Health and rehabilitation services to persons with disabilities in low-income contexts in light of the Convention on the Rights of Persons with Disabilities

Bergen University College, 24th June 2016

Arne H Eide

• SINTEF Technology and Society, Department of Health
DISABILITY MODELS

Medical model

Interactional model

Bio-psycho-social model

Social model
International Classification of Functioning, Disability and Health (WHO 2001)

- ICF
Rehabilitation

• Rehabilitation is a treatment or treatments designed to facilitate the process of recovery from injury, illness, or disease to as normal a condition as possible


• Rehabilitation of people with disabilities is a process aimed at enabling them to reach and maintain their optimal physical, sensory, intellectual, psychological and social functional levels. Rehabilitation provides disabled people with the tools they need to attain independence and self-determination (WHO - http://www.who.int/topics/rehabilitation/en/)

• CBR as “a strategy within general community development for the rehabilitation, poverty reduction, equalization of opportunities and social inclusion of all people with disabilities” (WHO 2010)
Disability and poverty as overlapping phenomena

Marginalisation; isolation; economic, social and political deprivation; lack of access to; education / employment / healthcare / legal and political processes / healthy food / adequate housing / credit
THE DISABILITY/POVERTY CYCLE (Yeo 2003)
Key international policies

• Millennium Development Goals (MDGs) 2000 - 2015
• Sustainable Development Goals (SDGs) 2015 -
UNITED NATIONS CONVENTION ON THE RIGHTS OF
PERSONS WITH DISABILITIES (2008) (CRPD)

**International human rights treaty**: legally binding instruments concluded under international law

- Article 19 - Living independently and being included in the community
- Article 20 - Personal mobility
- Article 25 – Health
- Article 26 - Habilitation and rehabilitation
- Article 32 – Assistive technology
CRPD – Article 26 Habilitation and rehabilitation

• 1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

• a. Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

• b. Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

• 2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

• 3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.
The need for rehabilitation in a global perspective

• WHO (2011): 1 billion persons with disability globally

• Approximately 2/3 of individuals with disability in the world live in poor countries

• The demand for rehabilitation is large, supply is limited – and for many/most non-existent

• Statistics/information about demand and supply of rehabilitation is inadequate, in particular in poor countries
Global Atlas of the Health Workforce
Disability & rehabilitation services in the shadows

- In the global public health arena, rehabilitation services have been overshadowed by more dramatic efforts, such as combating infectious diseases with immunization (GHIs)
- Most medical schools and schools of public health around the world do not incorporate a disability and rehabilitation component in their curricula
- The role of rehabilitation in the global health arena is expanding as persons with disabilities and other stakeholders are drawing attention to the rights and needs of persons with disabilities
- Rehabilitation providers possess unique knowledge and skills to optimize the care of persons with disabilities
Reality of medical rehabilitation in poor countries

- Adequate medical rehabilitation is lacking in most/all developing countries
- When/if available, medical rehabilitation is largely an urban based service – and unaccessible to the majority of disable (distance and costs)
- Physicians with rehabilitation training are uncommon

- The level of training among physical therapists vary widely
- Occupational therapists are uncommon
- Speech therapists, rehabilitative nurses, and psychosocial personnel are rare
- Prosthetic and orthotic personnel availability and level of training varies
Community – Based Rehabilitation (CBR)

- The declaration of Alma Ata (1978) – the first international declaration advocating primary health care as the main strategy for achieving the World Health Organization's goal of "Health for all"

- 1978/79: WHO introduced CBR

- 1979: *Training in the community for people with disabilities* – a manual to provide guidance and support for CBR programmes and stakeholders, including people with disabilities, family members, school teachers, local supervisors, and community rehabilitation committee members


- 2004: 2nd Joint position paper on CBR (ILO, UNESCO, IDDC, WHO)

- 2011: CBR Guidelines & CBR Matrix
CBR is based on the principles of CRPD

- Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons
- Non-discrimination
- Full and effective participation and inclusion in society
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
- Equality of opportunity
- Accessibility
- Equality between men and women
- Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities
CBR and the CRPD

- CBR IS BASED ON THE PRINCIPLES OF CRPD:
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CBR: Community – based rehabilitation

- CBR is implemented in around 100 land
- CBR is largely a concept for poor countries
  - A few examples of implementation in high-income countries
- Introduced by WHO in the 1970-ies
- As a response to
  - Lack of health services and rehabilitation for the poor population (the large majority) in developing
  - Ideological shift – from institution building to primary health care
- Substantial variations in models, level of ambitions, scope
- Development from medical rehabilitation to community development
CBR stakeholders

Person with disability and family

Community leaders, teachers, health and community workers

Local gov, NGOs, disability groups

National government, political leaders, media

Local government, political leaders, media

National government, political leaders, media

Local government, political leaders, media

National government, political leaders, media

Local government, political leaders, media

National government, political leaders, media
CBR Guidelines

• Adopted 2011

• Joint document:
  • WHO – World Health Organization
  • UNESCO – United Nations Educational, Scientific and Cultural Organization
  • ILO – International Labour Organization
  • IDDC - International Disability and Development Consortium

6 booklets: Introductory, Health, Education, Empowerment, Social, Livelihood, Supplementary
CBR local management structure (example)

- School authorities
- CBR committee
- Local authorities
- Health centres/PHC/hospitals
- Mid-level CBR managers
- CBR manager
- Community health centres. Health/outreach workers
- Community facilitators or volunteers
- CBR workers
- Primary/Secondary schools
## CBR and the Norwegian model

<table>
<thead>
<tr>
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<th>CBR</th>
<th>Den norske modellen</th>
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<tbody>
<tr>
<td>Employees</td>
<td>Largely low- or semi-skilled who are given basic training</td>
<td>Professionals with formal higher education</td>
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<tr>
<td>Competence</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Technology</td>
<td>Simple, based on CBR manual and training</td>
<td>Subject-specific, highly developed</td>
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<tr>
<td>Organisasjon</td>
<td>Different models, i.e. both/combination of NGOs/civil society and public health/other services</td>
<td>Two levels: Specialist health services, and primary health care</td>
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<td>Objective</td>
<td>Improvements in functioning, changes in family, community development, inclusion/participation</td>
<td>Primarily improvements in functioning and adaptations in the environment</td>
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<td>Relation to local community</td>
<td>Integrated in local community, multifaceted</td>
<td>System level, separated from the community</td>
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<tr>
<td>Ideology</td>
<td>Human rights, combination of medical, social and interactionist models</td>
<td>Medical paradigm</td>
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Studies on living conditions

- Namibia (2003)
- Zimbabwe (2003/13)
- Malawi (2004/2016)
- Zambia (2006/2014)
- Mocambique (2009)
- Lesotho (2010)
- Swaziland (2011)
- South Africa (2006)
- Botswana (2013)
- Angola (2016)
- Nepal (2015)
Serious or insurmountable problems in accessing health care, by country. Percent (Equitable)
Results from LC studies in southern Africa (2003 – 2014)

Gap analyses - assistive devices
Results from LC studies in southern Africa (2003 – 2014)
Results from LC studies in southern Africa (2003 – 2014)

Source of assistive device by country

- Namibia
- Zimbabwe 2003
- Zimbabwe 2013
- Malawi
- Zambia
- Mozambique
- Swaziland
- Lesotho
- Botswana
Results from LC studies in southern Africa (2003 – 2014)
General impression

• Large unmet needs
• Serious quality problems
• Authorities (LICs) do not take the responsibility for supply of assistive devices
• Service delivery (assistive devices) is limited and with different actors that are not co-ordinated
• Existing services: distribution of devices, lack of training, adaptation and maintenance
• Charity/donations dominate the supply chain
• Until now (2015): no joint global effort to improve service delivery of assistive devices in low-income countries
• (WHO – GATES)
Problems and solutions

- **Key problem areas:**
  - Lack of health personell (and quality)
  - Weak infra structure
  - Disrupted and non-functioning public (health) services
  - Donations/charity – dilemma

- **Possible solutions:**
  - Utilize existing resources
  - Low-threshold and out-reach services (CBR)
  - Simple, adapted technology
  - V vitalisation of existing services (capacity building); service delivery chain
  - Poverty perspective
  - Activation of civil society (DPOs +)
  - CRPD
Examples of Inappropriate Wheelchairs and Provision
Inappropriate Wheelchair Provision
Example of Inappropriate Provision and Follow Up
Self-made wheelchair