Policy Brief on

Community Based Rehabilitation

Developed by:

CBR Global Network (CGN) and

Indian Forum for Rehabilitation and

Assistive Technology (IFRA)

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Executive Summary

1. The Need for Rehabilitation:

Currently, global estimates of the need for rehabilitation services show that **at least one in every three people in the world needs habilitation and rehabilitation** at some point in the course of their illness or injury or disability. Data collected for the Global Burden of Disease study 2019 informs this analysis[1] and is used to calculate the prevalence and years of life lived with disability (YLDs) of 25 diseases, impairments, or other consequences of these diseases, selected as relevant for habilitation and rehabilitation interventions.

Key findings are that:

- In 2019, **2·41 billion individuals** had conditions that would benefit from habilitation and rehabilitation, contributing to 310 million YLDs. This is one in every three people of a global population of 7.7 billion[2].
- This number had increased by 63% from 1990 to 2019. This number belies the common view of habilitation and rehabilitation as a service required by only few people. Habilitation and rehabilitation is relevant to most people at some point in their life, yet in many low- and middle-income countries, less than 50% of people receive these services that they require.

2. The WHA Resolution 58.23 on disability makes clear the linkages between increasing demand for habilitation and rehabilitation services and poverty, war and violence, environmental degradation, diseases like HIV and AIDS and accidents. It also highlights the specific needs of vulnerable populations groups - women, children, older people and those affected by malnutrition or living in poverty.

However, though habilitation and rehabilitation is needed for 33% of global population (1 in 3) but for persons with disabilities (15% global population - 1 in 7) is often the first step and a prerequisite for optimizing ability, equal rights and opportunities. Hence, within this global picture of need, the habilitation and rehabilitation needs of children, youth, adults and senior citizens with disabilities, especially those are poor and living in low and middle income countries, for whom lack of access to habilitation and rehabilitation and assistive technology is an insurmountable barrier. This subsequently prevents their full and equal access to health, education, livelihoods and inclusion in their community.

Global Report on Disability, UN Disability Flagship Report, UN Disability Inclusion Strategy and review of Sustainable Development Goals (SDG) clearly demonstrates the link between poverty and disability. Persons with disabilities are disproportionately represented in the poorest quintile of populations, living below the poverty line and lacking adequate access to food, clean water, sanitation, energy, assistive technology etc. Many are homeless or in institutions which lack facilities. Lack of financial capacity makes it nearly impossible for poor persons with disabilities to access habilitation and rehabilitation services, which are mostly located in big cities and that too often with the private facilities. Failure to address rehabilitation needs will mean induced poverty and barriers to attaining other goals will remain in place.

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[1] Global estimates of the need for rehabilitation based on the Global Burden of Disease study 2019: *a systematic analysis for the Global Burden of Disease Study* (2019) *Cieza et al.*

[2] United Nations, Department of Economic and Social Affairs, Population Division (2019) *World Population Prospects 2019: Highlights* (ST/ESA/SER.A/423).

Habilitation and Rehabilitation services needs to be brought **closer to communities** as an integral part of primary health care if it is to reach more people in need. Rehabilitation has not been adequately prioritized in low and middle income countries and is under-resourced despite growing individual needs and societal benefits from addressing these.

3. Global policy context and key frameworks for Rehabilitation include:

The WHO **Declaration of Alma-Ata** (1978) identified primary health care as an essential component of public health and essential to meeting the goal of Health for All. Alma Ata declaration clearly outlines, health care needs to be preventive, promotive, curative and rehabilitative. This was reaffirmed in the **Declaration of Astana** (2018), in which global leaders reaffirmed the commitments expressed in the ambitious and visionary Declaration of Alma-Ata and the 2030 Agenda for Sustainable Development, in pursuit of Health for All. World leaders have vowed to strengthen primary health care (PHC) systems as an essential step toward achieving universal health coverage (UHC) – PHC is a gateway for UHC.

Community Based Rehabilitation (CBR) and Primary Health Care (PHC): to realize the mandate of the Alma Ata to ensure rehabilitation services within PHC, to mitigate prejudice or perception about rehabilitation services is expensive and a luxury that can be left for charitable institutes to handle and considering the resource limitation of the low- and middle-income countries, the World Health Organization in partnership with other UN agencies, Governments and nongovernmental organizations, introduced the **Community Based Rehabilitation (CBR)** concept **to include Rehabilitation as an integral part of Primary Health Care (PHC).** Since then, CBR is being practiced in more than 100 countries, and been seen as only solution for the majority living in low- and middle-income countries, even today.

Resolution WHA58.23 on Disability (2005) of the World Health Assembly includes prevention, management and rehabilitation and urges countries to promote and strengthen **community-based rehabilitation (CBR)** programmes that are linked to primary health care and integrated in the health system. Further to this the WHO **Framework on integrated people-centred health services** (2016) is a call for a fundamental shift in the way health services are funded, managed and delivered. It supports countries progress towards universal health coverage by shifting away from health systems designed around diseases and health institutions and towards health systems designed for people.

United Nations Convention on the Rights of Persons with Disabilities (2006) specifies (Article 26) that access to habilitation and rehabilitation for persons with disabilities is a human right, and States parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, and promote the availability, knowledge and use of assistive devices and technology, designed for persons with disabilities, as they relate to habilitation and rehabilitation[3].

Rehabilitation 2030, A Call for Action (2017) highlighted the increasing global unmet need for rehabilitation, and called for coordinated action and joint commitments among all

3 Equal emphasis should be given to habilitation and rehabilitation. As defined in the CRPD, Habilitation and Rehabilitation enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social, and vocational ability, and full inclusion and participation in all aspects of life.

stakeholders to raise the profile of rehabilitation as a health strategy that is relevant to all people across their lifespan and across the continuum of care. However, it fell short on how to realize this ambitious goal considering this emerging need and WHO's own the most successful initiative the **Community Based Rehabilitation (CBR)** was not included.

The **Sustainable Development Goals 2030**, pledge to leave no one behind, including persons with disabilities and other disadvantaged groups, and has recognized disability as a cross-cutting issue, to be considered in the implementation of all of its goals. The **SDGs** state that greater access to rehabilitation services is required to *"Ensure healthy lives and promote well-being for all at all ages"* (SDG 3) and to reach SDG Target 3.8 "*Achieve universal health coverage (UHC), including …. access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all*."

4. Approaches to increasing healthcare and rehabilitation

There is growing interest in task shifting approaches to healthcare with evidence of success. Driven by shortages of physicians, unbalanced workforce distribution in rural versus urban areas, and financial constraints, disruptive, low-cost health-care delivery models are emerging and improve access to care. There is substantial evidence that ***task shifting and or sharing is an important policy option*** to help alleviate workforce shortages and skill mix imbalances. Defined as delegating tasks to existing or new cadres (with less training or with tailored training) task shifting is a potential strategy to address these challenges. It is endorsed by varied agencies:

- WHO PHC philosophy soundly based on providing care in the community as well as care through the community, PHC addresses not only individual and family health needs, but also the broader issue of public health and the needs of defined populations;
- PHC is a whole-of-society approach that includes health promotion, disease prevention, treatment, **rehabilitation** and palliative care. PHC is therefore the first element of the care continuum and Community-based rehabilitation (CBR) within PHC can make this possible for the majority of persons with disabilities; and other population groups needing rehabilitation
- WHO endorses makes most health care interventions community-based such as community detection and management of non-communicable diseases (NCD's);
- World Bank endorses community driven development programmes (CDD) as important elements of an effective poverty-reduction and sustainable development strategy;
- International Federation of the Red Cross/Red Crescent successfully uses approaches centred on community volunteers to address health care challenges.

There is **evidence of success from Community Based approaches to Rehabilitation According to WHO** PHC addresses not only individual and family health needs, but also the **broader issue of public health and the needs of defined populations.** Accordingly, **Community-based rehabilitation (CBR)** initiated by WHO (1978) has since developed to cover a wide range of multisectoral approaches working to improve the equalization of opportunities and social inclusion of people with disabilities, including but not limited to only rehabilitation – it continues to address all areas of healthcare and beyond.

To address broader issue of public health and the needs of populations with disability, WHO in partnership with ILO, UNESCO and civil societies developed and launched **Guidelines for Community Based Rehabilitation (2010),** which encompasses 5 key areas - health, livelihood, education, social and empowerment. This broader approach made an important contribution towards potentially achieving the MDGs and now the SDGs for people with disabilities with more than 100 countries implementing CBR as a primary strategy to deliver on articles of the UNCRPD. Some agencies refer to the approach as Community Based Inclusive Development (CBID) as it addresses all the areas of basic needs.

Demonstrable results from existing work of developmental agencies support a rationale for addressing gaps between supply and demand for habilitation and rehabilitation via home-based and community-based services that are people centred, locally owned and appropriately skilled. Like access to good health, CBR also has been seen as an escape route from poverty. CBR is implemented through the combined efforts of people with disabilities, their families and communities, and relevant government and non-government health, education, vocational, social and other services.

The first important outcome of CBR is to reach every person with disability, everywhere who still face barriers in participating equally in family and community life because of stigma that denies fundamental rights, access and equality of opportunities. Acknowledging their number, the nature of disabilities and challenging attitudes is a key first step towards rehabilitation and inclusion.

CBR activities are cost-effective, and have delivered encouraging results in increasing independence; enhancing mobility, improving communication skills; augmenting educational/vocational opportunities; influencing community attitudes positively; and in facilitating social inclusion of people with disabilities. Where no specialized affordable rehabilitation service exists, even today **Community Based Rehabilitation** is found to be the only option**.**

Organization of persons with disabilities (OPD`s) Disabled peoples' organizations (DPOs) in low- middle-income countries are effective at improving participation and ensure that their members (disabled persons) are active in decision-making spaces so that no one is left behind. They are the key stakeholder, facilitating access to CBR programmes and through these meeting basic needs and well-being of persons with disabilities. Specific improvements in participation in community consultations, social activities, and DPO membership are noted. Additionally OPDs advocate and improve accessibility in the home, school and workplaces. Reasonable accommodations adopted include better access to information, to sanitation and toilet facilities, rehabilitation and Government social welfare services thus improving the inclusion of persons with disabilities in society.

CBR programmes have a **positive impact on the well-being** of persons with disabilities in most areas of intervention: health, education, livelihoods (including opportunity for employment), disability rights, and social participation. CBR is all about community intervention using available local resources – hence, community participation and ownership is a key ingredient for success of any CBR. Even today, majority of persons with disabilities are victims of stigma and prejudice - society's attitude towards persons with disabilities. Beside rehabilitation and health care services, CBR plays a catalyst role in terms of changing mentalities and fighting prejudice and exclusion.

CBR programmes bring **positive effect upon the lives of children with disabilities** and also on the health, knowledge, social connectedness and empowerment of their **parents and**

caregivers. Important improvements for caregivers are noted after a period of home-based therapy with their child. Greater focus on family caregivers is sensible because they provide for most needs of older people and persons with disabilities. It is important to recognise the value of non-healthcare workers and supporting family members for caring and including persons with disabilities in all walks of life. This needs to be fore grounded in policy, planning and programming.

Self-help groups and Organization of persons with disabilities associations of persons with disabilities, are the primary stakeholders for CBR, contribute to **sustainability of the approach**. Linking these groups with other successful community-based or local organisations such as women's federations, can also help sustain the initial good practices introduced.

5. The Ask:

Currently (2019) the WHO Rehabilitation 2030 Call for Action sets out key activities described in detail in Rehabilitation in Health Services a Guide for Action and these are:

- Creating strong leadership and political support for rehabilitation at sub national, national and global levels.
- Strengthening rehabilitation planning and implementation at national and sub national levels, including within emergency preparedness and response.
- Improving integration of rehabilitation into the health sector and strengthening intersectoral links to effectively and efficiently meet population needs.
- Incorporating rehabilitation into universal health coverage.
- Building comprehensive rehabilitation service delivery models to progressively achieve equitable and affordable access to quality services, including assistive products, for all the population, including those in rural and remote areas.
- Developing a strong, multidisciplinary rehabilitation workforce that is suitable for each country context and ensures rehabilitation, as a topic to be included in all health workforce education efforts.
- Expanding financing for rehabilitation through appropriate mechanisms.
- Collecting information relevant to rehabilitation to enhance health information systems, including system-level rehabilitation data and information on functioning using the International Classification of Functioning, Disability and Health (ICF).
- Building research capacity and expanding the availability of quality evidence for rehabilitation.
- Establishing and **strengthening networks and partnerships in rehabilitation**, particularly between low-, middle- and high-income countries.

CGN and IFRA members **endorse these activities with focus more on home-based and community-based rehabilitation services and hence, call for CBR to be universally applied** across countries, not limited to pilot projects and limited geographic treatments. Systems to deliver CBR need to be established and aligned with the primary healthcare delivery structures in all countries; and to make best use of organization of persons with disabilities, community volunteers and home based carers to expand the workforce, delivering the appropriate skills to these cadres. CBR must be included as an integral part of service delivery strategy especially within PHC/UHC and hence, in any resolution including the one on highest attainable standard of health for persons with disabilities and rehabilitation for all, to be adopted in the World Health Assembly in 2021 and expected to be tabled in the World Health Assembly in 2022 respectively.

CGN and IFRA recommend that

1. A WHA Resolution on highest attainable standard of health for persons with disabilities is adopted in 74th session of the WHA in 2021.
2. A WHA resolution on rehabilitation for all be adopted in 2022.
3. The two proposed resolutions mentioned above should have a central emphasis on the role of CBR as a strategy for habilitation and rehabilitation service delivery, especially in low and middle – income countries.

CGN and IFRA suggests that specific recommendations are made to Country Governments through this Resolutions

1. Trained village health / rehabilitation workers should play a pivotal role in early identification and intervention for persons with disabilities.
2. Regular surveys should be periodically updated to collect the data available at the field level and so to address all diseases and disabling conditions
3. Strengthen the Primary Health Care system in countries and integrate community based rehabilitation (CBR) approach as an integral component of the primary healthcare as outlined by WHO.
4. Promote a developmental model of habilitation and rehabilitation services where every person gets opportunities to develop their potential to the maximum. Adaptations and positive discrimination including reasonable accommodations should be facilitated at all levels.
5. Priorities children, women and aged populations especially those are with multiple and or severe impairments within CBR. CBR to develop as a vehicle to strengthen PHC and other community-based interventions such as immunization, NCD management or provision of assistive technology. Home-based services should be made available through community level workers. Caregivers to be trained and their work recognized (and possibly compensated for).
6. People with intellectual impairments, severe and or multiple impairments, chronic conditions and mental health needs require special attention and some aspects of which can be brought within the scope of home-based and or community-based care, especially within CBR.
7. CBR should be implemented universally with greater investment and supported by modern digital technology to ensure benefits of CBR reaches to everyone, everywhere – leaving no one behind.
8. All healthcare professionals should be equipped to deal with disabilities and chronic conditions from the perspective of the individual and their context. Rehabilitation should come to be viewed in its wider sense as a social inclusion and rights-based issue not as a more narrow, medical issue.
9. Additional study is needed to research, evidence, and document effective CBR practice from across the Globe; this should be promoted to share learning and inform future developments.
10. Special focus should be directed towards impact from empowerment of all persons with disabilities including women with disabilities, and where this has allowed them to lead and become an integral part of rehabilitation systems and wider society.

End notes

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