	assisting_pers
	<input type="checkbox"/> Identifying role models	Value:	identifying_ro
	<input type="checkbox"/> Encouraging and supporting women with disabilities	Value:	encouraging_an
	<input type="checkbox"/> Building partnerships with other development actors	Value:	building_partn
	<input type="checkbox"/> Facilitating access to start-up capital	Value:	facilitating_a
	<input type="checkbox"/> None of the above	Value:	none_of_the_ab
	<input type="text" value="+ Click to add another response..."/>	Value:	AUTOMATIC
abc	Does your organization undertake any other self-employment activities? (please specify)		
	▼ Which of the following wage employment activities does your organization undertake? (select all that apply)		
	<input type="checkbox"/> Raising awareness about the work potential and right to employment of people with disabilities	Value:	raising_aware
	<input type="checkbox"/> Enable and assist people with disabilities to find jobs (eg. referrals, job search support, labour market surveys, training)	Value:	enable_and_ass
	<input type="checkbox"/> Supporting workers with disabilities to retain employment	Value:	supporting_wor
	<input type="checkbox"/> Building partnerships and networking with the employment sector	Value:	building_part
	<input type="checkbox"/> None of the above	Value:	none_of_the_ab
	<input type="text" value="+ Click to add another response..."/>	Value:	AUTOMATIC
abc	Does your organization undertake any other wage employment activities? (please specify)		
	▼ Which of the following activities related to financial services does your organization undertake? (select all that apply)		
	<input type="checkbox"/> Promoting the habit of saving among persons with disabilities	Value:	promoting_the_
	<input type="checkbox"/> Confronting self-exclusion by persons with disabilities from financial services	Value:	confronting_se
	<input type="checkbox"/> Identifying role models (eg. entrepreneurs with disabilities)	Value:	identifying_ro
	<input type="checkbox"/> Facilitating access to mainstream financial services	Value:	facilitating_a
	<input type="checkbox"/> None of the above	Value:	none_of_the_ab
	<input type="text" value="+ Click to add another response..."/>	Value:	AUTOMATIC
abc	Does your organization undertake any other activities related to financial services? (please specify)		
	▼ Which of the following social protection activities does your organization undertake? (select all that apply)		
	<input type="checkbox"/> Ensuring that people with disabilities are included under existing provisions (eg. awareness raising)	Value:	ensuring_that_
	<input type="checkbox"/> Facilitating access to food, water and toilet facilities for people with disabilities	Value:	facilitating_a
	<input type="checkbox"/> Ensuring business and accessibility	Value:	ensuring_bu

<input type="checkbox"/> Ensuring access to health care and assistive devices		Value:	ensuring_acces
<input type="checkbox"/> Ensuring access to personal assistance when required		Value:	ensuring_acces_1
<input type="checkbox"/> Ensuring disability-related costs are met where necessary		Value:	ensuring_disab
<input type="button" value="+ Click to add another response..."/>		Value:	AUTOMATIC
Does your organization undertake any other social protection activities? (please specify)			
Which of the following types of social development activities does your organization undertake? (select all that apply)			
<input type="checkbox"/> Personal assistance		Value:	personal_assistance
<input type="checkbox"/> Relationships, marriage and family		Value:	relationships__marriage_an
<input type="checkbox"/> Culture and arts		Value:	culture_and_arts
<input type="checkbox"/> Recreation, leisure and sports		Value:	recreation_leisure_and_spo
<input type="checkbox"/> Justice		Value:	justice
<input type="button" value="+ Click to add another response..."/>		Value:	AUTOMATIC
Which of the following personal assistance activities does your organization undertake? (select all that apply)			
<input type="checkbox"/> Working with disabled people's organizations to meet personal assistance needs		Value:	working_with_d
<input type="checkbox"/> Assisting people with disabilities to develop individual support plans		Value:	assisting_peop
<input type="checkbox"/> Supporting training opportunities (for persons with disabilities and/or personal assistants)		Value:	supporting_tra
<input type="checkbox"/> Ensuring families are supported in their roles as personal assistants		Value:	ensuring_famil
<input type="checkbox"/> Preparing for and managing crisis situations		Value:	preparing_for_
<input type="checkbox"/> Encouraging a move away from institutional care		Value:	encouraging_a_
<input type="checkbox"/> None of the above		Value:	none_of_the_ab
<input type="button" value="+ Click to add another response..."/>		Value:	AUTOMATIC
Does your organization undertake any other personal assistance activities? (please specify)			
Which of the following activities related to relationships, marriage and family does your organization undertake? (select all that apply)			
<input type="checkbox"/> Challenging and addressing stigma, prejudice and discrimination		Value:	challenging_an
<input type="checkbox"/> Providing support for parents (parents with disabilities and/or parents of children with disabilities)		Value:	providing_supp
<input type="checkbox"/> Working with families to promote independence		Value:	working_with_f
<input type="checkbox"/> Helping to prevent domestic violence		Value:	helping_to_pre
<input type="checkbox"/> Supporting people with limited social networks		Value:	supporting_poo
<input type="checkbox"/> None of the above		Value:	none_of_the_ab
<input type="button" value="+ Click to add another response..."/>		Value:	AUTOMATIC
Does your organization undertake any other activities related to relationships, marriage and family? (please specify)			
Which of the following activities to related to culture and the arts does your organization undertake? (select all that apply)			
<input type="checkbox"/> Promoting the use of culture and art for social change		Value:	promoting_the_

<input type="checkbox"/>	Supporting families to participate in cultural events	Value:	supporting_fm
<input type="checkbox"/>	Encouraging people with disabilities to participate in culture and the arts	Value:	encouraging_pe
<input type="checkbox"/>	Working with mainstream cultural organizations and groups to promote inclusion	Value:	working_with_m
<input type="checkbox"/>	Working with spiritual and religious leaders and groups to promote inclusion	Value:	working_with_s
<input type="checkbox"/>	None of the above	Value:	none_of_the_ab
	+ Click to add another response...	Value:	AUTOMATIC

abc Does your organization undertake any other activities related to culture and the arts? (please specify)

▼ Which of the following recreation, leisure and sports activities does your organization undertake? (select all that apply)

<input type="checkbox"/>	Identifying local recreation, leisure and sports opportunities	Value:	identifying_lo
<input type="checkbox"/>	Facilitating the participation of people with disabilities in recreation, leisure and sports	Value:	facilitating_t
<input type="checkbox"/>	Using recreation and sport to raise awareness about inclusion	Value:	using_recreati
<input type="checkbox"/>	Encourage mainstream recreation, sports and leisure programmes to become inclusive	Value:	encourage_main
<input type="checkbox"/>	Developing and supporting disability-specific recreation, leisure and sports programmes	Value:	developing_and
<input type="checkbox"/>	None of the above	Value:	none_of_the_ab
	+ Click to add another response...	Value:	AUTOMATIC

abc Does your organization undertake any other recreation, leisure and sports activities? (please specify)

▼ Which of the following activities related to justice does your organization undertake? (select all that apply)


<input type="checkbox"/>	Developing an understanding of the local legal context	Value:	developing_un
<input type="checkbox"/>	Developing networks and alliances with relevant stakeholders	Value:	developing_net
<input type="checkbox"/>	Raising awareness about rights	Value:	raising_aware
<input type="checkbox"/>	Promoting access to informal legal mechanisms where appropriate	Value:	promoting_acce
<input type="checkbox"/>	Supporting legal action where appropriate	Value:	supporting_leg
<input type="checkbox"/>	None of the above	Value:	none_of_the_ab
	+ Click to add another response...	Value:	AUTOMATIC

abc Does your organization undertake any other activities related to justice? (please specify)

▼ Which of the following types of empowerment activities does your organization undertake? (select all that apply)

<input type="checkbox"/>	Advocacy and communication	Value:	advocacy_and_communicati
<input type="checkbox"/>	Community mobilization	Value:	community_mobilization
<input type="checkbox"/>	Political participation	Value:	political_participation
<input type="checkbox"/>	Self-help groups	Value:	self_help_groups
<input type="checkbox"/>	Disabled people's organizations	Value:	disabled_people_s_organizat
	+ Click to add another response...	Value:	AUTOMATIC

▼ Which of the following advocacy and communication activities does your organization undertake? (select all that apply)

<input type="checkbox"/>	Carrying out a basic communication assessment of your organization's communications	Value:	carrying_out_a
<input type="checkbox"/>	Providing persons with disabilities support to develop communication skills	Value:	providing_pers
<input type="checkbox"/>	Addressing communication barriers (eg. in the home, in the community)	Value:	addressing_com
<input type="checkbox"/>	Providing support for self-advocacy by persons with disabilities	Value:	providing_supp
<input type="checkbox"/>	Ensuring staff are effective communicators	Value:	ensuring_staff
<input type="checkbox"/>	None of the above	Value:	none_of_the_ab
	+ Click to add another response...	Value:	AUTOMATIC
abc	Does your organization undertake any other advocacy and communication activities? (please specify)		  
	▼ Which of the following types of community mobilization activities does your organization undertake? (select all that apply)		  
<input type="checkbox"/>	Find out about the community (eg. through situation analysis)	Value:	find_out_about
<input type="checkbox"/>	Working to build trust and credibility within the community	Value:	working_to_bui
<input type="checkbox"/>	Raising awareness about disability in the community	Value:	raising_aware
<input type="checkbox"/>	Motivating the community to participate	Value:	motivating_the
<input type="checkbox"/>	Create opportunities for community participation	Value:	create_opportu
<input type="checkbox"/>	Bringing relevant stakeholders together	Value:	bringing_relev
<input type="checkbox"/>	Building capacity in the community	Value:	building_capac
<input type="checkbox"/>	Celebrating community achievements	Value:	celebrating_co
<input type="checkbox"/>	None of the above	Value:	none_of_the_ab
	+ Click to add another response...	Value:	AUTOMATIC
abc	Does your organization undertake any other community mobilization activities? (please specify)		  
	▼ Which of the following activities related to political participation does your organization undertake? (select all that apply)		  
<input type="checkbox"/>	Ensuring staff develop awareness of the political system	Value:	ensuring_staff
<input type="checkbox"/>	Facilitating development of political awareness among persons with disabilities	Value:	facilitating_d
<input type="checkbox"/>	Raising disability awareness within the political system	Value:	raising_disabi
<input type="checkbox"/>	Facilitate access to political processes for persons with disabilities	Value:	facilitate_acc
<input type="checkbox"/>	None of the above	Value:	none_of_the_ab
	+ Click to add another response...	Value:	AUTOMATIC
abc	Does your organization undertake any other activities related to political participation? (please specify)		  
	▼ Which of the following activities related to self-help groups does your organization undertake? (select all that apply)		  
<input type="checkbox"/>	Providing assistance to form new self-help groups	Value:	providing_assi
<input type="checkbox"/>	Developing partnerships with existing self-help groups	Value:	developing_par
<input type="checkbox"/>	Encouraging inclusion of people with disabilities in mainstream self-help groups	Value:	encouraging_in
<input type="checkbox"/>	Encouraging self-help group members to participate in development initiatives	Value:	encouraging_se
<input type="checkbox"/>	Encouraging self-help groups to join together	Value:	encouraging_se_1

<input type="checkbox"/>	None of the above	Value:	none_of_the_ab
<input type="checkbox"/>	+ Click to add another response...	Value:	AUTOMATIC
<hr/>			
.abc	Does your organization undertake any other activities related to self-help groups? (please specify)		
<hr/>			
<input checked="" type="checkbox"/>	Is your organization a disabled people's organization?		
<input type="checkbox"/>	Yes	Value:	yes
<input type="checkbox"/>	No	Value:	no
<input type="checkbox"/>	+ Click to add another response...	Value:	AUTOMATIC
<hr/>			
<input checked="" type="checkbox"/>	Which of the following activities related to disabled person's organizations does your organization undertake? (select all that apply)		
<input type="checkbox"/>	Working with disabled people's organizations	Value:	working_with_d
<input type="checkbox"/>	Ensuring access to development initiatives for members of disabled people's organizations	Value:	ensuring_access
<input type="checkbox"/>	Encouraging disabled people's organizations to support development initiatives	Value:	encouraging_d
<input type="checkbox"/>	Supporting the formation of community-based disabled people's organizations	Value:	supporting_the
<input type="checkbox"/>	None of the above	Value:	none_of_the_ab
<input type="checkbox"/>	+ Click to add another response...	Value:	AUTOMATIC
<hr/>			
.abc	Does your organization undertake any other activities related to disabled person's organizations? (please specify)		
<hr/>			
<input checked="" type="radio"/>	Are you familiar with community-based rehabilitation?		
<input type="checkbox"/>	Yes	Value:	yes
<input type="checkbox"/>	No	Value:	no
<input type="checkbox"/>	+ Click to add another response...	Value:	AUTOMATIC
<hr/>			
<input checked="" type="radio"/>	Are you familiar with the United Nation's guidelines on community-based rehabilitation?		
<input type="checkbox"/>	Yes	Value:	yes
<input type="checkbox"/>	No	Value:	no
<input type="checkbox"/>	+ Click to add another response...	Value:	AUTOMATIC
<hr/>			
<input checked="" type="radio"/>	How frequently do you consult the United Nation's guidelines on community-based rehabilitation?		
<input type="checkbox"/>	Very frequently	Value:	very_frequent
<input type="checkbox"/>	Frequently	Value:	frequently
<input type="checkbox"/>	Occasionally	Value:	occasionally
<input type="checkbox"/>	Rarely	Value:	rarely
<input type="checkbox"/>	Very rarely	Value:	very_rarely
<input type="checkbox"/>	Never	Value:	never
<input type="checkbox"/>	+ Click to add another response...	Value:	AUTOMATIC

<input checked="" type="radio"/>	▼ How relevant is the community-based rehabilitation approach to your organization's work?	
<input type="checkbox"/>	Very relevant	Value: very_relevant
<input type="checkbox"/>	Relevant	Value: relevant
<input type="checkbox"/>	Fairly relevant	Value: fairly_relevant
<input type="checkbox"/>	Of limited relevance	Value: of_limited_relevance
<input type="checkbox"/>	Not relevant	Value: not_relevant
<input type="checkbox"/>	+ Click to add another response...	Value: AUTOMATIC
<input checked="" type="radio"/>	▼ Has your organization participated in or administered a community-based rehabilitation program?	
<input type="checkbox"/>	Yes	Value: yes
<input type="checkbox"/>	No	Value: no
<input type="checkbox"/>	+ Click to add another response...	Value: AUTOMATIC
abc	Please describe the community-based rehabilitation program that your organization participated in (key partners, activities, results).	
<input checked="" type="radio"/>	▼ Do you think community-based rehabilitation is useful in post-conflict settings like Gulu?	
<input type="checkbox"/>	Yes	Value: yes
<input type="checkbox"/>	No	Value: no
<input type="checkbox"/>	+ Click to add another response...	Value: AUTOMATIC
<input checked="" type="radio"/>	▼ How useful is community-based rehabilitation as a strategy in post-conflict settings?	
<input type="checkbox"/>	Very useful	Value: very_useful
<input type="checkbox"/>	Useful	Value: useful
<input type="checkbox"/>	Somewhat useful	Value: somewhat_useful
<input type="checkbox"/>	Not very useful	Value: not_very_useful
<input type="checkbox"/>	+ Click to add another response...	Value: AUTOMATIC
abc	Why is community-based rehabilitation a useful strategy in post-conflict settings?	
abc	Why do you believe community-based rehabilitation is not useful in post-conflict settings?	
<input checked="" type="radio"/>	▼ Would you be willing to participate in a follow-up interview to further discuss the challenges and opportunities to working with persons with disabilities in Gulu?	
<input type="checkbox"/>	Yes	Value: AUTOMATIC
<input type="checkbox"/>	No	Value: no
<input type="checkbox"/>	+ Click to add another response...	Value: AUTOMATIC
<input type="checkbox"/>	Please indicate your preferred date and time to participate in an interview. The researcher will be in contact with you to confirm an interview time and location.	

## **Appendix B: List of Acronyms**

<b>ACORD</b>	Agency for Cooperation on Research and Development
<b>CAR</b>	Central African Republic
<b>CBR</b>	Community-Based Rehabilitation
<b>DPO</b>	Disabled persons' organization
<b>DRC</b>	Democratic Republic of the Congo
<b>DSM-5</b>	Diagnostic and Statistical Manual of Mental Disorders 5 <sup>th</sup> Edition
<b>FARDC</b>	<i>Forces Armées de la République Démocratique du Congo</i>
<b>HSM</b>	Holy Spirit Movement
<b>ICC</b>	International Criminal Court
<b>ICF</b>	International Classification of Functioning
<b>IDP</b>	Internally displaced person(s)
<b>ILO</b>	International Labour Organization
<b>LRA</b>	Lord's Resistance Army
<b>NGO</b>	Non-government organization
<b>NRM/A</b>	National Resistance Movement/Army
<b>NUDIPU</b>	National Union of Disabled Persons of Uganda
<b>NUWODU</b>	National Union of Women with Disabilities of Uganda
<b>PWD</b>	Persons with disabilities
<b>SAGE</b>	Social assistance grants for empowerment
<b>SGBV</b>	Sexual and gender-based violence
<b>SPLA</b>	Sudan People's Liberation Army
<b>UN</b>	United Nations
<b>UNDESA</b>	United Nations Department of Economic and Social Affairs
<b>UNDP</b>	United Nations Development Programme
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organisation
<b>UNHCR</b>	United Nations High Commissioner for Refugees

<b>UPDA</b>	Uganda People's Democratic Army
<b>UPDF</b>	Uganda People's Defence Force
<b>WFP</b>	World Food Programme
<b>WHO</b>	World Health Organization

# Appendix C: Research Ethics Approval

File Number: 04-17-11

Date (mm/dd/yyyy): 05/08/2017



**Université d'Ottawa** **University of Ottawa**  
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

## Ethics Approval Notice Social Sciences and Humanities REB

### Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Lauchlan	Munro	Social Sciences / Others	Supervisor
Colton	Brydges	Social Sciences / Others	Student Researcher

**File Number:** 04-17-11

**Type of Project:** Master's Thesis

**Title:** Development Programming for Persons with Disabilities in Gulu, Uganda

<b>Approval Date (mm/dd/yyyy)</b>	<b>Expiry Date (mm/dd/yyyy)</b>	<b>Approval Type</b>
05/08/2017	05/07/2018	Approval

**Special Conditions / Comments:**  
N/A