The 30th Anniversary of National Rehabilitation Center for Persons with Disabilities

Report of International Seminar

International Cooperation to Develop Inclusive Society

February 13, 2010

National Rehabilitation Center for Persons with Disabilities
Japan

WHO Collaborating Centre for Disability Prevention and Rehabilitation

This report and Power Point data are put on a website of the Center.
http://www.rehab.go.jp/english/whoclbc/seminar.html

Program

Time & Date : 10:30～16:30, February 13 (Sat.), 2010
Place : The College, National Rehabilitation Center for Persons with Disabilities (NRCD)

Facilitator: Motoi Suwa, Director, Research Institute, NRCD

10:30 ***Opening Address*** Tsutomu Iwaya, President, NRCD

10:40～12:00 ***Keynote Lecture***

1 **"CBR Concept and Strategy of Rehabilitation for Persons with Disabilities"**
Chapal Khasnabis, Technical Officer, Disability and Rehabilitation Team WHO

2 **"CBR Activities in Syria"**
Shintaro Nakamura, CBR Expert at JICA Syria

12:00～13:00 ***Lunch***

13:05～14:25 ***Presentation***
Moderator: Hiroshi Kawamura
Director, Dept. of Social Rehabilitation, NRCD

1 **"International Standardization and Accessible Design"**
Shigeru Yamauchi, Professor, Waseda University

2 **"Collaboration on Teaching Therapeutic Massage, and Establishing Acupuncture Training in Malaysia – Let your hands do the talking!"**
Saburo Sasada, JICA Senior Volunteer in Malaysia

3 **"Rehabilitation Expert Training and International Cooperation"**
Noriko Tomioka, Technical Adviser, Secretariat of Japan Overseas Cooperation Volunteers, JICA
Professor, Bukkyo University

4 **“Cooperation between Japan and China from the Establishment of China Rehabilitation Research Center till Present”**
Dong Hao, Vice Director, China Rehabilitation Research Center, People’s Republic of China

5 **“A Plan for International Collaboration in Rehabilitation Service and Research ”**
Hur Yong, Director, National Rehabilitation Center, Republic of Korea

14:25～1435 ***Coffee break***

14:35～15:40 ***Panel Discussion***

“Future international cooperation for development of inclusive society”

Panelists

1 Miyoko Tawa, Director, Social Security Division, JICA
2 Chapal Khasnabis
3 Shintaro Nakamura
4 Dong Hao
5 Hur Yong
6 Tsutomu Iwaya

15:40～16:10 ***Question and Answer***
with audience

16:15 ***Closing Address***
Fumio Eto, Director, Training Center, NRCD

Facilitator: Mr. Motoi Suwa

Presentation: Dr. Shigeru Yamauchi

Presentation: Mr. Saburo Sasada

Moderator: Dr. Hiroshi Kawamura

Presentation: Dr. Noriko Tomioka

Panel discussion

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Opening Address

Tsutomu Iwaya
President
National Rehabilitation Center for Persons with Disabilities

Welcome, ladies and gentlemen, to this international seminar. I would like to extend my appreciation once again. I do not know whose behavior was bad today, but we have very bad weather today and if anyone were to be blamed, I think it is myself. I again would extend my appreciation from the bottom of my heart for having so many people here today.

Our center was established in 1979 and since then, from the various aspects, we have been involved in international cooperation. Especially for a long period of time we had the guidance of JICA and conducted the P&O where the prosthetic technicians had been invited throughout the world so they can join the training course at our center. Since the startup of the CRRC, we collaborated for the period of more than 20 years to develop rehabilitation system for persons with disabilities in China. A couple of years ago, the Korean National Rehabilitation Center and our center became sister centers.

Thirty years ago, at the time of 1979, if we look back—I think it was in 1978 that the Declaration of Alma Ata was announced and in 1981 the International Classification of Impairments, Disabilities and Handicaps (ICIDH) was proposed and also the UN's International Year of Disabled Persons was declared.

I think it was like the embryonic period of the concept of disabilities and rehabilitation of persons with disabilities. Since then the concept of disabilities has developed enormously, starting from the medical model converted to a social model. Today in the clinical practice of rehabilitation for PWD, we aim at social participation or inclusion as goal.

Community based rehabilitation (CBR) is a strategy to develop societies inclusively. It was announced in 2004 by WHO, UNESCO and ILO in Joint paper on CBR. In the future, we have to develop rehabilitation systems based on the CBR strategies. To realize an inclusive society, our activities should be based on medical, social and psychological models.

Looking back at the past three decades as well as looking at the future, we need to think about what the international cooperation is and I hope that you will leverage this opportunity to think about these topics. Today we have the main guests from WHO Geneva, Mr. Chapal Khasnabis. Also we have Mr. Shintaro Nakamura who is working

in Syria. And we have members from China and South Korea rehabilitation centers that we have a deep relationship with. We have guest speakers from those two centers as well. Also today, we have a couple of people from Colombia as special guests. The members from Colombia, could you please stand up? We are cooperating JICA project to develop rehabilitation system for landmine victims in Colombia. These people are the members. For the next two weeks, they are going to receive training here in Japan. The fruit of this CBR seminar, I hope that you will bring back to your country, Colombia.

Lastly, in opening this seminar, we have received enormous support from the Japanese Society for Rehabilitation of Persons with Disabilities and I would like to extend my appreciation to the association: Thank you very much. And I hope this one-day seminar will be a fruitful one. Thank you very much.

Keynote Lecture

CBR Concept and Strategy of Rehabilitation for Persons with Disabilities

Chapal Khasnabis
Technical Officer
WHO, DAR

I am sorry for my English, but I cannot help it. It is a great pleasure and honor for me to be here on this historic day. I bring greetings from the headquarters, regional office and country office. We would like to continue our relationship for the next 30 years at least. Our partnership is very useful and fruitful, and we want to continue further. So thank you very much for inviting me. I know the talk, which I am going to give now, is not very easy, a lot of fundamentals are there, so I have been asked to speak on the CBR concept and the strategy of rehabilitation for persons with disabilities, focusing more on future direction. But we cannot talk about future if we do not understand the past; we do not understand the present. So I will start from the past and gradually I will take you towards the future.

As Dr. Iwaya said, the disability was posited purely in the 1970s and 1980s as a medical model. In the medical model, disability is the problem of any individual, directly caused by disease, trauma or other health condition, which requires medical care provided in the form of individual treatment by professionals. It still stands the same in most parts of the world.

In the slide, there is a lady standing and she lost her leg from the hip, hip disarticulation. The daughter is standing beside her. Now I am sure if she goes to any rehab center, the doctor, prosthetic therapist, will work on giving her a very good hip disarticulation prosthesis. But if I tell you the story of this lady, the day she was amputated through her hip, her husband left her because the husband thought, she is now my burden. So it changes definition from medical to social because her priority now from her prosthesis is to ensure that her daughter gets food and education. That is why the medical model if we stick to it exclusively, then we will not be able to do total human service. Then, from this kind of realization and also the disabilities movement, the social model has come of disability where disability is seen mainly as a socially created problem and basically is a matter of the full integration of individuals into society.

Disability is not an attribute of an individual, but it is created by the society. The girl in the slide, she is in a wheelchair, she is quite mobile where there are no barriers, but where there are barriers, she is more dependent. So society makes people more disabled

than their impairment. Now, unfortunately, there are two groups: one that was promoting the medical model and one that was promoting the social model. And these two groups were not working together though their goal was the same. So the WHO International Classification of Functioning, they came up with a biopsychosocial model, which is a combination of the medical and social model because the WHO realized that we need both. In ICF, they defined disability as an umbrella term for impairments, activity limitation and participation restrictions. It is not just impairment; it has gone one step beyond impairment. It is activity limitation and participation restriction.

So, the disability and impairment, there is a difference. And if we do not understand this difference, we will never be able to do it proper justice to rehabilitation. An impairment is a health condition which causes some impairment: I have diabetes but it is neglected, I have a food problem, I had an amputation, but my context environment where I live in, if they are hostile or have a negative attitude, even if I have the best prosthesis or a wheelchair I will not be able to move in the society freely. I will not be able to be a productive member, so disability is a more umbrella term. It is an interaction between the individual and the society.

According to the definition of the ICF, it is characterized as the outcome or result of a complex relationship between an individual's health condition (impairments, activity limitations or participation restrictions) and contextual factors (environmental and personal), even the socioeconomic factors can create disability. Now the social model has gone one step further and now people are talking about the human rights model. In the human rights model, the promotion of inclusive society where barriers are identified and removed becomes a part of obligation. It is the government or state's responsibility. The countries who are ratifying the convention, it is their responsibility, so by law, that they have to remove the barriers. And that is the convention of the rights of persons with disabilities.

A country that ratifies the Convention agrees to be legally bound to treat persons with disabilities as subjects of the law with clearly defined rights as any other person. The Convention on Persons with Disabilities, according to the convention, there is another definition that has come. There is the ICF definition; there is also a convention definition of personal disabilities. And it is defined in the convention that persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. If you see Article 3 of the convention, on the general principles, the general principles say that respect for inherent dignity, individual autonomy, non-discrimination, full and effective

participation, inclusion in society, equality of opportunity; accessibility. And we have to see where rehabilitation fits in this term. If we can link rehabilitation, what has been described in the general principles, then rehabilitation has more future and it will be more useful and more related. But if it is not, then we have a problem in the future. So we have to see how rehabilitation is connected well and linked well with the general principles of the convention.

In the slide when Kofi Annan visited the WHO and met the DG, he said that this convention is a dawn of a new era for around 650 million people worldwide living with disabilities. So the convention is a new chapter and we have to see how our activities strengthen and fit in the chapter.

Now rehabilitation if you see the definition in different societies, different organizations, overall rehabilitation include measures to provide and/or restore functions, or compensate for the loss or absence of a function or for a functional limitation. So heavily it is focused on restoring, maintaining, compensating, enouncing function.

In the UN standard rules in 1993, they say that rehabilitation is the prerequisite for equal participation. If you do not have rehabilitation, much participation will not be possible. If you do not have a wheelchair, if you do not have a prosthesis, if you do not have medical care, you will remain confined inside the house. You never go out of the house, so rehabilitation has a role, very definite and very clear role towards participation.

Now rehabilitation related to health services focuses more on medical/surgical interventions; physiotherapy, occupational therapy, prosthetics/orthotics, speech therapy, rehabilitation medicine. These are the common branches of rehabilitation. And in the slide, there is a small girl who is just seven years old, lost her leg due to landmines in Nepal, so the whole life ahead, so we have to think rehabilitation also in the long term. It is not in the short-term or a one-time affair.

What rehabilitation has been defined in Article 26 of the Convention? In Article 26, it says that it is a set of measures to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. We have to see that whatever we are doing in the domain or in the name of rehabilitation, it leads to maximum independence, full participation and inclusion. If we cannot achieve that, then whatever rehabilitation we will do, it will have no impact in the long-run.

Rehabilitation services, how we deliver rehabilitation services, and as I said before, we believe that there is a role of the medical model still today and for some impairment groups more than others. And medical or physical rehabilitation mostly institute best rehabilitation. They are usually delivered through a big institute which is mostly best in

the capital or the big cities. We call it IBR, institute based rehabilitation. But it also has outreach programs, mobile, but this is a very individual model and quite a strong medical model, whereas the community-based rehabilitation has a more community model. It is more a development model. It is a more inclusive model. It is not only the individual; it is individuals, his or her family and the community. It focuses more on inclusion and participation.

Now, we talk about the rehab services which should be available to the capital to the community. Most rehabilitation services are based in the capital or in the big cities, but the people, 50 percent of the people still live in the rural areas, so the challenge is how we take the services from the capital to the rural areas. In the slide, you will be able to recognize a big center in the capital and those are the rural areas in Gansu Province. And in the two different pictures, you will see the disabled people's quality of life in the city and in Gansu province, because the services are mostly still in the big cities. We do develop a lot of policy, but we do not respect the practice or the reality, so we develop policy sitting in the UN or headquarters in Geneva, New York or some big city, when the reality is quite different. We have to see that how our policy is more related to the practice.

We have to see the rehabilitation to inclusion. The goal of the rehabilitation is not rehabilitation. The goal of the rehabilitation should be participation and inclusion. Whether it is in Japan, India, Nepal, Africa or any country, the goal should be the same. In the slide, the girl on the left has a disability. She has been trained as an orthotist and she not only has a good life, but she is making other disabled girls' lives much better in rural areas of Nepal. And the slide on the right, I am showing many people in the area from the Kokoren project of Japan, people with mental illnesses, but they are very included in the community life.

So the disability and rehabilitation, we have to see in terms of development, in terms of human rights, in terms of the Millennium Development Goals and the Convention. If we do not relate rehabilitation with these big development initiatives, rehabilitation will never be mainstreamed. Rehabilitation will never get money from the mainstream development initiatives. There are big mainstream initiatives in the country, like the Millennium Development Goals, but they do not talk one word about disability. They do not talk one word about rehabilitation. Why? Because we have not been able to connect that rehabilitation contributes in development, that rehabilitation contributes in countries' economies. We have to sell rehabilitation better than just fixing individuals' leg or hand. In the slides, there are pictures from Pakistan. This girl from the earthquake, she just became paraplegic due to the earthquake and she delivered a baby in the

hospital in the paraplegic ward. No husband, she is paraplegic, her whole life ahead. Whereas on the left is a lady from Togo in Africa where poverty is extreme and she has only this tricycle. And because of this tricycle she can manage to feed the family, so rehabilitation makes an impact, but we have to know how to sell it. And the two young girls in the regular school with their orthosis. Orthosis helping this child to the school. If there were no orthosis, they would never be in school, so by 2015, education for all, you cannot achieve it if there is no rehabilitation, but we do not say this.

The CBR is part of the general community-development strategy. CBR was introduced as a part of community-development strategy. But we learned a lot in the last 30 years. It is not the same CBR today what we wrote in 1979. CBR is a flexible, dynamic and adaptable strategy to different socio-economic conditions, terrain, cultures and political systems throughout the world.

CBR is equally applicable to poor countries, rich countries, low-income countries and medium-income countries. And it does exist in different forms and different names. In the slide, there is a girl from Nepal and a boy from Korea and both are supported by CBR programs. Now CBR is implemented through the combined efforts of persons with disabilities, their families, organizations and communities, and relevant government and non-governmental organizations (NGOs) working in the development sector. It is a combined effort. It is not an individual's effort, or not an individual professional's effort. It is a combined effort of the community, community leaders, disabled people, their families, rehab professionals. All have to work together to ensure full inclusion. In the slide, this is China again. This man is so happy because he gets the support from the local political leader, local men and everybody is involved in the total community development program and poverty alleviation program. Because of this, the quality of life even for the people who are staying in the rural areas are quite good because community leaders, policy makers, local government, political leaders, all are working together and that is the key of any CBR. No CBR will survive without community participation. However poor a community is, there are some resources within the community and we have to optimize that and make use of those resources.

Disability models, and many people talk quite passionately about these models (medical, social, human rights). I attended different forums. In some forum, they talk about the medical model; in some forum, they talk about the social model; and in some forum, they talk about the human rights model. And they do not talk together. All are different groups. Somebody said that medical model, two social model, two human rights model. It is not the case. You cannot do that, so we believe in a comprehensive model, where we need the medical model, the social model and we need the human

rights model. And you see, I put a percentage mark because what percentage of that different model depends on different socioeconomic conditions, different conditions of individuals. A quadriplegic or paraplegic requires more medical help than the blind, so we have to understand different contexts, different realities and not just jump in one train and say, this is the buzzword, this is the where the whole world is going, let us go. We have to really see the bigger picture and understand things more holistically and work together.

Now, we had a big meeting of CBR in 2003 in Helsinki, where we said that CBR has to change with the time and the realities. And CBR has been defined as a multi-sectoral strategy to facilitate Community-Based Inclusive Development. In 2003, we thought about how CBR from rehabilitation goes to more inclusive development. And CBR means development activities are inclusive of people with disabilities and their families and it is community-based. If it is not community-based, we do not believe that program can be appropriate or sustainable in the long-run. CBR promotes total well-being, equal rights and opportunities for all. Again, the capital to community. ILO and UN together, we published this joint position paper and once we published it, people asked us how to do it. It is good that you write a nice book, but how do you do it? Since then, we have started to write CBR guidelines which you will be happy to know that we are launching this year on the 27th of October, these guidelines. We worked in the last four, five years heavily on developing these guidelines. These guidelines will change the way CBR rehabilitation for disabilities has been practiced in the past and how it will be practiced in the future.

Many of you may be familiar with this famous diagram of ICF, where there is a health domain, the universe of well-being has been defined. There is the health domains and within the health domains there are different functioning and there are other domains which are relate to health (work, education, participation) and there are some grey areas in between where the two overlap. It is not a black and white. Here is health, here is education and we should not work together. You cannot have health promotion without the involvement of primary school teachers, so there are many sectors overlapping and they are interlinked. Now CBR is promoting this concept of total well-being. I am sure that many of you if I ask you, what is the definition of health? You will say health is physical, mental and social well-being. But can physical, mental and social well-being happen without income? If I have no money in my pocket, can I have physical, mental and social well-being? If I have never been educated, can that be sustained? To ensure well-being, to ensure health, we need to see that there is a greater

link between health, education and income or the livelihood sector. That is what we are trying to work on.

We said that CBR has five components, like five fingers. But empowerment is central because that is what we aim for, for disabled people and their families to be empowered, but it should be having health, education, livelihood and social. These four, they are all ministries. It has to be inclusive. All the sectors have to be inclusive. All has to work together. But among all this, we have targeted these four ministries. At least if the health, education, livelihood and social, they do their job, we will have a big step forward. We will have quite a big achievement. And that is what we are targeting. We developed this CBR matrix together again and these guidelines will refer to each chapter of this CBR matrix and will tell you how to do it. It will come with solid recommendations, examples how to do it.

Now, what is inclusive development? That all the development has to be inclusive of disabled people. So development initiatives have to have an inclusive approach and that leads to inclusive development. CBR is community-based inclusive development, so inclusive development, but has to be community-based. Our concern is, if the inclusive development, we only talk, again, it will benefit those elite people, rich people or middle-class people of the cities or the capitals. It will not go down to everywhere in the country. To ensure that it reaches everybody, the inclusive development has to be community-based. And that is community-based inclusive development. We talk about inclusive education. It is quite common. But we do not talk about inclusive health. We do not talk about inclusive livelihood. We need to talk. We need to ensure the health sector, livelihood sector, all becomes inclusive and this will lead to inclusive development which will lead to inclusive society and society for all. This is all our dream, that we have a society where all are equal with equal rights.

The philosophy of community-based inclusive development is that all development initiatives are inclusive and community-based. Rule number one: All development initiatives are inclusive and community-based. These development initiatives are disabled people-centered and community centered. It should not be professional-centered. It should be people-centered. Remove barriers for active participation by encouraging community action. Foster self-reliance, equal rights and opportunities. And in many parts of the world, the majority of disabled people are poor, so work on poverty alleviation and promotion of total well-being.

These CBR guidelines are an example of partnership and consensus. So many UN organizations, three UN organizations, 26 civil societies and 150 global experts have been working together for the last five years to develop these guidelines. It is not what I

am talking, Chapal is saying. Actually I am the collective voice of the whole group of the way the future of CBR will be. This is a bit crazy slide, but you have to have a national rehab center in any country, but the national rehab center should have regional or provincial centers and each of these centers should have many CBR partners. Then only you can cover the whole country. Otherwise, with no other way, you cannot cover the whole country. Partnership with the CBR is the key to our success.
Rehabilitation and CRPD, if you again, the general principles of the Convention, if I bring it, the outcome of the rehabilitation should be quality of life, inclusion and participation. I bring the rehabilitation core and link with the Convention general principles, so the outcome of any rehabilitation should be enouncing quality of life, promoting full independence, inclusion and participation. A partnership with institute-based rehabilitation and CBR can make this possible.

I will give you a case study. In this case study, there is a girl called Haseena. Now CBR worker identified Haseena when she was 15 years old. She lives in a poor slum in the outskirt of Bangalore in India and she has never been out of her house. She has never been to school. A CBR worker found time to convince her that she can change her life. Her family can help her to change her life. So they refer her to her to the health centre for medical and surgical need. She had a big mole on her face and severe contractures of the legs due to polio. She has been operated on her legs three times. She has gone through plastic surgery, then orthosis and a crutch, so she is mobile. But should we stop here? Next year, who will pay for her orthosis? Who will pay for her crutch? Again the government? Insurance? Or should she depend on charity. But she has never been to school. The reality is like this in many developing countries, in many different parts. So orthosis and elbow crutch enable her to work on two legs and assisted her to be like any other girl in the community. For the first time because of a successful rehab program, she came out of her house and mixing with other girls now she has friends. CBR workers realized that she cannot go back to the school at the age of 16 or 17. She cannot get a job in the formal sector, so they focused on the informal sector. They trained her as a beautician, as a hairdresser. And then she got a job as a hairdresser and earned enough money to take care of herself and her family. Haseena got married to the boy of her choice and having maximum independence, full physical, mental, social and vocational ability, and participates in all aspects of life—the general principles of the Convention. So rehabilitation facilitates exclusion to inclusion. Rehabilitation facilitates to make these general principles of the Convention a reality. And a combined effort of the Rehabilitation Centre, CBR, Haseena and her family made this possible. It is not one

person who can do it. It is not one organization who can do it. We need a combined effort, combined approach, to make this happen. And if you see Haseena's face and figure, you can say that rehabilitation makes a difference. Thank you very much.

CBR (Community Based Rehabilitation) Activities in Syria

Shintaro Nakamura
CBR Expert at JICA Syria

Good morning, everybody. Now I am working in Syria as an expert dispatched from JICA and thank you very much for offering me this precious opportunity to talk to you. I know that there are experts and professors and specialists in the field of disability and international cooperation and I am humbled to stand here in front of all the experts, but I would like to report to you straightforward what I am now doing in Syria and what the advices are. I hope that you will give me the advice based upon my presentation. Thank you.

This is the overview of my presentation today. First, I would like to talk to you about what the country Syria is like. After that, I would like to explain to you about the practical project that we are now working on. In the latter half of the presentation, I would like to talk about more conceptual issues, including my personal aspects.

To begin with, and by the way, ladies and gentlemen, have you ever heard of the name Syria? It is the name of the country. Please raise your hand if you know the location of Syria. Thank you. That means that 80 percent of our audience know the place of Syria. Thank you. This is the place of Syria. It is in the Middle East. Let me give you the detailed map. In the North, there is Turkey, in the East side is Iraq and in the South is Jordan, in the West is Lebanon. Those are the neighboring countries. In the Southwest side is Palestine, or Israel. Now, Syria and Israel are in conflict over Golan Heights, what to do about Golan Heights. The public language is Arabic. The population is 19 million and the size of the country is just half of Japan, but the majority is desert. People cannot live there. Ninety percent are Islamic and the remaining ten percent are Christians. In the daily life, religious values are deeply rooted. For the standard of economic development, GDP per capita is US$4,511 and based upon purchase power parity, this is less than one-seventh of that in Japan. It is not an extreme poverty country where people will starve to death, but it is still under development. There is a big difference between the rich and the poor. That is my feeling toward the country.

This relates the situation of persons with disabilities. It is said that two percent of the population has disabilities, but there are no trustworthy numbers for this. In 2004, the Law for the Disabled was stipulated and one of the items is to register. If you register as a disabled person, you can get free medical service. Of course you can get free medical service even without a disability in the national public hospitals. But if you register, you will get a free pass for the transportation and there are also reductions of certain tax

rates, etc. But for the public transportation, this is only for the government-operated public transportation services. As for the other, the majority of transportation is run by private companies, so there is not a big profit. There are only a few people who can purchase a car and this is for those who can own a car. There is only registration that has been done. For the cash benefit, there is a cash benefit, but this is only provided to poor families with cerebral palsy children and this is only for poor families and there is not much merit for this.

Looking at the registered people, a majority is men or CP children. Why men? It is because if you register and then you do not have to go to the service to the military.

The service provision is mainly the function of the domestic NGOs. Some NGOs offer money or cash, income or food as a part of their support for poor families, and also there are some NGOs that specialize in disability. They mostly provide medical, educational or vocational rehabilitation. I said that 90 percent of the population is Islamic and through the Islamic values, the support for the poor people is very highly valuated, so charitable activities are very popular. This picture is the mosque in a certain village. There is a high tower, as you can see, and there are these mosques in any village so that people come to pray. When they come to pray, they offer 100 yen or 200 yen although it is a very small amount.

Also during the Ramadan period, the fasting period, they give money, and parties are hosted by charitable organizations. Those who are willing to pay money to donate will gather to the party. They will declare how much they would like to donate. I think that is the kind of event that is sponsored by some NGOs where they say, I will donate 100 yen, 200 yen. That is the case and gradually the declared money value will increase. An adult will say, I will offer 10,000 yen or I will offer 20,000 yen for donation. And if you say the same number as the previous person said, you are a little ashamed and I think that is the idea that they have. Lastly, those who offered or declared the biggest monetary value, how much do you think that monetary value would be? Two million yen. I think if that is in Japan and then I think the people's incentive will be to just pay exactly the same as the previous person, but maybe in this country people want to stand out and be respected by others, want to look more handsome. I think they are leveraging the character of the people. That is what I thought.

This is about the history of the CBR project. In 2003, the Ministry of Social Affairs and Labor (MOSAL) requested and started it. At the beginning, there were only three villages and then it expanded to additional two villages after that. In the year 2005, the national coordination mechanism, the National CBR Committee was established and also the CBR Office under MOSAL functioned as the secretariat of the National CBR

Committee as well as a planning, coordination and supervisory body was established. As JICA, we decided to dispatch experts and also to dispatch JOCVs to offer technical support.

The location where we offer projects to, it is hidden over here, but here you can see the name Damascus, the southern part of the country very close to Lebanon. This is the capital city, Damascus. All the villages are located within one hour by car from Damascus.

Here is the purpose of the project. The ultimate goal is that persons with disabilities participate in every aspect of the society. To do so, the empowerment of persons with disabilities and their families as well as the development of more empowering environment in the community is needed. For the empowerment, those disabled people must go outside the house and have communication and socialize with others. For the environment development side, local volunteers and a network of key persons in the community have been developed as well.

Then, I would like to explain what kind of networking in the society has been done. Here is the picture. The center is the CBR coordinator. This is the example from Harran village. This person is PWD himself and centering this person, the Baath Party, Syria's main ruling party. This is only one dominant party in Syrian political regime, which means that this party has the biggest power. This is the chief of the village from the Baath Party, the next is the mayor of the village, the next is the representative of a local charitable organization called 'Jamayet Khairieh' in Arabic. And also this is the school children's group. This Baath Party is on top of this group. Mainly the primary children will be gathered and called upon. And under the umbrella of the Baath Party, there is a Women's Federation. There is a village development center, a public health center and a cultural center as well. They are now expanding the network of support like this. Also, there is a network together with external resources including NGOs providing special support education for children with intellectual disabilities, self-help groups, government institutions for vocational training and medical rehabilitation as well as private enterprises. At the bottom, you can see the company called the Asseel Underwear Company. This company is very aggressive about supporting the disabled people. Through these supports, the villagers will be able to receive the external special support.

For another activity, there are awareness-raising activities. This picture, like I said before, this is the seminar held together with the Women's Federation. In the seminar, for example, the resource person herself had a visual impairment and she made a speech. Also in this picture, you can see the women with the scarf or the veil, and she is the

village CBR volunteer and she is now talking about the CBR activities in her village. By doing these kinds of activities, the CBR volunteers could be further recruited and villagers get aware of the abilities of persons with disabilities as well. There is also a provision of opportunities for societal participation and development of CBR volunteers through activities such as physiotherapy, group study, sport activities or it can be handicrafts making.

Some children participate in the summer camp. This picture is the drama played by village children with disabilities as a part of it. The play scenario was written by a CBR volunteer and that volunteer also has a disability. This picture is the participation in the local exhibition. They sell handicrafts, beads, rattan basckets to cover the material cost as well as to let the villagers know about the activities of CBR.

Let me repeat the main purposes of the activities, which are; to provide opportunities for persons with disabilities to go out of their homes and socialize with their neighbors and participate in local activities, to empower the persons with disabilities and their families, to develop local resources and local volunteers. Up to here, I have explained to you how the CBR situation has been changed.

Now, I would like to tell the stories of the people involved in CBR. This woman with the scarf is Ms. Someiya and she is a woman from Hijane village, where we are working on a project. She has moderate difficulties in moving and speaking because of cerebral palsy. She used to go to a local primary school, but at the age of 12 she also became visually impaired. At that time, she was a very shy girl and it was very difficult for her to say to her teacher that she cannot see the letters on the blackboard clearly. She failed the exam twice to go to the next grade. Since then, she stayed at home and just supported the housework, house chores, and that was what she was doing. In the year 2003, when the CBR project started in the village, she was the service recipient, but after that she became a volunteer and after two years time, she started learning Braille to support the visually impaired children. Also, she secretly wrote poems and her hidden talent was developed. Like I said before, she started to write the play scenario for the summer camp. Before joining the CBR activities, she thought, why me? Why do only I have disabilities in such a situation? But starting the CBR activities, she found out that she can be a support and be useful to other people. By joining, she has now been able to overcome the difficulties she had in the past. She says, "I cannot imagine what I would have been like if CBR hadn’t begun." She is now one of the most active CBR volunteers in Hijane village and she is also working as a coordinator. In the left picture here, she is now teaching the Braille to 2 visually impaired children. And on the right, she is interviewed by the TV crew from UAE, a nearby country. Before starting CBR, she was

so shy that one could never imagine that she is doing like this. However, so she grew up to be able to express herself in front of public..

Here is another gentleman, Mr. Muhammad-Hashmeh. He is the representative of CBR Harran Office and he has a mild to moderate physical disability in his leg. In 2004 when JICA came over to his village, he started participating in CBR activities as a volunteer and he became very active. He became a local representative of MOSAL's CBR Office because that was his wish as well. This is what he had to say. "Before knowing about CBR, I tried to overcome my disability by trying to become the same as other non-disabled people as much as possible, and when there were some people with disabilities on TV, I tried to distract other people's attention from the TV, so I was not ready to face my disabilities as a reality. But now that I joined the CBR activities, I started taking interest in disabilities and people with disabilities and now I feel like wanting to help other people with disabilities. Now, I feel proud when I walk with other people with disabilities." Through CBR activities, he became able to face disabilities head-on and started to want to support other people with disabilities. Now he is working for coordinating and networking local resources as well as establishing a self-help group of local persons with disabilities.

Another gentleman in the village is Mr. Abu Aanas. He is a religious leader in a village called Kafreen. He also works at the local public health center as a health official. Every Friday, as a religious leader, he preaches at the mosque. He is one of the most active volunteers, so during the Friday service at the mosque or at weddings, he sometimes takes such opportunities to emphasize and communicate to the villagers the importance of accepting people with disabilities and including them.

I am giving this example to view CBR from Islamic value. And this is what he said. "Prophet Mohammad said 'He is not a believer if he sleeps well when his neighbor is hungry'. In Islam, God bless the person who helps other people, and the people who take the hand of a person with disabilities to help him to be a member of the community will be accepted to heaven." He also had this to say, "A person with or without disability has a responsibility as a member of the community. This is why we have to take their hands to become members of the community." I guess this is his belief as well as an Islamic way of thinking. He said, "My village was inclusive even before the CBR. However, since the start of CBR, persons with disabilities and their families became less and less shy or embarrassed."

CBR became possible by such persons, and there are persons whose lives changed by CBR.

If I Summarize what has been achieved, the first is the empowerment of persons with disabilities. Persons with disabilities got empowered as we have seen the examples of Mr. Muhammad-Hashmeh and Ms. Someiya. The second is the motivated volunteers. Currently about 40 people are participating in CBR activities. The third is that, thanks to the efforts by Mr. Hashmeh, the local key persons, such as mayors, school principals and religious leaders in the villages are now being involved in activities for persons with disabilities.

What has not been achieved? The first is local initiative and sustainability. In some villages, current activities would not be carried out without support from JICA. For instance, in the case of group study, stationery, such as supply of notebooks and pencils, what to do about the supply? In the past, JICA bore all the cost for such supplies, but with that, once JICA completes its project in a particular village, the village can no longer carry on with such activities. There is such a concern. In the village, there are philanthropic organizations and groups or local development organizations, so people are trying to get a budget from such organizations to maintain these activities. And the empowerment of people with disabilities is still weak. Mr. Muhammad-Hashmeh and other people are working very hard to organize groups of persons with disabilities. And also networking of local resources, it is not enough still. In this case, the arrows on the picture show how starting from the coordinator, there is only one-way activity. As for those concerned, people will say that they are willing to help and cooperate but they are not sure specifically what to do and how to go about it, so community leaders and key persons, their input is not enough. Further, key persons and other people concerned in the community, they are not yet networking at the moment. Also, local government support is not well organized yet. Especially in Syria, the government tries to control all aspects of people's livelihood. That is the nature of the country, so with that, if we want to make use of a classroom at a school that is not being used, we need to get permission. Also to use the facilities at cultural centers and the permission cannot be given by the local authorities, they have to go to the governorate or even to the central government level. Therefore, in such a very centralized country, support by the central government is also very important and necessary.

If I say the biggest challenge, it is how we can internalize the ideas and concepts of CBR in the community. At the moment, CBR tends to be regarded as something special or just a set of activities. That seems to be how villagers understand CBR, but that is not good enough. In terms of people's everyday livelihood and also in their day-to-day usual activities, CBR should be reflected.

The WHO also says that CBR is a strategy. Therefore, this CBR strategy should become a part of the natural manner of people's everyday life. In anthropology, people talk about formal occasion and daily occasion, and it seems that still in Syria, CBR is regarded as something special for a special day, but it must become more daily-oriented. CBR requires the involvement of a number of different stakeholders, so we need a mechanism to coordinate all these participants at the municipal and governorate levels.

That was the activity in the community, in the village, but also the Syrian central government is making its effort to establish CBR Office and National CBR Committee. In Syrian National Disability Plan, CBR is included as one of the undertakings to be promoted. As a new approach in 2009, CBR units were appointed in each governorate. Members include governorate officials and representatives of local NGOs. There will be training given to CBR unit members and after that they will take the initiative to promote CBR in each governorate. In this picture here, this is the National CBR Committee and CBR Office at national level, and CBR units at governorate level. Here together with the staff members of the governorate office, the local NGO members are participating in this CBR unit. When it comes to services to be given to persons with disabilities, the reality is that it tends to be NGOs that give such services, so it, I think, is a realistic approach.

I already talked about JICA, so I will skip these. What about the future? Now we have CBR units, so we will develop their capacity and give advice to their activities. What we are thinking now is to provide training in Japan and Thailand for CBR unit members and others. As for the activities in the villages, what is being offered by JOCV volunteers should be gradually handed over to the community members. They are focusing on networking in the community so that CBR will continue.

That was the first part of my talk. I only have ten minutes, so I will try to be quick here.

As for myself, I have been long involved in the government administration work. Currently, I am working together with the Syrian government. In terms of CBR, what should the government do? That is what I have always been thinking about. The government approach is to promote standardization by laws and regulations so that similar approaches can be taken nationwide. On the other hand, in the case of CBR, community initiatives are emphasized. So there should be different approaches undertaken in different communities.

A natural question is ‘Is this not a contradiction?’ Surely, between the government approach and the CBR approach, there could be a discrepancy there. But in order to practice CBR approaches, there are several conditions that must be met, many of which

are related to administrative or government work. For instance, decision making should take place closest to the community. Otherwise, spontaneous initiatives on the part of the community will not proceed effectively. Another condition is that self-help activities should not be discouraged by the government sector. And activities by local resources and volunteers should not be discouraged by the government sector. In the case of freedom of association, the concept there is quite different from the concept we have in Japan, so when you want to organize a group or start an organization with persons with disabilities, the government always becomes very suspicious. The government at least should not get in the way when people with disabilities try to organize a self-help. Otherwise self-help activities will not succeed. These, in a sense, are non-interference policies.

Going further, decentralization should take place as much as possible. Other active initiatives that the government can take are; to decentralize decision making so that the community can make their own decisions, to develop coordination schemes between different departments, to share good practices, to provide professional services which cannot be offered by local resources, or to recognize and support local initiatives. More active involvements include human resources development for CBR, financial support for development and activities of local coordinators, who are indispensable to CBR, and also financial support for development and maintenance of community centers, which are also very essential.

Now, since I myself am involved in international cooperation, let me talk about my idea about international cooperation. There are government-based initiatives and private-based initiatives. The government-based initiatives include; capacity development of officials of central and/or local government, advice for policy development, capacity development of professionals and key persons in the community. Private-based initiatives are more community-based, for example, to go to a particular village to undertake activities there. These are the main initiatives of the private sector. These two different approaches could coordinate and work together for the activities to be more effective. More specifically, under the private-based initiative, a NGO which goes to community can find a key person. This is an advantage of private-based initiative over the government-based initiative. For such a key person, various training can be provided under the government-base initiative. They, in turn, can be resource persons to empower officials of central and local governments at the seminar under the government-based initiative So it works both ways. Through such an approach, community key persons or candidates for such key persons would lead to changing of

the mentality on the part of local and central governments, which in turn leads to the government supporting the community. I think that would be possible.

For CBR to be promoted effectively, people are key. That is why I gave you an example of Ms. Someiya. It is such people who can change the way people think at the government level. It is the people who run the hardware. For instance, the officials of local government, by changing their way of thinking and mentality, that in turn would step up the willingness on the part of the central or local government to do more, to give more support. It does not necessarily mean for the government to employ private-based organization people, but in different schemes, the government can be active in making use of and capitalizing on such human resources on a project basis.

Before closing, what about Japan? How can Japan be involved in CBR? Firstly, partnership between government-based and private initiatives. When you think about the number of different support schemes of Japan, where there is quite an amount of resources that can be applied for CBR. There is group training, JICA's policy advice, country-focused training, JOCV, etc. Also at Japanese embassies overseas, there is the Embassy's grassroots human security grant aids and NGO's technical and financial cooperation already available.

When I was in Laos, I was involved in these kind of activities. In my activities and cooperation with Japanese NGO, we identified certain human resources. And I have an experience of supporting such persons with visual impairments through a scheme of Japan Braille library, in which Mr. Sasada in today’s resource persons is involved. There are various different groups with their strengths and weaknesses, for all these different groups to work together, they can complement each other.

Another possible involvement in Japan is to network among various countries. So far in the countries with which Japan has been cooperating already, there is already a pool of human resources who have been trained and developed, so such people can share their ideas and experiences with persons in other developing countries. That in turn will lead to mutual empowerment, I think. As a Japanese organization, it can take active initiative in developing such networks. For instance, to give you one example, when I was in Laos, for people with visual disabilities in Laos, those with similar disabilities in Malaysia and Thailand taught how to use computers. That Thai person had an experience of staying in Japan by Daskin schlorship to study computer. He himself is blind. The other person was Malaysian who was trained under the scheme of Japan Braille Library. It, in turn, is the Thai and Malaysian visually disabled people teaching how to use computers for their counterparts in Laos. The arrangement was done by

Japanese. Sometimes it is difficult to offer or request help if you are direct neighbors. In such a case, Japan can act as an intermediary as well to propose such schemes as well. This is the end of my presentation. Thank you very much for your attention.

Presentation

International Standardization and Accessible Design

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Thank you very much for your introduction. My name is Yamauchi. Today, I would like to speak about the international standardization and accessible designs. Many, I would like to take up two things. There are two take-home messages. I would like to speak about the roles played by this organization and also I would like to speak about the collaboration between Japan and Korea. The central role played by the NRCD and the relationship between Japan and Korea.

First and foremost, I would like to speak about the roles that should be played by international standardization. I will be brief here. The standardization of the international stage would enhance reliability and safety so that a kind of assurance for safety and reliability from the user's point of view and then also this could have an impact for the use environment so we are able to understand the compliance between the equipment and the user environment. Certainly, the public purchaser would have good peace of mind for the standardization because of the fact that they are able to have a good understanding as to the level of quality that will be provided by that equipment. Manufacturers are able to say that they are in line with the regulations. It is also possible to have good consideration for the safety so they are able to have a good rule of thumb as to the level of safety that they have to take into account for that product to go into the market. In that respect, it is very important for many entities, including regulatory authorities which would use them as a tool to follow the law.

Now I would like to talk to you about the history of the standardization here in Japan. Back in the 1970s, Dr. Iida, Dr. Hatsuyama and Dr. Kakurai—all of them have already passed away –they were the central driving force for this kind of initiative and they were working in the precursor of the National Rehabilitation Center for Persons with Disabilities (NRCD). They were the driving force in coming up with these standards. These are the Japanese standards called JIS. I received pictures from Dr. Hatsuyama.

I have never seen this myself, but this kind of initiative within the National Rehabilitation Center. Back then, they were mainly meant for artificial limbs or P&Os and then after that, this work of standardization was transferred to the Japanese Association of Rehabilitation Medicine. They had been focusing mainly on P&Os, wheelchairs, walking sticks and so forth. Then, there had been concern as to whether it

is appropriate for the Japanese Association of Rehabilitation Medicine to tackle with this, so another transfer got started. At this moment, the Japan Assistive Products Association, Japanese Society of Prosthetics and Orthotics, Association for Technical Aids, National Institute of Technology and Evaluation and other organizations started to be involved. In other words, this Association of Medicine broke into some of the organizations responsible for the standardization of these devices. We also have one more entity, which is the Japanese Ergonomics Society. This has been involved from a different perspective. That is what we are looking at this moment.

In thinking about the international standardization, what kind of internationalization can we think of. In this field, we have three organizations which are relevant to us. The ITU is the oldest, the International Telecommunications Unions—it had a different name back then, but still it started out with Marconi's Morse signal. Back then, it was imperative to have a standardization for the signals for telecommunication. That was the reason why they started working on the standardization for this part in order to enable all the people to use Morse signal. This is the oldest ever international standards body. Then in 1900, the International Electrotechnical Commission (IEC) was formed. Initial they had a different name, but in 1935, they had a new name and at this point, the new name is IEC. The reason why they established this organization is that back then they started to see the diffusion of the distribution of electricity to each home and they wanted to standardize the signals for the electricity transmission or power transmission. Then, the International Organization for Standardization (ISO) was formed. Back then, when it was formed in 1926 they had a different name. In 1947 they reorganized themselves to form the International Organization for Standardization. Whatever the case, the precursor to the ISO was established in 1926. Sometimes we call them IOS or ISO. This is a misunderstanding, but in English, we use the term ISO, but in Japan we use the term *aiso*. ISO in Greek is isos, which is relevant to the nature. But still, we are not able to use the term ISO to mean International Organization of Standardization, but we are able to use the ITU or IEC to mean the organization.

Then, I would like to speak for a moment about the devices. Within ISO, they have the technical committee or TC, and TC168 is responsible for prosthetics and orthotics. Prof. Morimoto is responsible for this organization, so he is representing Japan. Then, they have varied groups, WG1, WG2 have been represented by Dr. Tobimatsu, WG3 by Mr. Aikawa of the Research Institute. The prosthetics and orthotics, all these, Dr. Tobimatsu and Mr. Aikawa are representing the NRCD. Prof. Morimoto is not from the NRCD, but we can say that it is highly represented by NRCD.

The next one here is the next working group. Working Group 1 which is assistive products for walking. Dr. Yano was involved in it. At this moment, Mr. Tanaka is responsible. Then we have the WG8, tactile walking service indicators. I am representing Japan here. There are many people who are participating in the wheelchair SC1 and Mr. Hirose is very active in this arena. Then, the classification and terminology SC2 has been participated by myself and Dr. Inoue. In aids for ostomy and incontinence, no one from the NRCD. Then, hoists for transfer of persons, this is the dormant sub-committee. And SC7 is undergoing the final process. This is meant for accessible design for assistive products. We had the voting which was finalized last year in December. I am expected to serve as the chairperson for this committee.

Accessible design will be the most important issue that I would like to speak about today. One more thing that I am very much involved in is TC159/SC4/WG10 which is accessible design of consumer products, I am also responsible for this. Here we use the term "accessible design" and "accessible design" there. This is a very important key word, so I would like to speak about that. Before that, allow me to give you the history behind it.

Back in 2002, the Northeast Asia Standards Cooperation Forum was held which was a collaborative meeting between Japan, China and Korea. All the people and experts in the field of standardization met together and decided to have an annual meeting in order to decide on the kind of activities we will proceed in the international field. It is not necessarily about certain areas, but rather it is meant for the discussion as to how we are able to discuss, how we are able to cooperate with the international organizations. In 2003 we agreed on the cooperation in the field of accessible design. The issue is what kind of cooperation we can have and then for human ergonomics (TC159), we could have a new work item proposal. We decided to make a joint proposal for the new work item, so this was actually done for five items. Japan, Korea and China would have to serve as the project leaders—co-project leader is the term we use. For these items, we serve as co-project leaders. Then, we have the coordinator, so to speak, for the co-project leaders.

With that kind of structure, we are making proposals for five items. One of them is being tackled by myself, as was explained earlier. In 2007 we agreed on the cooperation in the field of assistive products in this field, but we have to say that we were not looking at the same thing with the same understanding, so last year for the entire year, we had discussions to have an alignment of understanding and direction. One thing that came out of last year's discussion was the collaboration in TC173/SC7 which is the accessible design of assistive products. Then, at the same time, we decided to have a

collaboration and information exchanges for the standardization of other fields as well. We decided to have exchanges of view for other assistive products as well. SC7 will be established and the finalization of the process will be sometime around fall this year, so we will have to work on this till then.

I use the term accessible design. This is a key word and this has been a very strictly or clearly designated or defined word. Guidelines for standards developers to address the needs of all the persons and persons with disabilities, this is the ISO/IEC Guide 71. The meaning here is that we create design focusing on the principles of extending standard design to people with some type of performance limitation to maximize the number of potential customers who can readily use a product, building or service, which may be achieved by three methods. Namely, (1) by designing products, services and environments that are readily useable by most users without any modification, (2) by making products or services that are adaptable to different users, for example, adapting user interfaces, and (3) by having standardized interfaces to be compatible with special products for persons with disabilities. These are the three ways in which accessible designs are implemented or enabled. This is the design which is accessible but this is not merely accessible, but rather one of the three methods should be realized to make it accessible so that the persons with disability can utilize them.

The last one is universal design. Universal design and accessible design are different. Still, item 1 of the accessible design is very much similar to universal design. Universal design is good in terms of theory, but theory is something that will not be attained in the real world. In that respect it is not feasible, but accessible design is feasible. Plus talk is just one more example. This is something that was developed much earlier than the introduction of accessible design. This is the speech unit for diabetic retinitis patients, which is serving as an attachment to the glucose meters. We incorporated the speech unit or speaking unit. That means that the people who do not have any vision can understand their glucose levels when they have diabetes. With the attachment of the widely-used equipment, it is possible for persons with disabilities to utilize them. This is what accessible design is all about. That is the reason I made this introduction. That is all from me. Thank you very much.

Collaboration on Teaching Therapeutic Massage, and Establishing Acupuncture Training in Malaysia -Let your hands do the talking!-

Saburo Sasada
JICA Senior Volunteer in Malaysia

My topic is very overarching and my subtitle is "Let your hands do the talking". I initially wanted to have the subtitle be the real big title, but I thought that you may misunderstand the content of the presentation if I make "Let your hands do the talking" a title.

I will show you two maps. Here, this is the map of Malaysia. I have been dispatched to Penang, an eternally warm country and no winter coming and the people are very open-hearted, relaxed, very rough and carefree, and very social people. It is a very easy to live in country. However, there are dark sides and bright sides. For the dark side, they do have a difficulty in planning so they may not be that diligent and they do not have any meetings to learn something from the failures that have been made or that existed in past projects. So I would like to follow this agenda.

The first, about the contents. I will briefly explain four parts, dividing in four parts: 1 the outline, 2 key points of the collaboration, 3 the current pending issues and 4 he hope for the future. This is the picture and this is the entrance of the St Nicholas Home SNH. The appearance is very nice and clean, but there is a lack of transparency and there are organizational difficulties, such as the top-down giving of orders in the organization. Those are some of the dark parts.

This is the chapters and some of the points. There are two sub-chapters and here is 1-1. This is a remote. In the year 2002, the massage program was already established and that is the body oil massage and leg reflexology. Those were already put in place and I decided to teach other things. Students are in the latter half of their twenties. This is different from Japan which is about 40 in intake stage. Another thing is that the men and women are separated when we conduct lessons. Female teacher will teach women and a male teacher will teach men. That is something that reflects the character of the Islamic country, Malaysia. It is a strict no-no to touch the other gender's body. After finishing course, they will work at massage shops in the town and they will receive a commission of 50 percent. It is not a fixed salary system. These are my students and there are only six in the picture, but there are more students in reality. Here, again, a picture. This is the picture of the body oil massage.

Chapter 1-2, these are the problems they have. There are two points. One is that the basic education is not necessarily equipped by the students. Twenty percent of the total have not graduated primary schools. In the official sites, it says that the Malaysian people exceed finishing basic education more than 90 percent, but that is not the case. The parents would like to hide that their children have not been to school. It is quite rare that because of poverty they are not able to send their children to school, but still a low education level is a problem. There are massage people from overseas for the simple work. This is because the government is inviting the overseas, outside, foreign workforce both legally and illegally too. That means that visually impaired local people need to face very strict competition. To my students, I am telling them that they should skill-up on massages so that they will not fail in the competition with foreign workers.

The next point is the key points of the collaboration. Because in this country there is a conventional oil massage method, then I will be confronted with the local teachers, so I decided to teach them shiatsu, the non-oil massage. The purpose is the medical treatment and also from eight months on, the acupuncture hands-on, that is what I have started to teach them.

Here, I would like to explain to you from item 1 to starting from the highest priority. The first point is the tactile communication, "Let your hands do the talking!" The therapist's hand will communicate by touching their hands on the body of the client. You should not just follow simply the manual. You should communicate through your hands with the body of the patient. That is necessary, but it is difficult, even here in Japan.
Next is a picture.

Now I am teaching them how to do the tactile, Qigong exercise lesson. There are three basic rules: good posture, abdominal breathing and imaging Qi-circulation. These three major principles are the prerequisite for teaching the Qigong exercise. I also teach the Qigong exercise which will enhance the health and also the healing power. By enabling this, by themselves, I ask them to teach to their clients. Next is the Qigong exercise picture.

Next is item 3, to teach the basic shiatsu lesson in sitting chair position. In Malaysia you teach them on a tatami mat, but I will teach them sitting in a formation of the motorbike posture, which is the reverse of a seat on a chair, to teach the basic procedure. Usually, we teach them in a prone position because they lie down on their stomachs. When they lie down, they feel relaxed and sleepy, so sitting on a chair in a motorbike posture is better. Also, they have a clear mindset and men and women can be mixed in the same class and it can be efficient.

The next point is the fusion massage. Historically, there are countries that are highly-evaluated for their massages, such as Japan, China and Thailand. They have very good massage procedures, so those countries, I have incorporated into one massage. I call this a fusion massage. I still name this shiatsu. It is because I am Japanese. Then, from here on there is a mattress and I teach maybe shiatsu using the mattress. This is what you call a digital vibration or binding legs. You bind the legs and convey the vibration to relax the pelvis and the lower part of your body.

The fifth is, Practice First, Theory Second. Because there are some without the basic education skills, the theory is very difficult to teach, so first comes the practice. When the time comes that we need to teach the background of the practice itself, I teach them together, incorporating the practice with the theory. There are the basic medicine textbooks, guides to anatomy and physiology are available and an anatomy models were donated from JICA. Because some of them have difficulty reading, tactile teaching tools are very effective for them. Here is the picture, so spinal and pelvis models. Now the students are looking at the pelvis and spine. Also, they are looking at the internal organs and chest cavity.

The sixth point is the PDCA cycle to improve the quality of the staff. PDCA stands for Plan, Do, Check and Action. The idea is to improve the efficiency in various fields. I think this will help to systemize the efficiency for those who are not aware of this kind of idea. Next is the table of the PDCA.

The seventh is to take note or keep a record. This goes without saying, but still those who have not had basic education, it is important to keep the record in their minds. Next is the case report or the medical chart.

The eighth is teaching acupuncture. I taught to six people, not only the practice, but also the theory and hands-on clinical practice. Thanks to the volunteers, we have been able to accomplish higher than our expectations at the beginning. There are slight differences in capability, but I used the tools that I brought from Japan and safety came first, of course. This is the picture of when they do the acupuncture. For the moxibustion, we use warm moxibustion.

Current pending issues. There are two in total. One is that there are not enough teachers because of the low salary or low social status. Those are the reasons. Another concern is, I have requested the extension of my JICA assignment period. I have finished my assignment period, but I would like to again be dispatched to the country and I am requesting that. For this shiatsu, even for two years, I think we can accomplish a certain degree, but for other fields, acupuncture, you need to have more time to teach them. This one is chapter 4, the hope for the future. This is mainly that we would like to

support the empowerment of the people. The voices of the visually impaired people are very weak so we would like to structure a system so that they can open seminars for elevating their skills and if they can be opinion leaders in the organization, I think it would be very helpful.

Before I finish, I made another additional handout, so please focus on the one strip of paper handout. Here it says key points, advantages and pending issues of Sasada's presentation. There are three major points: 1 s that the awareness according to the assignment of PWD, the merit is that I have been able to stand in the same position with other visually impaired people and I have been able to collaborate and help in the skill-up. Through these activities, it will help them to empower, but the concern is that there is a very big gap in the society and maybe this is not only in this country, but the PWDs are the second citizens in many cases. That is my impression. The society is in a situation of disorder. There are many foreign people, foreign workers and it seems to be very difficult for the visually impaired people to secure their workplace.

The second point is the international cooperation as the equivalent to the collaboration. When you say international cooperation, it is like looking from the top-down, but if you say collaboration, it is more in an even position, which is better. And by having collaboration, I gained accomplishments and have been able to have a challenge and I felt that this is a very worthwhile activity for me. I am humbled to say this, but I now have wider vision and knowledge has been accumulated, so here there are many religions and customs and there are many, many limits and some of the volunteers feel desperate facing those limitations in the country.

The third point, occupation for PWD. Looking globally, they are unique, depending on the country, region or area. The advantage looking at three decades is that Eastern Asian countries developed economically and in developed countries, the major work for the visually impaired is massage in Japan. There were shorthand and typists and telephone operators that existed in Malaysia, but it does not happen anymore. The major occupation is massage and I think this will continue. The concern is that from the market theory, sometimes we cannot compete with the sighted people, so the government or the society needs to consider this matter. Malaysia to be a developed country in the future, this will be needed. Did I finish my time? Time is up. Thank you very much.

Rehabilitation Expert Training and International Cooperation

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Thank you for your introduction. I am Tomioka, working as a technical advisor for JOCV in the field of rehabilitation for the people with disabilities. I understand you have printed handouts of my slides, which may require more than 15 minutes to explain in detail. So I am afraid that I have to skip some of the slides or parts of them, but I hope you have some time to check the handouts later. When you attend a seminar on international cooperation, you may have the image that international cooperation is something unique and special. However from my various experiences, such as visiting different working sites of JOCV activities to discuss on-going issues, reading their reports, giving workshops to counterparts and/or trainees in and from the developing countries, and attending international conferences, I would like to emphasize that the most important issue is how you learn from the actual past-present-future situations of working field. This is the very basic foundation in international corporation. Be the field in Japan or overseas, be it CBR or the medical/educational field, this is the first message that I like to convey to you at the beginning.

Today, keeping that in mind, I would like to review and look back on history how Japan has developed in this area through international cooperation and think about how our experiences can be applied in our on-going and future activities for rehabilitation expert training and international cooperation. Having been one of the first generations in the field to rehabilitation, more specifically being an occupational therapist, I think this is one approach to learn from the actual situations.

As for the current status of international cooperation in this field, Ms. Tawa will be giving a detailed report later on, so I will be very brief on this issue. Let us get started.

1. Impetus for rehabilitation expert training

In the early part of the 1960s, rehabilitation expert training started in Japan. The forerunner was an economical recovery as shown in the Economic White Paper of 1955, stating that “we are no longer in a postwar situation” and then the revised ‘social insurance systems’ including health insurance were introduced. The economic growth

and the improved infrastructure for social security in the early 1960s was the basic foundation for the development of experts training in this field. However, at that time, Japan was being supported by WHO, so it dispatched a study group to come up with recommendations to improve medical care and rehabilitation in Japan. Also WHO fellowship fund-based trainees were sent abroad to learn rehabilitation medicine in advanced countries.

Reports from trainees and recommendations from WHO facilitated the forming of a study group in the Ministry of Health and Welfare. This study group presented the interim report “The present state and provisions for medical rehabilitation in Japan” It was a comprehensive and government-initiated report to recommend various measures to improve rehabilitation system in Japan. It also pointed out the priority of starting expert training in occupational therapy (OT) and physical therapy (PT). This report became a turning point by providing long-term perspectives on health care development in Japan.

2. The first school started with later legalization; job opportunities increased 10 years later

The budget was secured to start a three-year technical school. Some people recommended a four-year university education, but there were no requests coming from universities and the government would not take the lead there. The 3-year technical school system is similar to nursing school at that time, with the exception of taking only 20 students per year and WHO would send an advisor to guide a program acceptable internationally.

Historically the school was born before legal regulations were established. The Tokyo National Chest Hospital School of Rehabilitation started as the first school in 1963, then Kyushu Rehabilitation College affiliated with Kyushu Rosai Hospital started in 1966, and then the Tokyo Metropolitan Government started Fuchu Rehabilitation School in 1969. For the first ten years or so, these three schools contributed to the expert training being partially assisted by foreign teachers. All of them have already been discontinued or been promoted to become a 4-year university degree course.

The legal regulation was established as“Physical Therapists’ and Occupational Therapists’ Act”in 1965 to qualify and register as health care professions. Finally, about ten years later, medical fee reimbursement system for PT and OT services was established in 1977. Without this, even if PT or OT is employed to provide needed services, there will be no financial basis for hospitals to continue these services. Therefore the newly adopted reimbursement system within the national health insurance

structure made the solid financial foundation to develop job opportunities for PT and OT. This is a big step for sustainable development of expert training.

If you look at expert training system in developing countries, the foundation or basis to secure employment for newly trained people was not established. In many cases this may cause a brain drain from its own country and/or from the field of rehabilitation resulting in never-ending shortage of needed human resources. If you are going to develop and train needed specialists and/or assistants, what is necessary is to make sure that you create some measures to provide job opportunities for these people as well. Without this consideration, the expert training through international cooperation will be one-sided and not effective in a long run, which is a lesson from our history of expert training.

3. International cooperation to secure Rehabilitation experts: WHO advisor and employed foreign teachers

In Japan, expert training through international cooperation started with employing qualified foreign therapists as teachers in addition to the WHO funded advisor (PT expert or OT expert) who worked at the National Tokyo Chest Hospital School of Rehabilitation. In the slide, I showed how many foreign teachers were employed at above mentioned three schools. Roughly speaking, over some 7 to ten years, it was necessary to work with foreign trained teachers, full time or part time, but after that it was handed over completely to Japanese teachers. This means that, if you exclude the preparatory period, 7-10 years will be enough for a country to accomplish the minimum level of sustainable independence for expert training.

Currently so to speak “CBR policy” may have a negative impact to develop a formal training program in developing countries due to the expenses to be invested to facilities and/or human resources. In fact, what are most costly are human resources, not hardware or facilities. At that time in Japan, the exchange rate between the Japanese yen and the US dollar was 360 yen. To employ foreign teachers under those circumstances was quite expensive for any Japanese organizations to pay according to the advanced country’s standard. It was also impossible to find a qualified expert volunteer in those days. I assume that full time employed foreign teachers were paid much higher than the government high officials.

But Tokyo hospitals did that and so did Kyushu Rosai Hospital and Tokyo Metropolitan Fuchu School. These situations raised a motivation to try to expedite the process to nurture and develop our own teachers, although there was also some support coming from WHO. From the very beginning, development and fostering of teachers

was a main concern for school directors and small number of candidates was sent to abroad to study and obtain qualification.

Facility-wise, Tokyo National Chest Hospital no longer needed so many wards and buildings and facilities already existed could be used. The main building shown was the only new construction with classrooms, office and library requiring minimum investment to facilities. I used to work here as an assistant and I assume that the idea was to spend more money on people rather than on hardware with limited budget. The left photograph is the third graduation ceremony in 1969, the teachers were in the front row. The right photo shows a class of microscope lab in anatomy using the donated old microscopes.

4. Lessons learned from international cooperation in rehabilitation expert training in Japan

As a summary of the first part of my presentation, I put 6 points of lessons we learned from the early stages of expert training in Japan. First, the starting policy was clear as a national policy focusing on education of technical professions rather than trying to develop elite academic professions. Second, many applicants were oriented toward professional qualifications and motivated to become skilled specialists in a new field of 'Rehabilitation'. It is a key issue in any area of expert training that graduates will become role models to promote new profession in that country.

Third, the directors of starting schools were usually medical doctors who believed in the necessity of such human resource development were vital to improve the quality of medical rehabilitation. They had this firm belief as medical professions, so what was taught was quite medicine-oriented. Curriculum emphasized a lot of basic medical subjects, such as anatomy, physiology and clinical subjects. Besides, in those days, PT and OT practice were mainly medical model-based in rehabilitation advanced countries. In the long-run, I think this has been a good trend as it turned out to provide a solid foundation to improve the overall standard of the development and education in health related professions.

Fourth, there should be a planned strategy to develop the hand-over and/or bridging human resources during the first ten years of technical transfer of expert training. Those human resources would become empowering nuclei to foster a culture of professionalism. In other words, some degree of autonomy of the new-born health related profession is the minimum requirement for the survival and/or sustainable development of the profession to become able to contribute to upgrade health care in that country.

Fifth, owing to the support of WHO advisors, professional organizations for PTs and OTs were separately established as a voluntary NGO after the first set of graduates became registered therapists by passing the first national examinations. Both NGOs are contributing greatly to the further development of the professions. I have to point out that, in Japan on the whole, such a culture of professionalism was already there, as what we had to do was to carry on with that. Such a basic culture, fundamental culture, having existed, that was very helpful. I may say that the lack of traditional culture of professionalism will be a factor of fragile sustainability of health related expert training in developing countries.

Sixth, as I was saying, employment for the newly trained skilled specialists had to be stabilized. This means that some measures to sustain job opportunities should be put into place along with the international cooperation in rehabilitation expert training. In Japan it took about ten years to establish the health insurance reimbursement system for physical and occupational therapy services. This helped to increase job opportunities in medical care services. Presently there are quite few workshops going on in developing countries to train and/or upgrade CBR workers mainly provided by NGOs. However, it is rare to find a scheme to support new and/or better job opportunities for those trainees.

As in advanced countries the concept of empowering good will volunteers recruited from ordinary people does not fit into the reality of the developing countries, often resulting in the discontinuation of voluntary activities caused by the termination of the grant-in-aid or decreased incentives. So CBR workers or whatever it is, skilled specialist or non-skilled workers, you need to provide an environment or place where certain income could be generated or assured. Such a foundation must be there in the first place to start with any type of training program. The Malaysian CBR scheme had introduced the concept of ‘paid-volunteers’ into CBR training programs to reinforce the stability of human resources, which can be a model for good practice of CBR as a part of inclusive social development.

5. Factors of human relationships in international cooperation

I know that there is ‘no-if’ in looking back history, we have been going through different processes as recipients of international cooperation in rehabilitation expert training. And as a witness of many happenings, I would like to make some comments on issues of human relationships. First, it is my impression that the different concepts and methodologies could be translated on the language level, but the hard part is to transfer the underneath culture-dependent concepts and methodologies of interpersonal- related

rehabilitation skills. It requires time consuming endeavor, and some of them may not be possible to transfer.

Let me give you an example. The rehabilitation medicine is a branch of so to speak 'Western medicine' which has developed based on psycho-social values and traditions of individual independent responsibilities and obligations leading to mutual relatedness by contract. It is almost impossible to understand and integrate those new concepts in relation to Japanese culture and traditions which valued more emotional inter-dependent relatedness of mutual 'holding and being-held'. Especially I had to face the gap and took me a long time to understand the value of helping independence in activities of daily living, not as practical training methodologies, but as more fundamental approach to help people with disabilities. This is a theme to evolve with socio-cultural changes in any country.

The next sample is a more positive acceptance of culture-depended relatedness, which was not intentionally taught by foreign teachers but was integrated into our culture through modeling the foreign teachers' strong professionalism. Their cool-headed, not emotionally involved, consistent rational professional relatedness with patients, students, and colleagues, did give a strong impact and positive influence on the counterpart, the Japanese.

Looking back these examples, I am sure that the system development is quite important as I already pointed out, but what it boils down is people; i.e. the coincidental relationship between key persons may also become a key issue in the process of international cooperation. There must be a stable and consistent involvement of key person's on the recipient side. In terms of stability and consistency I think we were lucky to have strongly committed Japanese key persons as school directors, and very good qualified WHO advisors who stayed long enough to cultivate professional relationship with Japanese students in the early days. In international cooperation it will be a difficult speculation to know the key persons' involvement in terms of stability and continuity of the governance on the recipient side. However if people change over quickly, the basic foundation to develop mutual understanding relationship will not be established.

Then, what are the desirable qualities requisite for a foreign advisor and/or non-native expert from the recipient point of view? The most important qualities are capabilities of presenting visually and/or demonstrating whatever they want to convey to recipients; i.e. skills, knowledge, and experiences, and so on. A solid professional identity supported by broad profound view and his own principles should be there as a part of total personality. The communication skills to make clear distinction between imposition and

rational assertion are essential. Rational explanation of why something is necessary should be presented step by step, led by cool-headed assertion and not forcing own views from the top down, especially when talking about education.

I remember one example of student promotion and drop-out issue. The application of school rules and regulations are rather strict to drop-out poor achieving students to the extent to dismiss them or advise them quitting. In those days at professional technical schools, that kind of trend was not common in Japanese culture. However the advisors were quite consistent to advocate the standard quality of expert training for the sake of future Japan regardless of technical school or university. This was a very big contribution of foreign teachers of early development of expert training in Japan. Luckily these new advocacy trend mixed with Japanese traditional professionalism became a part of shared reality of new-born profession of physical therapy and occupational therapy. It has been quite common to have students failing in clinical internship even they did well in academic classes. This new educational culture, in a way, was a good advantage to quality assurance of expert training in rehabilitation. Nowadays I hear that some parent of failed students' claim the school teachers that failures are caused by poor teaching, which tells us that good professionalism will not be sustained without constant efforts by practitioners.

How about the language barriers? We were not expecting foreign teachers to speak Japanese, and I assume non-native teachers had no intention of learning Japanese with the expectation of Japanese to learn English. If necessary, translators were requested and used. It was not often but when there was disapproval of traditional values of the country, which conveyed negative messages non-verbally, it became latent conflicts to spoil straight and honest communication. There were some Japanese-American teachers working with no advantage or disadvantage over Western teachers. However, they pointed out that Japanese people will accept opinions of "white foreigners", but not the "Japanese-American", suggesting that Japanese inferiority complex toward western advanced countries may be a possible source for our discrepancy.

6. Grass-roots international cooperation in developing human resources in Rehabilitation

How much time do I have? We are running out of time already. Oh, how time flies.

Now, about grassroots-level rehabilitation, what are we doing, especially as Japanese overseas volunteers (JOCV)? To hurry to a conclusion, we are not directly involved in specialists and/or expert training, although we provide services for clients in various setting, NGOs and/or schools, hospitals and CBR centers, where they may be involved

with a sort of on-the-job training to staff. In some countries providing expert training schools, JOCV may become involved with clinical teaching for student trainees and/or giving some lectures on technical issues. But those involvements are limited to special occasions. According to what we hear from the reports from the volunteers overseas, students learn lots of theories in classroom setting, but the actual clinical skills are missing as application of those theories. Especially in the area of assessment and treatment planning processes are lacking resulting in a stereotyped program to every client with different dysfunctions and life background.

General impressions from grass-roots activities of JOCV in developing countries except in some Asian countries, it is quite frequent that volunteers are not seen as formally trained experts in rehabilitation fields worthy of possible outside sources to provide some useful practical skills, comments and advices. Reasons would be a lack of communication in their native language at the beginning and a lack of information among counterparts about Japanese advances in the field, in addition to inclinations towards European and/or American culture among professional leaders in local communities. It is also a common situation that Rehabilitation was perceived more as being a medical-oriented services provided by experts not as a corroborative team-work with clients. It has been pointed out by many Japanese rehabilitation-related volunteers that a lack of concern for approaches toward independent daily life was quite common not only among rehabilitation related professionals and workers but among clients and their families in developing countries. It has been long since CBR policy launched , but there has been a big gap between what was said and what was being done in the field of CBR.

Some of the major conflicts faced by senior expert volunteers working at training schools are, in most cases of developing countries, teachers and students are highly motivated to acquire technical skills and knowledge but not interested in promoting professional culture as new evolving health professions. And that graduates from universities with degrees are more elite and looks for better employment opportunities, which would lead to brain drain and/or uneven distribution of professional manpower in big cities. I may generalize that it is very difficult to find formally educated and trained rehabilitation experts involved grass-roots human resource development and taking leadership in developing community health care including CBR

In slide I showed some statistics to show numbers of JOCVs in medical related occupations, with 7 occupations in the frame, to clarify the ones I am working as technical advisor in the field of rehabilitation. I will skip the detail as time is running out. I also showed some photos of JOCV activities with 5 important key issues leading

to satisfactory volunteer activities in international cooperation. Health, physical fitness and safety management come first, and the second is a trial and error learning abilities. Language skills could be important, but the capacity for on-the-job learning based on trial and error problem solving method with good enough footwork is more important. This is my basic foundation for today's speech.

As I pointed out the influence of professional culture in development of human resources, I compared the essence of international professional organization of PT and OT excerpted from the website.. Roughly speaking, as shown in the slide, there are about 102 PT organizations being a member of WCPT (World Confederation for Physical Therapy) comprising one half of UN member countries, whereas the number of WFOT (World Federation of Occupational Therapists) member countries is about 68, comprising one third of UN's. In terms of international educational standard, the WFOT has a policy of maintaining the required minimum standard of occupational therapy education, and new schools are to be reviewed to become the WFOT approved school.. In the case of PT education, there is no such a minimum standard due to a variety of reasons, such as kinesio-therapist and physiotherapist in some developing countries have different professional identities which interrupts the development of unified minimum requirement for education of integrated "physical therapy profession". The chart shows a list of countries where PT and/ or OT professional organization belongs to its international organizations. If you have some time, please have a look.

At JICA there are many other programs in relation to experts and specialists training in rehabilitation. I am sure somebody else will touch upon this topic later on, so I will not get into this except 'JIMTEF' program. The Japan International Medical Technology Foundation (JIMTEF) provides group training and individual training programs in 14 different medical-related areas including PT and OT. The slide shows the numbers of trainees in different areas and, so far, 20 and 55 for OT and PT overseas trainees came to Japan and worked with Japanese therapist in various clinical settings as grass-roots international cooperation. Even though there are some issues to be reviewed for better programming, these schemes of grass-roots involvement of Japanese practitioners are to be enhanced more actively along with rehabilitation related NGOs activities.

In summary, JICA and Japanese NGOs have been working in a variety of different international cooperation activities in the field of rehabilitation. However, it is not rare to find projects and programs are being implemented along with Japanese bureaucratic sectionalism which may cause less interested and/or scattered interventions. The things are not working effectively together in a counterpart country. To avoid these pitfalls

there must be a strategy to review and share overall perspectives among Japanese donors involved with rehabilitation related activities in regard to what would be the desirable and realistic outcomes in terms of comprehensive and sustainability of total rehabilitation processes.

Formal education of rehabilitation professionals and human resource development of non-professional CBR workers or empowerment of concerned people needs to take place hand in hand As Mr. Chapal Khasnabis, WHO technical officer, pointed out that CBR needs to be a comprehensive model encompassed with medical, social and human right models, the same comprehensive approach should be taken in strategies of human development.

It is my personal impression that WHO's CBR policy led to some misunderstanding and/or promotion of less emphasis on experts training; even it did not intend to do so. Specific concepts and how that can be translated into practice will be transformed along with time and situational changes. I think there should be some modification on CBR policy and strategies to include professional education and provision for facilities. I believe the developing countries require the knowledge and skills of experts more than any other countries, so international cooperation should place focus on both sides of human development. Thank you very much.

Cooperation between Japan and China from the Establishment of China Rehabilitation Research Center till Present

Dong Hao
Vice Director
China Rehabilitation Research Center
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International experts, ladies and gentlemen, good afternoon. Today, especially for Chinese people is traditional New Year's day, so I am excited to send my best wished for all of you. Good luck and happiness!

When we look back at the history of rehabilitation development in China, we definitely owe it to the cooperation with the Japanese government, JICA and the International University of Welfare and Health and Nihon Rehabilitation College. In the last century, 1985, Mr. Deng Pufang, the chairman of the Disabled Persons Federation, visited Japan for a friendly visit to implement the volunteer assistance to the China Rehabilitation Research Center. At that time, a close relationship between China and Japan began. We will never forgot those passed away seniors, Mr. Tsuyama and Mr. Hatsuyama who made extraordinary contribution to development of the rehabilitation cause in China. We thank old friends, Mr. Nihei, Mr. Kimura, Mr. Iwaya, Mr. Eto and so on. We thank the young generation from Japan who are now working hard for the rehabilitation cause in China.

JICA aids program to CRRC from 1986 to 1997 with the purpose of helping China to construct the first comprehensive rehabilitation organization for the disabled. This is the signing ceremony for the first project in 1986. At that time, China had not got one rehab center, so the Japanese government provided volunteer assistance. 3.3 billion Japanese yen, it was a very big free economic aid. It was composed of architecture, equipment and rehabilitation medical apparatuses. These are all the photos are the reminder and memory of the outset of close cooperation under the chairman of the Disabled Persons Federation, Deng Pufang.

In this picture we can see in the south part of Beijing, this is just farm area, the Japanese experts come on the construction field, Tsuyama-sensei and Nihei-sensei. This is the construction site of CRRC. Altogether more than 170 persons, Japanese experts, come to China to train our staff. At that time, in Beijing we have a Sino-Japan Friendship Hospital and in the hospital enlightenment education for rehabilitation medicine began. Mr. Nihei at that time was very young, maybe 50 or 30 to 40 years old.

Mr. Tsuyama, yes, it was 1987. It was three training classes, the Chinese are trainees. This is the graduation ceremony for the first class for rehabilitation medicine. We not only introduced the rehabilitation concept, we also introduced rehabilitation equipment and apparatuses from Japan at an early time last century. These are the trainees. In this picture, I think there are a lot of teachers from NRCD, maybe someone in this seminar. The awarding certificate of completion. Meanwhile, tens of staff from CRRC were dispatched to the Japan training program. Here is a picture. Our staff came to Japan. This is a cultural program.

In 1988, China had its own China Rehabilitation Research Center. At that time, we could establish the China Rehabilitation Research Center. Everywhere were vegetable fields. This was a gift from the Japan National Rehabilitation Center. Sino-Japan to join hands to promote the rehabilitation. We hung this character on the wall of our meeting room. We regard it as a great goal to cooperate with our Japanese friends. Yes, we should have a congratulations. This is Mr. Hatsuyama and Mr. Nihei. The lady is the director of the CRRC at that time. When the China Rehabilitation Research Center was established, it worked as a technical resource in the development of a rehabilitation course for disabled persons in China. It was also the training base for nationwide professionals. It also acted as a demonstrative role in the national exchange. Up to now, the construction area of the CRRC, about 10,000 million square meters. We have about 1,100 staff. In CRRC, we have the Boai Hospital, the Rehabilitation Medical College, we have the Social Service Guidance Center, Institute of Rehabilitation Information, Institute of Rehabilitation Medicine and also an Institute of Rehab Engineering.

This is our team model. This is the Rehab Medical College, Information Institute, Medical Institute, Engineering Institute and the Social Service Guidance Center. You know, in China, we have a national center but with a shortage of rehabilitation professionals. I heard that in Japan you have more than 100 PT schools, but in China we have not got even one. We just train rehabilitation professionals in the medical university. They just occupy a tiny part, so the start phase of the JICA project began. From 2001 to 2008, JICA phase 2 project began. The project created a precedent four-year undergraduate education program of rehabilitation in China. Most of our teachers were from the Japan International University of Welfare and Health. The goal of the phase 2 project was to cultivate a group of backbone teachers in China and then we designed a curriculum for PT and OT, which integrated well with the international curriculum.

Three, compile and add to the first set of textbooks in China in rehabilitation. This picture is a professor who is giving a lecture, Mr. Maruyama, Prof. Sugihara, Prof.

Fujisawa, Prof. Nanu. We had the first set of textbooks for education in rehabilitation. More than 19 persons of our staff were sent to Japan. Six of them got a postgraduate degree. Now, we have a basis of education for a diploma. We have an undergraduate training, we have a postgraduate training, we have a doctorate training and post doctorate raining. In 2006, this picture is through a JICA similar conference. Mr. Akai, he is the chief expert in this conference.

Yes, we do cannot forget old friends. We created an Old Friends Visitor Center. Mr. Nihei, Mr. Eto, Mr. Kimura, she is Mrs. Asai and Mr. Suyama, they visited our center. For phase 2 of the JICA project, altogether 38 Japanese experts have been received to CRRC. By joint efforts of Japanese and Chinese experts, this program proceeded very well and made a great achievement.

Also, we made a great achievement in the rehabilitation in China, but in China the economy grows fast, but it is unbalanced. We have a National Center, we also have more than 30 provincial-based rehabilitation centers, but in the provincial-based rehabilitation centers, we have not got enough staff, we have not got enough professionals, so we have a third phase JICA project. At present in China, disabled persons occupy a very large population, more than 80 million with disabilities in China. Professional rehabilitation doctors and therapists are badly needed. There is a great gap between rehab and treatment in different areas. Also, recognition of rehabilitation is not so high compared with Japan.

In 2008, we began the third phase of the JICA program. The training program for Chinese rehabilitation professionals from the middle and western regions of China from Beijing used the distance education network to Chongqing to Shanxi to Guangxi. We believe that the implementation of this program will greatly improve and promote the popularization of rehabilitation knowledge, rehabilitation professional training in the whole country, especially the middle and western regions of China.

Actually, we have a long complete history with JICA and also we want to radiate it to other places, Shanxi in the Northeast part of China where the development is not so high. Guangxi and Chongqing are in the East part of China. The population with disabilities is also a large population. This is a program planning conference with lots of experts from Japan. This picture shows the Japanese experts in our center working. This is my first time here three years ago, I visited the National Rehabilitation Center. Also, for the phase 3 project, our leader Mr. Lee and our leader delegation visited the National Rehabilitation Center. I remember this was an exciting moment because it was the first time that this distance education network successfully got connected. This is the

Japanese coordinator. These are the loaned experts from Japan, Ms. Fujisawa from Japan. This is the distance education system.

By now, nearly 20 experts of rehab education and network administration of this distance education have been dispatched to CRRC to get instruction. Introduced by Mr. Tsuyama, previous president for the Japan National Rehabilitation Center for Persons with Disabilities, the cooperation between CRRC and the International University of Health and Welfare headed by Mr. Takagi, the first program is the satellite, the Sino-Japan Remote Rehabilitation Medical System. We use this medical system and we can hear the seminar, we can case-study and do training programs. This was in the middle of the 1980s. This is the opening ceremony. We also dispatched students to further their studies in the International University of Health and Welfare in Japan. We also hosted academic conferences with the Department of PT of the International University of Health and Welfare. This is the first academic conference for PT in the China Rehabilitation Research Center. This is the fifth. Students from the International University of Health and Welfare also were in practice in CRRC. From 1997 to now, nearly 120 students in nine groups came to CRRC to have clinical practice. The students in the PT Department in our center, pediatric department. This is the traditional Chinese herbal medicine, visiting the Beijing massage hospital. These are the Japanese university students after the get-together.

From 2002 to 2007, cooperation programs for exchanging talents had been conducted between CRRC and Nihon Rehabilitation College. Numerous teachers and students were dispatched to CRRC to practice. Five to eight staffs of CRRC were also dispatched to Japan to visit and the Sino-Japan friendship got promoted through various activities. This is the Nihon Rehabilitation College. This is our center.

This lady from Japan, Mrs. Kato, she is an editor in Japan. Every year, she went to the China Rehabilitation Research Center and donated some apparatuses and maybe some money to the disabled children. She is a respectable lady, Mrs. Kato. She is herself a disabled person. We always moved.

We also have a very friendly communication with Japanese organizations, such as welfare aids. This picture shows a cooperation program with Japan Bobath Memorial Hospital. From the last century, the 1980s to now, the China Rehabilitation Research Center received great help and support from the Japanese government from the beginning. A lot of the Japanese government officials visit our center. Ms. Ogata, the president of JICA, visited our center.

Actually, 20 years have passed. We began from introducing the rehabilitation concept from Japan and now we are cooperating with the Japanese, with the Norwegians, with

the America people, with Germany, etc. We believe that rehabilitation in the world has a prosperous future and cultivating of the rehabilitation talents is always a significant part in our cooperation.

China has a large number of persons with disabilities, which offers a large amount of samples for rehabilitation research. Therefore, further international cooperation, especially in related fields of evidence-based rehabilitation medicine, is very bright. As we know, China has traditional Chinese medicine. In the Western world, they call it alternative medicine, such as herbal medicine, massages, acupuncture and so on. We would like to share this and work together on it. Thank you.

A Plan for International Collaboration in Rehabilitation Service and Research

Hur Yong
Director
National Rehabilitation Center
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Thank you for the kind introduction, Mr. Suwa. As in the order, I will be the last presenter. And it is my honor to be the very last presenter of the day. The National Rehabilitation Center has not experienced collaboration with other countries, so I would like to introduce my situation of the PWD in Korea and introduce our NRC in Korea and future plans on how to join international collaboration.

Before I talk about my topics, I would like to briefly mention the needs for international collaboration in the rehabilitation field.

First of all, international collaboration enable to share the worth and importance of rehabilitation. Second, it may enable us to teach and learn from others' successful rehabilitation experiences and programs. Third, these cooperative activities will help us establish some kinds of international cooperative entity or system.

We define the PWD as a person who has a significant limitation in everyday living because of physical, mental or functional impairment. By this definition, the number of PWD reaches about 2.2 million in Korea. It is about 4.6 percent of the entire Korean population. This number has steadily increased because of the number of the elderly population growing rapidly. Korean already entered an ageing society and lifestyle-related diseases increased. The categories of disabilities defined by the Korean Disability Law have kept increasing for the last couple of decades. In 1989, there were only five disability categories, such as upper or lower limb impairment, visual impairment and so on. In 2000, another five were added, such as brain disorder, autism, mental disorder and so on. In 2003, those last three disability categories were included aging, respiratory organ disorder, liver disorder and so on. This graph shows the number of PWD from 1989 to 2008. As you can see, the number increased rapidly during the period. The number in 2008 is about 12.7 times greater than that in 1989. This graph shows the number of registered PWDs by disability type. The highest is upper and/or lower limb impairment.

Several disability laws have been enacted in Korea like this. In 1981, the Welfare for PWD Act. In 1990, the Act of Employment Promotion for PWD. Recently, the Special

Law for Promoting Purchases of the Products Produced by PWD in 2008. Korea's disability policy also has been developed. The first period of disability policy development was a five-year plan and began in 1998. The second one was 2003 and the third one began in 2008.

The plan's ultimate vision is to promote the integration of the PWD into society. The 58 agendas are divided into four areas: 15 agenda items are related to improvement of disability welfare service, ten are about the promotion of economic activities of the PWD, 16 agendas are concerning improvement of education and cultural activities for PWD, and last, 17 agendas are about increase of PWDs participating in society.

This is the picture of the NRC building. This is an overview of the NRC organization. As I said, there are three major divisions. They are the Rehabilitation Hospital, the Rehabilitation Research Institute and the Rehabilitation Educational and Administrative Services. The vision of NRC is " To faith in our Potential and NRC will be with you". We have three strategies. They are (1) made-to-order rehabilitation training, (2) deliverance of best rehabilitation medical service, and (3) ensuring a happy life for PWD through rehabilitation research. We have a number of special rehabilitation programs as follows. For example, daytime rehabilitation training, community-based rehabilitation, disability prevention education and so on.

The NRC is planning and leading Korean CBR projects. The number of local area centers participating in the CBR projects has steadily increased over the last decade from 16 in 2000 to 45 in 2006. The CBR projects are involved in health promotion, medical rehabilitation, family support and social participation for home-dwelling PWD. It has been only about 20 years since the Korea began its first CBR projects. Between 2000 and 2009, the nationwide CBR project began. From 2010, we are going to begin the new approach to CBR recommended by the WHO's new guideline. We are planning to apply the comprehensive approach to CBR project using the new WHO guideline. First, extend the local CBR project further throughout the nation. Second, develop a CBR model reflecting characteristics of local communities and we will continue to make efforts for international collaboration through getting involved in CBR projects for developing countries and personnel exchanges. Last year, Korea joined the Development Assistance Committee (DAC), so in the level of MIC in Korea, we prepared something on how to prepare the international collaboration program.

Now, I would like to introduce the NRC Research Institute a little. The NRC Research Institute opened with three departments in November 2008. The major accomplishment was 18 research projects, five trial products and seven patent applications and we signed the Memorandum of Understanding with many research and

educational institutes in and around the country. The five trial products are a post-motorized easel, an elbow-assistive robot system, a pulling exercise system and so on. This motorized easel is to help mouth and foot painting artists. Disabled assistive robotic system assists spinal cord injury patients to move their elbow at their desired angle. The pulling exercise system allows patients to mimic the intact arm movement. Using these motor motions, the spinal cord patient can exercise their lower bodies as well as their upper bodies. By this wheelchair-based weighing device, wheelchair-bound PWD can measure their body weight. The NRC supported developing countries, such as Bulgaria and Colombia to build their own rehabilitation center and transferred our programs. Moreover, we had a number of international seminars and conferences.

We are considering plans for more cooperative international activity. First, we have several special programs, such as early return-to-society program, CBR program and disability prevention program. We are willing to transfer it to any international community that is interested. We may be able to provide the technological support and train visiting rehabilitation professional from other countries. Also, we want to extend our international network through scientific and personnel exchange across countries.
Finally, to promote international collaboration, I would like to propose as follows. First, multi-country investigative reports concerning disabilities and rehabilitation. Second, technological cooperation and personnel exchange. Third, cyber programs for rehabilitation expert training. And last, regular international workshop.

Now, I will show a couple of Korea's winter views, snow-covered Korea is really beautiful. This is the royal palace, the so-called Gyeongbokgung, located in Seoul city. This is one of the most Buddhist temples in Korea called Bulkuksa. I appreciate your attention. Thank you.

Panel Discussion

Panel Discussion

Moderator Kawamura*:* We will now start the panel discussion: Future prospects of international cooperation. Let me introduce myself. I will be the moderator for the panel discussions. My name is Kawamura of National Rehabilitation Center for Persons with Disabilities. Future prospects are the topic for exchange of comments. To start with, we will spend some ten minutes to hear about JICA. We have already heard several times about JICA in the presentations, so from JICA we will hear from Ms. Miyoko Tawa, Director of the Social Security Division. She will present to us approaches taken by JICA in the field of social security and rehabilitation and future prospects.

Tawa*:* Thank you. Let me start. First of all, I would like to congratulate you for the 30th anniversary of National Rehabilitation Center for Persons with Disabilities and thank you for inviting me to this commemorative seminar today. Today's seminar is being held to think about international cooperation, to develop inclusive society. At JICA, inclusive and dynamic development is one of the visions. All people beyond race, religion, gender or disability, to recognize the development issues they themselves face, participate in addressing them and enjoy the fruits of such endeavors. JICA is trying to give support to such initiatives and to promote development where poverty reduction and economic growth will realize a virtuous cycle. Now, I would like to introduce to you what JICA is doing in the field of supporting persons with disabilities. Looking at the current situation of developing nations, the social security system is underdeveloped and persons with disabilities cannot be educated sufficiently. It is difficult to find job and they are likely to become poor. According to the World Bank statistics, about 20 percent of the poor population of developing nations has disabilities. Without solving the problem or issue of disabilities, achievement of the MDGs will not be possible. Against such a backdrop, at JICA, so that persons with disabilities can join equal opportunity to participate in the society with all the differences they have, namely disabilities, that is our goal. In order to realize social participation and equality, we are trying to take two approaches, namely empowerment of the persons with disabilities, their family members and organizations of persons with disabilities. Another is mainstreaming to incorporate the viewpoint of persons with disabilities for all development aids. In terms of empowerment, this would be support rendered on a rather microscopic level focusing on persons with disabilities and facility members. In this aspect, we would like to render support putting emphasis on collaboration with NGOs.

Also as for empowerment, not just supporting the persons with disabilities, but also we believe that it is important t improve the environment in order to support the empowerment. In the case of JICA, which is involved in inter-government assistance, JICA is very good in these fields, for instance, to develop infrastructure or put into place ministry laws in relation to persons with disabilities. Also in terms of education, to have education systems in place so that equal opportunities can be given for education to the persons with disabilities. When establishing or pursuing the development goals for education, the same goal should be incorporated for the persons and children with disabilities as well. When building structures and buildings with the support of JICA, such buildings should also be developed to make it friendly for persons with disabilities as well. Here are some specific examples of JICA. One is called the Asia-Pacific Development Center on Disability Project (APCD Foundation); another example is the rehabilitation project taking place in Costa Rica. The APCD was established in Bangkok in Thailand in order to empower persons with disabilities of the Asia-Pacific nations and also to promote a barrier-free society. This was established in 2002 to create a society where persons with and without disabilities can coexist. We are collaborating in some 33 countries at the moment. We are involved more specifically in networking and coordinating with the governments and NGOs and also to develop human resources and to give information related to disabilities. In 2007, a new phase of cooperation started and in order to render support to cover those people who were more difficult to cover in the past, such as persons with hearing difficulties or impairment and intellectually disadvantaged people. We are also giving necessary support so that the APCD can become independent and autonomous as an international organization in the future. Led mainly by those who were trained under APCD, organizations of persons with handicapped are being established and there are different approaches being taken in different countries for coexistence of people with and without disabilities. One is in the Philippines to establish barrier-free facilities and also in Myanmar there is cooperation with government and NGO for textbooks dissemination and enlightenment. Also inter-regional community networks of persons with disabilities are being developed and established.

Next, I will introduce to you the rehabilitation project in Costa Rica. This project is taking place in the Brunka region, one of the poorest regions in Costa Rica. In order to strengthen the collaboration of rehabilitation-related organizations, to improve medical rehabilitation service and to develop an environment for people with disabilities finding jobs, to promote CBR and also to empower persons with disabilities. In order to

promote social participation of such people, it started in 2007 springtime. Already two years have passed and already impacts are seen. For instance, in the Brunka region, in terms of the ICF index for persons with disabilities, there have been substantial improvements and people who were trained in this project with CBR, especially those persons with disabilities, are playing a major role. They have established several CBR regional committees in different regions. For instance, in one community, the residents' needs were investigated in order to preserve water resource development locally. All these efforts are leading to the vitalization of the community as a whole, not just limited to supporting persons with disabilities. In closing, in order to proceed with international cooperation into the future, I would like to touch upon a couple of the challenges that we are faced with. Firstly, I just introduced to you two projects which proceeded fairly successfully and we considered what the major driving force was for success. This is collaboration of cooperating organizations and cooperating NGOs and participation of these as well as persons with disabilities, so there is high ownership there. The basic stance or concept for a project is not just to implement given solutions, but it is important to encourage thinking for themselves and work out the actual measures to be taken and approaches to be made. That seems to be effective. However, when the project originally started, because we emphasized so much, the initiative of the counterparts, the activities did not proceed very effectively, but once the counterparts started to have their own initiative and started to learn what they were, the project proceeded very effectively and faster than expected.

The second point, this is also a challenge for myself personally. The outcomes of the project and the impact borne out of projects should be continuous and should develop independently and autonomously. How that can be secured is a challenge. In other words, for instance, an empowered person/individual, how that person can work on other people surrounding him or her and work on the community and all the local governments and spreading all the way to the national level, how such a system could be developed and put into place, that is a big challenge ahead of us. So far, JICA's technical cooperation sometimes tended to be just creating a model and when it came to further development and dissemination, it was left to the counterpart government, but the question is, was that good enough? For instance, the impact of successful projects perhaps could be incorporated into a national policy, so an individual project success could be spread to the local level, regional level and further to the national level. That is the challenge ahead of us. That concludes my presentation. Thank you.

Moderator Kawamura: Thank you very much. You have introduced to us a variety of wide-ranging activities of JICA and you gave a very good and clear-cut outline of your activities. We would like now to get into the discussion. We would like to have a free discussion among the panelists. Then after that, perhaps we could have 15 minutes or so taking questions from the floor so that we have an interactive discussion with the audience at the end of this session. First, we would like to ask President Iwaya of National Rehabilitation Center for Persons with Disabilities to say a few words.

Iwaya: First and foremost, allow me to express my sincere appreciation to all the panelists who made wonderful presentations for this seminar. As was mentioned by Prof. Yamauchi, our center been working in the last 25 years or so covering mainly the scientific part of rehabilitation and governmental field. Against this backdrop, already 20 or 30 years have passed since we started working on international cooperation and now we are facing a hindrance. We try to teach our knowledge and techniques to foreign people, we try to lead professionals in the scientific research. That is the kind of role that we have been playing. This means that internationally we have been leaders and the technology of the country of Japan has been providing contributions to developing countries. However, the kind of technologies that we have may not in line with the needs or demands of the developing countries. We are now looking back into what we are doing right now. We have to question ourselves as to whether what we are doing makes sense or not. That is the reason why we are inviting from all over the nation and from abroad to think about this. Since last year, we had several opportunities to meet Mr. Chapal Khasnabis who has been quite active in the field of CBR and we have learned a great deal from him about the CBR concept. We are providing support and assistances to PWD. In what way we, non-disabled persons, are able to be involved in CBR movements based on the social model? In that respect, we were able to learn a great deal. His presentation was very good food for thought. Last year, we saw a change of the national government and within the national government there is a new entity which is responsible for the establishment and planning of the measures for the people with disabilities, so a new discussion is now taking place in order to have new initiatives for people with disabilities.

Experts from China and South Korea and most of the participants are the professionals of medical fields. We recognize the importance of the social model theory, but we believe the medical model should be incorporated in CBR. The medical model is considered to be rather outdated. In some cases, we are told that we are outdated and this is a very uncomfortable situation. I myself have been feeling uncomfortable living

in the era of the situation where people look at us as outdated society centering too much on the medical model. But now, we are very much relieved to know the tricycle, which was introduced by Mr. Chapal, to the fact that we have the medical model, social model and also the human rights model. In order to have an inclusive society, we have to have the collaboration of these three aspects. We have to have an intertwining relationship between these three parts. I was very encouraged to know the new concept introduced by Chapal-san. Then, in what way should medical professionals and medical rehabilitation specialists be involved in the CBR? In what way are they able to make contributions to the CBR? That is the kind of question I have. In whatever situation, the important strength of the medical model is that it is very logical, so being logical is about looking at the disability or the state of diseases in a very logical manner. Explanations can be made in a logical manner. This logic could be a basis for the creation of the national policies and starting of the project. Utilizing that kind of good point of the medical model, we could make a contribution. The medical model would not be a central actor on the stage, but rather the medical model could be a supporter which would not be on the stage, but behind the stage. That is the kind of thing we can do. That is the impression we have at this moment in thinking about the new model.

Today, fortunately, we have visiting experts from the Chinese Rehabilitation Center and the South Korean Rehabilitation Center. In the Eastern Pacific region, including Eastern Asia, Japan, Korea and China will be the leaders, so we are almost able to say that we are advanced nations altogether and we would be able to play a role. Certain responsibilities should be exercised by these three countries. This is my renewed impression listening to your presentations. That is my entire impression reflecting on the current situation and the presentations that were made. Allow me to once again express my sincere gratitude to all the speakers.

***Moderator Kawamura**:* Thank you very much. Ms. Tawa earlier discussed issues related to JICA. The major pillar here is participation to society and the alleviation of poverty, which should result in having jobs, so the opportunity of employment should be the final goal. This is a social aspect of the activity. Now, Dr. Iwaya talked about the roles of CBR in rehabilitation. We do have the medical model as one pillar within CBR, so there should be some role that is played by the medical model or medical entities. But, as was mentioned by Mr. Chapal, we have to involve multi-stakeholders. All the parties involved, all the stakeholders involved should be able to collaborate with each other for the persons with disabilities. This is where we are able to find solutions, so all the parties or all the stakeholders can participate with each other in symbiosis. We are

able to be there together making a contribution on their own. About this issue, could you make a comment? We would like to seek for some comments from the panelists. Chapal-san, would you like to make a comment?

***Chapal**:* Thank you very much. I think the question and answer, both have been given by Dr. Iwaya because he asked first, how the medical model or medical professionals can contribute in CBR. In the later part he said that the medical part can support the social model, so the question and answer are there. I really do not know what more to add. What I think what is important is that the medical and rehabilitation professionals have to look to a disabled person more as a partner and involve the disabled person in the decision-making process, instead of them making all the decisions about them. If we change our attitude a bit, I think we will cross big hurdles and the problem is that what I am saying sometimes we face a situation where there is a disabled peoples' group on the North Pole and the rehabilitation professionals are on the South Pole. But both are working for the same goal, but their approaches, their understanding and experiences make it different. We are in this new millennium where we have more education, more knowledge, more learning, so we should make use of those and see how we can work together for the same goal. A little bit more of a closer approach. If you have seen the CBR guidelines, before there was a lot of overlap and confusion, but what you can do, I cannot do and many disabled people will not be able to do. Everybody has their areas of expertise, so we have to see how we take benefit of these areas of expertise for a common goal, which is a better quality of life for everybody, disabled and non-disabled.

There is another area that we have to understand. If you see the global disabilities movement, it is mostly led by a group who has been affected by some disease in their early life when the health sector was not developed well. If you look at the average age of this movement, that movement group is also aging. The whole aging will take over this disability paradigm, so we have to understand that the same blind group that we see now or the same polio group that we see now in the center stage of the disability movement, they will not be here tomorrow. Tomorrow means 20 to 30 years down. We will have more elderly people with some kind of chronic condition. The only young people we will see more are those with spinal cord injuries, road traffic accidents. But we will have a lot of people with chronic conditions, diabetes, cancer, cardiovascular diseases and age-related impairment, so we have to really understand that everything is changing and if we do not change our attitude and our approach, the only do we become obsolete. But if we really keep the pace with the time and with the changes, then we will always stay a step ahead. That is where I think the future is taking us. We have to look

at disability in a larger perspective. We have to see disability also in connections with aging. I think that is a big issue if we do not deal with it now. We will have a bigger problem in the future.

***Moderator Kawamura**:* Thank you very much. We would like to take some more comments from other panelists. I think you are sharing one another. How about Mr. Nakamura?

***Nakamura**:* With regard to CBR, what kind of role the medical specialists are needed for or asked to play. Like the president mentioned, as Mr. Chapal's said, it is not that whether it is one or the other between the medical model or the social model. Instead it depends on disease type or the context, the percentage will change, but all the factors are all necessary. I truly agree on this idea. In practicing CBR in Syria, we have the cases where medical judgments or medical rehabilitation, typically physiotherapy, are indispensable. Even though we ask the power of the volunteers, there are some aspects where the volunteers are not enough to cope with. Medical judgment is necessary to judge whether this or that particular case is difficult enough to need professional medical rehabilitation. Otherwise they will lose the opportunity to take appropriate rehabilitation. Therefore, no matter how much we say that CBR is rooted down to the local community, we need to have external resources of professional medical knowledge and skills.

I do not know what will take place in Syria in the future, but if the government will propel CBR as a country, they need to develop in parallel those who have professional rehabilitation skills.

***Moderator Kawamura**:* Dr. Dong, how?

Dong: When we are talking about the CBR, we have faced the same problems. Maybe IBR is easier than CBR systems. For China the government pushed efforts to set up CBR systems, but the problem is that we have not got enough professionals. I think the problem exists in developing countries and developed countries. Just in the presentation, I mentioned that distance education maybe we can use it as an initial program in international cooperation. As I have heard, in Japan some universities have an Internet-based education system. In China, the JICA phase 3 project is going on to set up a distance education system taking advantage of the Internet. I think maybe we can use this Internet-based distance education system to connect the separate countries. Maybe this is one of the methods to educate not only professionals but also the disabled

persons themselves. Maybe this is the key problem in setting up the system of CBR. Thank you.

***Moderator Kawamura**:* Thank you very much. You raised a very important point, Doctor. Previously, in Ms. Tawa's presentation there was the keyword of ownership. She highlighted that. That the project needed to be independent and for that to be sustainable, the audience needs to have their own ownership and that is very important. Dr. Dong Hao now mentioned that including people with disabilities, of course regardless to say the professionals, but also people with disabilities need to have the distance education utilizing the Internet to share information and education. On top of that, the necessity of human development for the CBR and also the common information of CBR will be accumulated. In the future, some international cooperation, I think that the Internet or distance education utilization are important. I think that was your message. Everybody can incorporate. Everybody can join to make decisions and the ownership will be shared. I think we can see the cycle running here. For this point, from Korea, Korea is a very advanced country in terms of the Internet. That is what I have heard. Dr Yong Hur, could you please tell us about the future vision of Korea in this aspect?

***Hur**:* I think the CBR project is very difficult and there are many problems to extend in our country. As you know, the paradigm of disabilities changed very rapidly, but we do not forget that in spite of our rapid changing paradigm, we think about developing countries and OECD countries separately. Most of all, the new WHO guideline points out strongly especially the social model. Most developing countries still need only medical service. When we do international cooperation, we must decide what the priority project in their own country is. Of course the rehabilitation problem is very important, but in Korea's experience - I told you about the Korean situation - although nearly 20 years have passed, still a nationwide CBR project has not been set up, If we want to collaborate with developing countries about CBR project, we must consider what the priority project is. Thank you.

***Moderator Kawamura**:* Thank you very much. I would like to ask Ms. Tawa once again. JICA and connecting through the Internet to many conference, like TV conference, I know that JICA is utilizing these Internet devices and international cooperation and especially in the persons with disabilities field, ICT utilization, IT utilization, what are you thinking about this matter?

Tawa: Thank you for your question. Going back to the presentation that I made earlier. I talked about the indicators to measure the quality improvement of life of the people living in Brunka. There has been transfer of technology based on the ICF principles in the Brunka community centering around professionals of medical rehabilitation. The Brunka version of the checklist or the indicators for the measurement of the quality of life improvement, so for the medical rehabilitation facilities, they use this common checklist as the indicator for the quality of life. They are written in Spanish, but the translation was there and I took a look at it. For example, for ADL of the in-patients and also other patients, for example, the dressing and toileting and others. All these are measured and the periodical measurement is taken using that indicator or the index system. This way, they are able to have some more appropriate intervention or assistance for these individuals. This is done in a partial basis, but still this is gaining momentum. That is why I use the term effectiveness for that project.

Moderator Kawamura: Thank you very much. Dr. Iwaya, please.

Iwaya: I would like to ask Mr. Chapal, today our senior, Mr. Sasada had wonderful activities in Malaysia. He reported to us on his activities in Malaysia. As for in the medical rehabilitation arena, the traditional medicine and its methodology can be utilized more. That is what I think. It is because it is based upon Western medicine, such as the technologies and systems that are very expensive. The Eastern medicine service would be the basis of the Western medical offering. If we were to have real CBR in place, then it could be in the rural area where no specialists exist. By offering this traditional medicine, I think we can utilize more opportunities on CBR. I know that the WHO has published a book on this matter. Chinese medicine in the WHO, how are they thinking about developing the traditional medicine or the Chinese medicine? I would like to hear the idea of the WHO on the future vision on traditional medicine or Chinese medicine.

Moderator Kawamura: Mr. Chapal, please.

Chapal: Before I go to Dr. Iwaya's question, I would also like to make a comment on what Dr. Dong Hao has said about distance education. If we want to cover the whole of China with CBR, I do not think that there is any alternative to distance education. We are seriously considering that kind of developing training package which people can use over the Internet to learn CBR. Also, in case of difficulties, they can refer with their peers again using the Internet technology. We have tried this in the prosthetic/orthotic

sector quite a lot and we have had quite a good success, so we are really waiting on these guidelines to be out because before we go there we have to develop a good training package. Only once we develop a good training package, then we can think about digitizing and doing it through the Internet. It is our long-term dream and I would be very happy to work with Chinese and other counterparts here to develop this further, because if we do not take advantage of this ICT, I think it would be a great crime, because there is no other way we can cover China or even India in real terms. So, I am very happy with your point.

Now, traditional medicine. You know in the WHO, there is a big department on traditional/alternative medicine and at most of the World Health Assemblies, a huge debate takes place whether WHO should promote or not promote it. The biggest resistance comes from the medical community. CBR is community-based, CBR is context-based, and CBR is culture-based. That is why we respect and we believe in this. And in the CBR guidelines, we mention the role of traditional medicine and alternative medicine, In many countries, specialists of traditional/ alternative medicine are the only people who are accessible. In many African countries, they are the only people who can set the bones in fracture. The issue is should we stock ban everything without finding the alternatives, or we do their capacity building so that they do their thing in a right and better way. This is a huge debate and it will go on and I do not see any immediate result. The only way to break this is that medical professionals, people like you all, if you all promote, it has the most chance of inclusion. But if it comes from the non-medical professionals or traditional medicine group, then it will never happen. Because I am particularly interested in this subject, I attended a discussion during the World Health Assembly and all this is a very hot issue. I believe in it, WHO believes in it and there are still a lot of efforts to include this, because in many places those are the much better solution.

Moderator Kawamura*:* Thank you very much. Now from the floor, if you have any questions or comments, or if you have any inputs. You might want to say something. To help the discussion from here on, if you have any questions or comments, could you please raise your hand? Right. Now, not just from the panel members, but also we would like to involve the floor for the discussion. In the order of those of you who raised your hands, so the first three people who raised their hands, please? Please wait for the microphone.

***Inoue**:* My name is Inoue, Research Institute of National Rehabilitation Center for Persons with Disabilities. Mr. Chapal, I have a question to you on the issue of the elderly and the big emerging problem. The aging issue, the elderly issue and the disability issue should be considered together, as it was pointed out. Recently, I have started to worry about the aged society and something bothers me. What you presented today, centering on the empowerment concept, the concept of rehabilitation, when you think about the aged society, will it work? Will that model apply for the aged society as well? If you could care to comment on that, persons with disabilities and people who are old. In the case of elderly people, they are closer to death and on their way to dying, so can we take the same approach or use the same concept for the elderly versus persons with disabilities.

***Moderator Kawamura**:* Mr. Chapal, please.

***Chapal**:* If you have seen in one of my slides, it said that CBR is a flexible, adaptable strategy and very context-based. What CBR can happen in Korea, I cannot do that CBR in Pakistan or in Yemen. Everywhere it has to be different because it is context-based. But CBR is a strategy. The strategy is that it should be people-centered, people-controlled, people-owned. It should not be externally imposed on people. These are the fundamentals, so even if it is an older population, if you want to do CBR, it should be older people-centered. It is their design, their own, they are participating. You have to really modify, you cannot copy the exact CBR of disabled people for the older people. In the CBR guidelines, this is a problem we have. That we have given a lot of case studies and examples, but we have written in the very first line that all these case studies and examples are just to give some ideas. Please do not copy it without contextualizing it. Okay? The copying makes all the mistakes and problems. If you want to try CBR in the elderly population, you have to modify it a bit. Suppose that if I do a CBR in Syrian villages and in Damascus, there will be some difference. The CBR I will do there or in Korea, Seoul, there will be some difference. That difference only we have to recognize and understand and with our knowledge and skill modify and adapt it accordingly. Then it will work. Otherwise, it will not work.

***Moderator Kawamura**:* Dr. Inoue, are you satisfied? Ueno-san, I think. Can you identify yourself please?

***Ueno**:* I am Ueno of Japanese Society for Rehabilitation of Persons with Disabilities. I have a question to Dr. Yong Hur and Dr. Dong and also Mr. Chapal, if you have any

comment later. Dr. Iwaya presented some issues earlier on and as he pointed out, the role to be played by professionals or experts in CBR, from that viewpoint, different approaches have been taken with different histories. We discussed a lot about what experts should do, how professionals should be. Mr. Chapal talked about community-based. You showed many examples of that. Within the communities CBR is to be practiced. That was the main emphasis point, I think. So, professionals versus persons with disabilities or non-disability. It tends to be somewhat of a dichotomy, but if you take a community-based approach, sometimes you must go hand in hand together toward the same common goal. I think that is another possibility as an approach. Dr. Yong Hur and Dr. Dong, in your versions of CBR within the community for the people with a variety of problems, what approaches are you taking? And how do they approach persons with disabilities? If the time allows, please I would like to ask Mr. Chapal to comment as well.

Moderator Kawamura*:* Thank you very much. Dr. Dong Hao and Dr. Yong Hur, either of you. Dr. Yong Hur, please.

Hur : Thank you. I agree with your point on what is the importance of community-based. As I pointed out, in our Korea project, it is not so extended nationwide as I think in spite of nearly—it takes ten years. I think in my opinion, the weak point is that there is not enough infrastructure in the community base, so I try to make infrastructure in the nationwide level. You need some nation wide projects, but there is very limited support about that. We changed, NRC did. This year, 2010, we will start five primary public health centers for the pilot project in CBR, of course, which will be fully supported from our NRC without government-level approved budget. This is just the NRC-level. We will try to have five public health centers as a pilot project. Of course, we handed out some manuals for CBR projects and held a workshop, so we make a standard model of the CBR project in Korea. I think for the successful CBR project, the most important thing is infrastructure in the community base and we must consider the characteristics in the community base. Especially in Korea, we have interests in dwelling PWD. Several projects contain that, but the most important thing is anyway community-based handling the relationship. Thank you.

Dong*:* Thank you. Just as Mr. Chapal mentioned, the community-based rehabilitation is flexible. Copying may make mistakes. In China the things are different. First, to set up a CBR system, we need an idea or knowledge. Even in the clinical context, some

doctors do not understand what community-based rehabilitation is. Some of the government officials do not understand what CBR is. That is the problem, so we want to set up the system. First, in China, we should teach the government officials. We need the guarantee of the law first. Then, we need the technique. The technique from professionals. As I said, in China there is a shortage of professionals in rehabilitation, so to solve this problem we need to put more efforts to enhance our education system in rehabilitation. Third, I think the insurance policy is very important. In the recent five years, China began an insurance reform, not as Japan. Not every Chinese person has medical insurance. Just in the recent five years, the government put forward to enable that everyone had medical insurance. But actually the commercial insurance did not cover all fees of rehabilitation. That is a problem. We also need to teach and tell the insurance companies that some expense in rehabilitation needs to be covered by this system. In China to set up CBR is not the technology, it is also the conception, the idea, the knowledge and it needs the policy support.

Moderator Kawamura: Thank you very much. Mr. Chapal, would you like to make a further comment?

Chapal*:* No, thank you. I will be happy if China can come forward in the near future to plan a national training workshop or national workshop to sensitize the professionals and key government officials on the importance and benefit of CBR and then really come up with a national CBR plan. If that kind of request comes from China, I am sure we, from the WHO side, will do our best to support that kind of initiative.

Moderator Kawamura: Thank you very much. Someone over there behind Ms. Ueno. Would you please identify yourself?

Suzuki*:* I am from the Information Center for Persons with Developmental Disorders of NRCD. My question is for Mr. Chapal, Dr. Yong Hur and the person from JICA. First, Mr. Chapal, about CBR, I plan to ask you a question. First and foremost, thank you very much for your wonderful presentation and your comments. Depending on the social context and the history, we have to have different approaches. We understand that. Now, we have to have the approaches in the different communities and societies. Perhaps each and every community will have to have their way of conducting CBR. As to a strategy on information distribution, I have stayed in Southern Africa and worked for the Ministry for two years, one thing I realized is that there have been huge differences between urban areas and rural areas. In the rural area, it is very difficult to get a hold of

information they need, so there is a divide of information. In the urban area, Internet is effective, so there is information provision, which is enhanced by the Internet in addition to grassroots approaches collaborating with private sectors like NGOs.

On the other hand, in the rural area, then in that situation we can ask, some way of getting information, for example, is to ask for a favor for somebody who is very influential in that village, what we call top-down approaches, could you tell us as to how we are able to provide information to the rural community. Mr. Yong Hur, about South Korea, I am sure that the Internet utilization is much higher than in Japan. The number of Internet accesses is much higher than in Japan. As a national research center, in what way do you secure information for the people with disabilities to get a hold of information? Ms. Tawa, you talked about indices for the enhancement of the quality of life among PWDs. You said that there has been an improvement. In what way have you used the indicators or the indices for the enhancement of the quality of life?

***Moderator Kawamura**:* All right, so if you are ready, please answer. Mr. Chapal, would you like to answer now?

***Chapal**:* I have to, right? She pointed out that I have to answer this. Thank you very much for raising this question. I think that is why CBR is more important and you must have seen in my presentation how putting emphasis on capital-to-community, because you know that most of the facilities' information, everything is in the capital and big cities. The community does not get it. At the same time, I also traveled a lot in Africa and I go there often. In Africa, there is a proverb: when an old man dies, a library dies with him. When an old man dies, a library dies with him. That means that every old man, the village leaders, is like a small library. Africa is a very good rich oral culture, so that is what the strength of CBR is. That if we can identify those local leaders, train them, inform them, give them the information in the local language, not in English and not through the Internet, then it will go to the people. We also use a lot of mosques, churches and other religious festivals and meeting points to spread this message. This is the only way those areas you can reach quicker. Our challenge is actually to keep this CBR guidelines translated in as many languages as possible. Also, we are going to tape it, so you have an audio version. Although our major aim is for the blind people, but it is for everybody. Even if they do not have the book at hand, they will have the whole tape in their hand. There are different options we are taking, but the success of the CBR guidelines will depend on whether we can reach the community or not. It is not whether we can reach the capitals and big cities or not. We are taking multi-pronged strategies to

ensure that happens. That is very well written, even in the CBR guidelines to target those village leaders, community leaders, the priest, religious leaders - any leaders - and influence them because they are the messengers of your information. I will try to use them rather than going for the information technology. But things are changing quite fast. In Africa, if you see the proliferation of mobile phones, there are more than in Japan. In Ethiopia, they just changed their phone numbers to ten digits. The people are dying out of hunger, but ten-digit phone numbers. There are a lot of mysteries in this world, so we have to see –and that is why I say again CBR is context-based. You can see what can work in what country and use that to spread your message. Thank you.

Moderator Kawamura*:* Dr. Yong Hur.

Hur : You asked me about IT infrastructure in Korea concerning CBR. Yes, the IT industry is relatively well-developed in Korea, but my personal opinion is that where we apply the tele-CBR projects or tele-rehabilitation is limited in its spectrum. Now we try to help to make a so-called cyber market for our PWD in Korea. Just this year, we started it as a pilot project. According to my staff, it takes about six months for it to be fully set up. When we set up our cyber market, we could enter any place in our country and there is a lot of information about PWD, for example, rehabilitation medical service and assistive technologies and all the administrative service for PWD and so on. We will set up a cyber market of PWD nationwide this year. Thank you very much.

Moderator Kawamura*:* Ms. Tawa.

Tawa*:* Thank you for your question. Going back to the presentation that I made earlier. I talked about the indicators to measure the quality improvement of life of the people living in Brunka. There has been transfer of technology based on the ICF principles in the Brunka community centering around professionals of medical rehabilitation. The Brunka version of the checklist or the indicators for the measurement of the quality of life improvement, so for the medical rehabilitation facilities, they use this common checklist as the indicator for the quality of life. They are written in Spanish, but the translation was there and I took a look at it. For example, for ADL of the in-patients and also other patients, for example, the dressing and toileting and others. All these are measured and the periodical measurement is taken using that indicator or the index system. This way, they are able to have some more appropriate intervention or assistance for these individuals. This is done in a partial basis, but still this is gaining momentum. That is why I use the term effectiveness for that project.

***Moderator Kawamura**:* Thank you. Well, time is running short. Mr. Nakamura and President Iwaya, we would like you to make some further comments. Would you like to make some final comments to conclude this discussion?

***Nakamura**:* Thank you for this opportunity. In what I talked today, the biggest message that I wanted to communicate to you is that we have to focus more on people. It is not necessarily only in the field of CBR but also in doing anything. The most important thing is to empower the people. Some international collaboration initiatives, limited supports are provided for a wide variety of people. However, it is better, I believe, to focus more on the key people. We can identify people who can play a key role and then we can provide support from the government side and the private side through various schemes. As a matter of fact, I worked with officials of Ministry of Labour and Social Affairs of Lao Government before going to Syria. If you work in the ministry, it is very difficult if not impossible to identify people who are the diamond in the rough. Fortunately, I was able to have good cooperation with the Japanese NGOs to develop social welfare human resources in Laos. Also in promoting CBR in Syria, I think we have to look into the key persons such as the persons I presented today, and empower them more.

***Moderator Kawamura**:* Finally, we would like to ask President Iwaya to say a few words.

***Iwaya**:* Thank you. Today I was able to listen to the talks, which were very impressive to me, and I was able to learn a great deal. Looking back, I have to say that I am an elderly person. When I became a medical doctor, senior doctors told me the medical treatment to certain people should be conducted to provide treatment so that that person will be able to function well in the society. Dr. Dong showed the pictures of Dr. Tsuyama and we learned from Dr. Tsuyama that we have to provide support or treat people in order to makes sure that that person will come to society so that that person can function well. But now, looking at the situation at this moment, doctors have different specialties and are fragmented. Within that specialty, they are very good players, but their functions or activities are only limited to their specialty. That is something that I feel a little bit of concern. Looking at the Japanese situation, the treatment will be done in the hospital and then the rehabilitation will be asked to the next hospital. It is difficult for patients with chronic illness or residual disabilities to find receiving pans in our societies, especially in the local area we do not have enough

receiving pans for such people discharged from the big hospital. Nobody will be able to find the solution, so we do have a problem.

Today, this is the meeting for special people in special fields. What I wanted to share with you is that when we move out of our specialties, half step or one step out, we still need to connect with other people in other fields. I think that is important. But in reality, our center has celebrated its 30th anniversary and we need to think about the local collaboration and have a better system to do so. We are also considering the plan, too. Internationally, we need to take a half step out. About the CBR and looking for the inclusive development, we are wishing from the bottom of our heart to have better collaboration in the international arena. Thank you very much.

***Moderator Kawamura**:* Time is up. Today we had quite a long discussion time and flew by like the wind. The topic was to think about the international cooperation in this arena and the central topic is that people with disabilities should join for making decisions and that is the idea of the inclusive society. Just recently, we have free and prior informed consent, so we have to make a decision, but this should be always after the information provision, so that is the prerequisite for the participation. As was mentioned by the President, we tend to have discussion as an expert or the people specialized in certain fields, but one thing that we have to do as a minimum responsibility is that we look at PWDs and their family members and residents of the communities and then we provide the necessary level of information to them, so we conduct the activities so that we are able to enhance their participation based on their agreement. We can have activities enabled by ICT or we can utilize people who are knowledgeable and influential in that area. Also, we are able to utilize people who are very highly respected in the arena in the communities. That is CBR, that is the kind of thing that we covered. We also listened to the future perspective of JICA. Based on this, we would like to have continued discussion in the future. With this, we would like to close this session. Thank you very much. Please give them a big hand.

Closing Address

Fumio Eto
Director
Training Center
National Rehabilitation Center for Persons with Disabilities

Thank you very much. My name is Eto, and I am the director of the Training Center of National Rehabilitation Center for Persons with Disabilities (NRCD). Today we are celebrating the 30th anniversary of NRCD and also we have been serving as the WHO Collaborating Center for Disability Prevention and Rehabilitation for the last ten years or more. Then, on this occasion, we decided to have a seminar entitled "Inclusive Society and International Collaboration".

In the morning session, we had the lecture by Mr. Chapal representing WHO. He shared with us the CBR matrix and the model for CBR. Then, in the morning session, we listened to Mr. Nakamura's activities in Syria and he also taught us as to how we can tackle international collaboration.

In the afternoon, we had five presentations about the international collaboration. In particular, we listened to the presentation by Dr. Dong from the China Rehabilitation Research Center (CRRC). We are very appreciative to him since he said that we have been providing good support for them. We looked at the size of the hospital of the CRRC. It is much larger than that of the NRCD here in Japan. We would like to continue to have collaboration with them. Also, we would like to our appreciation to Dr. Yong Hur from South Korea representing the National Rehabilitation Center in South Korea. He talked about the recent activities in the organization in detail. We talked about the use of the Internet, which was taken up in the panel discussion. Within the National Rehabilitation Center, they are looking at differences in the service in order to deal with the aging society. This is something that we can learn from them getting into the aging society era. Within the NRCD, we also give heed to the graying population.

Then, we had a panel discussion following the five presentations. Mr. Kawamura chaired this panel discussion. With his very good leadership, we were able to have a very fruitful discussion about CBR, what kind of inclusive development can be made was covered. Also, from the floor we received many comments and questions.

At the end of this session, we would like to express our gratitude to the Japanese Society for Rehabilitation of PWD (JSRPD), since we received tremendous support from the JSRPD for the holding of this seminar. Tomorrow the JSRPD will have a seminar for CBR and international collaboration at the Toyama Sunrise . So if you have time, we would like you to go visit that seminar and listen to the seminar.

At this point, I would like to express my sincere appreciation to each and every one of you for spending your entire day for the seminar. I am sure that you are all tired, but thank you very much for your participation.