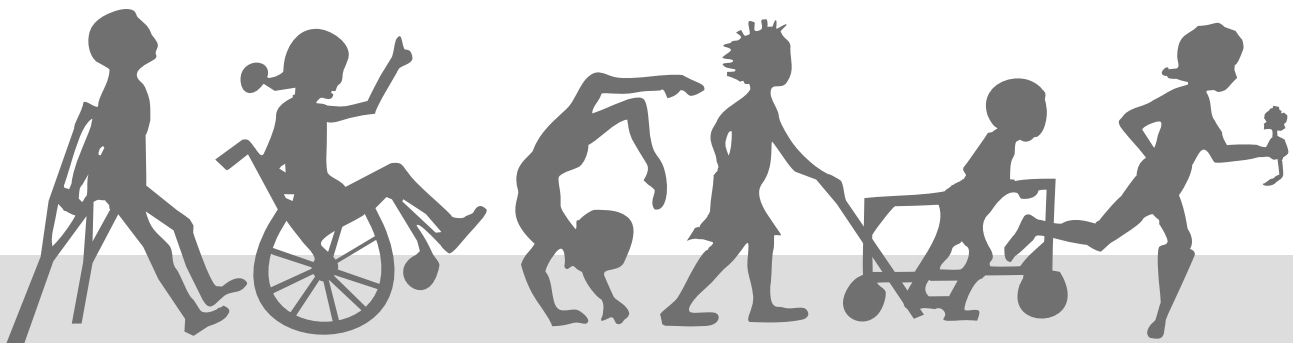


Behinderung und internationale Entwicklung

Disability and International Development



Psychische Gesundheit/Mental Health





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Editorial

Liebe Leserinnen und Leser,

wie hätten Sie diese Schwerpunktausgabe genannt? Mentale Gesundheit und Behinderung im Entwicklungskontext? Oder mentale Gesundheit, Behinderung und Entwicklung? Oder einfach mentale Gesundheit und Entwicklung? Die scheinbar einfache Frage berührt das Verhältnis von Erkrankungen/Beeinträchtigungen mentaler Gesundheit und Behinderung im allgemeinen und im Kontext von Entwicklung(szusammenarbeit). Ob wir mentale Erkrankungen und Beeinträchtigungen mit Behinderung gleichsetzen oder deutlich davon unterscheiden, hängt offensichtlich von unserem Verständnis dieser Begriffe ab. Es hat auch mit der Relation zwischen (chronischen) Erkrankungen, ihrer Stigmatisierung und Behinderung zu tun.

Während den Einen die Antwort leicht fällt, indem sie unter Beeinträchtigungen mentaler Gesundheit v.a. neuropsychiatrische Erkrankungen verstehen und Andere genauso klar Menschen mit Beeinträchtigungen der mentalen Gesundheit gleichsetzen mit Menschen mit Behinderungen, bleiben die Zuordnungen schwierig und bedürfen einer differenzierten Sichtweise. Und wie sind z.B. Epilepsie und wie intellektuelle Beeinträchtigungen zu verorten? Vor dem Hintergrund weiterer wissenschaftlicher Erkenntnisse, sich wandelnden Modellen und Haltungen scheint eine gefestigte Position nicht einfach, zumal sich im Bereich mentaler Gesundheit/Erkrankungen/Beeinträchtigungen die Dominanz des medizinischen Modells, wenn auch im Wandel begriffen, hartnäckiger hält als im Behinderungsbereich – oder sollten wir besser sagen „als im Bereich anderer Behinderungen“? Besteht die Lösung darin, wie in einigen aktuellen WHO-Publikationen, von einem sog. „weiteren Spektrum“ zu sprechen, das „mentale, neurologische und Substanzmissbrauchsstörungen umfasst“? Es kann helfen, sich ein integriertes bio-psycho-soziales Modell (wie in der ICF) zu eigen zu machen, zwischen Schädigungen von Körperstrukturen, funktionellen Beeinträchtigungen und Behinderung von Partizipation zu unterscheiden und sich außerdem auf die VN BRK zu beziehen, in der im englischsprachigen Original festgestellt wird, dass zu Menschen mit Behinderungen auch solche mit „mental impairment“ gehören.

Klar jedoch – unabhängig von unserem Begriffsgebrauch und Kategorisierungen – sind die unerhörten Menschenrechtsverletzungen, die viele Menschen mit Beeinträchtigungen der mentalen Gesundheit selbst in Einrichtungen von Gesundheitsdiensten erfahren, weswegen Vereinigungen von SelbstvertreterInnen nicht nur von „NutzerInnen“, sondern auch „Psychiatrie-Überlebenden“ sprechen. Zugleich hat aber der allergrößte Anteil von Menschen mit mentalen Erkrankungen/Beeinträchtigungen in sog. Entwicklungsländern keinen Zugang und auch keine Aussicht auf Zugang zu psychologischen oder psychiatrischen Serviceeinrichtungen. Wir freuen uns deshalb, Ihnen mit dieser Schwerpunktausgabe Beiträge anbieten zu können, deren AutorInnen sich wenig erforschten Aspekten, partizipatorischen Methodologien und Inklusion im Bereich mentaler Gesundheit widmen.

Wir wünschen Ihnen eine einsichtsreiche Lektüre.

Ihre Redaktionsgruppe

Dear Reader,

if you were to entitle this issue, how would you have named it? Mental Health and Disability in Development? Or Mental Health, Disability and Development? Or just Mental Health and Development? This seemingly simple question addresses the relation between mental health (conditions) and disability and their situatedness in low- and lower middle-income countries and within the field of development cooperation respectively. If we declare mental health conditions as equaling disabilities or as something different, obviously depends on our understanding of mental health (conditions) and that of disability. It also tackles the question how certain (chronic) illnesses and disability relate to one another.

Whilst some people easily find an answer by claiming that mental health conditions clearly are neuropsychiatric diseases and therefore not disabilities and others are clear in their position that a person with a mental health condition is a person with a disability, the matter is not quite as simple at a second glance. Where, for example, shall we position epilepsy or intellectual disabilities? As a review of more than 50 up-to-date publications plus the articles in this issue show, it is not easy to find a solid stance on the shifting ground of paradigms, models and approaches; especially so as the dominance of the medical model is more persistent, yet shifting, in the field of mental health than in disability – or must we now say "than in other fields of disability"? Do we find a way out by turning to talk about a *wider spectrum* which includes mental, neurological and substance-use disorders as currently some WHO publications do? It may help to adopt an integrated bio-psycho-social perspective and to differentiate between impairments, functional limitations and participation restrictions. It may also help to remember the discourse around HIV/Aids and disability.

What is clear, nevertheless and independent of our categorisations and choice of terms, are the outstanding human rights violations which persons with mental health conditions experience – to an extent and also in service delivery institutions in response to which major self-advocates associations suggest to speak of "users and survivors of psychiatry". Yet, in low-income countries the vast majority of persons with mental health conditions never have the chance to enjoy or endure any service provision. Thus we are glad to provide you with articles whose authors respond to some of those challenges and problems by engaging in under researched fields, participatory methodologies and inclusion.

We wish you a gainful reading.

Your editorial board



Violating the Right to Health: How Partner Violence and Disability Undermine Women's Mental Health in Cambodia

Jill Astbury

Women's subordinate social position, poverty and socioeconomic disadvantages are known risk factors for their higher rates of common mental disorders but women with disabilities have often been excluded from taking part in research. Research was conducted in Cambodia on the impact of disability and partner violence on women's mental health. Women with disabilities experienced significantly higher levels of psychological distress than women without a disability and the presence of partner violence further accentuated this disparity. Gender sensitive mental health services are urgently needed.

Introduction

The right to the highest attainable level of health including mental health is a fundamental human right noted in the charter of WHO and many international treaties. Yet the enjoyment of the right to health is far from universal and remains heavily contingent on social position (Marks 2005).

The lower a person's socioeconomic position the worse their health including their mental health (Marmot 2007, Patel/Kleinman 2003, Miranda/Patel 2005). Massive inequalities in health remain both within and between countries (Wilkinson/Pickett 2009, Friel/Marmot 2011). The health effects of the social gradient in health are exacerbated by the differential status of men and women. Gender inequity is pervasive and deeply entrenched in most societies. It is characterised by disempowerment at many levels that denies women the right to self-determination, serves as a powerful barrier to development (Marmot 2007) and undermines women's health in general and women's mental health in particular (Astbury 2010).

Gendered, Social Challenges to Development in Cambodia

Cambodia is regarded as a least developed country and ranks 137 out of 182 countries on the United Nations Human Development Index (UNDP, 2010).

Women in Cambodia, like their counterparts elsewhere in South East Asia, occupy a subordinate position in the culture that impacts negatively on life opportunities, self-perception and mental health (Niaz/Hassan 2006).

The Australian Agency for International Development (AusAID) noted in its report *Australia's strategic approach to aid in Cambodia, 2010-2015* (AusAID 2010) that Cambodia's progress towards its Millennium Development Goals (MDGs) is mixed especially for the MDGs

related to women. No discernible progress has been made on MDG 5 and the maternal mortality rate has not changed since 2000. Cambodia's maternal mortality rate is 540 per 100,000 live births and is the highest in South East Asia. Similarly, for MDG 3, which concerns gender equality, progress is described as "slow" and coexists with high rates of violence against women. The report highlights the severe marginalisation of persons with disabilities and recognises that for poor people generally and women and persons with disabilities in particular, new ways have to be found to ensure their needs are recognised and prioritised.

Neglect of Mental Health in MDGs

Mental health is not identified as a priority in the MDGs of Cambodia or any other country despite the fact that common mental disorders impact most upon the poor and contribute to a significant proportion of disability adjusted life years (DALYs) and years lived with disability (YLDs) in both developed and developing countries (Miranda/Patel 2005). Women are over-represented by a ratio of 2:1 in diagnoses of depression (Astbury 2001) and depression is among the top 10 leading causes of disease burden in low-income countries (WHO 2008).

The neglect of mental health is even more puzzling as health and education are at the centre of the MDG vision for development (Miranda/Patel 2005). Improving women's mental health will not only contribute to progress towards gender equality but reduce the burden of disease caused by depression, violence and injury.

Evidence on Gender-Based Violence and Mental Health

In Cambodia, two recent national surveys have revealed that around one in five Cambodian



women has been the victim of violence by an intimate partner; women are reluctant to disclose or seek help for this partner violence and social attitudes serve to reinforce the culturally condoned silencing of women who suffer the multiple human rights violations such violence represents (National Institute of Public Health, National Institute of Statistics, Cambodia and ORC Macro 2006; Ministry of Women's Affairs 2010).

In the *Violence against women: 2009 follow-up survey*, 81% of women reported that they would keep quiet and do nothing if they were abused by a spouse. The same study underlines the contributory role of intimate partner violence (IPV) to the burden of physical and mental disability that in turn acts as a sizeable impediment to achieving progress on MDGs. For example, 25% of women reported physical illness or weight loss as a result of domestic conflicts, 66% reported becoming anxious, fearful or depressed, 68% reported being unable to sleep and 12% admitted to feeling suicidal (Ministry of Women's Affairs 2010).

These findings are congruent with those of the large WHO Multi Country Study on Women's Health and Domestic Violence against Women (Garcia-Moreno/Jansen/Ellsberg et al. 2005). This study involved 15 sites in ten geographically, culturally and economically diverse countries. Cambodia did not participate in the WHO study and the only South East Asian country involved was Thailand. In all settings, women who had ever experienced partner physical or sexual violence or both had significantly higher levels of emotional distress and were more likely to have thought of and to have attempted suicide than women who did not report such violence (Garcia-Moreno/Jansen/Ellsberg et al. 2005).

Operational definitions of physical violence and sexual violence by an intimate partner used in the Multi Country Study and in the current research included a range of behaviours. Physical violence by an intimate involved acts that ranged in severity and included being slapped or having something thrown that could hurt the woman, being pushed or shoved, hit with a fist or something else that could hurt, being kicked or burnt on purpose or threatened with the use or actual use of a gun, knife or other weapon. Sexual violence by an intimate partner included being physically forced to have sexual intercourse when the woman did not want to, having sexual intercourse when she did not want to because she was afraid of what her partner might do and being forced to do something sexual that she found degrading or

humiliating (Garcia-Moreno/Jansen/Ellsberg et al. 2005).

Paucity of Evidence on Women with Disabilities (WWDs)

WWDs were not specifically included in either of the two Cambodian surveys or in the WHO Multi-country study, leaving an important gap in the evidence base on how violence affects the psychological well being of WWDs. However, a recent meta-analysis of research studies on the risk of violence amongst persons with disabilities revealed that WWDs face a significantly higher risk of violence than those without disabilities (Hughes/Bellis/Jones et al. 2012).

The precise links between gender-based violence (GBV) including partner violence and the mental health of WWDs have not been well elaborated. However, a number of risk factors have been established for the common mental disorders such as depression, anxiety and somatic complaints in which women predominate and which make a significant contribution to the global burden of disease (Prince/Patel/Saxena et al. 2007). These risk factors are associated with gendered, structural inequalities and include women's higher levels of poverty, lower levels of education, lower social and occupational status, higher rates of unpaid or poorly paid work and their exposure to intimate partner and other forms of gender-based violence (Patel/Araya/de Lima et al. 1999, Astbury 2001). In addition, WWDs, whether or not they have a pre-existing serious psychological disorder such as schizophrenia or bi-polar disorder, are more likely than their counterparts who have neither a physical or mental disability to experience various forms of stigma, discrimination, social exclusion and the denial of basic human rights such as the right to education, respect for their human dignity and access to health care that independently predict poor mental health. When added to the structural risk factors and the GBV that undermine women's mental health, these additional forms of unfair treatment that fall most heavily on WWDs, suggest that WWDs are likely to face an even greater risk of developing common mental disorders and to experience a reduced subjective sense of psychological well being (Burns 2009)

Consequently, the need for robust studies on mental health and violence against persons with disabilities, now lacking in most regions of the world, especially in low-income and middle-income countries, has become increasingly well recognised (Miranda/Patel 2005, Burns



2009, Hughes/Bellis/Jones et al. 2012). Evidence from such studies is required to identify and prioritise the needs of WWDs who experience violence and inform the development of more comprehensive health policies and more disability inclusive health and violence services (AusAid 2010).

Research Questions

The current paper responds to this need for evidence by examining the links between disability, violence and women's mental health. Specifically, it investigates the following research questions:

- How do WWDs differ from those without disability on indicators of socio demographic position in Cambodia?
- Do WWDs have higher rates of partner violence than women without disabilities?
- How does violence and disability, separately and together, impact on women's mental health?

The findings derive from an analysis of data collected in the survey component of a larger mixed methods study entitled *Triple jeopardy: gender-based violence, disability, rights violations and access to related services among women in Cambodia*. The study is funded by AusAID, through an Australian Development Research Award (ADRA). It is a collaborative project between Australian and Cambodian partners, involving Monash University, CBM-Nossal Institute Partnership for Disability Inclusive Development and the International Women's Development Agency (IWDA) in Australia and Banteay Srei, an NGO working on positive change and empowerment for women, and the Cambodian Disabled People's Organization (CPDO) in Cambodia.

Research Design and Sample

A cross-sectional survey was conducted via face-to-face interviews with 354 Cambodian women aged between 18 and 45 years between March and November 2011. Half the sample comprised WWDs (177) and the other half were women without disabilities (177). A power analysis revealed a total sample of 330 was sufficient to detect a difference between WWDs and those without, regarding the proportion who reported partner violence. Slight oversampling occurred to allow for possible sample attrition. The field sites were selected to broadly reflect the distribution of population in Cambodia. Just over a quarter of the sample (26.3%) was drawn from the urban sites of

Phnom Penh and urban Siem Reap and nearly three quarters (73.7%) was drawn from the rural sites of Battambang, rural Siem Reap and Kampong Speu.

Method of Recruitment

Recruitment took place at the household level and identification of WWDs relied on information supplied by the local partners in the research, Banteay Srei and CDPO working in collaboration with local commune councils. Women without disability were selected from households in the same vicinity as WWDs, to permit broad socioeconomic matching between the two groups. Participants were recruited from two urban and three rural sites.

To be eligible to participate in the study, WWDs had to be able to comprehend and communicate sufficiently well to respond to questions included in the survey questionnaire and to give informed consent to participate in the research.

Materials

The semi structured questionnaire used in the face-to-face interview questionnaire was based on that employed in the WHO Multi Country Study on Women's Health and Domestic Violence against Women. Topics in the questionnaire included the socio demographic characteristics of participants, their patterns of disability, gender norms and beliefs, mental health, types of violence, patterns of disclosure and help seeking by women who reported violence, reproductive health and financial autonomy.

The WHO questionnaire was modified to include the Washington Short Set of Questions on Disability (Washington Group 2006) and the number of questions from the WHO questionnaire was reduced to ensure the burden of taking part in the study was not too onerous, especially for WWDs.

Mental health was assessed using the WHO Self-Reporting Questionnaire (SRQ) (Beusenberg/Orley 1994). This 20 item, well validated screening measure of psychological distress was designed for use in developing countries and includes items related to the common mental disorders including depression, anxiety and somatic symptoms. The SRQ has been used in numerous international studies including the WHO Multi Country Study on Women's Health and Domestic Violence against Women.

Findings will be presented in the following order: The socio demographic profile of the sample will be presented first, followed by a



comparison of WWDs and those without. Next, the proportion of WWDs reporting different types of disability, the prevalence of different types of partner violence and the mean score on the SRQ for the total sample will be documented. Finally, differences between WWDs and those without a disability will be examined in relation to partner violence and how this violence impacts on their mental health as measured by the SRQ.

Socio Demographic Characteristics of the Sample

The mean age of participants was 31.7 years (sd=8.3). 61.6% (218/354) had ever been married or partnered, 76.3% (270/354) had ever attended school and 76.0% (269/354) reported that they earned money. The most common type of work, undertaken by 48.7% was seasonal work (131/269). Table 1 shows differences between WWDs and those without on these socio demographic characteristics.

Socio demographic Variables	WWDs N= 177	Women without disabilities N=177	p value
Age (mean)	32.1 years	31.4 years	ns
No schooling	28.2%	19.2%	ns
Never married/partnered	57.6%	19.2%	0.000
Not married now	75.1%	28.8%	0.000
Lives with birth family	71.1%	44.6%	0.000
Earns money	70.6%	81.4%	0.018

Table 1: Comparison of WWDs and women without disabilities on socio demographic characteristics

WWDs were slightly older on average than those without disabilities and a higher proportion had never been to school, but neither of these differences was statistically significant. Chi squared analysis showed that WWDs were significantly overrepresented among those who had never married or lived with a male partner. This finding is consistent with other studies on WWDs reported in the recent World Report on Disability (WHO/World Bank 2011). Similarly, a significantly higher proportion of WWDs were living with their birth family compared with women who did not have a disability and a lower proportion of WWDs were not currently married.

Profile of Disability

The Washington questions ask about the level of functional difficulty a person encounters. For example, the question on visual impairment is phrased *Do you have difficulty seeing?*. Responses to this and the other Washington questions were rated as follows: 0= no difficulty, 1= some difficulty, 2= a lot of difficulty and 3= cannot do at all. A single category to indicate *significant difficulty* was devised by combining those who reported *a lot of difficulty* with those who reported *cannot do at all*.

WWDs who had significant difficulty on any of the Washington questions included 18.9% with difficulty seeing, 6.8% difficulty hearing, 45.1% walking or climbing stairs, 21.7% difficulty remembering or concentrating and 13.7% difficulty communicating.

Partner Violence

Several questions about physical, psychological and sexual partner violence were included in the interview. A single category of *any partner violence ever* was developed based on whether a participant answered Yes to any of the questions on the different types of violence ever perpetrated by a partner.

The lifetime prevalence of any type of *any partner violence ever* for the participants who had ever been married or lived with a male partner and answered this question was 49.7% (88/177). The rates for specific types of partner violence were as follows: 24.3% (43/177) for physical violence, 43.5% (77/177) for psychological violence and 18.6% (33/177) for partner sexual violence.

Of the 45 WWDs who had ever been partnered, 60% (27/45) had experienced some type of partner violence ever, compared with 46.2% (61/132) of ever partnered women who did not have a disability. Although partner violence ever was reported by a higher proportion of WWDs than those without a disability, the difference was not statistically significant. A similar pattern was found the specific types of partner violence and no significant differences between WWDs and those without a disability were found.

Mental Health

The measure of psychological distress used in this study, the SRQ, assesses common mental disorders including symptoms of depression, anxiety and somatic complaints. It thus enquires about *common problems that may have both*



ered you in the past 4 weeks. Each of the 20 problems or symptoms is scored as 0 if the symptom is absent and 1 if it is present. This results in a minimum possible score of 0 and a maximum possible score of 20. In other words, the lower the score is on the SRQ the higher the respondent's level of psychological well being while the higher the score is on the SRQ, the lower the respondent's level of psychological well being.

SRQ Scores

The mean score on the SRQ for the total sample was 12.3 (sd=5.0; sd = standard deviation). Both WWDs and women reporting any partner violence ever, had higher mean SRQ scores than those found for the total sample. The mean SRQ score for WWDs (13.7, sd=4.5) and the mean SRQ score for women who reported partner violence ever was very similar (13.5, sd=4.2). To clarify the relationships between disability, any partner violence ever and SRQ scores, a further analysis was carried out as shown in Table 2.

Any violence	Disability status	Mean	SD	N
No	No	10.4930	5.25594	71
	Yes	13.3333	5.50935	18
	Total	11.0674	5.39949	89
Yes	No	12.9508	4.41371	61
	Yes	15.0000	3.45298	27
	Total	13.5795	4.23103	88
Total	.00	11.6288	5.01966	132
	1.00	14.3333	4.41073	45
	Total	12.3164	5.00130	177

Table 2: Mean SRQ scores by 'any partner violence' and disability status

This shows that women who reported No to partner violence and had no disability, had a mean SRQ score (10.49, sd=5.23) that was significantly lower than that of women who reported No to partner violence but had a disability (13.33, sd=5.5) (F value=6.08, 1df, p=0.015)¹.

Women who reported Yes to partner violence but did not have a disability, had a significantly lower mean SRQ score (12.95, sd=4.41) than women who reported Yes to partner violence and had a disability (15.00, sd=3.45). This difference was even more statistically significant (F value=8.55, 1 df, p=0.004) than the previous

analysis and demonstrates that it was the combination of disability and partner violence that resulted in the highest level of psychological distress documented in the study.

A significant difference was also found when only those women without a disability were considered. Even here, women who reported no partner violence had a significantly lower mean SRQ score (SRQ=10.49, sd=5.25) than those who reported some form of partner violence (SRQ=12.95, sd 4.41) (F value =6.08, 1df, p=0.015)¹. This finding mirrors the results of the WHO Multi Country Study.

It should also be noted that for WWDs who reported any partner violence ever, a very high proportion answered Yes to many of the individual items on the SRQ. For example, 92.6% reported they were easily frightened, 96.3% reported they felt nervous, tense or worried, 92.6% said they had trouble thinking clearly, 92.6% reported they found it difficult to enjoy their daily activities and 88.9% said they were easily tired.

Conclusions

Previous research has shown that economic and development indicators including poverty, low income, poor education, female gender and economic inequality strongly predict common mental disorders amongst women in developing countries (Patel et al. 1999).

The same factors are certainly important in Cambodia (AusAid 2010) and exerted an influence on the findings of the current study. This is shown by the fact that women who had never experienced partner violence and did not have a disability, still had a higher mean SRQ score than women who reported partner violence. Indeed, the level of psychological distress in women who might be considered to be at a low risk for poor mental health was still higher, as evidenced by their mean scores on the SRQ, than that of women from all 15 sites of the WHO Multi-country Study on Women's Health and Domestic Violence against Women (Garcia-Moreno/Jansen/Ellsberg et al. 2005). Further investigation of the specific sociocultural determinants of poor mental health including traditional gender norms, is needed to better understand the increased psychological suffering of Cambodian women.

However, the findings clearly show that partner violence and disability, acting separately but more importantly in combination with one another, exert additional negative effects on women's mental health. Indeed, a strong graded relationship was revealed between vio-



lence, disability and SRQ scores. The lowest SRQ scores were found amongst women who had never experienced violence and did not have a disability; SRQ scores then increased for women reporting either partner violence or had a disability and reached their highest for women reporting partner violence who had a disability. For this group of women, their score of 15 out of a possible total SRQ score of 20 indicates that they experienced symptoms of almost pervasive psychological distress that reflected depression, anxiety, suicidal thoughts, confused thinking and decreased energy compared with other participants in the study. Of major concern, was the finding that nearly all these women said they were easily frightened, nervous, tense and worried, unable to think clearly or enjoy daily activities.

To paraphrase Sen (1999), these findings strongly suggest that the combined impact of disability and partner violence profoundly affects women's mental health and reduces women's freedom to live lives they have reason to value.

As well as being denied a broad range of opportunities, educational, social and occupational, WWDs with violence related mental health issues are faced by a virtual absence of relevant, affordable and accessible services. At the present time, the Ministry of Women's Affairs in Cambodia is conducting a study to assess the feasibility of establishing a one-stop shop model for women affected by violence and is mapping existing services for victims of violence. The findings of this study will provide evidence of the extent of existing services and enable an estimate of unmet need to be established. Non-government organisations like the Transcultural Psychosocial Organization (TPO) and Banteay Srei (Citadel of Women) have been working for a number of years with victims of gender-based violence. TPO has a Community Mental Health Programme and in 2011 offered psychosocial services for victims of GBV in Battambang and Banteay Meanchey Provinces (TPO 2012). Banteay Srei uses a rights based approach and works in villages throughout Cambodia to improve women's lives. It has a safe house (women's refuge) in Battambang that offers emergency accommodation and food, counselling, legal and other services to women and children affected by GBV.

Mental health is slowly being integrated into the primary health care system as part of Cambodian National Program for Mental Health 2011-2012, but there is a severe shortage of mental health care professionals. In addressing this problem, it is essential for the mental

health workforce to acquire a gender lens, to understand how gender-based violence and disability contribute to severe psychological distress and to recognise the large gender disparity in the rates of common mental disorders affecting the largest proportion of the population (Astbury 2001). It is also desirable that, where possible, the effectiveness of counselling or other mental health interventions should be evaluated to ensure that they confer discernible psychological benefits on those they seek to help and to monitor that no harm is being done. The TPO offers a useful model in this regard. It has undertaken evaluations of its counselling services for victims of gender-based violence and has been able to demonstrate significant reductions from pre intervention to post intervention in a range of symptoms including excessive worrying, fear, nightmares, sadness and low mood, to name a few (TPO 2012).

Mental health service providers must be able to deliver gender-sensitive, trauma focussed counselling in order to respond appropriately to the violence and other human rights violations that have undermined women's mental health. Without this, women who disclose violence in the context of seeking mental health care will run the risk of being judged, blamed and further traumatised by health care providers. Good mental health care is not reducible to particular therapeutic techniques or psychotropic medications; the relationship between provider and patient is of paramount importance and heavily influenced by provider attitudes and values. As more than half of Cambodia men and women believe even extreme partner violence such as stabbing, shooting or throwing acid at his wife is justified if she is argumentative or disagrees with him (Ministry of Women's Affairs 2010), the training of the mental health workforce which comes from the same background population, must challenge any therapeutically destructive beliefs or traditional gender norms that condone the routine violation of women's human rights.

Women centred responses demand validation and non-judgemental attitudes towards any experiences of partner or other forms of violence that are identified or disclosed. As this study shows, WWDs who report partner violence have significantly elevated levels of psychological distress and thus have the greatest need for meaningful psychosocial assistance that acknowledges the full context of their lives.

Raising the awareness of policy makers and mental health care providers is a critical first step in the development of properly integrated services able to identify and respond to



women's mental health care needs, especially those of WWDs. Such awareness will help dissolve the rigid boundaries that presently separate disability, gender-based violence and mental health services.

Not only is there no health without mental health but equally it can be said there is no real development as long as women's human potential, safety and psychological continues to be compromised by gender-based violence and other violations of their human rights.

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Notes

- 1 The F value is a measure of the size of the difference in the mean scores of the two groups that have been compared. The associated p or probability value shows how significant this difference is. The general rule is that a p value which is 0.05 or less should be reported as significant. This value means that there are less than 5 chances in a 100 that the difference between the groups could have happened by chance. Similarly, a p value of 0.01 means that there is less than 1 chance in a 100 that the difference could have occurred by chance and a p value of 0.001 means that there is only 1 chance in a thousand that the difference could have occurred by chance. The degrees of freedom (df) reported in the analyses are derived from the number of groups being compared minus 1 eg for 2 a two group comparison the df would be 1df (2-1= 1).

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Zusammenfassung: Die untergeordnete soziale Rolle von Frauen, Armut und sozioökonomische Benachteiligung sind als Risikofaktoren für erhöhte Raten von allgemeinen psychischen Erkrankungen bekannt. Frauen mit Behinderungen wurden allerdings oft von der Teilnahme an Untersuchungen ausgeschlossen. Die Forschung, die in Kambodscha durchgeführt wurde, untersuchte die Auswirkungen von Behinderung und Gewalt

in der Partnerschaft auf die psychische Gesundheit von Frauen. Frauen mit Behinderungen erleben signifikant höhere Grade von psychologischem Stress, als Frauen ohne Behinderung, wobei die Präsenz von Gewalt in der Partnerschaft diese Unterschiede weiter verstärkt. Geschlechterspezifische psychologische Gesundheitsdienste werden dringend benötigt.

Résumé: La position sociale subordonnée des femmes, la pauvreté et les désavantages socio-économiques sont des facteurs de risque connus pour leur taux surélevé de troubles mentaux courants; pourtant prendre part aux recherches est souvent exclu pour les femmes ayant un handicap. Des recherches ont été menées au Cambodge sur l'impact du handicap et de la violence conjugale sur la santé mentale des femmes. Les femmes avec un handicap présentent un degré de souffrance psychologique significativement plus élevé que les femmes n'ayant pas de handicap, et l'existence de violence conjugale vient accentuer cette disparité. Il est urgent de développer des services de santé mentale sensibles au genre.

Resumen: La posición de desventaja social de las mujeres, la pobreza y los problemas sociales son factores de riesgo para los trastornos mentales. Sin embargo, las mujeres con discapacidad a menudo son excluidas de la participación en proyectos de investigación. En un estudio realizado en Camboya, el impacto de la discapacidad y de la violencia de pareja fue investigado con respecto a sus consecuencias a la salud mental de las mujeres. Las mujeres con discapacidad sufren una angustia psicológica significativamente mayor que las mujeres sin discapacidad y la presencia de la violencia por la pareja refuerza esta desigualdad. Por este motivo, se necesitan servicios psicosociales sensibles a la problemática de la violencia de género.

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Socio-Anthropological Action-Research on Gender-Based Violence and Mental Health. A Disability Approach in Western Rwanda

Olivia Névissas

There is a wide range of barriers to protection from Gender-Based Violence, to a *good enough* mental health and to empowerment of people with disabilities. To gain a clearer understanding of the disability, mental health and Gender-based Violence (GBV) issues raised by several episodes of violence and collective trauma, Handicap International's Community Mental Health and Gender-Based Violence project has carried out an action-research project. The aim of this was to involve communities in the process of identifying specific vulnerability factors in two districts of Rwanda's Western Province (Rubavu and Rutsiro). We concentrated our attention on regional idiosyncrasies of the geographical, socio-economic, cultural, familial and community environment.

Introduction

The origins of GBV and psychological distress in Rwanda are varied, interlaced and superimposed. In particular economic insecurity and social exclusion, the traditional roles of females and males determined by cultural and social norms and the weaknesses in the systems of protection, etc, appear as risk factors that could explain GBV and psychological distress. The survey underlined also several reasons explaining that victims of GBV do not seek assistance because of fear of reprisals, feeling of shame, distance from protection services, absence of medical coverage and of proves of violence. Then community and local stakeholders have insufficient information on existing legal measures, and the current monitoring system is not capable of ensuring the global welfare of victims of Gender-Based Violence living with disabilities. Therefore the current action-research took an interest in resources existing at the community level that could support Handicap International's Mental Health project.

In order to reach the first objective of identifying the risk factors, we used an *ecological model* called the Disability Creation Process (Fougeyrollas 1997), which considers the interaction between personal, familial, socio-cultural, political, economic and environmental vulnerability factors. The second objective was to identify the most vulnerable groups affected by GBV and psychological distress in eight areas of the two districts, by questioning specific vulnerability factors of each group. The third objective was to map the local resources (decentralised medical, legal and social services, civil society organisations, local, national and international Non-Governmental Organisations (NGOs)).

In response to the two first objectives, we

managed to deconstruct the prevalence of psychological distress and Gender-Based Violence (GBV), as well as other forms of subservience not related to gender. In our action-research, we focused on five types of impairment: intellectual, sensorial, motor, and more particularly on mental and psychosocial impairments. We analysed them as resulting from the interaction between the specific characteristics of individuals (biological, functional and identity-related) and the characteristics of the context in which these individuals live (micro - personal, meso - community and macro - societal) (Fougeyrollas/St-Onge 1998) and how violence in general and psychological distress could endanger the life habits of the most vulnerable groups (access to protection and health services, social participation, etc.).

Methodology

Our qualitative data-gathering methods were based on socio-anthropological and participatory action-research principles: for instance, we led an ethnographic survey on each of the eight sites in the two districts. This fieldwork focused on carrying out group discussions, individual semi-directive interviews in *Kinyarwanda* (local language) and observations. Interview forms were completed by six qualified researchers. Compilation and triangulation of collected data allowed us to do an inductive analysis underlining the influences of gender, disability (and the attached stigmas resulting from norms and local representations), the different forms of *customary* violence, the living conditions and difficulties in accessing services and environment on *mental illness* or *psychological distress*. We have attempted to comprehend people's life trajectories, their idiosyncratic vulnerabilities



(physical, biological, psychological and socio-economic), and, also their capacity for coping with unfavourable situations by taking advantage of available resources.

The population surveyed (189 respondents) met criteria of personal (sex, age, type of disability), but also familial, socio-economic characteristics (marital, professional status) in different geographical situations. The knowledge construction process of this action-research was based on a participatory approach in which local stakeholders professionals (local authorities, police, health centres and civil society groups) worked in close collaboration with the research team.

However, our aim was to go beyond collaboration to actually mobilise the population by raising collective awareness of their problems and the difficulties they encounter in accessing the local resources offering multi-sector protection (medico-psychosocial, legal and economic).

Concepts Used

"Generally speaking, mental health care is aimed at any type of vulnerability leading or liable to lead to mental disorders and/or psychological distress and which reduce a person's defence capacities and ability to adapt to the social, cultural and political demands of his or her environment" (Handicap International 2011a:15).

Good enough mental health can be defined as: "The capacity to live with oneself and with others, in the search for pleasure, happiness and a meaningful life; in a given but not immutable environment that is transformable through the activity of individuals and human groups; without destruction but not without revolt, meaning the capacity to say "No" to what goes against the needs of individual and social life, which in turn allows a true "Yes"; implying the capacity to suffer whilst remaining alive, connected with oneself and with others" (Lyon Declaration 2011, par. 2-8).

The concept of *empowerment* (a term meaning "to become capable, to engage with a power") refers to a *power*, which initially resides in the occurrence of an event, in an encounter between individuals or groups and their environment. Empowerment calls for a *transformation*, or a passage from one state to another, with the idea of "a new way of existing in the world" (of doing, feeling, thinking and acting) (Stengers 2002: unpagged).

Mental disabilities are due to a permanent or temporary experience of either serious mental

disorders (schizophrenia, manic-depressive disorder, depression) or traumatic disorders occurring as a result of a person being confronted with a situation in which his or her physical and/or mental integrity has been threatened and/or effectively harmed (Handicap International 2011a:23).

Psychosocial disabilities are due to psychological distress of whatever origin (migration, exile, natural disasters, poverty, homelessness, loss of family and/or social ties, loss of a job, social stigmatisation, etc.). The disabilities that result from these situations partially disrupt people's ability to participate in their society by undermining their linguistic and behavioural capacities: people sometimes could lose their social skills and their ability to seek protection and assistance.

Findings

The risk factors explaining GBV and mental health disorders which have been identified in this action-research are:

- 1) Linked to the geographical environment when this environment has a direct influence on the nature of the violence and on the physical accessibility of protection and health services.
- 2) Linked to socio-economic conditions limiting access to education, health, decent housing, and emancipation from persecutors.
- 3) Linked to a lack of information or too limited knowledge of rights and laws among the vulnerable groups identified, as well as among certain authorities and community-based organisations.
- 4) Linked to insufficient financial, human and material resources for health facilities and protection services.
- 5) Linked to cultural resistance (prejudices, representations) with regard to gender, mental disorders and disability.
- 6) Linked to personal characteristics (age, sex, profession, social and marital status and disability).

Our research has established a significant association between trauma, violence and mental health. There are clearly still deep physical and psychological injuries and traumas from the genocide, wars and massacres. These go some way to explaining the domestic or intra-community violence and the psychological, economic, physical and sexual violence directed against women and children. There is a significantly higher prevalence of anxiety disorders, fears and sleep disorders, associated with behavioural or personality disorders and psychiatric disorders such as traumatic stress, among



people who reported being victims of physical or sexual abuse during the genocide. The findings of a survey carried out by the Ministry of Health in 2009 reveal that 79.4% of the population has experienced a traumatising experience in the course of their life, 28.54% of the population is suffering from trauma and 53.93% of the population is suffering from both depression and trauma (Munyandamutsa/Nkubamugisha 2009).

According to our research, the most widespread form of Gender-Based Violence is economic violence perpetrated by men against women (wives, sisters and daughters) and notably between husband and wife (inequitable sharing or appropriation of all family or conjugal assets, theft, economic exploitation – especially of genocide or HIV/AIDS widows). These conflicts of an economic nature lead to the appearance of other forms of violence: sexual, physical and then psychological. Sexual violence in the form of marital customary rape, threats of forced sex or actual forced sex, or physical acts against a woman's corporal integrity (molestation, sexual harassment) particularly concern young, single girls, married women or women in illegitimate couples. From our sample of 189 respondents, out of 134 women interviewed all were victims at least once in their life of some form of gender-related violence, 38% were young girls and single mothers aged between 18 and 25, most of them orphans and heads of household. Then comes the 26-35 age group (25.4%) and the 36-45 age group (14.2%), corresponding to women living as a couple (25.3%), widows (21.7%), or married women (10.9%). The way in which Gender-Based Violence is a feature of everyday life indicates that male domination still goes unchallenged, with a total absence of recourse (possibilities of divorce, escape or imprisonment of the husband) for most of the victims. Demonstrating male power and domination and humiliating women to increase their feeling of inferiority was found to be the main reason for committing rape. The prevailing conception of sexuality is still that men should be able to dispose freely of a woman's body and that a man's sexual impulses should not have to be controlled.

Another group vulnerable to violence is made up of boys aged between 12 and 25 who have lost at least one parent and/or are forced to live on the streets. They are thus at risk of ill treatment, exploitation or theft of family assets by relatives or the community.

Lastly, little is known about violence against people with disabilities, as it tends to remain *in-*

visible. Because of their disabilities, these people are victims of many types of discrimination and are often defenceless victims (Handicap International 2007/2012). They receive little or no recognition from the community and are often overlooked in gender and GBV policies. In our sample, there are a large proportion of people living with psychosocial impairments among the total number of people with disabilities interviewed (51.7%). Women are more affected by psychological distress (38.1%) than men (13.6%), especially those with motor, psychosocial or intellectual disabilities. Widowers and/or men who survived the genocide also present severe forms of stigma¹ (Goffman 1975) and suffering caused by the conflicts they have lived through, their status as a widower or survivor suffering from post-traumatic disorders or domestic violence. The national policy on gender equality launched in 2004 and its messages about combating Gender-Based Violence have been misinterpreted by women and seized upon to reverse the balance of power and take revenge on men (Handicap International 2012b:37). When these men have disabilities that prevent them from working, women no longer see their husbands as having a social or economic function in the household, which they consider to be justification for depriving them of property, food, a home and sex. These men fear that their masculinity will be questioned, so they do not reveal to the authorities and the community their subordinate position, or the violence to which they are subjected by their wives. Our observations brought us to the conclusion that suicide appeared to be a marker of psychosocial failure in this group.

Discussion

Reasons for Not Talking About the Past

In addition to these obstacles, this survey reveals that both men and women are reluctant to talk about their experience of being victims of violence as they are afraid of being seen as *weak*. The women are afraid of not being taken seriously or of reprisals by the perpetrators. The community is often seen more as a restraint than a lever for the victims. The wars have in fact weakened family and social links and solidarity (sharing of property and wealth, and acting for the common good), resulting in a diminution of community feeling. In this sense, the community can no longer necessarily fulfil its protective function because it is no longer a strong *resource* as it lacks what motivates individuals and binds them together according to attachment figures and modes of attachment



and detachment (Latour 2000).

By looking at things from this angle we can see that a family's *worthiness* has depended entirely on the victim's capacity to keep silent, to hide, to deny the violence committed against him or her. The family and community circles reveal themselves to be a closed space, but also a place for secret intimacy, sexuality and sexual practices, sometimes incestuous, which must be protected from intrusions and from view, as well as from anything that could give rise to shame. Anxious to maintain social and community cohesion and avoid any further conflict, members of the village, neighbours, do not always want to hear (i.e. accept, acknowledge) the realities described by people and groups vulnerable to violence.

Social Stigmatisation of People with Disabilities and Suffering of Psychological Distress

From the collected data, we could confirm our hypothesis that social and cultural representations of gender, of a particular type of disability or of social or marital status are at the origin of the social exclusion of victims of violence and/or of people in psychological distress. Psychological distress is still taboo, imprisoning the individual and the whole of his or her membership group in a genocidal story that cannot be told. Often confused with an explanatory model of a different origin and associated with the Post-Traumatic Stress Disorder diagnosis category (*ihungabana*: "to be upset, disturbed"²), psychological distress is unacceptable as it casts doubt on the effectiveness of collective efforts of reconstruction, grieving, remembrance and group dynamics. In response to the question of what can be done about it, some fatalist respondents of the survey said that "we all have our cross to bear", that we should resign ourselves to it. This injunction has serious consequences in terms of somatic and mental health: do not moan, do not complain, do not talk or you will bring shame upon yourself and earn the contempt of your relatives and your community.

Mental illness is also considered as a burden, a disability among other disabilities. Different etiological models and representations of disability have appeared. The magical-religious belief that disability is caused by spirits or demons deprives the disabled person of a part of their humanity. For women, their femininity and sexuality, or the right to sexuality, are barely acknowledged, excepting certain beliefs that sex with a virgin is a cure for HIV/AIDS or that the sexual urges of women with intellectual dis-

abilities are uncontrollable as these women are not conscious of their acts (Handicap International 2011b/2012a). Furthermore, psychological distress in people with disabilities, especially those who are victims of gender-related violence, is often considered to be *congenital*, i.e. there is no external reason. In other words, it is considered to be an intrinsic part of the person's disability (Handicap International 2012b).

Conclusion

This type of research action offers an objective foundation on which to later base operational directives and policies for responding to the scale of the needs. Despite certain methodological limitations (hemmed-in populations, sensitive subjects of violence and intra-familial or community conflicts, short time of the field-work, etc.) the data gathered have enabled us to establish the current situation in these districts. The mapping of local resources (protection systems) and the analysis of care pathways has revealed that only a handful of local social networks are capable of responding and that early prevention measures and the coordination of health and non-health actors need strengthening. Indeed, the absence of comprehensive and coordinated management of violence and mental health issues, combined with the vulnerability of the victims (and their families) and health problems worsened by high alcohol consumption and a prevalence of HIV/AIDS call for specific interventions. These interventions must strengthen the capacities of local stakeholders (civil society, authorities and communities), to help rebuild social and intra-community links and to offer a response to situations of extreme hardship. Efforts should be made to improve access to protection and assistance services for people with disabilities and to raise awareness and involve families, communities, local and national stakeholders in changing the social representation and treatment of people with disabilities.

Notes

- 1 According to Goffman, a stigma is born of the relationship between personal attributes (corporeal, personality traits, etc.), stereotypes and norms. Discrimination appears, justified by an ideology reinforcing the stigma, which then influences behaviour towards people to whom a stigma is attached.
- 2 Term invented by professionals after the genocide meaning the "traumatised", the weight of psychological suffering caused by events, as there was no word for "trauma" in Kyniarwanda.

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Zusammenfassung: Es existiert ein breites Spektrum von Hemmnissen für den Schutz vor geschlechtsbedingter Gewalt, ausreichender psychischer Gesundheit und

Empowerment von Menschen mit Behinderungen. Um ein schärferes Bild von Aspekten von Behinderung, psychischer Gesundheit und geschlechtsbedingter Gewalt zu bekommen, die durch verschiedene Folgen von Gewalt und kollektiven Traumata verursacht werden, hat Handicap International im Zuge der Programme zu Community Mental Health und Gender-Based Violence ein anwendungsbezogenes Forschungsprojekt durchgeführt. Das Ziel dessen war es, die Gemeinschaft in den Prozess der Identifikation spezieller Vulnerabilitätsfaktoren in zwei Bezirken in Rwandas westlichen Provinzen (Rubavu und Rutsiro) einzubeziehen. Der Fokus der Aufmerksamkeit lag dabei auf regionalen Eigenheiten bezüglich der geographischen, sozio-ökonomischen, kulturellen, familiären und der gemeinschaftlichen Situation.

Résumé: Nombreux sont les obstacles à la protection contre les violences liées au genre, à une santé mentale «suffisante» et à une autonomisation des personnes handicapées. Pour améliorer les connaissances sur les questions du handicap, de la santé mentale et des violences fondées sur le genre (en anglais, Gender-based violence, GBV), soulevées par différents épisodes de violence et de traumatisme collectif, le projet Santé mentale communautaire et violence liée au genre de Handicap International a conduit un projet recherche-action. Le but consiste à inclure les communautés dans le processus d'identification de facteurs spécifiques de vulnérabilité dans deux districts de la province ouest du Rwanda (Rubavu et Rutsiro). Nous avons concentré notre attention sur les particularités régionales liées à l'environnement géographique, socio-économique, culturel, familial et communautaire.

Resumen: Hay una serie de obstáculos que impiden la protección contra la violencia de género, de la salud mental y del empoderamiento de las personas con discapacidad. Para obtener una comprensión más clara de la relación de estos tres componentes, Handicap International ha realizado en el oeste de Ruanda un proyecto de Investigación-Acción-Participante que se llama "Salud Mental Comunitaria y Violencia de Género". En las dos provincias Rubavu y Rutsiro, diferentes comunidades participaron activamente en el proceso de identificar los factores específicos de vulnerabilidad. Se presenta en este artículo los resultados sobre las características regionales del entorno geográfico, socioeconómico, cultural, familiar y comunitario.

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Participatory Data Analysis: Inclusive Research in Mental Health and Development

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Participatory Data Analysis (PDA) is a participant-driven method for data analysis developed by *BasicNeeds* to include people with mental illness or epilepsy in applied research and inform specific policy and practice actions that will directly improve their lives. The purpose of this paper is to describe and analyse PDA practice within *BasicNeeds*. Case studies from Kenya and Ghana display the process in action, where findings and recommendations from PDA have been reported and shared with local government stakeholders to advocate for an increase in livelihoods resources devoted to people with mental illness or epilepsy. Essential features for PDA are identified, and key lessons discussed.

Introduction

Background

Participatory Data Analysis (PDA) is a participant-driven method, which includes people with mental illness or epilepsy in applied research in order to inform specific policy and practice actions that will directly improve their lives. PDA takes its roots from Participatory Action Research (PAR), a research approach that includes a participatory component, an education component and a social action component. One of the main purposes of PAR is to empower those involved to participate in social change. The approach has been applied to various settings over the past 70 years, and takes many forms depending on the context of the research (Kindon/Pain/Kesby 2007). But in all cases, the research is driven to some degree by the local population being studied. While specific techniques for PAR may differ, the participants usually formulate research questions, produce and analyse their own data—often collectively, and make very specific recommendations for action within their specific setting (Kindon/Pain/Kesby 2007). In this way, the research is participatory in nature, seeks to educate the participants about the research process and the data generated, and is used immediately for social action within the area studied. The degree of participant collaboration with researchers is variable and some entirely user-led mental health research has been applied in the U.S., U.K. and Canada (Cook/Shore/Burke-Miller et al. 2010; Martin/Murphy/Chan et al. 2009; Gillard/Turner/Lovell et al. 2010).

While a participatory research process has been used for and with people with mental illness or epilepsy in high-income countries, it has not yet widely been used among those with mental illness in low- and middle-income countries (Chene/Garcia/Goldstrom et al. 2005). The perspectives of users living with mental ill-

ness or epilepsy remain largely unheard, as they are often poor and further marginalised due to stigmatisation within their communities (Sharan/Gallo/Gureje et al. 2006). As such, researchers and policy makers often overlook the needs and valuable insights expressed by users (Patel/Kleinman 2003). This is surprising given that such methods have been successfully applied with other populations where health disparities exist (Cornwall/Jewkes 1996).

BasicNeeds

Participatory Data Analysis is a Participatory Action Research method developed by *BasicNeeds* (BN), an international mental health organisation working with people with mental illness or epilepsy in India, Nepal, Pakistan, Sri Lanka, Lao PDR, Vietnam, China, Ghana, Kenya, Tanzania, Uganda and the UK. PDA has been used in BN program locations to gather and analyse data, after which it is shared with local government stakeholders for advocacy efforts. BN is committed to ensuring that people living with mental illness or epilepsy are included in development interventions and that their voices are brought to local, national and international debates on mental health and development. Its model is founded on the principle of active participation, making PDA a very key component. PDA may also be used among those with Post Traumatic Stress Disorder (PTSD) in BN program sites that have faced conflict, such as Uganda. This paper explains the PDA process, discusses issues involved in its use among people with mental illness or epilepsy, and provides suggestions for incorporating PDA in other settings.

PDA in Practice

Sampling

While the precise format of a PDA session may vary in implementation from setting to setting,



and adapts to local capacities, the sessions follow a broad, systematic approach. PDA sessions always include a convenience sample of around 50 people with mental illness or epilepsy and caregivers who have been recruited through consultation meetings to participate in the PDA sessions. All participants must give informed consent before they are included in any PDA session, which are held within the community and generally span one to three days.

Training

The basic elements of PDA sessions begin with a training workshop designed to engender an appreciation for research and an understanding of how data analysis fits into the research process. When PDA is conducted for the first time, topics in the workshop include: what is data, why data is collected, how it is analysed and what is the capacity for results to contribute to social improvement. These focus areas are explored through animated group discussions and participatory activities, including mock research projects conducted in small groups. Guidelines for analysis are then discussed in a clear, step-wise format and the remainder of the session focuses on analysis and recommendations. Simplicity is stressed throughout the training.

Data Collection

Individual Data

During the analysis sessions, the entire group is broken down into small groups of 8-10 people. These discussion groups are provided with individual data on each small group participant. Individual data may include clinical records or any other relevant records maintained detailing the situation of individual program participants. The analysis process begins with these records being read aloud in small groups. Each group requires at least one literate person. Often during the process of reading in the group, the individual data is spontaneously evaluated for accuracy.

Discussion Group Data

After listening to the individual data details, the group collectively identifies and discusses key issues, such as inadequate access to health services or other interventions, lack of family support or provision of care, and the impact of stigma and discrimination. An animator, researcher or member of the community facilitates the group discussion. At times these persons have a personal experience with mental illness. The individual data has been used as a springboard for discussion of the group's collec-

tive experience with these issues, thus generating new data. These issues are identified by the participants and recorded on note cards.

Analysis

This new data is coded by placing the cards on large sheets of paper under thematic headings previously determined by BN staff, utilising an *a priori* qualitative coding technique. The themes vary depending upon the overall purpose of the PDA session. The group then collectively generates recommendations to address the priority challenges. The analysis process involves a number of iterations, depending on the stakeholders involved in a particular program. It occurs initially within groups of people living with mental illness and their carers, and then progresses to groups of community volunteers, members of partner organisations, health service providers, the local BN field team and in some cases, state officials. At each stage of analysis, the synthesised documents of the previous phase of analysis are incorporated as valid evidence into group discussions. The progressive nature of PDA facilitates a synthesised document that includes a thorough appreciation of the key issues and priorities, which is based on the lived experiences of a wide range of stakeholders. This document is then distributed to all stakeholders as a report.

Case Studies

The first PDA session took place in early 2004 in Uganda and has since been implemented in *BasicNeeds'* Tanzania, Kenya, Lao PDR, Sri Lanka and Ghana programs. Two case studies are included below, one in Kenya and one in Ghana exemplifying how PDA has been incorporated into the BN intervention process.

Kenya

Purpose

In January 2009, *BasicNeeds* held two PDA sessions in lower Kabete, a new rural program area in Kenya. The purpose of these PDA sessions was to examine the livelihoods context for people with mental illness or epilepsy in this program area. Since this rural program was relatively new, the purpose of these PDA sessions was to better understand the role poverty plays in the lives of people with mental illness or epilepsy.

Sample

Within this program area, 400 people with mental illness or epilepsy had been identified



(by community-based workers) and diagnosed by a psychiatrist or trained medical personnel. From this population, all individuals who had their socioeconomic or livelihoods information documented in individual data were invited to participate in a PDA session. This resulted in 50 individuals who accepted to participate, including both program participants and caregivers.

PDA Process

The PDA sessions were held in a local church over the course of one day. For the first session, a *BasicNeeds* Research Officer divided the PDA participants according to gender into two working groups, in order to understand how both men and women were impacted in their unique livelihoods. During the second PDA session, a new set of PDA participants was divided into two groups, with one group of people with mental illness or epilepsy and another group of caregivers. A facilitator and a process recorder, both community workers, were included in each group. The participants discussed all of livelihoods information in the Individual Files. Six themes were chosen by the Research Officer due to their relevance to the study topic: livelihoods, housing, caregiving, treatment, health services and acceptance by the community. During the PDA session, each group first identified specific economic activities carried out by people with mental illness or epilepsy and their families. The ensuing analysis discussion responses were written by the process recorder and later grouped under the five themes by the participants.

PDA Session Outcomes

One of the key ideas emerging from the PDA sessions was that some poverty for people with mental illness or epilepsy may be attributed to a general lack of resources in the area for generating income, and many experienced social isolation. It was also discovered that in general, female caregivers tend to generate the income, which directly benefits their families so as they spend more time as a carer, the family poverty situation increases. The findings from these community-level PDA sessions have been reported in a research study produced by *BasicNeeds* and shared with government stakeholders (Oginga/Kingori 2009).

Ghana

Purpose

BasicNeeds also held PDA sessions in Ghana in December 2008. The overall aim of this PDA session was to examine participant and stake-

holder perceptions and concerns of a local horticulture project for people with mental illness or epilepsy. The PDA session findings were used to evaluate the effectiveness of the horticulture project.

Sample

Two BN Ghana Research Officers organised PDA sessions in Tamale and Accra. All horticulture project participants were invited through project farm managers to participate in the study. A total of 33 individuals (9 from Tamale and 24 from Accra) were available to participate in the PDA sessions.

PDA Process

The Tamale PDA session was held at the horticulture project site and the Accra PDA session was held in a conference room at a local hospital. PDA participants brought their own individual files to the venue and each was read aloud. In this case study, a Research Officer further animated the individual file discussion by introducing a set of pre-determined discussion prompts. The discussion guide prompts were:

“Describe the activities undertaken at the project site.

Mention reasons for joining the project.

What benefits have you gained from the project?

What constraints have you faced?

How can the constraints be overcome?”

The Research Officer also filled the role of the process writer in recording the analysis process for each session. Since most of the program participants were illiterate, the Research Officers grouped responses under themes established in the discussion guide. At this point, the PDA sessions resumed with the addition of community stakeholders, including project farm managers, community psychiatric nurses, the kitchen matron from a local hospital and the director of a local mental health clinic. The responses were coded using an *a priori* coding technique, and were then read aloud to the participants with mental illness or epilepsy, after which they had the opportunity to amend their responses. The analysis continued as the above mentioned stakeholder participants listened and added inputs.

PDA Session Outcomes

During the PDA sessions, key issues were identified, including motivations for joining the horticulture project. The project had positively impacted people with mental illness in a variety of ways, but it was also identified that the products are perishable and restrict the ability of



participants to store food. Successful projects will also require harnessing resources and providing support for farm managers in purchasing equipment and expanding the farm to allow for more participants. These findings and recommendations have been used to assess the horticulture project and allow *BasicNeeds* to work with primary stakeholders on developing new programs (Antwi-Bekoe/Ohenebah Mensah/Yaro 2009).

Analysis

Essential Features of PDA

While the circumstances and specific objectives for PDA's use in these contexts has differed somewhat, the following are considered essential components of the PDA process. This analysis is based on all BN PDA experiences over time since 2004.

1. Shifting Power to the User

First, participants work together to identify key issues in the data and to ascertain priority concerns to collectively generate recommendations. A group animator helps guide the process; however, it is ultimately a collaborative exercise owned by the participants themselves. Second, the training workshops and participatory analysis process embrace a *Freirean* approach to learning, whereby the knowledge and life experiences of participants are central to the education process (Heaney 1995). This approach contrasts with a top-down, hierarchical learning framework whereby a teacher dictates information to oppressed students, who are disengaged from the process and further marginalised (ibid. 1995).

2. Education

Participants usually have little or no knowledge of any evaluation process before joining the PDA process. It is a vital objective of PDA to have people learn how to evaluate for themselves their own circumstances and the various programs in which they are involved. Furthermore, generating operational recommendations relies on the evolution of a collective critical consciousness based on shared understandings and a common purpose. Therefore, mutual education is integral to the process.

3. Self-Help and Community Building

Before participating in a BN program many participants have never met other people within their community who are faced with daily challenges of mental illness. It allows participants to gain an appreciation for the struggles of others

who are dealing with similar experiences. Building networks enables people to feel less isolated and, by acquiring an awareness of common challenges, to gain a meta-perspective of the shared needs requiring attention within the community.

4. Critical Thinking

The resultant sense of shared purpose stimulates discussion of how to more effectively address these priority needs within the community. Through this process, PDA facilitates an appreciation among its participants of the power of the collective to question and initiate positive social change. Recorded reflections offered by participants at the close of various PDA sessions demonstrate the unexpected sense of achievement experienced, and their own surprise at the capacity of people with mental illness or epilepsy to successfully engage in PDA and generate results.

5. Research-to-Action

The aim is for this experience to contribute to a process of inclusion and collective reflection, which can lead to empowerment. Ensuring that results lead to visible actions relevant to increasing everyday functioning and development reinforces the potential for empowerment. Acting on the recommendations is therefore a fundamental aim for the output of PDA.

6. Policy Participation

In addition to their contribution to positive social change, the generated recommendations provide insight into local perceptions of needs, desires and culturally specific notions of recovery. *BasicNeeds* aims to use this understanding to design innovative, culturally specific development interventions, which focus on improving quality of life and reintegration rather than isolated symptom reduction. Finally, through PDA, *BasicNeeds* aims to bring participants' voices to the policy arena where participants can ultimately influence policies affecting their own lives.

Key Lessons

Relevance Is More Important than Generalizability

The process is continually improved and refined though it faces many challenges. Participatory activities are, by nature, not restricted to specific techniques and clearly defined protocols of particular academic disciplines. In the case of PDA, the process has been influenced by a range of research methods, theories and con-



ceptual frameworks, which have been adapted to produce an approach that is tailored to the operational environment and local contexts within which BN operates. Appropriateness and context specificity of the participatory approach have been considered paramount, as they ensure that the analysis and recommendations remain grounded in the socio-cultural and practical everyday realities of the local environment. Due to this pragmatic requirement for flexibility, it cannot develop into a one-size-fits-all model.

It is important to emphasise that the primary objective of PDA is not to provide rigorous, replicable research results. Rather, PDA aims to bring participant understandings, which are a critical source of knowledge derived from the first-hand experience of people with mental illness or epilepsy, to the mental health and development debate. However, as the approach develops and is further applied in different settings, the methods and process can be further standardised to increase generalizability to similar populations but not at the expense of local relevance.

Adaptability Is More Important than Formulae

The process may be unpredictable as its implementation depends on the effective engagement of individual participants as well as the aptitude of the facilitator in group-dynamics and animation, and their ability to create an effective mutual learning environment. Where participants have had little or no schooling, or prior experience of a formal investigative activity such as PDA, the skill of the facilitator is particularly important. Additionally, since PDA sessions may serve different purposes, sometimes a second-level analysis with stakeholders may be required as shown in the Ghana case study. Also, the reliability of group discussions may be assessed through comparing group responses with individual interviews.

Addressing Power Relations between Participants and the NGO

Despite efforts to establish egalitarianism in the PDA process, whereby all participants are ensured equal opportunity to contribute their own opinions, power differentials between the participants and facilitator as well as within the group of participants are often difficult to overcome, although this is a common challenge to all participatory research processes. The facilitator represents *BasicNeeds*, an NGO that offers the possibility of a better future for the community. Fear of losing services may therefore cause participants to refrain from criticising interventions or services that may be associated

with *BasicNeeds'* programs, raising questions about whose needs are being met by the PDA process. Great care is therefore taken to create a non-threatening environment and to convince the participants of the importance and value of their honest input, and of the capacity for their collective criticisms to initiate positive social change. Care is also taken to discuss when some recommendations may not be taken up.

Addressing Equality between Participants

Careful attention must also be paid to ensure that participants, who are routinely socially excluded, such as women or individuals with severe mental illness or epilepsy, are given equal opportunity to speak out. This helps to prevent internal power relationships from allowing certain participants to dominate the process. If values of mutual education and democratic systems of decision-making are not sustained throughout PDA, tolerance of divergent viewpoints may not prevail. Engaging multiple voices of experience and eventually acquiring group consensus is important for generating a comprehensive list of collective recommendations. Therefore managing power differentials within the group is a challenging but critical task. Power differentials may be addressed by separating people from different genders, diagnoses or age groups, and separating people with mental illness or epilepsy from their carers.

The Challenge of Empowerment

Participatory research processes are generally believed to empower the participants. The definition of empowerment is widely debated but has been commonly defined as an increased ability to make choices (Kabeer 1999). Advocates of participatory approaches argue that an open, democratic environment of learning where people engage in dialogue, are listened to and negotiate a majority consensus is, in itself, a strategy for achieving empowerment (Kindon/Pain/Kesby 2007). In practice, participatory approaches are prone to group consensus where only a few voices from within the group are actually heard. This is a particular concern for marginalised populations such as poor people with mental illness or epilepsy. Mere participation in the PDA process does not necessarily empower individuals, which is difficult to measure, but provides a framework for empowering action (Beresford 2002). At this stage, empowerment is seen as a long-term goal rather than a definitive achievement of PDA.



Selecting Participants Fairly

Fair subject selection dictates that research objectives rather than other biases (such as convenience sampling) should form the basis for recruitment of participants into a study and that those who bear the risks of participation in the research should also benefit from it (Khanlou/Peter 2005). Fair subject selection poses a challenge for the PDA approach in that it is not always easy to determine who from any given community might benefit from participation. BN programs exist in many areas providing a large sample pool for PDA. While such a sample may not meet the most stringent requirements for scientific representativeness, our sample numbers suggest that these PDA sessions are likely to contain viewpoints representative for BasicNeeds program participants.

Confidentiality and Informed Consent

The collection of data for use in PDA takes place in communities that generally place greater importance on sharing than privacy. In this socio-cultural context, there are very few activities relegated to the private realm; people actively participate in the daily business of their neighbours. However, some people with mental illness or epilepsy may desire privacy to avoid further stigma. This may be demonstrated in a lack of ability to recruit someone to participate in a PDA session. Despite the recognition that less emphasis is placed on confidentiality in the local operational context, *BasicNeeds'* places great emphasis on informed consent. In all situations where personal information is shared in a collective session, or is to be used at a later date to inform advocacy work, the concerned individual and their family members are informed of the motivations and goals for documenting the evidence and the potential future uses for the information. Individuals may choose not to have their personal information used at any time during the process. Outside of the PDA sessions themselves, participant names are not used (unless consent is given) for any other purpose the analysis material may serve.

Conclusion

BasicNeeds works, by including the perspectives of people with mental illness or epilepsy in its development interventions, to bring valuable local insights to global mental health debates and to policymakers. PDA gives depth and substance to the experience of being part of a mental health and development program as it brings the views and experiences of the participants and their carers to the centre of the pic-

ture. This enables them to feel part of a meaningful exchange that is about their collective view and may also guide the program implementer in their efforts. PDA, while it faces some limitations, has produced both qualitative and quantitative evidence that is produced at the grass roots level. This systematic recording and quantification of program participant's experience in a program is relatively rare, particularly when it is used to understand experience and progress over time. The extent to which this data can be aggregated and used at a higher level is an interesting question since its greatest influence is probably on the life of the group itself. However, the knowledge gained is hugely valuable for a rich deep understanding of context, and the proper and thoughtful presentation of material on a case study basis may be useful for specific programmatic understanding. Additionally, PDA promotes a better understanding of what it is like to be both poor and mentally ill and, at one and the same time, to be in a program and in a process that ultimately will better the participant and his or her family.

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Zusammenfassung: Partizipative Datenanalyse (PDA) ist eine von BasicNeeds entwickelte teilnehmergesteuerte Methode der Datenanalyse, um Menschen mit psychischen Erkrankungen oder Epilepsie in die angewandte Forschung einzubeziehen und um über spezifische Richtlinien und praktische Maßnahmen zu informieren, die ihr Leben unmittelbar verbessern können. Die Intention dieses Artikels ist es, die PDA-Praxis innerhalb von BasicNeeds zu beschreiben und zu analysieren. Fallstudien aus Kenia und Ghana zeigen den Umsetzungsprozess, in dem Ergebnisse und Empfehlungen der PDA berichtet und mit Mitgliedern der lokalen Regierung geteilt wurden, um für eine Verbesserung der Ressourcen zum Lebensunterhalt für Menschen mit psychischen Erkrankungen oder Epilepsie einzutreten. Ausschlaggebende Merkmale für PDA werden identifiziert und wichtige Erkenntnisse diskutiert.

Résumé: L'analyse participative des données (APD) est une méthode d'analyse de données animée par les participants, développée par BasicNeeds, afin d'inclure les personnes ayant une maladie mentale ou souffrant d'épilepsie dans la recherche appliquée, et de nourrir

les politiques spécifiques et les actions pratiques susceptibles d'améliorer directement leurs vies. L'objectif de cet article est de décrire et d'analyser la pratique de l'APD par BasicNeeds. Des études de cas au Kenya et au Ghana présentent le processus en pratique, où les résultats et les recommandations issus de l'APD ont fait l'objet d'un compte-rendu et ont été transmis aux acteurs du gouvernement local afin de plaider pour une augmentation des ressources vitales allouées aux personnes avec un handicap mental ou épileptiques. Les structures essentielles pour une APD sont identifiées et les leçons clés font l'objet d'une discussion.

Resumen: El Análisis Participativo de los Datos (APD) es un método de análisis de datos orientado a los participantes, que fue elaborado por la organización BasicNeeds con el motivo de incluir a las personas con enfermedad mental o epilepsia en la investigación aplicada. La meta es informarles de mejor manera sobre las estrategias políticas específicas y proyectos prácticos que puedan mejorar sus vidas. El objetivo de este artículo es, describir y analizar la APD como parte de BasicNeeds. Los estudios de casos en Kenya y Ghana describen el proceso y cómo conclusiones y recomendaciones de la APD llegan a los actores locales y los tomadores de decisiones para lograr un mejoramiento de los recursos para las personas con enfermedad mental o epilepsia. Se identifica en este texto las características esenciales de la APD y se discute los resultados mas importantes.

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Mentale Gesundheit und *Inclusive Volunteering* – Konsequenzen für einen internationalen Freiwilligendienst

Marianne Irmeler

Mentale Gesundheit wird im Kontext inklusiver Freiwilligendienste insbesondere hinsichtlich der positiven Auswirkungen von Freiwilligendiensten auf die mentale Gesundheit eines Menschen diskutiert. Ebenso wird die Teilnahme an einem Freiwilligendienst häufig als Möglichkeit der beruflichen Rehabilitation für Menschen mit mentalen Beeinträchtigungen betrachtet. In diesem Artikel werden ein Überblick über den internationalen Forschungsstand in Bezug auf die Partizipation von Menschen mit mentalen Beeinträchtigungen an internationalen Freiwilligendiensten vermittelt sowie die Konsequenzen für zwei beispielhaft vorgestellte deutsche Programme skizziert. Ein Praxisbeispiel zum Prozess der inklusiven Gestaltung des deutschen ASA-Programms gibt Hinweise auf die nationale Entwicklung.

Einleitung

Auf der einen Seite kann *Volunteering* entsprechend der bisherigen internationalen Forschungsergebnisse einen positiven Einfluss auf die mentale Gesundheit von Menschen mit und ohne Behinderung haben. Auf der anderen Seite verweisen die bisherigen Forschungsergebnisse im Bereich *Inclusive Volunteering* auf eine geringere Akzeptanz von Menschen mit Beeinträchtigungen der mentalen Gesundheit im internationalen Freiwilligendienst als beispielsweise gegenüber Menschen mit körperlichen Beeinträchtigungen. In dem vorliegenden Artikel soll ausgehend vom derzeitigen Forschungsstand zu mentaler Gesundheit und *Inclusive Volunteering* aufgezeigt werden, welche Konsequenzen sich aus den Erkenntnissen bisheriger Studien für einen internationalen inklusiven Freiwilligendienst ergeben. Des Weiteren wird anhand eines Praxisbeispiels der Prozess zur Gestaltung einer deutschen Organisation erläutert.

Inclusive Volunteering und Mental Health

Die Begriffe *Inclusive* oder *Supported Volunteering* bzw. *Inklusiver Freiwilligendienst* sind im deutschen Sprachraum noch wenig bekannt. Die Organisation *Volunteering Ireland* (2004) bietet folgende Definition: "Supported volunteering can be defined as the process of assisting volunteers with additional support needs in obtaining and maintaining genuine and meaningful volunteering placements through the provision of relevant supports" (*Volunteering Ireland* 2004:3). Eine äquivalente deutschsprachige Definition findet sich bislang nicht. Demzufolge wird in diesem Artikel der englischsprachige Begriff *Inclusive Volunteering* benutzt. *Inclusive Volunteering* steht im Kontext der Förde-

rung von Partizipation von Menschen mit Beeinträchtigung wie sie nicht nur in der UN-Konvention über die Rechte von Menschen mit Behinderung gefordert wird (vgl. z.B. BRK, Art. 1 „Zweck“, Art. 26 „Habilitation und Rehabilitation“ & Art. 29 „Teilhabe am politischen und öffentlichen Leben“), sondern auch im Grundgesetz der Bundesrepublik Deutschland verankert ist (vgl. BMJ SGB IX).

Mentale Gesundheit wird von der WHO wie folgt definiert: "Mentale Gesundheit ist ein Zustand des Wohlbefindens, in dem der Einzelne seine Fähigkeiten ausschöpfen, die normalen Lebensbelastungen bewältigen, produktiv und fruchtbar arbeiten kann und imstande ist, etwas zu seiner Gemeinschaft beizutragen" (WHO 2001: Fact Sheet N°220). In Anlehnung an diese Definition kann die Beeinträchtigung der mentalen Gesundheit demgemäß sowohl eine Ursache für eine Behinderung sein als auch eine Behinderung die Ursache für die Beeinträchtigung der mentalen Gesundheit eines Menschen sein kann. Bei zusätzlicher Betrachtung der UN-Behindertenrechtskonvention (Art. 1, Absatz 2) wird ebenso deutlich, dass Menschen mit einer Beeinträchtigung der mentalen Gesundheit, sofern diese „[...] in Wechselwirkung mit verschiedenen Barrieren [den jeweiligen Menschen] an der vollen, wirksamen und gleichberechtigten Teilhabe an der Gesellschaft hindern können“, zu Menschen mit Behinderung gezählt werden. In Bezug auf die in diesem Artikel hinzugezogenen Studien werden Menschen mit einer Beeinträchtigung der mentalen Gesundheit im Zusammenhang eben genannter Bedingungen als Menschen mit Behinderung betrachtet.

Im Folgenden wird zunächst der bisherige Forschungsstand zu mentaler Gesundheit im *Inclusive Volunteering*-Sektor beschrieben. Anschließend wird erläutert, welche Bedeutung



diese Forschungsergebnisse für einen internationalen inklusiven Freiwilligendienst haben. Im Zentrum steht hierbei die Frage, welchen Beitrag internationales *Inclusive Volunteering* bei einer Stärkung der mentalen Gesundheit leisten kann.

Forschungsstand

In den bislang vorliegenden Forschungsergebnissen zum Bereich *Inclusive Volunteering* wurden wenige Differenzierungen auf unterschiedliche Beeinträchtigungen vorgenommen. In den Arbeiten von Miller, Stroud und Schleien/USA (z.B. 2005/2005a/2005b), der australischen Organisation Scope (2004), des Institute for Volunteering Research/ Großbritannien (z.B. 2004) oder von Bruce/Australien (2006) wurden zwar ansatzweise die unterschiedlichen Bedürfnisse sowohl der Freiwilligen als auch der Organisationen des Freiwilligendienstes untersucht, es bleibt aber in der Regel bei allgemeinen Studien zum Freiwilligendienst von Menschen mit Beeinträchtigung. Lediglich in den Arbeiten von Clark (2003) und dem *Community Service Volunteers* (CSV 2008)/ Großbritannien finden sich spezielle Studien zu Mental Health-Projekten im Freiwilligendienst. Im Folgenden werden die spezifischen Ergebnisse zu Mental Health und *Inclusive Volunteering* vorwiegend anhand der Ergebnisse von Miller, Stroud und Schleien (2005), CSV (2008) und Scope (2004) dargestellt.

Miller, Stroud und Schleien (2005) befragten in einer Studie 755 Organisationen von Freiwilligendiensten in Amerika, Asien und Europa zu ihren Erfahrungen mit Freiwilligen mit einer Beeinträchtigung. 77% der befragten Angestellten der Organisationen konnten über Erfahrungen in der Beschäftigung von Freiwilligen mit Beeinträchtigung berichten. Die Erfahrungen bezogen sich u.a. auf Menschen mit körperlichen oder sensorischen Beeinträchtigungen, mit geistigen Beeinträchtigungen und mit mentalen Beeinträchtigungen (ebd.:8). Miller, Stroud und Schleien (2005) erläutern, dass viele der befragten Organisationen generell eher Menschen mit einer körperlichen Beeinträchtigung in ihren Freiwilligendienst aufnahmen als Menschen mit einer mentalen oder geistigen Beeinträchtigung. Zu der zurückhaltenden Einstellung gegenüber dem genannten Personenkreis werden nur Vermutungen angeführt und keine eindeutigen Belege formuliert. Miller, Stroud und Schleien (2005) nehmen an, dass die Organisationen aufgrund der eher unkalkulierbaren möglichen Schwierigkeiten sich hierbei zögerlich zeigen. So sei es z.B. einfacher Barrierefreiheit für einen

Menschen im Rollstuhl zu planen, als für einen Menschen, der evtl. in sozialen Kontakten begleitet werden muss oder unter starken tagesabhängigen Stimmungsschwankungen leidet (vgl. ebd.:8).

CSV (*Community Service Volunteers*) führte bis 2008 etwa 100 Freiwilligenprojekte mit über 4500 Freiwilligen mit Beeinträchtigungen der mentalen Gesundheit durch. Die Projekte wurden zum Teil evaluiert und wissenschaftlich begleitet. Die Ergebnisse der Studien von CSV beziehen sich vor allem auf die Vorteile, die *Inclusive Volunteering* für die soziale Inklusion von Menschen mit mentalen Beeinträchtigungen leisten kann. An der hier diskutierten Studie nahmen 150 Freiwillige mit Beeinträchtigungen der mentalen Gesundheit teil, die zwischen 2005 und 2007 im Freiwilligendienst tätig waren. Die Teilnehmenden der Studie selbst berichteten u.a. von folgenden positiven Erlebnissen: neue Freundschaften (29%), erhöhtes Selbstvertrauen (29%), Erlebnis anderen zu helfen und einen Beitrag für die Gemeinschaft zu leisten (18%) (CSV 2008:8). Ein besonderer Schwerpunkt von CSV ist die spezielle Förderung von Freiwilligenprojekten, die Freiwillige begleiten, die nicht nur eine mentale Beeinträchtigung erlitten haben oder gegenwärtig erleiden, sondern auch einen so genannten BME (*black and minority ethnic groups*) background haben. Bei *Capital Volunteering*, einem Projekt von CSV, hatten 44% der Beteiligten einen BME-Hintergrund (ebd.:13). CSV möchte in diesem Rahmen insbesondere Projekte für Flüchtlinge und Asylsuchende mit Beeinträchtigungen der mentalen Gesundheit fördern.

Die Organisation Scope (2004) führte mit 186 australischen Organisationen eine Befragung durch. Auch hier hatten bereits 75% der Organisationen Freiwillige mit einer Beeinträchtigung beschäftigt (Scope 2004:8). Scope stellte jedoch im Gegensatz zu Miller, Stroud und Schleien (2005) differenzierter dar, welchen Anteil die unterschiedlichen Beeinträchtigungen bei den befragten Organisationen einnahmen. Dadurch zeigte sich, dass 30% der beschäftigten Freiwilligen Menschen mit Beeinträchtigungen der mentalen Gesundheit waren. Damit gehört diese Gruppe zu den drei am häufigsten beschäftigten Personengruppen, nach Menschen mit einer körperlichen Beeinträchtigung (47%) und Menschen mit einer Beeinträchtigung des Hörens (36%) (ebd.:9).

In den genannten Studien wird als ein positiver und nachhaltiger Einfluss auf die Lebensqualität von Menschen mit Beeinträchtigungen der mentalen Gesundheit, die an Freiwilligenprojekten teilnahmen, die Möglichkeit zur an-



schließenden beruflichen Rehabilitation identifiziert (vgl. Corden 2002; Volunteering Ireland 2004; Institute for Volunteering Research 2002). Corden (2002:32) erläutert hierzu, dass Freiwilligendienste als Sprungbrett in die bezahlte Beschäftigung erkannt wurden. Menschen, die arbeitslos sind, könnten über Freiwilligendienste Kompetenzen erwerben, mit denen sie bessere Möglichkeiten auf dem ersten Arbeitsmarkt hätten. Auch *Volunteering Ireland* (2004:18) betont die Möglichkeit, Berufserfahrungen zu sammeln, um anschließend in eine bezahlte Beschäftigung übergehen zu können, gerade für Menschen, die auf dem ersten Arbeitsmarkt Diskriminierungen unterliegen (wie z.B. Menschen mit Beeinträchtigungen oder Menschen, die lange Zeit arbeitslos waren). Weder Corden (2002) noch *Volunteering Ireland* (2004) diskutieren hierbei in kritischer Form die notwendige Abgrenzung von Freiwilligendiensten zu Praktika. Während Praktika eindeutig dem Ziel der beruflichen Qualifizierung dienen, ist einem Freiwilligendienst sowohl die Persönlichkeitsentwicklung der Freiwilligen sowie die Möglichkeit das dem Menschen innewohnende Bedürfnis, anderen zu helfen, immanent (vgl. Possart 2006:12; *Volunteering Ireland* 2004:16).

2003 veröffentlichte Sherry Clark vom National Centre of Volunteering/Großbritannien basierend auf einer zweijährigen Studie den bislang einzigen Leitfaden zur Partizipation von Menschen mit Beeinträchtigungen der mentalen Gesundheit in Freiwilligenprojekten sowie gemeinsam mit *Volunteer Now* (2011) die darauf aufbauende Checkliste *Mental Health & Volunteering*. Die Checkliste fasst in fünfzehn Punkten zusammen, in welcher Form sich eine Freiwilligendienstorganisation auf die Beschäftigung von Menschen mit Beeinträchtigungen der mentalen Gesundheit vorbereiten kann. Des Weiteren werden Hinweise zur Begleitung der Freiwilligen formuliert. Hierbei werden sowohl Assistenzpersonen erwähnt als auch die Durchführung einer Probephase, die sowohl der Organisation als auch den Freiwilligen die Möglichkeit geben soll, Schwierigkeiten zu identifizieren (vgl. *Volunteer Now* 2011).

Eine ausführliche Grundlage bietet des Weiteren die Publikation von Hershey (2005) „*Survival Strategies for Going Abroad: A Guide for People with Disabilities*“. Aus dieser Publikation wurde ebenfalls eine Checkliste erstellt, die sich jedoch im Gegensatz zu der von Clark (2011) an die Freiwilligendienstleistenden selbst richtet und nicht an die Organisation. Hershey zählt achtzehn Punkte auf, die einem Menschen mit Beeinträchtigung bei der Vorbereitung eines

Freiwilligendienstes im Ausland dienen sollen. Sie geht hierbei sowohl auf unterschiedliche Beeinträchtigungen ein als auch auf unterschiedlichste Formen der Assistenz (sowohl Begleithunde als auch Hilfsmittel und Assistenzpersonen).

Konsequenzen für den internationalen Freiwilligendienst

Ausgehend von dem erläuterten Forschungsstand wird im Folgenden erläutert, welche Bedeutsamkeit diese Ergebnisse für einen internationalen inklusiven Freiwilligendienst haben.

In Betrachtung der Ergebnisse von Miller, Schleien, Brooke und Merrill (2005b) und Trembath, Balandin und Togher (2009) wird deutlich, dass Freiwilligendienste sowohl für Menschen mit als auch ohne Beeinträchtigung präventiv auf die Stabilisierung der mentalen Gesundheit einwirken können. Miller, Schleien, Brooke und Merrill (2005b:19) erläutern, dass eine Tätigkeit im Freiwilligendienst das Selbstwertgefühl, die Lebenszufriedenheit, das Selbstwirksamkeitsempfinden, die körperliche Gesundheit sowie das persönliche Erleben von Freude erhöhen kann. Des Weiteren könne ein Freiwilligendienst bei positivem Verlauf Depressionen vorbeugen. Ähnliche Bereiche identifizieren Trembath, Balandin und Togher (2009:87): ein gesteigertes Wohlbefinden, die Stärkung von Empowerment, eine Verbesserung nicht nur der physischen, sondern auch der mentalen Gesundheit sowie ein gesteigertes soziales Engagement.

Selbstwertgefühl, Selbstwirksamkeitsempfinden und Selbstakzeptanz sind Teilkonstrukte des Selbstkonzepts. Das Selbstkonzept ist die subjektive Theorie eines Menschen über sich selbst, seine Fähigkeiten und sein Aussehen, die sich aus der Summe selbstbezogener Einschätzungen ergibt (vgl. Schütz 2000:189). Ein positives Selbstkonzept wird als Resilienzfaktor nicht nur für die mentale, sondern auch für die physische Gesundheit bezeichnet (vgl. Laskowski 2000:9). Wagner und Alfermann (2006:340) ergänzen, dass das Selbstkonzept eine „wichtige psychosoziale Gesundheitsressource“ sei und die Lebensqualität eines Menschen determiniere.

Ausgehend von denen von Miller, Schleien, Brooke und Merrill (2005a) berichteten Bedenken innerhalb der Organisationen des Freiwilligendienstes bzgl. Menschen mit Beeinträchtigungen der mentalen Gesundheit und unter Einbezug der Checkliste zu *Mental Health & Volunteering* von Clark/*Volunteer Now* (2011) s.o. und dem *Guide for People with Disabilities* von



Hershey (2005) werden im Folgenden bedeutsame Aspekte für einen internationalen Freiwilligendienst für Menschen mit mentalen Beeinträchtigungen zusammengestellt. Hierbei ist zu beachten, dass sich die zugrundeliegende Literatur auf Programme im europäischen und außereuropäischen Ausland beziehen, während die hier angesprochenen Organisationen deutsche Programme durchführen: ASA – das entwicklungspolitische Lern- und Qualifizierungsprogramm ist ein Programm von *Engagement Global gGmbH - Service für Entwicklungsinitiativen*. *Weltwärts* ist der Freiwilligendienst des Bundesministeriums für wirtschaftliche Zusammenarbeit und Entwicklung (BMZ) in Deutschland.

Für einen internationalen Freiwilligendienst für Menschen mit mentalen Beeinträchtigungen lassen sich schließlich folgende bedeutsame Aspekte zusammenfassen, die z.B. in den Programmen ASA oder *weltwärts* berücksichtigt werden könnten:

Für Organisationen des Freiwilligendienstes:

1. Die eigenen Gefühle und Ängste bzgl. Beeinträchtigungen der mentalen Gesundheit bewusst machen.
2. Innerhalb der Organisation die Unterschiede zwischen Beeinträchtigungen der mentalen Gesundheit und Lernbeeinträchtigungen sowie geistigen Beeinträchtigungen verdeutlichen.
3. Nutzen von qualifiziertem Assistenzpersonal.
4. Reisebereitschaft und Reisefähigkeit der Person überprüfen.
5. Grenzen der Realisierbarkeit erkennen und akzeptieren.

Für Freiwillige:

1. Die eigene Beeinträchtigung realistisch darstellen.
2. Grenzen der eigenen Belastbarkeit erkennen und akzeptieren.

Deutlich ist, dass in einem internationalen inklusiven Freiwilligendienst insbesondere eine qualifizierte und intensive Vorbereitung die Basis für das Gelingen des Projektaufenthaltes bietet. Des Weiteren ist in diesem Kontext zu beachten, dass es nicht um eine alternative Therapie der Freiwilligen gehen sollte. Ein internationaler Freiwilligendienst kann jedoch sowohl präventiv auf die Stabilisierung der mentalen Gesundheit der Freiwilligen einwirken und zusätzlich Menschen, die eine Beeinträchtigung durchlebt haben, in ihrem Selbstkonzept stärken. Hier sei auf die Ergebnisse der CSV Studien verwiesen, in denen die Teilnehmenden vom Erlebnis berichten „einen Beitrag leisten zu können“ (CSV 2008:8). Eben dieser eigene Beitrag wird anfangs in der Definition der WHO

(2001) zu mentaler Gesundheit genannt „[...] imstande ist, etwas zu seiner Gemeinschaft beizutragen“ (Fact Sheet N°220). Die bisherigen Forschungsergebnisse können eine Basis bieten, um internationale Freiwilligendienste für Menschen mit mentalen Beeinträchtigungen zugänglich zu machen und um in diesem Zusammenhang *Good Practice*-Beispiele zu demonstrieren oder Studien für die Planung innerhalb der Organisationen hinzuzuziehen. Dennoch mangelt es gerade im deutschsprachigen Bereich an grundlegenden Forschungsergebnissen zur Partizipation von Menschen mit mentalen Beeinträchtigungen an internationalen Freiwilligendiensten.

Praxisbeispiel: Inclusive Volunteering

Im Folgenden wird beispielhaft der Prozess auf dem Weg zu einer inklusiven Gestaltung am Beispiel des ASA-Programms skizziert.

Vor über fünfzig Jahren entstand das ASA-Programm im Rahmen einer Studierendeninitiative: Arbeits- und Studienaufenthalte im Ausland. Das ASA-Programm bietet gegenwärtig jährlich etwa 250 Freiwilligen die Möglichkeit, an Projekten im globalen Süden teilzunehmen, Einblicke in die internationale Zusammenarbeit zu gewinnen, sowie interkulturelle Kompetenzen zu erwerben und sich anschließend im ASA-Netzwerk ehrenamtlich zu engagieren. Mittlerweile vereint das ASA-Programm fünf Teilprogramme: Im GLEN-Programm reisen zwei Freiwillige aus zwei unterschiedlichen europäischen Ländern in ein Projekt im globalen Süden aus. *ASApreneurs* gestaltet Projekte in Kooperation mit Unternehmen und anderen wirtschaftlichen Akteuren. Im Süd-Nord-Programm reisen sowohl zwei Freiwillige des Partnerlandes zu einer sogenannten Nordphase nach Deutschland als auch anschließend zwei deutsche oder schweizerische Freiwillige in einer sogenannten Südphase in das Partnerland. Weiterhin gibt es das ENSA-Programm für Schulklassen und das Basisprogramm, bei dem die Nordphase im Gegensatz zum Süd-Nord-Programm entfällt. Träger des ASA-Programms ist die *Engagement Global gGmbH - Service für Entwicklungsinitiativen*. Finanziert wird das ASA-Programm unter anderem vom Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung (BMZ), den meisten Bundesländern, deutsch-europäischen Partnerorganisationen, im Rahmen des Süd-Nord-Programms Partnerorganisationen im globalen Süden sowie im Rahmen von *ASApreneurs* unterschiedlichen Partnern aus der Wirtschaft. Das ASA-Programm versteht sich heute als „dynamisches Lernprogramm zur Ausbil-



„dung von gesellschafts- und entwicklungspolitisch interessierten, weltoffenen und kritisch nachfragenden Menschen“ (vgl. *ASA-Programm* 2012:o.A.).

Die Forderungen nach einer inklusiven Gestaltung des *ASA-Programms* begründen sich auf dem Nationalen Aktionsplan (2011) der deutschen Bundesregierung zur Umsetzung der UN-BRK. Für das hier behandelte Thema sind insbesondere die Punkte 3.8 *Mobilität* und 3.12 *Internationale Zusammenarbeit* des Aktionsplans von Bedeutung. Die im Maßnahmenkatalog unter *Mobilität* genannten Vorhaben zum Ausbau einer barrierefreien Reiseplanung und zur Unterstützung von Forschungsvorhaben für barrierefreie Mobilität werden für einen inklusiven internationalen Freiwilligendienst äußerst bedeutsam sein.

Im Handlungsfeld *Internationale Zusammenarbeit* sind für das *ASA-Programm* und *Inclusive Volunteering* folgende Maßnahmen von Bedeutung:

- eine inklusive Gestaltung von *weltwärts* und
- die Einrichtung einer Anlaufstelle für das Thema Behinderung und Entwicklung (BMAS 2011:174).

Demzufolge wird seitens der Bundesregierung eindeutig der Gedanke des *Inclusive Volunteering* formuliert: „Das Freiwilligenprogramm „weltwärts“ trägt dazu bei, den Arbeitsmarkt der Entwicklungszusammenarbeit für Menschen mit Behinderungen zu öffnen. Der finanzielle Mehraufwand bei der Entsendung geeigneter Bewerber/innen mit Behinderungen wird durch „weltwärts“ getragen“ (ebd.:174).

Neben den Forderungen zu *weltwärts* ist jedoch eine weitere Maßnahme zu erwähnen: „Es wird geprüft, ob in der geplanten und noch zu schaffenden BMZ-Servicestelle für bürgerschaftliches Engagement eine zentrale Anlaufstelle für Querschnittsthemen eingerichtet werden kann, die sich auch der Belange und Teilhabe von Menschen mit Behinderungen in der Entwicklungszusammenarbeit widmet“ (Ebd.:174). Die Servicestelle *Engagement Global* ist mittlerweile eingerichtet, eine derartige Anlaufstelle (mit Stand von Juli 2012) zumindest auf der Webseite noch nicht zu identifizieren.

Um den Prozess innerhalb des *ASA-Programms* zu forcieren, bildeten ehemalige *ASA-Programm-Teilnehmende* 2011 eine *Arbeitsgruppe Inclusive Volunteering*. Die AG hat sich das langfristige Ziel gesetzt, dazu beizutragen, *ASA* inklusiv zu gestalten. Hierbei sollten nicht nur Menschen mit mentalen Beeinträchtigungen, sondern allgemein Menschen mit jeglicher Beeinträchtigung berücksichtigt werden.

Angelehnt an Miller, Stroud und Schleien

(2005 6) werden von der AG *Inclusive Volunteering* folgende Bereiche berücksichtigt: (1) eine gute Passung der Fähigkeiten und Bedarfe der Freiwilligen mit ihren Projekten (2) Identifizierung und Bereitstellung geeigneter Unterkünfte und Assistenzen (3) Trainings für Mitarbeitende der Organisation zum bewussten Umgang mit Beeinträchtigung (4) die Schaffung von Informationsmaterial für Freiwillige mit Beeinträchtigung (5) Aufklärungsarbeit über die Vorteile inklusiver Strukturen. Die AG führte bisher folgende Aktivitäten durch:

Zu (1) wurde eine Befragung der *ASA-Programm-Teilnehmenden* 2011/2012 zur Einschätzung der einzelnen Projektstandorte, ihrer Ressourcen und Barrieren durchgeführt. Hierbei wurden sowohl Angaben zu den Arbeitsplätzen als auch zu den Standorten der Projekte erhoben.

Zu (2) wurde eine Online-Umfrage an die aktuell von *ASA* genutzten Seminarhäuser gesendet. Die Leitenden der Seminarhäuser in Deutschland und der Schweiz wurden hierbei gebeten, Angaben zur Barrierefreiheit ihrer Häuser zu machen.

Zu (3) sollen fortlaufend im Rahmen von *ASA-Seminaren* Workshops von der AG angeboten werden, an denen sowohl Haupt- als auch Ehrenamtliche eingeladen sind teilzunehmen.

Zu (4) und (5): Die AG sieht sich als Ansprechpartnerin für Menschen mit Beeinträchtigung, die sich für eine Bewerbung bei *ASA* interessieren. Des Weiteren arbeitet sie zurzeit an Informationsbroschüren sowohl für Freiwillige mit einer Beeinträchtigung als auch für nicht beeinträchtigte Teilnehmende des Programms, um für den Themenkomplex *Beeinträchtigung und Freiwilligendienst* zu sensibilisieren und die Vorteile inklusiver Strukturen herauszustellen. Übergreifend für alle Bereiche gilt eine stetige Wissensgenerierung, in der aktuelle Entwicklungen zum Thema *Inclusive Volunteering* aufgegriffen werden.

Aktuell wurde für den *ASA-Zyklus* 2012/2013 ein Projekt vom *Deutschen Blinden- und Sehbehinderten Verband* (DBSV) in Kooperation mit *Urece Sports and Culture for the Blind* (Urece)/ Brasilien vorgeschlagen. In diesem Projekt sollen zwei deutsche Freiwillige, ohne Sehfähigkeit bzw. mit Sehbeeinträchtigung, in Kooperation mit Mitarbeitenden von *Urece* Barrieren (z.B. im Öffentlichen Nahverkehr) für Menschen mit Sehbeeinträchtigung in Rio de Janeiro identifizieren. Die Ergebnisse des Projekts sollen anschließend den Menschen vor Ort dienen, aber auch für den Tourismus genutzt werden. Durch die gemeinsame Arbeit sollen sowohl die Per-



spektive der Menschen aus Rio de Janeiro berücksichtigt werden als auch die Perspektive möglicher Touristen. Richtlinien des DBSV können hierbei als Erhebungsinstrument dienen.

Um gemäß den Forderungen des Nationalen Aktionsplans nicht nur eine Beratungsstelle einzurichten, sondern auch Programme wie *weltwärts* inklusiv zu gestalten, bedarf es grundlegender Studien zur Partizipation von Menschen mit Beeinträchtigung in internationalen Freiwilligendiensten. Um Menschen mit Beeinträchtigung in diesem Bereich eine Teilhabe zu ermöglichen, muss zunächst herausgestellt werden, inwiefern die Zielgruppe überhaupt Zugang zu Informationsmaterial hat. Es bedarf nicht nur der Sammlung von Best Practice-Beispielen, die Menschen mit Beeinträchtigung ermutigen sollen, sich für Freiwilligendienste zu bewerben. Vielmehr sollte systematisch im Rahmen bedarfsorientierter Befragungen von Menschen mit Beeinträchtigung untersucht werden, wie ein internationaler inklusiver Freiwilligendienst aussehen müsste. Dazu sind angelehnt an Miller, Stroud und Schleien (2005) folgende Themen notwendig:

Zu (1) Welche Informationen benötigt eine Person mit Beeinträchtigung, um eine Projektbeschreibung als passend für sich zu identifizieren?

Zu (2) Welche Barrieren im Sinne von Umweltfaktoren können entstehen bzw. einen Menschen mit Beeinträchtigung daran hindern, an einem internationalen Freiwilligendienst teilzunehmen?

Zu (3) Was müssen Mitarbeitende von Freiwilligendiensten wissen, um Menschen mit Beeinträchtigung bedarfsgerecht in ihrem Programm zu begleiten? Von wem sollten Sensibilisierungstrainings durchgeführt werden und in welcher Intensität?

Zu (4) Welche unterschiedlichen Informationsquellen werden von Menschen mit Beeinträchtigung genutzt und wie müssten sie aufbereitet werden?

Zu (5) Welche Vorteile sehen Menschen mit Beeinträchtigung an einer Teilnahme an internationalen Freiwilligendiensten?

Ansätze partizipativer Forschungsmethoden (Flieger 2003; Bergold/Thomas 2010) können hierbei einen angemessenen Rahmen für Studien im Bereich *Inclusive Volunteering* bieten. Insgesamt kann hier nur Miller, Schleien, Brooke und Merrill (2005a:23) zugestimmt werden, dass weitere Forschung in diesem Bereich notwendig ist, um systematisch Prozesse zur Inklusion bei Anbietern internationaler Freiwilligendienste zu initiieren.

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Abstract: *Mental Health is discussed within the context of inclusive volunteer services, especially in relation to the positive effect of volunteering on the mental health of those involved. Also the article looks at the fact that volunteering is often considered as a form of vocational rehabilitation for people with mental health conditions. The article gives an overview of the state of international research in relation to the participation of people with*

mental health conditions involved in international volunteer services and sketches the consequences for two German model programmes. A practical example of the process of inclusive development of the German ASA programme outlines what is happening nationally.

Résumé: *Dans le cadre de services volontaires inclusifs, en particulier en ce qui concerne les effets positifs des services volontaires sur la santé mentale d'une personne, la santé mentale fait l'objet d'un débat. De même, la participation à un service volontaire est souvent considérée comme une forme de réinsertion professionnelle pour personnes ayant une incapacité mentale. Cet article livre un compte rendu de la recherche internationale sur la participation de personnes handicapées mentales aux services volontaires internationaux, et dresse une esquisse des conséquences à l'instar de deux programmes allemands présentés à titre d'exemple. Un exemple pratique issu du processus d'organisation inclusive du programme allemand ASA fournit des indications sur le développement national.*

Resumen: *Este artículo presenta una visión general sobre el estado de la investigación en relación a la participación de las personas con discapacidad mental colocados en los servicios internacionales de voluntarios. Además se resume las consecuencias para dos programas alemanes ejemplares. Un ejemplo práctico del proceso de diseño inclusivo el programa alemán ASA ofrece informaciones sobre el desarrollo nacional.*

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Neue Resolution der WHO: Die globale Belastung durch psychische Erkrankungen und die Notwendigkeit für eine umfassende und koordinierte Antwort auf nationaler Ebene¹

Die 65. Versammlung der Weltgesundheitsorganisation (WHO) hat am 25. Mai 2012 die Resolution WHA 65.4 zu psychischer Gesundheit verabschiedet. Diese appelliert an die 194 Unterzeichnerstaaten, aktive Maßnahmen zur Verbesserung der Lebensqualität und Gesundheitshilfe von Menschen mit psychischen Erkrankungen durchzusetzen. Die Resolution basiert auf einem Bericht, der aufrüttelnde Daten erneut ins Bewusstsein ruft: mehr als 13% der Weltbevölkerung leiden an psychischen Erkrankungen (in Europa sind es etwa 20%), Tendenz stark steigend. Im Jahr 2030 sollen fünf der zehn mit den stärksten Beeinträchtigungen verbundenen Erkrankungen aus dem Bereich der Psychiatrie stammen: Depression, Alkoholsucht, Demenz, Schizophrenie und bipolare Störungen. Mit den in den letzten Jahren rasant gestiegenen Behandlungsfällen nehmen weltweit auch die Gesundheitskosten im Bereich Psychiatrie und Psychotherapie stark zu. 76% bis 85% aller psychisch erkrankten Menschen in armen Ländern und Schwellenländern erhalten keine Behandlung, in den Industrieländern sind es immerhin noch 35% bis 50%. Psychische Erkrankungen gehen häufig mit anderen Erkrankungen und sozialen Problemen einher. Weltweit sind psychische Erkrankungen vielfach kombiniert mit Suchtproblemen, HIV/Aids, häuslicher Gewalt, Armut und Arbeitslosigkeit. In den Industrieländern sind es vor allem die zunehmenden Demenz- und Depressionserkrankungen die zu Besorgnis Anlass geben. Besonderen Gefährdungen unterliegen psychisch erkrankte Menschen in Kriegs- und Krisengebieten, aber auch dort, wo psychische Erkrankungen in religiösen oder kulturellen Kontexten oder aus politischen Gründen als Stigmata gelten und kriminalisiert werden. Die Resolution erhebt fünf wesentliche Handlungsfelder als prioritär:

1. Die Unterzeichnerstaaten sollen in Form nationaler Aktionspläne umfängliche Strategien zum Schutz und zur Behandlung von Menschen mit psychischen Erkrankungen realisieren und Präventionsmaßnahmen stärken.
2. Die Strategien müssen menschenrechtlich fundiert werden, umfassende Maßnahmen gegen Stigmatisierung und Diskriminierung

von Menschen mit psychischen Erkrankungen beinhalten und vor allem auf die Stärkung der Betroffenen und deren Angehörigen abzielen. Ein Fokus liegt auf gemeindebasierten und nicht-institutionalisierten Angeboten.

3. Die Maßnahmen müssen mit umfassenden Analyse- und Evaluationsinstrumenten verknüpft werden, die zunächst für die Identifizierung von Trends im Hinblick auf Prävention und Gesundheitshilfe eingesetzt werden.
4. Mental Health (psychische Gesundheit) muss zu einem prioritären Arbeitsfeld innerhalb der gesamtstaatlichen Gesundheits- und Entwicklungsprogramme aufgebaut werden.
5. Die Unterzeichnerstaaten sind aufgefordert, sich mit dem WHO-Sekretariat im Hinblick auf die Erarbeitung ihrer Aktionspläne zum Erhalt und zur Förderung von psychischer Gesundheit zu koordinieren.

Die Resolution schließt mit der Aufforderung, die jeweiligen nationalen Aktionspläne zur psychischen Gesundheit dem WHO-Vorstand zu dessen 132. Sitzung vorzulegen.

In den Einzelländern wird es in der Folge darum gehen, dass die Umsetzung der Resolution durch die Zivilgesellschaft kritisch begleitet wird bzw. dort, wo sie staatlicherseits nicht aufgegriffen wird, die Umsetzung entsprechend einzufordern. Resolutionen haben die Schwäche, dass sie keine bindende Wirkung oder Verpflichtung nach sich ziehen. Sie sind anders als Menschenrechtskonventionen mit juristischen Mitteln kaum einklagbar. Um so wichtiger wird es für zivilgesellschaftliche Akteure sein, die Forderungen der Resolution in Bewusstseins- und Lobbyarbeit einzubringen. Bei der Formulierung des Aktionsplanes können sie sich als Partner anbieten und dabei eigene Ziele und Strategien formulieren.

In der Resolution WHA 65.4 fällt auf, dass sie immer wieder Bezüge zum Thema Behinderung aufgreift und dabei auch explizit die UN-Konvention über die Rechte von Menschen mit Behinderungen (BRK) nennt. Menschen mit psychischen Erkrankungen haben ausdrücklich das Recht, sich auf die Forderungen der BRK zu beziehen. Die Übergänge von psychischer Erkran-



kung zum Kontext Behinderung sind fließend.

In Deutschland haben unlängst zwölf große zivilgesellschaftliche Organisationen aus dem Bereich der Psychiatrie und Psychiatrie-Selbsthilfe eine wegweisende Stellungnahme zur BRK abgegeben und damit illustriert, wie notwendig es ist, Menschenrechte mit gesellschaftlicher Analyse und Forderungen zur Verbesserung der Lebenssituation von Menschen mit psychischen Erkrankungen zu verbinden². Ähnliches könnte in anderen Ländern aufgegriffen werden und in Beziehung zu den von der Resolution WHA 65.4 geforderten nationalen Aktionsplänen zur psychischen Gesundheit gestellt werden.

Im Sinne der Ottawa-Charta der WHO von 1986 wird Gesundheit nicht als ein vorrangiges Lebensziel sondern als ein Zustand des vollständigen körperlichen, geistigen, psychischen und sozialen Wohlbefindens definiert und als eine grundlegende Basis des alltäglichen Lebens für alle Menschen. Dies gilt es auch im Hinblick auf die Resolution WHA 65.4 und die Durchsetzung von psychischer Gesundheit zu beachten. Gesundheit ist damit kein Selbstzweck sondern basiert auf einem individuellen

Empfinden, das gesellschaftlich gepflegt und rechtlich geschützt werden muss. Über die Arbeit mit nationalen Aktionsplänen zur gesamtgesellschaftlichen Stärkung von psychischer Gesundheit sollten vor allem diese Aspekte Beachtung finden.

Notes

- 1 Engl. Original: The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level, siehe http://www.who.int/mental_health/en/ (letzter Zugriff 29.6.2012)
- 2 Stellungnahme der Verbände des *Kontaktgespräches Psychiatrie* in Deutschland zum Übereinkommen der Vereinten Nationen über die Rechte von Menschen mit Behinderung vom 15. Mai 2012, siehe unter <http://www.cbpcaritas.de/53606.asp?id=1412&page=1&area=efvkelg> (letzter Zugriff 30.6.2012)

Information: http://www.who.int/mental_health/WHA65.4_resolution.pdf

Thorsten Hinz



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Verbrechen zu beweisen,
die angeblich
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Kurzmeldungen/Announcements

Inklusion in internationalen Freiwilligendiensten: Gesetzliche Bestimmungen müssen geändert werden

Mehr als 60 Teilnehmerinnen und Teilnehmer diskutierten vom 12. bis 14. Juni in Essen beim internationalen Workshop *weltwärts alle inklusive!* über die Voraussetzungen, die erfüllt sein müssen, damit mehr junge Erwachsene mit Behinderung am weltwärts-Programm, dem Freiwilligendienst des Bundesministeriums für wirtschaftliche Zusammenarbeit und Entwicklung (BMZ), teilnehmen können. TeilnehmerInnen, die bereits Auslandserfahrungen im Freiwilligendienst gemacht haben machten deutlich, dass die Unterstützung durch Behörden für einen Freiwilligeneinsatz im Ausland unzureichend sei. „Die höchste Barriere für mich war, die Finanzierung einer persönlichen Assistenz im Ausland genehmigt zu bekommen“, berichtete eine der Rückkehrerinnen des weltwärts-Programms. Sozialämter finanzieren eine Assistenz im Ausland für maximal sechs Wochen – ein Freiwilligendienst im Ausland oder ein Auslandsstudium über mehrere Monate sind so nicht möglich. Die Teilnehmenden forderten daher die zuständigen Politiker auf, die gesetzlichen Bestimmungen zu ändern und an behinderungsspezifische Mehrbedarfe anzupassen. Außerdem forderten potenzielle Freiwillige eine Flexibilisierung der Freiwilligendienste für Menschen mit Behinderung. So sei zum Beispiel eine Altersbegrenzung von 28 Jahren, wie beim weltwärts-Programm, für viele Menschen mit Behinderung unangemessen, da diese aufgrund gesundheitlicher Einschränkungen möglicherweise mehr Zeit für Schule und Studium benötigten. Des Weiteren wurde deutlich, dass junge Menschen mit Behinderung selbst weniger Ängste vor einem Auslandseinsatz haben als die Entsendeorganisationen und dass viele Freiwillige durchaus bereit sind, größere Anstrengungen für einen Auslandsaufenthalt zu unternehmen, wenn die Einsatzstelle inhaltlich zu ihnen passt. Selbstvertretungsorganisationen forderten die Entsendeorganisationen auf, gezielt Informationen für Bewerber und Bewerberinnen in barrierefreier Form zu veröffentlichen. Der Veranstalter des Workshops bezev (Behinderung und Entwicklungszusammenarbeit) kündigte an, die Empfehlungen aufzubereiten und sich auch politisch für die Inklusion in internationalen Freiwilligendiensten einzusetzen. Unter den 10.000 Freiwilligen, die beim weltwärts-Programm des BMZ teilgenommen haben, waren lediglich fünf junge Erwachsene mit Behinderung. Das zeigt, dass Freiwillige mit Behinderung in Freiwilligendiensten deutlich unterrepräsentiert sind. Aus diesem Grund hat bezev das Pilotprojekt *weltwärts alle inklusive!* ins Leben gerufen, mit dem in Zukunft mehr Menschen mit Behinderung die Teilnahme am weltwärts-Programm

ermöglicht werden soll.

Information: <http://www.bezev.de/freiwilligendienst/weltwaerts-alle-inklusive.html>.

Wie Inklusion in der Entwicklungszusammenarbeit gelingen kann

Community Based Rehabilitation (CBR) ist eine besonders geeignete Strategie, um die Inklusion von Menschen mit Behinderungen in der Entwicklungszusammenarbeit zu verwirklichen. Das war das Ergebnis der internationalen Tagung *Von lokal bis global. Community Based Rehabilitation – eine Strategie zur Umsetzung einer inklusiven Entwicklung*, die vom 3. bis 4. Mai in Bonn stattfand. In Workshops und Vorträgen befassten sich die 80 Teilnehmerinnen und Teilnehmer mit den von der Weltgesundheitsorganisation (WHO), UNESCO und der Internationalen Arbeitsorganisation (ILO) entwickelten CBR-Leitlinien und diskutierten, wie Inklusion in der Entwicklungszusammenarbeit praktisch umgesetzt werden kann.

Charakteristisch für CBR ist, dass Projekte gemeindenah durchgeführt werden und Menschen mit Behinderungen und ihr Umfeld an Entscheidungsprozessen und an der Projektdurchführung aktiv beteiligt sind. Dieser partizipative Ansatz von CBR trägt somit entscheidend dazu bei, die von der UN Konvention geforderte Teilhabe von Menschen mit Behinderungen in die Praxis umzusetzen. Eine weitere Stärke der CBR Leitlinien ist es, dass sie auch in ländlichen Regionen mit begrenzter Infrastruktur angewendet werden können. Dabei werden alle vorhandenen Ressourcen gebündelt, denn CBR schließt Menschen mit Behinderungen, ihre Familien und Gemeinden sowie ExpertInnen mit ein. So wurden zum Beispiel in einer ländlichen Region in Indien unter der Verantwortung der Gemeindemitglieder und mit geringer Unterstützung des Staates über 50 barrierefreie Toiletten in kurzer Zeit gebaut. Ein Grund für den Erfolg von CBR Programmen sieht Chapal Khasnabis (WHO) in der Selbstverantwortung und Motivation der Gemeindemitglieder: „Entwicklung geht schneller und ist besser, wenn die Menschen sie selbst gestalten und die Verantwortung übernehmen.“ Referenten und Referentinnen zeigten anhand von Beispielen aus Malawi, Ägypten und Nepal, dass sich CBR in der Praxis bewährt hat. CBR wird bereits in 90 Ländern angewendet, so Mike Davies (Christoffel-Blindenmission), der zusammen mit vielen anderen Praktikern an den CBR-Leitlinien mitgewirkt hat. Wurde CBR ursprünglich für den Gesundheitsbereich entwickelt, kann der Ansatz heute in allen Lebensbereichen wie Bildung,



Gesundheit, soziale Sicherung, Arbeit und Empowerment angewendet werden. In der abschließenden Podiumsdiskussion machten sowohl staatliche als auch private Akteure der Entwicklungszusammenarbeit deutlich, dass die Inklusion von Menschen mit Behinderungen nicht Aufgabe von Expertinnen und Experten sei, sondern in der Verantwortung jedes Einzelnen liege – genau das ist der Ansatz von CBR.

Information: <http://www.bezev.de/wissen/tagungen/von-lokal-bis-global-community-based-rehabilitation.html>.

A World Without Barriers: Inclusion is a Human Right

World Future Council and Essl Foundation decide on long-term cooperation Hamburg/Vienna, 12th April 2012. Far too often persons with disabilities are being excluded from society. In order to change this situation, many countries have ratified the UN Convention on the Rights of Persons with Disabilities. However for those concerned, the implementation is not satisfactory. For this reason, the Essl Foundation and the World Future Council have decided to co-operate to help improve the legal situation of persons with disabilities worldwide. With a long-term cooperation, the two organisations want to work together to achieve the UN goals for inclusion of persons with disabilities. "To protect and to implement the rights of persons with disabilities, it is important to know the best laws and to promote their widespread implementation. Therefore, we look forward to working closely with the World Future Council," said Martin Essl, Chairman of the Essl Foundation. The World Future Council identifies laws that successfully promote sustainability and human rights worldwide and advises politicians on how to implement these laws.

The two organisations have already collaborated successfully in the past. Together, they brought 250 decision-makers to the international Zero Project Conference on Good Policies for Persons with Disabilities on 22-23th January 2012 in Vienna and then launched the Zero Project to monitor the national implementation of the UN Convention on the Rights of Persons with Disabilities all around the world.

"The Essl Foundation initiated, under the leadership of Martin Essl, an ambitious project - the Zero Project. We truly look forward to further cooperation," said Jakob von Uexkull, Chairman of the World Future Council. "We now need to identify the right laws quickly and effectively promote them."

The Essl Foundation and the World Future Council signed a five-year partnership agreement. In 2012 the Zero Project focuses on the right of persons with disabilities to work.

Information: <http://worldfuture-report.org/fileadmin/>

[user_upload/Press_releases/120412_PR_A_World_without_Barriers_-_Inclusion_is_a_Human_Right.pdf](#)

Social Protection High on the Agenda of EU Development Policies

On May 7th Light for the World together with the Dutch Coalition on Disability and Development organised a seminar on Social Protection and Disability in Developing Countries. The event was held in Brussels under the *End Exclusion - Let's Enable The MDGs* project.

Social protection issues are on the agenda of many CSOs and EU officials such as DG Development and Cooperation – EuropeAid is currently preparing a communication *Social Protection in EU Development Cooperation* following an online consultation. The communication is planned to be published in September 2012 and it is a follow-up to the last year's *Agenda for Change* communication.

Social protection can be a tool to make growth inclusive and sustainable by enabling people to participate in the economy, supporting a healthy workforce and providing protection against risk. Alicia Martin-Diaz from DG DevCo (Directorate-General Development and Cooperation) explained at the seminar that the emphasis of the European Commission (EC) communication will be on equity, efficiency, inclusion and social cohesion. According to the current EC vision, social protection should be based on internal country funding while the EC can help put social protection systems in place in partner countries. In some fragile states the EC could also pay for welfare transfers as an exception but what exactly the EU would fund is an open question at the moment.

Alexandre Cote from the International Disability Alliance emphasised that one of the principal aims of their work is to ensure that people with disabilities would be able to participate meaningfully in life. There are various tools to support people with disabilities in developing countries. Cash transfers work well in many cases but it is not the solution in countries where necessary services for disabled people are not available. Another major issue in managing support systems is *gate keeping* – figuring out the rules and conditions of who is eligible for the support and monitoring this is essential for such programmes to be successful.

Information: <http://www.endexclusion.eu/>.



UNICEF Calls for Social Inclusion of Children With Disabilities in Africa

A 17-year-old, who lost his sight at the age of ten due to river blindness, speaks for many of Africa's children with disabilities when he says: "I thought it was the end of my world, but with education, I am hopeful that I will be useful in society and not be a beggar in the streets." Bai Kamara is enrolled at the UNICEF-supported Educational Centre for the Blind and Visually Impaired in the capital Freetown where work is underway to put the Sierra Leone Child Rights Act into Braille.

Millions of children in Africa live with some sort of disability. On the Day of the African Child 2012, on June 16th, UNICEF called on families, communities and governments throughout the continent to protect children with disabilities from discrimination, violence and neglect, and to provide them with access to all the services they need to grow up healthy and live up to their potential.

"Children living with disabilities continue to be the most excluded among all groups of children in Africa. Only a small portion of them are in school, and far fewer receive the adequate inclusive education they need," said the Chief of UNICEF's Disability Unit, Rosangela Berman Bieler.

Country-specific information suggests that between five and ten per cent of all children in Africa grow up with disabilities. The leading causes of disability - in addition to genetic disorders and complications during birth - include poliomyelitis, measles, meningitis and cerebral malaria, as well as inadequate prenatal and neonatal health care services and inadequate diet leading to stunting.

So far, 25 out of 55 African countries have not yet ratified the Convention on the Rights of Persons with Disabilities that stipulates that children with disabilities should be protected against all forms of discrimination, and that they should have access to education, health services and protection from violence. By becoming a signature state, countries commit themselves to promote equal opportunities for people with disabilities.

School enrolment among children with disabilities is much lower in most countries than among other children. A 2011 UNICEF study undertaken in Madagascar found that on average only 11 per cent of children with disabilities attended primary school, with school attendance among girls much lower. Almost all children interviewed reported that they were ridiculed by other children. Because of such bullying, as well as a lack of inclusive practices, children with disabilities are more likely to drop out of school than their peers without disability. Their learning achievements are often worse than those of other children, because schools are not designed to cater for them and teachers are often not adequately trained.

Children with albinism are particularly at risk of be-

ing excluded and even attacked. Tanzania, the country with one of the largest populations of persons with albinism in the world, assembled children and adults with albinism in special protection centres to protect them from violence and even murder, fuelled by the belief that their body parts may give rise to good luck and fortune.

"I encourage the adoption of legislative measures to improve the socio-economic wellbeing of children living with disabilities and the implementation of protective and rehabilitative programmes," said Agnes Kabore Ouattara, Chairperson of the African Committee of Experts on the Rights and Welfare of the Child.

A number of countries in Africa introduced specific legislation, national policies or strategies to respond to the needs of children with disabilities. When it comes to implementing inclusive programmes and allocating adequate resources, however, many countries lag behind although there are examples of activities aimed at helping disabled children achieve their potential.

Rwanda is one of the countries that invested significantly in specialised education for children with disabilities. The number of children benefiting from special education increased from 632 in 2000 to around 17,000 in 2010. In Ghana, some 6,900 students went to special schools in 2009/2010. In Guinea, the NGO Nimba Centre -- with support from UNICEF -- organises a three year training course for almost 90 children in small trades, ballet, knitting, shoe-repair, literacy and sewing. The Ministry of Education in Lesotho has established a Special Education Unit which supports the integration of learners with special educational needs into mainstream schools and organises related training for teachers.

UNICEF is supporting the development of national frameworks for inclusive education in a number of African countries, which includes the training of teachers and the development of adequate learning materials and facilities. Further to this, UNICEF supports concrete interventions for children with disabilities, for instance through the distribution of text books in Braille for children with visual impairment in Zimbabwe.

Around the Day of the African Child, UNICEF offices throughout Africa, including in Benin, Guinea, Ghana, the Democratic Republic of Congo and Zimbabwe were supporting activities and public events to raise awareness about the situation of children with disabilities.

Information: <http://allafrica.com/stories/201206180384.html>.



New Online Resource Kit on Millennium Development Goals

CBM (Christoffel-Blindenmission) has recently launched a new online resource kit on the Millennium Development Goals (MDGs). The site features a range of easy-to-access resources to understand and advocate for the importance of disability-inclusive MDGs, now and for the future. On the website you can also find CBM's position paper on the post-2015 MDG framework.

Information: <http://www.cbm.org/MDG-online-resource-251195.php>.

Realising Universal Human Rights for Indigenous Persons with Disabilities

In conjunction with the 11th session of the Permanent Forum on Indigenous Issues held at UN Headquarters from 7 to 18 May, an interactive panel discussion was held on 11 May on the theme *Indigenous Persons with Disabilities: Overcoming Challenges to Achieving Rights and Inclusion in Development*. Panelists included Olga Montufar (Nahuatl, Mexico), Kamala Sen Chakma (Chakma, CHT, Bangladesh) and Ipul Powaseu (Papua New Guinea), who explored the complexities of an intersectional identity, as well as approaches to advancing the rights and inclusion in all aspects of development of indigenous persons with disabilities, particularly those in the Global South.

Information: <http://www.un.org/disabilities/default.asp?id=1598>.

New Asian and Pacific Decade of Persons with Disabilities (2013 to 2022)

The 68th session of the Economic and Social Commission for Asia and the Pacific (ESCAP), comprised of Member States of the Asia-Pacific region, adopted a resolution on 23 May 2012 to proclaim a new Asian and Pacific Decade of Persons with Disabilities for the period 2013 to 2022. The resolution, which was sponsored by the Government of the Republic of Korea and co-sponsored by the Governments of Australia, Bangladesh, China, Indonesia, Japan, Malaysia, Mongolia, Solomon Islands, and Thailand, was unanimously adopted by the Commission. The Decade will be launched on 2 November 2012.

Information: <http://www.unescapsdd.org/disability/meeting-document/resolution-asian-and-pacific-decade-persons-disabilities-2013-2022>.

WHO Quality Rights Project – Addressing a Hidden Emergency

The WHO has launched the Quality Rights Tool Kit, which supports countries to assess and improve quality of care and human rights conditions in mental health and social care facilities. The tool kit was prepared with input from international experts, including people with mental and psychosocial disabilities, and is based on the United Nations Convention on the Rights of Persons with Disabilities. Its aim is to give countries information on quality and human rights standards in facilities that must be respected, protected and fulfilled.

All over the world, people with mental and psychosocial disabilities experience a wide range of human rights violations, stigma and discrimination. The care available in mental health facilities around the world is not only of poor quality but in many instances hinders recovery. Training of staff is minimal and out-dated, and the level of knowledge and understanding of the rights of people with mental disabilities is very poor. It is common for people to be locked away in small, prison-like cells with no human contact or to be chained to their beds, unable to move. Inhuman and degrading treatment is common, and people in facilities are often stripped of their dignity and treated with contempt. Violations are not restricted to inpatient and residential facilities; many people seeking care from outpatient and community care services are disempowered and also experience extensive restrictions to their basic human rights. In the wider community, people with mental disabilities are denied many basic rights that most people take for granted. For example, they are denied opportunities to live where they choose, marry, have families, attend school and seek employment. There is a commonly held, yet false, assumption that people with mental health conditions lack the capacity to assume responsibility, manage their affairs and make decisions about their lives. These misconceptions contribute to the on-going marginalisation, disenfranchisement and invisibility of this group of people in their communities. A new paradigm is required, in which services promote recovery and emphasise the key elements of autonomy and participation of service users in all aspects of their treatment and private lives.

Violations often occur behind closed doors and go unreported. Unless people know that they are happening, action cannot be taken to stop them. For this reason, the World Health Organisation has initiated QualityRights, a new project to unite and empower people to improve the quality of care and promote human rights in mental health and social care facilities. This project not only provides training for health care workers and mental health service users to improve services, it will also leave a lasting legacy of respect for human rights.

Information: http://www.who.int/mental_health/policy/quality_rights/en/index.html, <http://www.who.int/>



mental_health/publications/QualityRights_toolkit/en/index.html, http://www.who.int/entity/mental_health/policy/quality_rights/WHO_QR_provisional_programme.pdf.

Call for Submissions: Sightsavers Calls for Innovative Solutions to Development Problems

Development organisation Sightsavers launches a new funding initiative available to NGOs, academic institutions, the private sector and disabled people's organisations, to help overcome challenges faced by the eye health and social inclusion sectors in developing countries.

The *Sightsavers Innovation Fund* is offering funding for innovative approaches which illustrate ways to overcome barriers in the promotion of eye health, inclusive education and social inclusion. Winning initiatives will receive up to £75,000 each to implement the suggested proposal over 18 months. The learning from these projects will be shared widely within the development sector as well as being used to inform Sightsavers' own programmes.

This is the first time that the organisation has funded programmes in this way and it is part of a three year Programme Partnership Arrangement that Sightsavers holds with the UK Government's Department for International Development (DFID). Sightsavers is offering a total of £1 million for this round of funding.

Sightsavers ran the Innovation Fund internally last year with the same goal of encouraging learning and innovation. The fledgling programme will look at how people with disabilities are affected by natural disasters and seeks to incorporate their needs into wider disaster management plans.

Information: www.sightsavers.org/innovationfund.

Beijing Forum: Removing Barriers, Promoting Integration

Chinese Vice Premier Hui Liangyu urged further efforts in building the social security and social service systems to ensure the basic rights and equal access to social activities for persons with disability. Hui made the remarks during his speech on behalf of the Chinese government at the Beijing Forum: Removing Barriers, Promoting Integration, an international forum held in Beijing.

Hui called for better work to help disabled people participate in social activities in a more comprehensive way and live a happier life with dignity.

Stressing that China has the world's largest disabled population, the vice premier said the living standard

and social security level for the disabled in the country had remarkably improved through the government's decades of work.

Hui called on governments and non-governmental organisations in countries around the world to join hands in efforts to help people with disability, improve their living conditions and promote their integration and development in the society.

The Chinese government will also continue its commitments in this field, fully implement the United Nations Convention on the Rights of Persons with Disabilities and ensure the disabled people's political, economic, social, cultural and educational rights, Hui said.

China currently has about 85 million people with disabilities, Wang Xinxian, vice chairman of the China Disabled Persons' Federation, said at the forum.

Over the last five years, China has provided new employment opportunities for about 1.8 million disabled people in the country's urban areas and ensured the livelihoods of over 6.1 million rural impoverished people with disabilities, Wang said.

Moreover, more than 10 million people with disabilities have received rehabilitation services of different levels in the five years, Wang stated.

He affirmed that by 2020, the basic living security system and public services will cover every disabled person in the country and they will enjoy better education and employment conditions.

Information: <http://english.peopledaily.com.cn/90785/7838288.html>.

Show Me Inclusion Creative Competition

This initiative from End Exclusion gives young people the opportunity to get creative about the inclusion of persons with disabilities. Submissions requested, can be video or audio files, drawings, sketches, etc. that will be reviewed by an international jury composed of experts from film, sport, politics and the disability movement. They will select the best *Show me Inclusion* idea of all, which will be made public on World Day for the Eradication of Poverty, 17 October 2012. The winning entry will be professionally produced and used worldwide as an awareness-raising tool. Deadline for submission of contributions: 16 September 2012.

Information: <http://bit.ly/SMLcontest>;
<http://bit.ly/SMLteaser>.

Rio+20 Outcome Document Includes Disability

Disability has been included in the Rio+20 Outcome Document – a result of the United Nations' joint efforts in advocacy and partnership toward disability-inclusive



development in the work of the United Nations and beyond.

The Rio+20 Outcome Document, *The future we want*, has five specific references to disability, namely: responsibilities of States to respect, protect and promote human rights and fundamental freedom for all (paragraph 9); participation and access to information and judicial and administrative proceedings for promotion of sustainable development (paragraph 43); affirming that green economy policies in the context of sustainable development and poverty eradication should ...enhance the welfare of persons with disabilities (paragraph 58(k)); commit to promote an integrated approach to planning and building sustainable cities and urban settlements, and commit to promote sustainable development policies that support inclusive housing and social services; a safe and healthy living environment for all, particularly, disabled persons (paragraph 135) and finally, stress the need for ensuring equal access to education for persons with disabilities (paragraph 229).

Information: <http://www.un.org/disabilities/default.asp?navid=46&pid=1600>,
<http://www.uncsd2012.org/content/documents/727The%20Future%20We%20Want%2019%20June%201230pm.pdf>.

Limbs For Life

About 80 percent of Manila's, Philippines, amputees do not have prosthetics or artificial limbs, according to a study conducted by the College of Allied Rehabilitation Sciences (CAReS) of the University of the East Ramon Magsaysay Memorial Medical Center (UERMMMC). "Basically, the cost and the accessibility are the main hindrances. We also do not have professional technicians," shares CAReS faculty member Dr. Josephine Bundoc. She says that most parts of a prosthetic are imported making it costly.

Prices of prosthesis will go down, Dr. Bundoc predicts, once most, if not all, its parts are fabricated and produced in the Philippines. But the thing is, there are a handful of prosthetic and orthotic technicians in the country.

This is one of the reasons why UERMMMC agreed to a partnership with The Cambodia Trust, a non-government organisation that leads in prosthetics and orthotics education, and Japanese NGO, Nippon Foundation, to establish a school specifically for this discipline. Last month, the three organisations inaugurated the Philippine School of Prosthetics and Orthotics (PSPO), the first of its kind in the Philippines. The degree has limited slots. They will get an initial 30 students for the first two years and screen them down to 15 to take the remaining course and hopefully finish it. "With training in the school come service and research. So the re-

search aspect of that would delve into tapping materials that we have here so that we shorten the time of fabrication and would also decrease the cost. These problems can be solved by having a school. That is the very reason why PSPO was established," Dr. Bundoc shares, who is also the program's coordinator. They explain that when there are already professionals, it will significantly lower the cost. For example a lower limb prosthetic that would normally cost P60,000 to P80,000 could be brought down to P8,000 to P16,000 since parts and technicians are already available in the region. Not only that, since these devices need maintenance, the school would produce professionals that can correct or repair damaged prosthesis. PSPO hopes to make the program sustainable and prioritise Filipino students for capacity building.

Information: <http://tinyurl.com/7tqluh4>.

Australia supports disability rights in the region

Australia is providing \$7.5 million in new initiatives to improve the rights of people with disabilities in developing countries, Foreign Minister Bob Carr announced today. "An estimated 15 per cent of the global population — one billion people — live with some form of disability, and are among the poorest and most vulnerable in developing countries," Senator Carr said. Australia will commit \$4.5 million to the Pacific Disability Forum to empower people with disabilities to reach their full potential.

The Pacific Disability Forum is the regional umbrella network of Disabled Persons Organisations in the Pacific, and 12th of June in Fiji it helped to stage an important event that brought together stakeholders from across the Pacific to discuss community-based rehabilitation approaches. "People with a disability are often made to feel invisible and shut out of community life. The Pacific Disability Forum brings people with disability together to have a stronger voice for their rights with governments, civil society and development partners — at local, national and international levels," Senator Carr said. "It provides leadership training for men and women with disability to lead social change in their countries and activities to increase community awareness and recognition of the needs and aspirations of Pacific people with disability."

Over the past year, Australia's partnership with the Pacific Disability Forum has helped 13 Disabled Persons Organisations across nine Pacific Island countries to raise awareness about disability rights in the Pacific. In 2011, Australia's contribution supported the advocacy efforts of around 111 Disabled Persons Organisations across the globe to advocate for ratification and implementation of the UN Convention on the Rights of Persons with Disabilities. As a result, more countries in



the region have signed or ratified the Convention on the Rights of Persons with Disabilities, including Papua New Guinea and Indonesia.

Information: http://www.foreignminister.gov.au/releases/2012/bc_mr_120613.html.

Malaysian Couple Compiles Encyclopaedia for People who are Deaf

The first encyclopaedic dictionary for the country's 20 million people who are deaf and hard of hearing was published early June, Xinhua news agency reported. The 200,000-word reference book embodies more

than 1,000 entries on medicine, education, psychology, sociology, rehabilitation, linguistics, law, history and culture concerning the life of people who are deaf. The book was compiled by a disabled couple living in east Anhui province's capital Hefei. "We first collected and sorted out relevant material by ourselves before consulting a number of experts across the country and invited them to make revisions to the book," said compiler Shi Li, a deaf woman who serves as deputy head of the provincial association of people who are deaf.

"The book shows that we're not alone, since it presents so many exchanges between people who are deaf across the world," said Wang Hongqing, a deaf man in his 50s.

Information: <http://www.bernama.com>.

Wie viel kann ein Kind ertragen?

www.kindernothilfe.de

Viele Kinder in den ärmsten Ländern der Welt leiden unter Armut und Ausbeutung. Werden Sie Kindernothilfe-Pate und schenken Sie Ihrem Patenkind Zukunft – durch Bildung, Gesundheit und Stärkung seiner Familie.

KINDER NOT HILFE

ACTIONKIDZ
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Das Spendensiegel ist Zeichen sorgfältig geprüfter Seriosität und wurde Kindernothilfe als erstem Hilfswerk am 13. März 1992 erstmals zuerkannt.

DZI
Spendensiegel

Gestaltung: Ralf Kämer; Foto: Hartmut Schwarzbach



Literatur

Njuguna Githagui und Dr. Anna-Claudia Guimbous (Hrsg.)

Sorge dich nicht, mein Sohn -

Ein kenianisches Leben im Rollstuhl

Berlin 2010, Pro BUSINESS Verlag

ISBN 978-3-86805-765-2

Njuguna Githagui wurde im April 1947 in Muthiga, einem Dorf im Nairobi angrenzenden Distrikt Kiambu, Kenia, geboren. Im Alter von vier Jahren zog er sich bei einem Unfall auf dem elterlichen Grundstück eine Kopfverletzung zu, die zu einer Gehbehinderung führte, der auch mehrfache Aufenthalte in – den seinerzeit kolonialen – Krankenhäusern alles andere als abhelfen konnte.

Neben seiner Leidensgeschichte, den Erlebnissen in seiner großen Familie und seinen verschiedenen Bemühungen um Hilfen berichtet er davon, wie er zu Hause das Lesen und Schreiben und schließlich auch die englische Sprache fließend erlernte, in der er seine Autobiografie verfasste.

Sie ist ein tief bewegender Bericht über ein Leben, in dem sich von Behinderung Betroffene in unseren Ländern auf psychischer Ebene sicherlich oft wiederfinden können, das jedoch von den Mängeln in den äußeren Bedingungen her vielfach nahezu unvorstellbar erscheint.

Die Übersetzerin Anna-Claudia Guimbous promovierte über die Situation Behinderter in Kenia. Von der Autobiografie, die sie während ihrer Forschung in einer Buchhandlung in Nairobi entdeckte, war sie so beeindruckt, dass sie sie für deutsche Leser zugänglich machen wollte. Nachdem sie unter vielen Mühen seine Adresse ausfindig gemacht hatte, besuchte sie den Autor erstmals 2004. Es war der Beginn einer wertvollen Freundschaft. – In einem Epilog ist geschildert, wie es Njuguna Githagui weiter erging, und kurze Überblicke über seine Volksgruppe und Behinderungen in Kenia ergänzen seine Geschichte (aus dem Buchumschlag).

Bezug: Dr. Anna-Claudia Guimbous, Tel./Fax: 02421-73898, Preis: 10,00 EUR + 0,85 EUR Versand.

Anne Leymant (Handicap International)

Inclusive Employment: How to Develop Projects which Promote the Employment of People with Disabilities and Other Vulnerable Populations

Lyon 2012

This policy paper applies the mandate and values of Handicap International to inclusive employment activities. It sets out the benchmarks for Handicap International's actions, choices and approaches and seeks to

ensure consistent practice between the organisation's programmes while taking into account the different contexts in which they operate. It is intended as a guide for teams working in this sector of activity. It defines the themes, explains how these activities fit into the organisation's mandate, identifies target populations and defines modalities of intervention (standard expected outcomes, standard activities) as well as monitoring and evaluation indicators.

Bezug: http://www.hiproweb.org/uploads/tx_hidrtdocs/InclusiveEmploymentPP05.pdf,

http://www.hiproweb.org/uploads/tx_hidrtdocs/InsertionProfessionnelleDC05.pdf.

Jennifer Baird et al. (HelpAge International and Handicap International)

A Study of Humanitarian Financing for Older People and People with Disabilities, 2010-2011

London/Lyon 2012

This study quantifies the funding provided by donors to meet the humanitarian needs of two vulnerable groups, older people and people with disabilities. Projects submitted to humanitarian aid appeals were examined, and the findings conclude that the needs of both older people and people with disabilities are being overlooked by the humanitarian system.

Bezug: <http://www.helpage.org/download/4f4222be3ce76/>, <http://www.helpage.org/download/4f452634317fd>.

Human Rights Watch

New Report on Barriers to Political Participation

Peru 2012

This report documents the legacy of a policy, changed only in October 2011, that arbitrarily denied people with sensory, intellectual, and psychosocial disabilities their right to vote, considering them legally incompetent to exercise such a decision. Human Rights Watch also examined the barriers that people with these and other disabilities face when exercising their political rights, including the difficulty of getting identity documents essential for voting, and the absence of support mechanisms to help people with disabilities make voting decisions.

Bezug: http://us-cdn.creamermedia.co.za/assets/articles/attachments/39470_hrw_peru0512.pdf.



CBM

Inclusion Made Easy: A Quick Program Guide to Disability in Development

Inclusion Made Easy is designed for program staff in international development organisations. It is a brief, practical guide on how to ensure programs are disability-inclusive. It offers basic inclusion principles, practical tips and case study examples. Part A focuses on disability-inclusive development principles and Part B on disability inclusion across a range of development sectors. Bezug: <http://www.cbm.org/Inclusion-Made-Easy-329091.php#additionalDownloads0>, <http://www.cbm.org/Inclusion-Made-Easy-329091.php>.

IKV Pax Christi und FairFin

Worldwide Investments in Cluster Munitions; a shared responsibility

IKV Pax Christi (Niederlande) und Netwerk Vlaanderen (Belgien) publizierten den ersten Bericht über *Worldwide Investments in Cluster Munitions: a Shared Responsibility* im Oktober 2009. Dieser war ein Bericht des damaligen Status quo über die Investition von Kreditinstituten in Betriebe die Streumunition entwickeln oder herstellen, über Finanzdienstleister die ihre Kredite für Hersteller von Streumunition zurückziehen und über gesetzliche Maßnahmen um die Investition in Streumunition zu verhindern. Ein erstes Update des Berichts erschien im April 2010. Diese Ausgabe, erschienen im Mai 2011, aktualisiert die vorherigen Berichte.

Die Studie ergab u. a., dass weltweit 137 private sowie öffentliche Finanzdienstleister rund 43 Milliarden US \$ in verbotene Streumunition investieren. Darunter befinden sich die führenden Investoren und Kreditgeber JP Morgan Chase, Goldman Sachs und Deutsche Bank. Des Weiteren wurde festgestellt, dass 38 Länder und Gebiete, wie z.B. Libyen, Syrien, Vietnam und Laos, nachgewiesenermaßen in bewaffneten Konflikten vom Einsatz von Streumunitionen betroffen sind.

Die NRO forderten zudem erneut ein deutsches Gesetz, welches die Investitionen in Streumunition untersagt. Ein diesbezüglicher Antrag der Oppositionsparteien war im März diesen Jahres gescheitert.

Roos Boer (IKV Pax Christi) erinnerte daran, dass Belgien, Irland, und Luxemburg ein solches Gesetz bereits verabschiedet haben und auch die Schweiz und die Niederlande folgen werden. Thomas Küchenmeister betonte, dass im Vergleich zur ersten Untersuchung von FairFin und IKV Pax Christi aus dem Jahr 2009 ein signifikanter Rückgang der Anzahl der Investoren als auch des Umfangs des Investments festzustellen sei. Damals wurden noch acht deutsche Finanzdienstleister mit Geschäftsbeziehungen zu Herstellern in Höhe von fast 1 Milliarde US-Dollar identifiziert. Aktuell identifizierte die Studie nur noch zwei involvierte deutsche Finanzdienstleister, die Geschäftsbeziehungen zu Herstellern von Streumunition in einer Größenordnung

von mehr als 550 Mio. US \$ unterhalten. Das Beispiel Allianz und Deutsche Bank zeige aber deutlich, so Küchenmeister, dass wir auch in Deutschland ein explizites gesetzliches Verbot des Investments in Streumunition benötigen, wie in anderen europäischen Staaten längst umgesetzt.

Bezug: <http://www.ikvpaxchristi.nl/files/Documenten/wap%20cluster%20munitie/CMC%20rapport%2025%20mei%202011/Worldwide%20Investments%20in%20Cluster%20Munitions.pdf;%20a%20shared%20responsibility%20-%202011.pdf>, <http://www.facing-finance.org/de>.

Pacific Disability Forum (PDF) and Australia Pacific Islands Disability Support (APIDS) Capacity Development for Effective and Efficient Disabled Persons Organisations in Pacific Island Countries

Disabled peoples organisations (DPOs) are committed to increasing their capacity, effectiveness and efficiency within their respective countries, so they can represent the interests of their own members and help meet disability-related local, national, regional and international goals. The current capacity of Pacific DPOs varies significantly and their pathways to greater capacity will be different in each country. Pacific Disability Forum (PDF) recognises that DPOs are responsible for their own capacity development and wants to ensure that any efforts to contribute to DPO capacity development are well conceived and likely to be successful.

In 2011-2012, PDF has undertaken a substantial practical research program aimed to contribute to this process. It has been working with its partner, Australia Pacific Islands Disability Support (APIDS) to facilitate research processes in each member country, and at a regional level. Over 18 months, the research provided opportunities for 11 member DPOs to: 1) reflect on and share what they know already about capacity and capacity development 2) learn about what works well and why develop new ideas and ways of working, 3) share their experiences with others, 4) be in a stronger position to negotiate with their own members and development partners about how to strengthen their capacity in the future.

Bezug: <http://www.apids.org/USERIMAGES/Final%20Fiji%20report%20July%202011.pdf>.



VERANSTALTUNGEN/EVENTS

- 10.09. - 21.09.2012 Training of Trainer (ToT) for Community-based Inclusive Development (CBID): towards Sustainability in Bangkok, Thailand.
Information: <http://www.apcdfoundation.org/?q=content/announcement-training-trainer-tot-community-based-inclusive-development-cbid-towards-sustai>; Contact: Mr. Somchai Rungsilp, International Training Manager; E-Mail: somchai@apcdfoundation.org.
- 14.09. - 15.09.2012 Conference of States Parties to the Convention on the Rights of Persons with Disabilities in New York.
Information: <http://www.un.org/disabilities/default.asp?navid=46&pid=1595>; Contact: United Nations Enable (website), Secretariat for the Convention on the Rights of Persons with Disabilities, @ Department of Economic and Social Affairs, Two United Nations Plaza, DC2-1382 New York, NY 10017, United States of America; Tel.: +1/21 29 63 01 11; E-Mail: enable@un.org.
- 17.09. - 21.09.2012 TRANSED 2012 – The 13th International Conference on Mobility and Transport for Elderly and Disabled Persons (TRANSED 2012) will be held in New Delhi, India.
Information: <http://www.transed2012.in>; Contact: TRANSED 2012 Secretariat, Svayam- An initiative of SJ Charitable Trust, Jindal Centre, 12, Bhikaiji Cama Place, New Delhi- 110066; Tel.: +91 11/41 46 23 23, +9111/41 46 20 80; Fax: +9111/ 26105671; E-Mail: secretariat@transed2012.in.
- 21.09.2012 Fortbildungsseminar: Inklusive Projekte II: Aufbau-seminar inklusive Projektplanung: Indikatoren in Köln.
Information: <http://www.bezev.de/wissen/fort-und-weiterbildung/aktuelle-seminare.html>; Kontakt: Behinderung und Entwicklungszusammenarbeit e.V., Wandastr. 9, 45136 Essen; Tel.: 0201/17 88 963; Fax: 0201/17 89 026; E-Mail: info@bezev.de.
- 05.10.2012 Seminar: Kultur und Behinderung in Bonn.
Information: <http://www.bezev.de/wissen/fort-und-weiterbildung/aktuelle-seminare.html>; Kontakt: Behinderung und Entwicklungszusammenarbeit e.V., Wandastr. 9, 45136 Essen; Tel.: 0201/17 88 963; Fax: 0201/17 89 026; E-Mail: info@bezev.de.
- 19.10.2012 Seminar: Bildung für Alle durch inklusive Bildung in Köln.
Information: <http://www.bezev.de/wissen/fort-und-weiterbildung/aktuelle-seminare.html>; Kontakt: Behinderung und Entwicklungszusammenarbeit e.V., Wandastr. 9, 45136 Essen; Tel.: 0201/17 88 963; Fax: 0201/17 89 026; E-Mail: info@bezev.de.
- 25.10. - 28.10.2012 Inclusion International Global Inclusion Conference in Washington DC.
Information: <http://www.thearc.org> and <http://www.inclusion-international.org>; Contact: Robin Powers, KD.2.03, 4-6 University Way; Docklands Campus, E16 2RD, London-UK; Tel.: +44/20 82 23 77 09; Fax: +44/20 82 23 60 81; E-Mail: robin@cmig.com.
- 29.10. - 02.11.2012 Rehabilitation International World Congress in Nairobi, Kenya.
Information: <http://www.riincheon2012.org/world/>; Contact: 22nd RI World Congress Organizing Committee Secretariat, Korean Society for Rehabilitation of Persons With Disabilities (KSRPD), 2nd Floor 990-2 Bangbae-Dong Seocho-Gu, Seoul, 137-849 South Korea; Tel.: +82/34 72 35 56; Fax: +82/34 72 35 92; E-Mail: RIKOREA@RIKOREA.OR.KR.
- 08.11. - 18.11.2012 WBU/ICEVI General Assemblies in Bangkok, Thailand.
Information: <http://www.wbu-icevi2012.org>; Contact: WBU enquiries: Penny Hartin, CEO, WBU; E-Mail: Penny.hartin@wbuoffice.org /ICEVI enquiries: Dr. Mani, CEO, ICEVI; E-Mail: sgicevi@vsnl.net.
- 26.11. - 28.11.2012 1st CBR World Congress: "CBR: The Key to Realising CRPD" in Agra, India.
Information: www.cbrglobal.org or <http://www.apcdfoundation.org/ecafe/en/node/12322>; Contact: MOBILITY INDIA, 1st & 1st A Cross, J.P. Nagar, 2nd Phase, Bangalore - 560 078. Karnataka, India; Tel.: +91/80 26 49 22 22 / 26 59 73 37; Fax: +91/80 26 49 44 44, Ext. 110; E-Mail: secretariat@cbrglobal.org.
- 28.11. - 30.11.2012 Creating New Futures For All: Children, Youth, Disability And Situations Of Forced Migration in Sydney.
Information: <http://sydney.edu.au/news/law/457.html> eventcategoryid=164&eventid=9546; Mary Crock; Email: mary.crock@sydney.edu.au
- 03.12.2012 Seminar: Menschenrechte, Behinderung und Entwicklungszusammenarbeit in Bonn.
Information: <http://www.bezev.de/wissen/fort-und-weiterbildung/aktuelle-seminare.html>; Kontakt: Behinderung und Entwicklungszusammenarbeit e.V., Wandastr. 9, 45136 Essen; Tel.: 0201/17 88 963; Fax: 0201/17 89 026; E-Mail: info@bezev.de.



Schwerpunktthemen kommender Ausgaben der Zeitschrift Focal Topics of Upcoming Issues

- 3/2012 Historie der Behindertenbewegung/History of the Disability Rights Movement (verantwortlich/responsible: Susanne Wilm, susanne_wilm@yahoo.de)
- 1/2013 CBR – Community Based Inclusive Development (Arbeitstitel) (verantwortlich/responsible: Gabriele Weigt, weigt@bezev.de)

Interessierte Autorinnen und Autoren mögen sich für nähere Informationen und unseren *Leitfaden für AutorInnen* bitte an die oben genannten Verantwortlichen wenden. Darüber hinaus sind Vorschläge für weitere Schwerpunktthemen willkommen unter gabi.weigt@t-online.de.

If you are interested in contributing, please contact the respective member of the editorial board mentioned above for more information and our Guidelines for Submissions. Moreover, we welcome ideas and suggestions for future focal topics which you can submit to our editorship at gabi.weigt@t-online.de.

Deadlines for the upcoming issues:

	3/2012	1/2013	2/2013
Hauptbeiträge/Focal articles	15.07.2012	15.10.2012	15.01.2013
Kurzbeiträge/Other contributions	15.08.2012	15.12.2012	15.02.2013

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