

SEA-Rehab-78
Distribution: General

Strengthening the Application of UN Standard Rules in the South Asian Region

*Report of an Intercountry Workshop
Bangalore, India, 15-18 September 2003*

WHO Project: ICP DPR 001



World Health Organization
Regional Office for South-East Asia
New Delhi
February 2004

© World Health Organization (2004)

This document is not a formal publication of the World Health Organization (WHO), and all rights are reserved by the Organization. The document may, however, be freely reviewed, abstracted, reproduced or translated, in part or in whole, but not for sale or for use in conjunction with commercial purposes.

The views expressed in documents by named authors are solely the responsibility of those authors.

CONTENTS

	<i>Page</i>
1. BACKGROUND AND INTRODUCTION	1
2. OBJECTIVES.....	2
3. PROCEEDINGS.....	2
3.1 Opening of the Workshop.....	2
3.2 Nomination of Office-bearers	3
3.3 Key Note Address	3
4. COUNTRY REPORTS	4
4.1 India	4
4.2 Myanmar	5
4.3 Nepal.....	6
4.4 Sri Lanka.....	7
4.5 Thailand.....	8
5. Critical Review of Issues and Measures to Overcome Them	9
5.1. Rule 2- Medical Care	9
5.2. Rule 3 – Rehabilitation.....	10
5.3. Rule 4 - Support Services	12
5.4. Rule 19 – Personnel Training.....	14
6. Recommendations	17

Annexes

1. Programme	18
2. List of Participants	19

1. BACKGROUND AND INTRODUCTION

An Intercountry workshop on “Strengthening Application of UN Standard Rules” was held at Bangalore from 15-18 September 2003. The UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities were adopted by the UN General Assembly in 1993. Though the rules are customary in nature, they imply a strong moral and political commitment. States are required under the Rules to remove obstacles to equal participation and to actively involve disability NGOs as partners.

The UN Standard Rules, for their very nature, have been recognized as a human rights instrument. In the first operative paragraph of Resolution 2000/51, the Human Rights Commission recognizes the UN Standard Rules as an evaluative instrument to be used to assess the degree of compliance with human rights standards concerning disabled people. The Commission recognizes that “any violation of the fundamental principle of equality or any discrimination or other negative differential treatment of persons with disabilities inconsistent with United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities is an infringement of the human rights of persons with disabilities.

In 1999, WHO (WHO/DAR) in consultation with UN Special Rapporteur on Disability and his panel of experts, developed a questionnaire based on which a study was carried out to assess the application of Standard Rules particularly Rule 2 on medical care; Rule 3 on rehabilitation; Rule 4 on support services and Rule 19 on Personnel training. Analysis of the responses received from 104 countries concluded that “the application of Standard Rules requires strengthening in all the four areas of investigation.”

Similarly, in April 2001, WHO/DAR organized a global conference on Rethinking Care from the perspective of disabled people. This conference also focused on the four Standard Rules. The report of this conference noted that “access to medical and related services is a basic human right and, therefore, must not be determined by the ability to pay and on the ground of other differences.”

The UN Special Rapporteur on Disability has observed that the Rules are used in many different ways and to a various extent over the world and it is

still a long way ahead before the Rules can be considered implemented. To ensure better implementation of the Rules, particularly those contained under Section 1, WHO organized a Workshop in Bangalore from 15-18 September 2003. Participants from Member States, representing the ministries of health and social welfare as well as persons with disabilities and their organizations in the South Asia region were invited. These countries included Bangladesh, India, Nepal, Sri Lanka and Thailand.

2. OBJECTIVES

- (1) To review the situation of application of the four Standard Rules (Rule 2 on medical care; Rule 3 on rehabilitation; Rule 4 on support services; and Rule 19 on Personnel training) in the participating countries and identify constraints and models of best practice;
- (2) To recommend strategies for overcoming the constraints for strengthening the application of the four Standard Rules, and
- (3) To promote learning from experiences and regional networking between countries and institutions.

3. PROCEEDINGS

3.1 Opening of the Workshop

Dr Madan Upadhyay, WHO Regional Advisor on Disability, Injury Prevention and Rehabilitation welcomed the participants and briefly outlined the purpose of the meeting.

Highlighting the importance of the workshop, Ms Eva Sandborg of WHO Head Quarters stated that "The workshop was the first one of its kind, and by way of a pilot workshop". The aim of the workshop was to learn from country experiences of implementing the UN Standard Rules on the Equalization of Opportunities related to health and how a strategy for its implementation could be developed. Thus, the focus of the workshop would be more on policy issues than technical, more on human rights issues than purely medical."

Mrs Anuradha Mohit of the National Human Rights Commission of India and Consultant for the meeting briefly analysed the rationale for the paradigm shift from charity to rights. She highlighted the importance of UN Standard

Rules as a policy instrument for guiding action based on human rights principles and values such as equality, dignity, autonomy, and freedom.

The inaugural ceremony was followed by a cultural programme presented by the students of **Raman Maharishi Academy for the Blind** and children from **Mobility India's** CBR Project.

(See Annex 1 and 2 for List of participants and programme)

3.2 Nomination of Office-bearers

Major H P S Ahluwalia, Chairman, Rehabilitation Council of India, Dr Pattaria Jarutat, Director, Sirindhorn Medical Rehabilitation Centre, Thailand and Mrs Anuradha Mohit, Special Rapporteur, National Human Rights Commission of India were nominated Chair, Vice Chair and Rapporteur respectively.

3.3 Key Note Address

Ms Eva Sandborg, WHO HQ, Geneva delivered the key note address on "The UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities – Comparison of Government and NGO responses. She mentioned the rules categorized under Chapter One, Preconditions, which were particular interest to WHO because they fell within the mandate of WHO's work. These rules were very important because they created the basis for the other rules. The Rule on medical care implied that girls, boys, women and men with disabilities, particularly infants and children, were provided with the same level of primary health care within the same system as other members of society. Ms Sandborg also presented the difference in Government and NGO responses to the study. The finding revealed that health and social services were generally not included in the mainstream programmes and schemes. She further pointed out that there were wide qualitative and quantitative gaps in providing medical care, rehabilitation and support services. She suggested that the involvement of DPOs at the planning, execution and monitoring levels needed to be stepped up in keeping with the Standard Rules. She further observed that sensitivity along with professional care would go a long way in serving persons with disabilities in making them self-dependent. Mass awareness on disability issues was required to sensitize (in terms of specific needs) and desensitize (in terms of pity) the public which would facilitate smooth implementation of disability programmes.

4. COUNTRY REPORTS

4.1 India

Approximately 50 million India's population of over one billion people have disabilities of one kind or the other. The Government of India has become increasingly concerned about the needs and rights of persons with disabilities. A multi-pronged strategy which includes interministerial and intraministerial coordination at the central, state and district levels has been deployed. As a result, a disability perspective is being increasingly incorporated in the mainstream developmental programmes and schemes.

The government has systematically promoted participation of people with disabilities at the policy level. It has taken cognizance of the changing profile of disabilities in the new millennium; preventive measures undertaken in the last two decades have brought about drastic reduction in disability on account of poliomyelitis, cataract and leprosy. Understanding of more recently identified disabilities like autism and multiple disabilities have presented specific challenges to which the Government of India has responded with alacrity.

Under the immunization programmes, vaccinations are given to infants and pregnant women for controlling six vaccine preventable diseases. In addition, vitamin A and iodine deficiency disorders are being addressed through special programmes for administering vitamin A to pre-school children and salt iodization programme. Similarly, Promotive activities are being undertaken by state governments to improve the nutritional status of pregnant women and children in the 0-6 years age group.

To develop human resources for the provision of rehabilitation services, six national institutes are in operation. The Rehabilitation Council of India regulates standards in the professional development for 16 categories of rehabilitation personnel. It has adopted a two-pronged approach to address the human resources recruitment to respond to the needs of people with disabilities:

(1) Development of specialized human resource on the one hand; and
(2) enhancing the capacity of mainstream educational institutions and professionals on the other. Under the scheme of purchase/fitting of aids and appliances, persons with limited income are provided appropriate assistive

devices free of cost, while others get these at 50% subsidy. The country has developed extensive production facilities for meeting the demand for aids and appliances. To break the nexus of disability and poverty, several measures such as establishment of Handicapped Finance Development Corporation, 3% reservation in jobs and allocation of 3% budget under all poverty alleviation schemes for persons with disabilities have been adopted.

The country has an impressive legal framework that includes four exclusive legislations and a plethora of administrative rules, regulations and orders related to disability prevention. India's Five Year Plans have been disability inclusive. However, real improvement started becoming evident from the Seventh Plan with a steep rise in the budget allocation. The gradual shift from welfare to rights is increasingly evident.

4.2 Myanmar

Myanmar has a population of 52.17 million. The country is divided administratively into 14 states. The national health policy was developed with the initiation and guidance of the national health committee in 1993. The national health plan (2001-2006) forms an integrated part of the national development plan in tandem with the national economic plan. The plan envisages ensuring effective implementation of the national health policy and strengthening health services in the rural areas. The Government of Myanmar has made a policy declaration concerning persons with disabilities, stating that all possible ways and means will be adopted to enable persons with disabilities to take full advantage of rehabilitation services.

Myanmar provides rehabilitation services for persons with disabilities in an institution-based model of rehabilitation since the early 1960s. There is a national rehabilitation hospital, 12 physical medicine and rehabilitation departments and 52 physiotherapy units attached to the general and specialist hospitals, and divisional hospitals. Under the project "upgrading of hospitals" the department of rehabilitation and physiotherapy units are envisaged at district levels. A community-based rehabilitation programme has been implemented since 1982, covering 288 183 people from 118 villages and 68 wards of 24 townships. An international evaluation team (external review) has strongly recommended expansion of the programme to cover the whole country in phased manner. A multidisciplinary team approach is used for prevention, early detection, assessment and treatment of impairment.

Assistive devices and equipment are being provided free or at a low cost to persons with disabilities. To adequately cater to the needs of persons with disabilities, lack of qualified staff has been identified as a critical deficiency. Therefore, the Government has adopted a multi pronged approach to train the staff in collaboration with government, nongovernment and international partners. Since 1999, 12 personnel from the Department of Social Welfare and four persons with disabilities have been exposed to workshops, seminars and training programmes abroad. Under the guidance of the State Peace and Development Council, the National Health Committee encourages the involvement of NGOs. This initiative will go a long way in according greater importance to the concerns of people with disabilities.

4.3 Nepal

Nepal is a multi-racial, multi-ethnic, multi-lingual and multi-cultural country. It has a population of 23.5 million of which, approximately 1.63 to 20 percent is estimated to have disability. In the absence of a uniform definition and inadequate survey methodology, current disability statistics in Nepal are considered to be not very reliable. The second long-term Health Plan up to 2017 has been evolved with the aim of improving the health status of people by strengthening the present infrastructure of preventive, promotive, curative and rehabilitative services.

The essential health care services in Nepal, include, among others expanded immunization, nutrition programme, leprosy control, eye care, ear care and mental health. The policy emphasizes multisectoral collaboration and coordination among government, private and civil society organizations. The Ninth Five Year Plan in Nepal has a clear focus on community based approach.

Significant improvement has been made in the prevention of disability through immunization, nutrition programme, early detection and intervention. Since November 2000, no case of polio has been reported. Nepal is likely to be declared polio non-endemic country soon. Vocational training of different kinds imparted to persons with disability for gainful socioeconomic rehabilitation.

Support services to people with disabilities are by and large provided by NGOs. The government facilitates import of assistive devices and has waived

export duty. NGOs are encouraged to design, develop and distribute assistive devices through both institution and community-based models. The country is facing acute shortage of sign language interpreters and low vision devices. Most of the private training programmes on rehabilitation are mostly offered by institutions and universities. The country has prioritized training of CBR workers, orthotic and prosthetic engineers and physiotherapists.

In Nepal, approximately 30 INGOs and 100 NGOs are working on disability in Nepal, out of 75 districts, 60 receive CBR services through NGOs. The country was reported to lack capacity in several critical areas for effective application of UN Standard Rules.

4.4 Sri Lanka

Sri Lanka is a small island with a land area of approximately 62 705 square kilometers. For the purpose of administration, Sri Lanka is divided into eight provinces, 25 districts, and 321 divisions. According to a CBR survey report, the prevalence of disabilities is estimated to be about 3.2 percent. Increase in road traffic injuries, improvement in life expectancy, stress due to socioeconomic hardship and protracted armed conflict have all resulted in a rapid increase in the number of disabled persons in the country.

The mainstream mechanism for providing modern as well as traditional medical care is also catering to people with disabilities. However, access is constrained by the attitude of health staff, lack of knowledge of health staff and non-availability of alternative medical treatment. Multi-disciplinary teams for the management of impairments are envisaged at the primary health level. Development of this model has been greatly constrained by lack of trained medical and paramedical staff, absence of community therapists and lack of coordination between the Health and Social Services Ministry. The national CBR programme of the Social Services Ministry has so far covered 28 percent of the population; for implementation of this programme about 3 000 CBR workers have been trained.

As a welfare state, Sri Lanka provides drugs and equipment free of charge to the people. Most physiotherapy and occupational therapy units are well equipped. The Social Services Department and NGOs supply hearing aids, spectacles and wheel chairs to the disabled. Poor quality of equipment

due to financial constraints, and dependence on donation of used equipment, has resulted in dissatisfaction among people with disabilities.

Poor quality of goods and services for people with disabilities in Sri Lanka has been attributed to the lack of a disability perspective in the National Health Care Policy. The training of personnel in health and rehabilitation needs to be stepped up. Similarly, quality assurance in the support services is urgently required.

4.5 Thailand

Thailand is spread over an area of 513 116 Sq Km. In the year 2002 its population was 62.799 million, of which 1.7% people are estimated to have a disability.

Medical services are delivered in collaboration with major stakeholders. Early intervention and availability of services at all levels have enhanced the overall status of health. However, limited budget and health finance regulations have constrained further development. Thailand has a national plan for the empowerment of people with disabilities which is executed in a multisectoral mode. The committee at the national and provincial levels one important structures consisting of representatives of government and civil society organizations. The office of the Committee for the Rehabilitation of Disabled Persons administers the national plan.

The support services provided by the government include assistive devices, sign language interpreters, social insurance schemes and provision of independent living programme. Rehabilitation services are provided by a multidisciplinary team comprising orthotics and prosthetics engineers and experts from the fields of deafness and blindness. Sirindhorn National Medical Rehabilitation Centre acts as a national coordinating unit for the programmes which have now been introduced in many provinces.

In conclusion, Thailand has a fairly modern legal and policy framework with a focus on disability. The administrative arrangements are backed by modest allocation of budget. Constraints of resources, both material and human, have limited further development. However, the overall climate is positive and disability issues are much more visible than ever before.

5. CRITICAL REVIEW OF ISSUES AND MEASURES TO OVERCOME THEM

The participants undertook a critical review of Rules 2, 3, 4 and 19 of the Standard Rules with a view to identifying problems and exploring strategies for improved application of Standard Rules. Four sessions, one each for Rules 2, 3, 4 and 19 were devoted for group work. Participants were provided a set of questions for each group to stimulate and encourage discussion. The questions were not exclusive and often the participants discussed all aspects related to these rules well beyond the set of questions.

5.1. Rule 2 - Medical Care

Group discussions on Rule 2 – (Medical Care) were held to examine the issues listed below:

Key issues

- (1) How do the medical systems respond to the health needs of persons with disabilities of different age groups?
- (2) Which aspects/components of health service should be further geared up to ensure equal access by people with disabilities?
- (3) To what extent organizations of people with disabilities participate in the planning, execution and monitoring?
- (4) Why is early detection of disabilities among children not effective?
- (5) What impact can the rising cost of medical care and limited access to health insurance have on the lives of people with disabilities?
- (6) Do people with disabilities in rural and urban slums encounter additional barriers to access medical services?

Barriers, problems and concerns

The following were identified as common problems and barriers to delivery of medical services to the disabled: attitudes of society and of the service providers, lack of proper reporting system for identification and follow-up of children with disabilities, inadequate ante-natal, natal and post-natal care, lack of awareness and knowledge about developmental milestones, lack of early intervention and inadequate allocation of resources for medical services. Lack of awareness, national commitment, and focus on disability in the national health policy, poor nutrition, and weak school health systems are common concerns in the Region.

Since disabled people need to access the medical services just as everyone else, the group recommended the following strategies to create disability inclusive medical services:

Overcoming problems

- Formulation of a health care policy for empowerment of persons with disabilities;
- Improving coordination among government agencies and stakeholders at local and intermediary level;
- Developing an appropriate local referral system to complement the medical services.
- Strengthening the school health systems to regularly screen children;
- Evolving effective monitoring and reporting systems for greater accountability;
- Raising awareness to shape attitudes of community and health workers regarding rights and needs of the disabled;
- Gearing up the community and primary health care system for early detection, assessment and referral;
- Ensuring subsidized medical services for those with no low-income or personal income;
- Developing centres for excellence in each country;
- Scaling up extension and expansion of outreach programmes;
- Promoting use of mobile clinics for far flung areas that have challenging topography.

5.2. Rule 3 – Rehabilitation

Key issues

Group work pertaining to Rule 3 – Rehabilitation examined the following questions

- (1) Why has the rehabilitation delivery mechanism remained underdeveloped?
- (2) Do all people with disabilities have equal access to rehabilitation, if not, what has hampered access for some?

- (3) Can rehabilitation professionals adequately manage disabilities at the community level?
- (4) How can the involvement of people with disabilities and their families be improved?

Barriers, problems and concerns

The group identified some obstacles in implementation of rehabilitation. These included lack of a national rehabilitation plan and absence of effective implementation where it existed. Since disability was not considered a priority issue, resource allocation for rehabilitation services was not sufficient. Implementation of legal and policy measures was constrained by lack of trained rehabilitation workers. Most rehabilitation centres did not have effective out-reach programmes. Weak or non-existent follow-up and accountability left ample room for questioning the quality of services. Impairment and rehabilitation components were inadequately designed and delivered in the training programmes. In-service and hands-on training in rehabilitation was not systematically provided. Participation of people with disabilities and their families in the planning, evaluation and monitoring was not mandated at local and middle levels.

The groups recommended the following steps to improve the implementation of rehabilitation services.

Overcoming problems

- Developing a national rehabilitation plan using UN Standard Rules as a guideline.
- Integrating the currently fragmented rehabilitation services into a framework of national rehabilitation programme.
- Developing pilot programmes for integrating rehabilitation in mainstream health services.
- Establishing formal link between out-reach programmes, referral services and follow-up activities.
- According priority to the training of persons with disabilities and families for their effective involvement throughout the rehabilitation process.
- Redefining the role of health personnel to include rehab component from a rights perspective.

- Developing day-care centers as part of community-based services for children with multiple disabilities.
- Introducing a national programme to strengthen grass-root self help groups of persons with disabilities and families.
- Training and developing appropriate rehabilitation personnel to meet the needs at different levels such as rehabilitation therapists, sign language interpreters, special educators, CBR workers, etc.
- Evolving a system to update information and knowledge of health workers regarding rights, duties, entitlements, benefits and special schemes for persons with disabilities at the community level.
- Developing a resource book listing services available for the disabled including those delivered by NGOs, INGOs and other private organizations.
- Developing mechanism and instruments for regular review in consultation with DPOs and families of the disabled. The latter have an important role in the review process.

5.3. Rule 4 - Support Services

Group work on Rule 4 – (Support Services) examined among others, the following questions.

Key issues

- (1) How do people with disabilities access the needed devices that are costly and are not covered under the scheme of subsidized or free aids and appliances?
- (2) What should be the role of government in the production and distribution of assistive devices?
- (3) How is the availability of personal assistance viewed and provided at work, schools and at home for the severely and with multiple disabilities of persons?
- (4) What type of assistance is needed by families having children with disabilities? Is it already available?
- (5) To what level national sign languages are developed and interpreters trained and made available?
- (6) Are DPOs involved in the design, development, distribution, repair and assessment of assistive devices?

Barriers, problems and concerns

The group identified some common barriers to the application of Rule 4 – (Support services). Although the family is perceived as a primary provider of personal assistance, formal arrangements by the government to empower the families are reported to be either non-existent or inadequate. The vicious circle of poverty and disability hamper access to even subsidized devices. Bureaucratic procedures and low literacy among the disabled pose additional barriers in obtaining devices. Absence of a mechanism for distribution of assistive devices in the rural and semi urban areas limits the opportunity. Reported poor use of assistive devices was attributed to non-availability of maintenance and repair services. The community workers lacked knowledge about assistive devices and were deficient in skills to help disabled people learn their use and maintenance. Initiatives on research on design, development and production were found to be deficient both by government and the private sector. Import and export policy were found to be restrictive. Formal agreement for free trade in assistive devices at SAARC level was reported to be missing. Limited opportunities to train technicians and production engineers also hampered access to support services by people with disabilities.

Overcoming problems

The groups made wide ranging recommendations for the better application of Rule 4 – (Support Services) as follows:

- Formulation of Government policy to ensure adequate production and efficient distribution through public and non governmental agencies.
- Specific measures to be initiated by Governments to support assistive devices should include:
 - Quality assurance and quality testing arrangements;
 - Exemption from duties and taxes;
 - Provision of interest-free loan for providing assistive devices;
 - Establishing a permanent mechanism to ensure improvement in design and production;
 - Organizing regular expositions and exhibitions of assistive devices;
 - Preferential loans and tax exemption to industry for the production of assistive devices, and
 - Adoption of purchase preferential policy for devices produced by an establishment run by people with disabilities, provided they met the quality requirement.

- Promoting development of low-cost, appropriate assistive devices, such as prefabricated orthotics;
- Promoting the production of devices using local materials;
- Developed devices according to the needs of persons with disabilities;
- Provision of subsidy or alternatively availability of interest free loans to be paid back in small installments for costly devices like computers, wheel chairs and modernized toilets;
- Establishing equipment banks in all countries to loan equipment for a specific period, as is done in Thailand and Myanmar;
- Systematic training of rehabilitation workers, persons with disabilities, their parents and family members in the use, repair and maintenance of assistive devices as appropriate;
- Development of a national sign language to improve communication among the deaf and hearing impaired by the countries in the region.
- Developing for training programmes for sign language interpreters, teachers of the deaf, family members and community workers in both traditional and distance mode.
- Developing training resources including compilation of a sign language dictionary based on various signs used in each country.
- Enhanced regional cooperation for availability of devices produced by the various countries in the Region through a fair trade agreement.

5.4. Rule 19 – Personnel Training

The groups examined the following questions relevant to the application of Rule 19 - Personnel Training.

Key issues

- With the incorporation of disability perspective in various programmes and schemes new training needs have emerged. How have the governments addressed this?
- What measures have been deployed to incorporate a disability component in the training of various health workers?

- Are the current training programmes on disability based on a human rights approach or do they still perpetuate the welfare model?
- Have the mainstream educational institutions responded adequately to the need for introducing programmes in disability management and rehabilitation?
- How can effective involvement of DPOs and parent associations be ensured in the planning and delivery of training programmes?
- How to ensure minimum standards and quality in the training programmes for rehabilitation workers?

Barriers, problems and concerns

The groups identified the following barriers common to the training personnel in rehabilitation of persons with disabilities. The human resource developmental policies and programmes lack a disability perspective. Poor coordination and the tradition of working in isolation limit the capacity of various educational institutions to address disability issues. Shortage of master trainers in the mainstream training institutions is a constraint. The pre-service and in-service training programmes for development personnel lack a disability component. Training materials/resources in rehabilitation are not easily available. Insufficient rehabilitation training opportunities for health workers, DPOs, community workers, peer guides and care providers pose extra challenges. Lack of resources, political commitment, and the indifference of the academic sector are traditional barriers.

The groups suggested the following for better application of Rule 19 – (Personnel Training).

Overcoming barriers

- Undertaking a systematic assessment of human resource requirements in rehabilitation to determine quantitative and qualitative gaps and needs.
- Developing a national policy for training personnel required at all levels.
- Establishing a mechanism to plan, guide and regulate training programmes for quality assurance, better coordination and uniform standards in rehabilitation.

- Mobilizing both traditional and distance modes of education for rehabilitation programmes for both deliveries of formal and non formal system.
- Mandating the involvement of people with disabilities and their organizations in the planning and delivery of training courses.
- Upgrading existing training programmes in line with technological, legal and other developments.
- Establishing a national and regional information documentation system for sharing of training resources and research findings.
- Undertaking a review of training materials with a view to carry out modifications necessary to remove redundant ideas and to incorporate human rights perspective on disability.
- Introducing compulsory internship in disability for all health and rehabilitation workers.
- Introducing in-service training on rehabilitation for all health and rehabilitation workers at regular intervals of service.
- Collaboration between WHO/SEARO and Rehabilitation Council of India (RCI) to promote regional cooperation for sharing of knowledge in developing course curricula and training strategies.
- Piloting formal and non formal training programmes using satellite and IT based systems. RCI and Indira Gandhi National Open University are already working in this direction and can be used as models of good practice.
- Conducting crash programmes for in-service training for primary health staff and rehabilitation workers on a priority. The rehabilitation Council of India is implementing such a programme.

Field visit

A half-day field visit to the head-quarters of Mobility India and their CBR project site was organized on 17 September. The institute is modelled on a universal design concept and thus allows complete accessibility to all categories of people with disabilities. Here the participants had a useful interaction with the staff who train people with disabilities, their families and community workers in rehabilitation, design, development and maintenance of assistive devices and vocational training. The CBR project in the urban slum setting showcased community involvement in a programme with a clear focus on children with disabilities.

6. RECOMMENDATIONS

To the Countries

- (1) A health care policy which goes beyond technical services for people with disabilities and strives to empower them to lead their lives more effectively should be formulated.
- (2) Programmes to raise awareness to shape the attitudes of community and health workers regarding rights and needs of the disabled should be initiated.
- (3) The use of mobile clinics to serve people in far-flung areas that have challenging topography should be promoted.
- (4) A national rehabilitation plan should be developed using UN Standard Rules as guidelines
- (5) Rehabilitation workers, persons with disabilities, their parents and family members should be trained in the use, repair and maintenance of assistive devices.
- (6) A systematic assessment of human resource requirements in rehabilitation should be undertaken to determine quantitative and qualitative gaps.

To WHO

- (1) WHO should pilot programmes for mainstreaming rehabilitation into health services.
- (2) WHO should facilitate development of regional strategy for training of appropriate rehabilitation personnel to meet the needs at different levels.
- (3) WHO should assist in development of appropriate policy guidelines to ensure adequate production and efficient distribution through government and nongovernmental agencies.
- (4) WHO should promote development of low cost, appropriate assistive devices such as prefabricated orthotics.
- (5) WHO should help countries to develop a mechanism to plan and regulate training programmes for quality assurance.

Annex 1

PROGRAMME

Day – 1

1800 – 2000 hrs Official Inauguration

Day – 2

Morning Session ➤ A keynote address on the results of analysis of UN Standard Rules questionnaires
➤ Country presentations about application of four Standard Rules in their countries
➤ Discussions

Afternoon Session ➤ Medical Care – Presentation on possible constraints and strategies
➤ Group discussions –Improving medical care
➤ Plenary discussions

Day – 3

Morning Session ➤ Rehabilitation services – presentation on possible constraints and strategies
➤ Group discussions – Improving rehabilitation services
➤ Plenary discussions

Afternoon Session ➤ Aids and Appliances – Presentation on possible constraints and strategies
➤ Group discussions – Improving P&O services
➤ Plenary discussions

Day – 4

Morning Session
(Extended) ➤ Personnel training – Presentation on possible constraints and strategies
➤ Group discussions – Improving personnel training
➤ Plenary discussions
➤ Final recommendations and conclusions
➤ Closing Session

Annex 2

LIST OF PARTICIPANTS

India

Major H P S Ahluwalia
Chairman
Rehabilitation Council of India
23-A, Shivaji Marg (Near Karampura Complex)
New Delhi – 110 015
Ph. 25913018, 25911965
Fax : 25911967
E-mail: rehabstd@ndc.vsnl.net.in or
rehabstd@nde.vsnl.net.in

Brigadier Jagmohan Uppal
Managing Director
Artificial Limb Manufacturing Corporation of
India (ALIMCO)
G.T. Road
Kanpur – 208016, Uttar Pradesh
E-mail: alimco_hq@vsnl.net

Mr Mahesh Chandrashekar
CBR and HR Programme Manager
Mobility India
1st and 1st 'A' Cross, J P Nagar, 2nd Phase
Bangalore, Karnataka

Myanmar

Dr Khin Myo Hla
Lecturer
Department of Physical Medicine
Institute of Paramedical Sciences
Yangon

Dr Win Nyi Shein
Physician (Physical Medicine)
Mandalay General Hospital

Dr Than Than Htay
Physician (Physical Medicine)
North Okkalapa General Hospital

Ms Daw Khin May Than
Head Mistress
Vocational Training School for Adult Disable
Department of Social Welfare
Ministry of Social Welfare, Relief and
Resettlement
Yangon

Nepal

Mr Kiran Prasad Shibakoti
Under Secretary
Ministry of Women, Children and Social Welfare
HMG of Nepal
Kathmandu

Mr Nirmal K. Devkota
President
Nepal Association of the Deaf and Hard of
Hearing
Head Office
Ratopul, Kathmandu
Tel: 977-1-4-498297, Fax: 977-1-4-443448
E-mail: nadh_deaf@wlink.com.np

Mr Prakash Maharjan
Interpreter to Mr Devkota

Mr Rajan Bahadur Raut
President
Nepal Association for Welfare of the Blind
Tripureshwore, Kathmandu

Dr Bishnu Prasad Pandit
Chief Specialist
Policy, Planning and International Cooperation
Division
Ministry of Health
HMG Nepal
Kathmandu

Sri Lanka

Mr R A Sirisena
Joint Secretary
Sri Lanka Federation of the Visually
Handicapped
74, Church Street
Colombo – 2
Tel: 00-94-1-305256 or 437768

Dr Lalith Wijeratne
Rheumatology Consultant
Colombo South Teaching Hospital
214, Waragoda Road
Kalubowila
E-mail: lalithsw@sitnet.lk

Dr S Pathinayake
Provincial Director
Southern Province
Office of the Provincial Director of Health
Services
145A, Lower Dickson Road
Galle

Thailand

Dr Pattariya Jarutat
Director
Sirinthorn National Medical Rehabilitation
Centre
Department of Medical Services
Ministry of Public Health
Nonthaburi
Tel: 66-2591 4242
E-Mail: pattariya@health.moph.go.th

Mrs Sunee Saisupaipon
Social Development Officer
Bureau of Welfare Promotion and Protection of
Children, Youth, the Disadvantaged Persons
with Disability and Older Persons
Ministry of Social Development and Human
Security
Bangkok
Tel: 66-2644-7991

Ms Phoranee Louineau
President
Parents' Association of the Intellectually
Impaired
Bangkok
Tel: 66-2591-4242, Extn. 1202

WHO Secretariat

SEARO

Dr Madan P Upadhyay
RA-DPR
SEARO, New Delhi

Mr Kalipada Das
Secretary – II
DPR/SEARO

Mrs Anuradha Mohit
India Spinal Injury Centre
C-3/3125, Vasant Kunj
New Delhi – 110070
Tel: 2689 7845 (R), 26130219 (O), 31014561
(M)
E-mail: anuradamohit@postmark.net or
anurathamohit@yahoo.com

Ms Sakshi
Assistant to Mrs Anuradha Mohit
Indian Spinal Injury Centre
C-3/3125, Vasant Kunj
New Delhi – 110 070

Headquarters

Ms Eva Sandborg
DAR

Dr Sunil Deepak
Consultant
DAR