Since it was rather difficult for us to summarize our discussion in an organized fashion, we list the points of pro and cons on major concepts expressed in the WFOT draft and other references on CBR.

1. We strongly support the CBR strategy expressed in *Draft Position Paper on CBR With and For People with Disability,* prepared by WHO, UNESCO, UNICEF and WHO, in 2002. We also welcome the International Consultation to Review CBR, which should have been held periodically, as possible.

2. We strongly suggest that UN Agencies make more innovative action plans to integrate past experiences on Primary Health Care and CBR to further the inclusive society worldwide; i.e. "Health and Enabling for All" would be the direction to be headed with CBR as a part of thematic action plans under this big umbrella. In this sense, the expression of "The WFOT could challenge the current name 'CBR' to be changed to 'CBE'-Community Based Enablement" seems to be rather misleading to signify that enabling is accomplished *only* through CBR.

3. We would prefer to use concrete examples of occupational therapy's role in CBR. Occupational therapy made considerable progresses in community practices during past decades (Ref. WFOT Bulletin: 40:Nov. 1999). It will be more clear to separate two distinct streams in CBR; one is the direction found in more developed nations (communities) toward shortened hospitalization and continuation of home-care and rehabilitation services in community with an emphasis of prevention of disability, and the other is the CBR with much less social resources available, more or less in its original concepts and strategies found in less developed and/or developing nations (communities). In Japan, occupational therapists are involved in both areas of practices, being confronted with the gap between the two, which would be the same gap shared among WFOT member countries. Thus we hope to see the WFOT position paper to make it clear that our profession by itself has many models and strategies toward 'CBR' and make suggestions with an emphasis on 'what shall WFOT and member associations do in near future to advance CBR, especially to reach more people with disabilities with an aim of an inclusive society' (as cited in WHO theme paper).

4. We suggest that occupational therapy's role after natural disasters is added to this paper. For example, Japanese occupational therapist volunteered to make temporary housing accessible for disabled persons after the Great Hanshin Earthquake in 1995. In addition, this would also be an example of CBR in a developed nation. It supports the idea that CBR can be beneficial in developed nations too. In Japan, there is some debate going on about reforming community services for older persons. Many perceive it as desirable that these services are based on CBR-practice on order to offer the best possible OT-services.

5. In regards to the gender issue that was raised in this paper: Disabled people share a disadvantaged position with other groups in most societies. In this sense CBR has a task in focusing on this disadvantaged position in addition to the special needs of persons with disabilities. We do not feel that the statement on gender issues as it is phrased now relates to this issue. Although we support the idea of equal opportunities for men and women, we are not aware that WFOT has a special statement or policy on this. Perhaps a policy should be formulated that stresses equal opportunities for ALL.

6. The paper raises some issues that have only recently come to the surface here in Japan and may be regarded as our developmental tasks and purposes to be addressed in the new future, such as:
   - teaching of community based occupational therapy as part of the school curriculum
   - participatory action research
   - human rights, what can occupational therapists do?
   - disability-studies from an occupational therapy point of view

- how can occupational therapy contribute to the inclusion of disabled persons in society and the empowerment of disabled persons.

7. In regard to “Challenges for occupational therapists and WFOT”, we believe it is worth to stress the wide scope of OT and to suggest that persons in need of measures to prevent disability are included as recipients of OT. Furthermore, we see OT adding much more emphasis on the environment and assisting the creation of supportive social structures based on an individual focus as a solid and standard base for OT practice.

a. We had some discussion about an OT role as social change agent. For some of us the writings in the position paper caused unease, because it invoked images of an almighty OT. Such images could easily lead to misunderstanding of the limitations of OT as primarily a health profession with the responsibility of intervening people's health condition. We must be realistic in our possibilities to help the people with disability and/or illness to become social change agents to execute basic human rights. On the other hand, our discussion identified specific contributions OT made on social changes and promoting the inclusion of disabled persons in mainstream society. For example, OTs had roles in collaborating with family-groups, educational projects and local community bodies. Perhaps it should be concluded that perceptions of what OT could contribute to social change is not fully appreciated by OTs as yet. (This may become an issue for policy-making by WFOT.)

b. As for the term occupational justice: We believe that the conceptualization of ‘justice’ is multi-facetted, but that the current discourse is dominated by the beliefs and religion of the great Western powers. The reality in much of Asia and Africa is that disabled people are confined to their homes and often lack even the most of basic health and welfare services. We therefore are not comfortable with the term occupational justice. However, we fully support the idea of promoting disabled persons' social participation. We recommend, therefore, the use of the more neutral terms: equal opportunities to access of services, inclusive society and empowerment, and so forth.

c. As for the suggestion of changing CBR into CBE: We acknowledge the dilemma of that the R is generally interpreted as merely denoting medical rehabilitation. However, in developing countries the severely disabled do not survive for want of medical care/treatment. Thus, most disabled persons are ADL independent, but have such needs as in regards to income-generation. In that sense CBE may be better. On the other hand, rehabilitation and OT start in the acute stages when medical treatment has priority. Furthermore, the reality is that medical doctors and health professions including OT, vocational trainers, and so forth may decide many services in a top-down fashion with little regard to equality in dignity and rights. Be that as it may be, medical services are often charged out of reach of persons who could benefit from these services. Considering all these arguments, we acknowledge that the world may be in need of a different framework. Nevertheless, on balance we think that for now it is a more realistic option to make an effort to promote rehabilitation in a wide sense and stress the social and human right aspects of rehabilitation. After all, rehabilitation means restoration of privileges and dignity, yet it lost this context along with the developing emphasis of technical and functional aspects of rehabilitation.

d. As for the term “political” aspects and skills: we feel more comfortable to use “collaborative” to avoid undue conflicts brought by the word “political” which may not fit the WFOT terminology as an international NGO.

8. There should be additional commentary in relation to the fact that there are only 57 WFOT member associations consisting of 120,000 occupational therapists unevenly distributed to developed nations. There should be a global strategy to change uneven distribution of health and rehabilitation professionals in relation to the “Health and Enabling for All” action plans cited above. The WFOT and each member association should be encouraged to collaborate with governmental and non-governmental activities to help grass-root CBR activities in developing countries where occupational therapy services do not exist and/or very scarce. The JAOT has been collaborating with Japan Overseas Cooperation Volunteers (JOVC) since 1976; the JAOT have helped the JOVC to recruit about 150 OT volunteers to developing

countries so far. We believe that this strategy of sending grass-root volunteers is a slow but most steady contribution of the national associations to develop CBR to reach more people with disabilities with an aim of an inclusive society.

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