Regional Strategic Framework on Community-Based Rehabilitation (CBR) in the South-East Asia Region 2012–2017

World Health Organization
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1. Background

Disability is an evolving concept and an umbrella term for impairment, activity limitation or participation restriction, which result from interaction between persons with health conditions and environmental factors (e.g. physical environment, attitude) and personal factors (e.g. age or gender)[1]. *The World Report on Disability* estimates that 15%-18% of the world's population have disabilities[2]. The causes include birth defects; injuries resulting from road traffic accidents, conflicts, falls and landmines; noncommunicable diseases (NCDs) such as diabetes, cardiovascular diseases and cancer; mental illnesses and intellectual impairment; ageing; and communicable diseases.[3] The WHO South-East Asia Region also has a significant number of people with disabilities due to polio, leprosy and tuberculosis.

Persons with disabilities are some of the most disadvantaged and marginalized people worldwide. About 80% of them live in developing countries.[4] The majority of those with disabilities live in chronic poverty. With good health care and rehabilitation services and the provision of barrier-free environments, people with disabilities can contribute to society instead of being passive recipients of charity. In 2006, a UN study found that 62 countries in the world had no national rehabilitation services and almost all of these countries were developing or underdeveloped nations[5]. Only 5%-15% of persons with disabilities in developing countries can access assistive devices[6]. People with disabilities in developing countries often depend on the support of carers who assist with activities of daily living, transport and social support, and provide emotional support and assist with decision-making. They are usually women, mostly unpaid, family members, friends or neighbours. They too may suffer ill-health due to their caring role.

Poverty is both a cause and consequence of disability.[7] Children with disabilities are less likely to attend a school than other children.[8] Persons with disabilities have higher

unemployment and have lower earning than persons without disability.[9] The cost of medical treatment, physical rehabilitation and assistive devices, contribute to the poverty and disability cycle. The Millennium Development Goals (MDGs) adopted by the UN in 2000 will not be achieved without the inclusion of people with disabilities, as they are disproportionately represented among people who live in poverty with limited access to education, health and social benefits. Solutions focus on ensuring social change, creating equal access to services and removing barriers that exclude people with disability. There is recognition of the need for community-based approaches and community-driven initiatives to ensure sustainable and inclusive development that benefits all.

This is not just an issue of the vicious cycle of disability and poverty. The present situation constitutes a violation of human rights. On 13 December 2006, the UN General Assembly adopted the landmark Convention on the Rights of Persons with Disability (CRPD).[10] The Convention complements existing human rights frameworks and builds upon UN standard rules on equalization of opportunities for persons with disabilities (1993)[11] and the World Programme of Action Concerning Persons with Disabilities (1982).[12] The main purpose of CRPD is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promote respect for their inherited dignity (Article 1). The Convention has not created any new rights, but ensures that existing rights are available to persons with disabilities.

The present approach to disability is based on the participation of persons with disabilities, a movement which began in the 1960s and adopted the slogan “nothing about us without us”.[13]

2. Community-based rehabilitation (CBR)

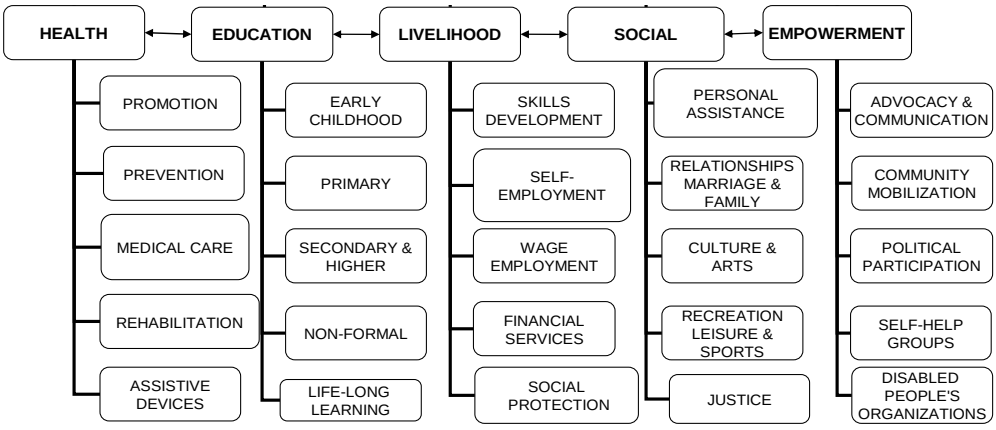
Community-based rehabilitation (CBR) was introduced in 1978, after the Alma-Ata Declaration of Health For All by WHO,[14] as a strategy to improve access to rehabilitation services for people

with disabilities. Current concepts of CBR are based on various international conventions, protocols, commitments and learning from more than 30 years of practice. These are given in detail in Appendix 2. CBR has now evolved into a multisectoral strategy to improve the quality of life of people with disabilities and ensure their empowerment, participation and inclusion in society.

The new CBR guidelines released in 2010 are based on the principles of CRPD.[15] They incorporate fundamental principles of empowerment, the mainstreaming of disability in the developmental agenda, human rights and social justice. They show how to make key development initiatives/programmes such as health, education, livelihood and social sectors inclusive of people with disabilities and their families. The guidelines were produced jointly by World Health Organization (WHO), International Labour Organization (ILO), United Nations Educational, Scientific and Cultural Organization (UNESCO) and civil societies, such as, the International Disability and Development Consortium (IDDC). The guidelines were approved on 19 May 2010 and shall remain valid till 2020.

These guidelines are supported by evidence that CBR significantly improves the quality of life of persons with disability, especially in less-resourced settings. Training of community workers in CBR is feasible and can be replicated across communities and countries. In high-income countries too, it brings positive social outcome, attitudinal change and improved social inclusion of persons with disability.

The CBR Guidelines are based on the CBR Matrix, a comprehensive framework for all sectors to work together with an inclusive and empowerment approach. This needs a twin-track approach of inclusion of disability in mainstream development policies and programmes and disability-specific programmes such as assistive devices, personal assistance, vocational training and job coaching, etc.



CBR is currently being implemented in more than 90 countries in the world and in all countries of the WHO South-East Asia Region in varying forms, different degrees and with varying national commitments. Specific reference to CBR exists in laws and policies of Bhutan, India, Indonesia, Myanmar, Sri Lanka, Thailand and Timor-Leste. The responsibility for disability affairs rests with differing nodal ministries such as health, social affairs/justice/welfare, etc. in SEAR Region member countries. They also have differing coordinating mechanisms and varying financial commitments. Civil societies also play an important role in promoting and supporting CBR. These have resulted in different models of CBR in different countries. In all countries there is scope for improvement and further development of CBR, and also consensus that CBR needs to be multisectoral with the inclusion of key sectors, such as, health, education and livelihood with a participatory approach. Improvement of the quality of life and empowerment of people with disabilities and their families are the essence of the CBR Guidelines.

A situation analysis of CBR in the South-East Asia Region in 2011 was undertaken to develop the strategic framework. A compilation on “CBR Practices in the SEA Region” was also developed.

The “South-East Asia Regional Strategic Framework for Action on Community-Based Rehabilitation 2011-2020” was

formulated during a Regional Expert Group Meeting held on 3-4 November 2011 in Faridabad, India. A group of experts, including persons with disability, from Member States and partner organizations provided invaluable inputs regarding the situation analysis of CBR in the SEA Region and the development of the Regional Strategic Framework.

The framework will guide in strengthening policy and action at the regional and national level. The framework focuses on the areas under WHO's mandate as a technical agency for health while acknowledging the multisectoral nature of CBR. The action areas focus on "doable and achievable actions" and Member States and partners are encouraged to go beyond this framework according to the availability of resources. Implementation of the action strategy will help in coordinated action by all stakeholders to reduce the burden of disability in the South-East Asia Region.

3. Principles

The Regional Strategic Framework is based on the principles of:

(1) a rights-based approach to CBR based on CRPD;

(2) inclusion and participation of persons with disabilities and their families at all levels – "Nothing about us without us";

(3) empowerment of people with disabilities and their families;

(4) inclusion of a disability focus in all development policies and programmes;

(5) a barrier-free accessible Region; and

(6) Partnerships, networking and convergence among the key stakeholders.

4. Vision

The creation of a barrier-free Region for disability where persons with disabilities and their families are empowered, having equal rights and opportunities.

5. The goal of the regional framework

The goal of the Regional Framework is to promote and strengthen community-based rehabilitation (CBR) in order to improve the quality of life of people with disabilities and their families through access to health and rehabilitation services, with harmonized actions among the Member States, the World Health Organization and development partners.

6. Objectives and action areas

CBR is a multisectoral strategy aiming for an inclusive society. The Strategic Framework focuses on the areas under WHO's mandate, particularly health and rehabilitation. It is recognized that the action areas identified are not a complete list of all actions needed but key areas for priority action. The importance of concerted harmonized action by all stakeholders is recognized and highlighted. Commitment and complementary action from other sectors and stakeholders is needed to achieve the vision towards which this framework is a stepping-stone. Close coordination of all stakeholders–Member States, WHO, partner organizations, collaborating centres and people with disability and their representative organizations–is required for alignment and harmonization of efforts. WHO will support and facilitate this and also advocate at multisectoral and regional levels to engage other sectors.

Five overall objectives with a number of specific objectives and action areas under each have been identified for this Framework. This will form the basis of development of an action plan to be endorsed by the Member States of the WHO South-East Asia Region.

Overall objective 1: Promote disability-inclusive health policies and legislation	
Specific objective	**Action areas**
1.1 Strengthen national legislation and health policy to be inclusive of disability and rehabilitation	➢ Advocacy to review, amend and develop health-related legislation and policies in line with CRPD and CBR guidelines ➢ Increase awareness of CBR and CRPD and the *World Report on Disability* among health policy-makers and planners
1.2 Support ministries of health to play a leading role in health-related rehabilitation	➢ Identify/establish and strengthen a focal point within the ministry of health to coordinate disability-related activities ➢ Advocate for review of business allocation between ministries so that ministries of health are responsible for health-related issues in disability.
Overall objective 2: Promote access to quality health and rehabilitation services in a barrier free environment	
Specific objective	**Action areas**
2.1 Enhance allocation of financial resources to increase access to health and rehabilitation	➢ Support the development of time-bound national implementation plans for health and rehabilitation-related disability issues (in mission mode or a similar plan with dedicated budget and third party scrutiny of utilization); ➢ Increase financial allocation for CBR at the district and sub-district level; ➢ Develop innovative mechanisms to implement CRPD/CBR; encourage private investment in public programmes.

2.2 Ensure the availability of quality, affordable and appropriate health and rehabilitation services at the primary, secondary and tertiary levels for persons with disabilities	➢ Ensure that the specific needs of women and children with disabilities, stigmatized groups and those with multiple disabilities and intellectual disabilities are met appropriately; ➢ Ensure that persons with disabilities have equal access without discrimination to health insurance and social protection schemes; ➢ Establish mechanisms for assessment, evaluation and certification of disability ➢ Support early identification and early intervention programmes for disabilities at the community level; ➢ Ensure availability and utilization of appropriate assistive devices and technologies at the district and sub-district level; ➢ Ensure that public and private health facilities are accessible to enable persons with disabilities to access health services on an equal basis with others.
2.3 Ensure adequate numbers of competent human resources for general health and disability-related intervention	➢ Amend curriculum to include disability and rehabilitation issues in the training programmes of health personnel at all levels; ➢ Sensitize health professionals on disability and the barriers faced by persons with disability; ➢ Introduce or strengthen different levels of CBR training in all countries of the SEAR Region; ➢ Develop measures to counter turnover of CBR workers; ➢ Promote affirmative action for people with disability to access higher education in health-related fields.

2.4 Enhance capacity for community-based rehabilitation	➢ Increase coverage of CBR to ensure access to rehabilitation for all persons with disabilities; ➢ Develop and strengthen regional, national and provincial or district resource centres for CBR; ➢ Increase capacity of CBR providers to deal with multiple impairment, autism and other complex disabilities.
2.5 Promote internal linkages within the health sectors to include disability.	➢ Integrate and strengthen CBR in primary health care; ➢ Strengthen health promotion and primary, secondary and tertiary prevention of impairments; ➢ Ensure inclusion of a disability focus in relation to noncommunicable diseases, mental health, leprosy, injury prevention and ageing; ➢ Hold regular coordination meetings within health care and develop action plans for disability in the health sector; ➢ Facilitate the convergence of IBR with CBR.
Overall objective 3: Promote participation and empowerment of persons with disabilities and their families/communities in all aspects of health care	
Specific objective	**Action areas**
3.1 Increase awareness and participation among persons with disabilities, families and communities on disability in health promotion, prevention and care	➢ Empower persons with disabilities to claim their health rights; ➢ Empower persons with disabilities and their organizations to ensure their participation in health service provisions; ➢ Persons with disabilities can participate actively as self advocates and promoters of healthy lifestyle.

3.2 Enhance participation of persons with disability in Community- Based Rehabilitation	➢ Ensure participation of persons with disabilities and their families or caregivers at all stages of rehabilitation: planning programmes, implementing, monitoring and evaluation ➢ Facilitate the establishment of disabled peoples' organizations and promote linkages to rehabilitation programmes; ➢ Increase community awareness on disability issues.
Overall objective 4: Develop partnership with other sectors for CBR	
Specific objective	**Action areas**
4.1 Develop and strengthen multisectoral coordination and partnership in line with the CBR matrix	➢ Development of regional, national, provincial and district-level cross-sectoral coordination mechanisms; ➢ Establish partnerships, networks and linkages with other key development sectors in keeping with the CBR matrix; ➢ Strengthen partnerships between government, civil society (especially DPOs), private sector and service providers (particularly health service providers).
Overall objective 5: Develop and strengthen knowledge management and information systems in the health component of CBR	
Specific objective	**Action areas**
5.1 To promote evidence-based practices in disability, CBR and inclusive development	➢ Improve disability data in the health system; ➢ Build capacity for disability and rehabilitation research in the region; ➢ Include persons with disability in determining a research agenda and strengthen their participation in research; ➢ Promote exchange of ideas and learning within

	the Region by strengthening the CBR Asia-Pacific network and national networks; ➢ Publication of good practices/lessons learnt for sharing/replication among Member countries.
5.2 To monitor implementation and evaluate the progress of CBR in the SEA Region	➢ Work towards the development of monitoring tools and indicators for evaluation; ➢ Conduct periodic updates of the country and regional situation of CBR.

Overall objective 1: Promote disability-inclusive health policies and legislation

Legislation and policy on health should be disability-inclusive and rights-based in line with the UN Convention on Rights of Persons with Disabilities (CRPD) and the CBR Guidelines. The CRPD details the health obligations of State Parties. Ratifying countries have to adapt their domestic legislation and adopt administrative measures to fulfill the health obligations. CBR is a tool for implementing the health obligations of Member States.

Specific objective 1.1: Strengthen national legislation and health policy to be inclusive of disability and rehabilitation

There should be active involvement of persons with disabilities and their representative organizations in the development of legislation and policies and other decision-making processes that concern them.

Action areas:

- Advocacy to review, amend, and develop health-related legislation and policies in line with CRPD and CBR guidelines

- Consultation with organizations of persons with disabilities;
- Advocacy at regional, national and subnational levels.

➢ Increase awareness of CBR and CRPD and the World report on Disability among health policy-makers and planners

- Develop awareness and information material for policy-makers and planners
- Conduct awareness sessions for policy-makers/planners held by persons with disabilities;
- Translate CBR guidelines into national languages.

Specific objective 1.2: Support ministries of health to play a leading role in health rehabilitation

The nodal ministry for disability issues in Member countries of the WHO SEA Region may be health, social, empowerment or justice. The role of the health sector in rehabilitation should be strengthened and supported.

Action areas:

➢ Identify/establish and strengthen a focal point within the ministry of health to coordinate disability-related activities

➢ Advocate for review of business allocation between ministries so that ministries of health are responsible for health-related issues in disability

Overall objective 2: Promote access to quality health and rehabilitation services in a barrier-free environment

Access to health and rehabilitation services is of paramount importance for people with disabilities to be equal members of society and live healthy and productive lives and must be ensured in all health programmes. As the focal UN agency for health and rehabilitation, WHO has the responsibility to support Member States to fulfill the health obligations in the CRPD (Articles 25 & 26). This is a key objective. Until affordable health and rehabilitation services are available and accessible, the majority of people with impairments will lead an isolated nonproductive life. Barrier-free or universally designed environments and the availability of information, communication, assistive devices and technologies enable persons with disabilities to participate on an equal footing with others.

Specific objective 2.1: Enhance allocation of financial resources to increase access to health and rehabilitation

Adequate financial resources are needed at the national and sub-national levels for the provision of health-related rehabilitation services.

Action areas:

- Support development of time-bound national implementation plans for health-related disability issues in mission mode with dedicated budget and third party scrutiny of utilization
    - Advocacy for budgetary allocation and its appropriate utilization.
- Increase financial allocation for CBR at the district and sub-district levels

- Develop guidelines for local government to implement or support CBR.

➢ Develop innovative mechanisms to implement CRPD/CBR: encourage private investment in public programmes

- Develop best practice models and pilot programmes.
- Involve local DPOs/NGOs in the implementation of CRPD/CBR.

Specific objective 2.2: Ensure the availability of quality, affordable and appropriate health and rehabilitation services at primary, secondary and tertiary levels for persons with disabilities

Health services need to be inclusive so that people with any kind of impairment can access health services like all other citizens close to the place they live or at the community level (Article 19, 25 and 26 of the CRPD). Article 20 stresses the right of people with disabilities to live within the community and that services should be available close to where they live. Many people with disabilities currently have no access to basic health and rehabilitation services.

Action areas:

➢ Ensure that the special needs of women and children with disabilities, stigmatized groups and those with multiple disabilities and intellectual disabilities are met appropriately

Women with disabilities are particularly marginalized. Children with disabilities also need particular attention. Certain groups are particularly stigmatized, such as people with leprosy, or those with mental illness and their caregivers. The burden of multiple impairments appears to be increasing. Birth asphyxia, accidents, injury, conflict and ageing may result in multiple impairments. Some childhood conditions such as autism are increasing throughout the Region.

Current CBR programmes often have expertise only in single impairments. Capacity-building is needed both for rehabilitation centres and CBR programmes for rehabilitation of those with multiple impairments. The cost of treatment, rehabilitation, assistive devices, and personal assistance can be significantly higher for people with multiple impairments and these may have a profound socioeconomic impact on them and their families. CBR can help address these issues in a cost-effective way by making services available at the community level and developing linkages with the specialized referral services.

Suggested action points are:

- Develop policies and strategies for inclusion of marginalized groups
- Ensure access to sexual and reproductive health care for women with disabilities
- Promote and utilize existing policy papers (e.g. technical papers on leprosy)
- Capacity building of CBR programmes for multiple impairments
- Develop respite centres and home support programmes
- Develop referral systems by establishing linkages with specialized services

➢ Ensure that persons with disabilities have equal access without discrimination to health insurance and social protection schemes

People with disabilities are often excluded from current health insurance policies and denied access to health care on the grounds of their disability. This is also important in the context of noncommunicable and other diseases.

- Review existing health policy on health insurance, health costs reimbursement and social protection schemes to ensure that people with disability have

equal access without discrimination (including for the provision and repair of assistive devices).

- Establish mechanisms for assessment, evaluation and certification on disability

With limited resources for disability benefits, countries need to ensure that those in the greatest need receive the benefits available. Available international and national tools will need to be modified according to local situations.

- Develop and modify regional and national guidelines and tools for assessment, evaluation and certification of disability.
- Ensure easy access to disability certificates preferably making it available for issue at the local level.

- Support early identification of and early intervention for disabilities at the community level

Early identification of disabilities and intervention results in improved outcomes of rehabilitation in both congenital and acquired impairments. This is particularly so for children with disability, as early identification and appropriate rehabilitation dramatically reduces developmental delay and fosters habilitation, rehabilitation and inclusion. With the relentless increase in noncommunicable diseases it is necessary to think beyond traditional rehabilitation scenarios which include certain health conditions and exclude others. For example, a child with cerebral palsy, on account of delayed milestones, is included while an older person with anaesthesia due to diabetes may not be included. Early identification and intervention tools need to be developed for emerging causes of disability. In addition early intervention is important in the context of the growing burden of disability due to injuries and violence.

Suggested action points are:

- Develop tools for early identification, particularly for children;

- Capacity building of CBR and health care providers for early intervention for children and new causes of disability;
- Develop guidelines, information and linkages to ensure disability prevention and early rehabilitation in injury management for health services and accident victims;
- Develop linkages with violence and injury prevention surveillance programmes for data collection;
- Include early identification and intervention in maternal and child health programmes and in home based early childhood education programmes within primary health care.

➢ Ensure availability and utilization of appropriate assistive devices and technologies at the district and sub-district levelS

➢ Ensure public and private health facilities are accessible to enable Persons with disabilities to access health services on an equal basis with others

Persons with disabilities are excluded from available health care by a host of barriers, including physical, environmental, attitudinal, limited access to information and communication, financial constraints etc. Access of persons with disabilities to health care at the primary, secondary and tertiary level must be ensured.

- Develop and disseminate regional and national standards and guidelines on accessibility; and make the health centre facilities barrier-free.
- Increase availability and use of information and communication assistive devices and technologies.
- Arrange and provide sign language interpreters whenever needed.

- Ensure that health professionals need to develop a positive attitude and treat persons with disabilities with respect.
- Address barriers in homes and transport systems that restrict movement and travel of people with disability, and thereby limit or impede their access to health facilities.

Specific objective 2.3: Ensure adequate numbers of competent human resources for general health and disability-related interventions

Health services are often the point of first contact with rehabilitation services for people with disability. All health personnel need to be aware of the rights-based approach to disability. Health personnel of all cadres need to have training in disability issues. Technical, management and other skills among CBR stakeholders need to be improved. Training is particularly required for CBR workers in the social and empowerment domains of the CBR Matrix.

Action areas:

- Amend curriculum to include disability and rehabilitation issues in the training programmes of health personnel at all levels.
- Sensitize health professionals on disability and the barriers faced by persons with disability.
- Introduce or strengthen different levels of CBR training in all countries of the SEA Region.
    - Strengthen and expand training in CBR, particularly to support empowerment and participation issues and management skills.
- Develop measures to counter turnover of CBR workers including:

- Instilling and reviving the spirit of volunteerism.
- Promote community ownership of CBR programmes.
- Consider incentives for CBR workers.

➢ Promote affirmative action for people with disability to access higher education in health-related fields.

Educational opportunities need to be opened to people with disabilities so that they can be service providers also and not always be restricted to being recipients of services. This will also contribute to the sensitization of all health professionals and awareness-building.

Specific objective 2.4: Enhance capacity for community-based rehabilitation

The reach of Community Based Rehabilitation must extend to all people with disabilities through increasing coverage and strengthening of available CBR programmes. Capacity at all levels needs to be strengthened.

Action areas:

➢ Increase coverage of CBR to ensure access to rehabilitation for all persons with disabilities

- Assess capacity gaps at the regional, national and subnational level.
- Develop urban CBR models.

➢ Develop and strengthen regional, national and provincial or district resource centres for CBR

➢ Increase capacity of CBR providers to deal with multiple impairment, autism and other complex disabilites

Specific objective 2.5: Promote internal linkages within the health sector to include disability

It is important that disability is mainstreamed in all health sectors to ensure access of people with disability to health services. Areas of particular relevance are elaborated further.

Action areas:

- Integrate and strengthen rehabilitation in primary health care

Outreach of CBR to all persons with disability can only be ensured by integrating with primary health care, which strives to reach out to all people at the village and community level. Primary health care (PHC) is now increasingly community-owned with good models of community participation in Sri Lanka, Thailand and Bhutan, and to a certain extent in India with the National Rural Health Mission. The transition in health care is an opportunity for developing linkages between PHC and CBR. A CBR programme as part of primary health care should ideally be supported with national funding and have nationwide coverage. Action steps to accomplish this are:

  - Training of the primary health-care workforce in disability;
  - Collection of best practice models;
  - Developing systems for access to aids and appliances.

- Strengthening health promotion of persons with disability and prevention of secondary impairments

Health promotion and prevention are areas which have not had adequate emphasis in community-based rehabilitation. Health promotion aims to increase control over health and its determinants, and empower people with disabilities and their families to enhance and/or maintain best possible levels of health.

Prevention–primary, secondary and tertiary–reduces the burden of disability. Medical, surgical, psychosocial and other interventions can prevent impairment and disability in various health conditions. Simple interventions such as early detection, proper exercises, along with judicial use of assistive aids and appliances can prevent the development of secondary impairment. For example the use of an appropriate wheelchair can prevent development of pressure sores. In addition, specialized services such as counseling, physiotherapy, occupational therapy and prosthetic and orthotic services are also needed to support people with disabilities in their communities for the prevention of secondary impairment.

Action steps to accomplish this are:

- Inclusion of persons with disabilities in general health promotion and prevention programmes
- Factsheets on health promotion for persons with disability
- Training modules on prevention of avoidable impairments
- Guidelines and tools for health workers and rehabilitation workers in prevention of disability.
- Prevention of disability in injury and violence prevention programmes

➢ Ensure inclusion of disability focus in relation to non communicable diseases, mental health, leprosy, injury prevention and ageing

The countries of the WHO South-East Asia Region have an increasing burden of noncommunicable diseases. Late detection, incomplete treatment, inadequate long-term medical supervision, shortage of care providers, specialists and hospitals, and non-availability of continuous finance mechanisms in the countries of the SEA Region will gradually increase the burden of disability due to NCDs.

Health promotion and prevention of NCDs is needed along with mechanisms for meeting the cost of continued care of NCDs. Leprosy programmes already include rehabilitation. General CBR programmes should also include persons affected by leprosy. Traditional CBR providers have often not included mental health in their service provisions. Action Points include:

- To ensure persons with disabilities have equal access to promotive and preventive therapy for control of noncommunicable diseases;
- To build capacity of CBR programme managers on noncommunicable diseases, leprosy and mental illness and ageing;
- Promote capacity building of leprosy programme workers for cross-disability rehabilitation;
- To develop training tools, and disseminate available guidelines and tools for NCDs, leprosy and mental disability;
- To develop innovative and sustainable models of financing for treatment of NCDs in persons with disabilities;
- To minute and archive documentation of case studies and good practices in these areas;
- To ensure people affected by noncommunicable diseases, leprosy and mental illness and adversely affected by ageing are included in all CBR programmes.

➢ Hold regular coordination meetings within health-care systems and develop action plans for disability within the health sector

➢ Convergence of IBR (Institution-Based Rehabilitation) with CBR (Community-Based Rehabilitation)

CBR has developed as a community-based bottom-up approach while IBR is often top down with poor community

involvement and participation. The transition in health-care systems is an opportunity for developing linkages between IBR and CBR. Present models of convergence are:

a. IBR centres with district or rural rehabilitation centres implementing or linking up with CBR programmes;
b. CBR programmes linking to institutional rehabilitation centres for specialist services;
c. Mobile camp approach or outreach activities from IBR, including innovative approaches such as mobile operation theatres and trains for specialized rehabilitation, provide mainly corrective surgeries. Follow-up is done through rehabilitation institutes or CBR. Linking up with CBR will help mobile camp or outreach services to ensure follow-up and better outcome. There are still gaps in convergence and linkages between IBR and CBR, partly due to lack of understanding, clarity and trust. The available regional models need to be evaluated and expanded to identify effective models based on the CRPD and CBR guidelines. These need to become part of national plans to ensure that persons with disability have access to specialized rehabilitation services. Action points include:

    - Effect capacity building of institution-based rehabilitation in CBR, particularly the social and empowerment domains;
    - To sensitize health professionals about the importance of self-help groups and disabled peoples organizations and develop guidelines for them as well as training modules for institutions on their formation;
    - To promote linkages between Institutes and local CBR programmes.

Overall objective 3: Promote participation and empowerment of persons with disabilities and their families/communities in all aspects of health care

The objective is to strengthen the inclusion and participation of persons with disabilities and their representative organizations in general health care and disability-specific programmes. They should be involved in decision-making processes, implementation, and monitoring and evaluation. Empowerment of people with disabilities and their families makes programmes effective and sustainable. It reinforces the commitment, "nothing about us without us."

Rehabilitation was traditionally practiced in a top-down manner with persons with disability being passive receivers of the medical/rehabilitation services. Article 3 of the UNCRPD emphasizes respect for the inherent dignity, individual autonomy and independence of persons with disabilities, including their freedom to make their own choices.

Specific objective 3.1: Increase awareness and participation among persons with disabilities, families and communities on disability in health promotion, prevention and care

For people with disability to participate in health programmes and receive the benefits of health services, their awareness about health and their rights needs to be increased. In addition, health personnel should be sensitized to disability.

Action areas:

- To enhance capacity of persons with disabilities to claim their health rights;
- To empower people with disability and their organizations to ensure their participation in health service provisions;

- Build awareness that persons with disabilities can participate actively as self-advocates and promoters of healthy lifestyle.

Specific objective 3.2: Enhance participation of persons with disability in community-based rehabilitation

Raising the awareness of the community on disability issues is crucial to full inclusion. For people with disability to participate in rehabilitation, rehabilitation personnel who have traditionally been care givers need to be made aware of the rights-based approach to disability.

Action areas:

- Ensure the participation of persons with disabilities at all stages of rehabilitation: planning programmes, implementing, monitoring and evaluation
  - To orient and train rehabilitation personnel in UNCRPD and rights-based approaches;
  - To train people with disabilities especially women, as CBR personnel;
- Facilitate the development of disabled peoples organizations and promote linkages to rehabilitation programmes
- Increase community awareness On disability issues
  - To develop community sensitization materials and programmes

Overall objective 4: Develop partnership with other sectors for CBR

Partnerships, networks, linkages and cross-sectoral collaboration in support of CBR need to be strengthened. It is recognized that a strong cross-sectoral coordination mechanism with inputs and

resources from all stakeholders is essential to implement CBR. Such a mechanism should exist at all levels: community, sub-district, district, provincial and national. In recognition of the role of civil society in CBR in many countries of the SEA Region, the partnership between civil society and governments must be strengthened.

Specific objective 4.1: Develop and strengthen multisectoral coordination and partnerships in line with the CBR matrix

Action areas:

- To develop regional, national, provincial and district level cross-sectoral coordination mechanisms;
- To establish partnerships, networks and linkages with other key development sectors in line with the CBR matrix;
- To strengthen partnerships between government, civil society (especially DPOs), private sector and service providers (particularly health service providers).

Overall objective 5: Develop and strengthen knowledge management and information systems in the health component of CBR

The objective is to develop the knowledge base for disability and rehabilitation. The gaps in information on disability in the Region require the strengthening of data collection systems. There are also gaps in knowledge on CBR and outcomes of rehabilitation in the Region. This is due both to a lack of research and a lack of monitoring and evaluation.

Specific objective 5.1: To promote evidence-based practices in disability, CBR and inclusive development

There is an urgent need for increasing the data and knowledge base on disability. Disability statistics are predominantly collected through censuses or using tools focused on a choice of impairments. Currently available statistics are mainly based on impairment-based definitions and not on social definitions which include participation. Improved data collection is needed for planning; the promotion of broader definitions and use of ICF as a framework for data collection on persons with disability will strengthen the data available for planning. Training in ICF appropriate to CBR providers is needed. More evidence is needed from the Region on the impact of Community Based Rehabilitation to strengthen the case for promotion of CBR as a strategy for all people with disabilities.

Action areas:

- To Improve disability data in the health systems:
  - To develop appropriate data collection system for CBR
  - Provide training in ICF appropriate to CBR
  - Ensure that management information systems at the primary, secondary and tertiary health levels maintain data on the number of persons with disability accessing health services (add column on Disabled Yes/No)
- To build capacity for disability and rehabilitation research in the region
  - To support training in research methodology with collaborating centres, rehabilitation institutes and CBR providers

- To develop an evidence base through impact studies on community based rehabilitation

- To include persons with disability in determining a research agenda and strengthen their participation in research
- To promote exchange and learning within the region by strengthening the CBR Asia-pacific network and national networks
- To publish good practices/lessons learnt for sharing/replication among member countries

Specific objective 5.2: Monitor implementation and evaluate the progress of CBR in the SEA Region

The objective is to strengthen evaluation and monitoring of CBR. An effective system for monitoring progress and evaluating outcomes and impact will be critical in measuring a country's progress in addressing disability and rehabilitation and the progress of CBR programmes at all levels. Monitoring will help ensure that programs are implemented, will detect problems and constraints, and support them to plan better for the future. Evaluation of outcomes and impact periodically is needed to document whether the planned strategies and activities have the desired impact.

Critical areas in evaluation and monitoring of CBR programmes are:

(1) Improvement in the health of the people with disability and access to rehabilitation.

(2) Inclusion of disability and rehabilitation in health systems

(3) Cross-sectoral linkages that need to be created and reinforced at various levels

(4) Support and partnerships

The situation analysis conducted in 2011 serves as the baseline information. This needs to be updated by detailed country profiles and regular updates every four to five years. In addition, State Parties are required to report on the UNCRPD Framework every two years. The WHO SEA Region will lead periodic reviews of Community Based Rehabilitation in the Region and conduct evaluation of the Framework at the regional level. It is hoped that national coordinating mechanisms will take the responsibility of reviewing national programmes.

Action areas:

- Work towards THE development of monitoring tools and indicators for evaluation :
  - To work towards the development of output and outcome indicators at the regional, national and subnational level
  - To ensure coherence of indicators in line with other strategies for disability
  - To work towards the development of monitoring and evaluation frameworks in detailed national action plans.
- Conduct periodic updates of country and regional situation of CBR
  - Conduct mapping and listing of organizations implementing CBR in the Region on a continued basis

7. Appendix

International declarations and commitments on disability

The first CBR Joint Position Paper published by ILO, UNESCO and WHO in 1994 described CBR as "a strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of persons with disability".

The Second Joint Position Paper by ILO, UNESCO and WHO in 2004 updated the first Joint Position Paper.[16] It redefined CBR as "a strategy within general community development for the rehabilitation, poverty reduction, equalization of opportunities and social inclusion of all people with disabilities" and promotes the implementation of CBR programmes"... through the combined efforts of people with disabilities themselves, their families, organisations and communities, and the relevant governmental and non-governmental health, education, vocational, social and other services". The paper recognized that persons with disabilities should have the access to all services available in the community; it emphasized protection of the human rights and call for action against poverty for government support in development of national policies.

UNCRPD

On 13 December 2006, the UN General Assembly adopted the Convention of Right of Persons with Disabilities, a landmark declaration on the rights of persons with disabilities. This built on previous declarations and documents such as the Universal Declaration of Human Rights adopted by all Member States of the UN in 1948 and the UN Standard Rules on Equalization of Opportunities of Persons with Disabilities (1993).

The purpose of the Convention is to promote, protect and ensure full and equal enjoyment of all human rights and fundamental freedom by all persons with disabilities and to promote respect for their inherent dignity.

WHO documents

The World Health Assembly resolution 58.23 in 2005 urged Member States "to promote and strengthen community based rehabilitation programme".

WHO published its "WHO Action Plan 2006-2011" in 2006, "Human Rights, Health and Poverty Reduction Strategies" in 2008[17] and subsequently a report on the Community-Based Initiative (CBI) in 2009.

Other UN documents

The UN General Assembly Resolution A/RES/64/131 in 2009 on "Realising the Millennium Development Goals for Persons with Disabilities"[18]

"Global Survey on Government Action on Implementation of Standard Rule on Equalization of Opportunities for Persons with Disabilities"[19] (2006)

"Mainstreaming Disability in the Development Agenda" (2008)

World Bank document on Community Driven Development (CDD)

UNESCO "EFA Global Monitoring Report: Reaching the marginalized" (2009) [20]

ILO "Facts on Disability in the World of Work" (2007)[21]

International Disability and Development Consortiums document on "Disability and the MDGs"[22] (2009)

8. References

(1) International Classification of functioning, disability and health (ICF), Geneva, World health Organisation, 2001(www.who.int/classfication/icf/en/)

(2) World report on disability http://www.who.int/disabilities/world_report/2011/en/index.html

(3) Disability and rehabilitation: WHO action plan 2006-2011, Geneva World Health Organisation, 2006 (www.who.int/disabilities/publications/dar_action_plan2006to2011.pdf)

(4) ElwanA.Poverty and disability: a survey of the literature. Washington, DC, The World Bank, 1999 (http://siteresources.worldbank.org/DISABILITY/Resources/280658-1172608138489/povertyDisabElwan.pdf,).

(5) Global Survey on government action on the implementation of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities. UN Special Rapporteur on Disabilty, 2006 (www.escwa.un.org/divisions/sdd/news/GlobalSurvey_Report_Jan30_07_ReadOnly.pdf).

(6) Assistive devices/technologies: what WHO is doing. Geneva, World Health Organization (undated) (www.who.int/disabilities/technology/activities/en).

(7) Disability, poverty and development.UK, Department for International Development, 2000 (www.make-development-inclusive.org/doscen/DFIDdisabilityPovertyDev.pdf).

(8) EFA global monitoring report: reaching the marginalized, Paris, United Nations Educational Scientific and Cultural Organization, 2009 (http://unesdoc.unesco.org/images/0018/001866/186606E.pdf).

(9) Facts on disability in the world of work, Geneva, International Labour Organization, 2007

(www.ilo.org/public/english/region/asro/bangkok/ability/download/facts.pdf).

(10) Convention on the Rights of Persons with Disabilities, New York, United nations, 2006 (www.un.org/disabilities/default.asp?navid=12&pid=150)

(11) The Standard Rules on the Equalization of Opportunities for Persons with Disabilities. New York, United Nations, 1993 (www.un.org/esa/socdev/enable/dissre00.htm).

(12) World Programme of Action Concerning Disabled Persons.New York, United Nations, 1982 (http://www.un.org/disabilities/default.asp?id=23).

(13) Introductory Booklet – CBR guidelines, WHO, UNESCO, ILO, IDDC, 2010.(page 15)

(14) Declaration of Alma-Ata: International conference on primary health care, USSR, 6-12 September, 1978, Geneva, World Health Organisation, 1978 (www.who.int/hpr/NPH/docs/declaration_almaata.pdf).

(15) Community-based rehabilitation guidelines http://www.who.int/disabilities/cbr/guidelines/en/index.html

(16) CBR: A strategy for rehabilitation, equalization opportunities, poverty reduction and social inclusion of people with disabilities (Joint Position Paper 2004). Geneva, International Labour Organization, 2004. (www.who.int/disabilities/publications/cbr/en/index.html).

(17) Human rights, health and poverty reduction strategies, Geneva, World Health Organization, 2008. (http://www.ohchr.org/Documents/Publications/HHR_PovertyReductionsStrategies_WHO_EN.pdf).

(18) Realizing the millennium development goals for persons with disabilities (UN General Assembly Resolution A.RES/63/1313). New York, United Nations 2009 (www.un.org/disabilities/default.asp?id=36).

(19) Global Survey on government action on the implementation of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities. UN Special Rapporteur on Disability, 2006 (www.escwa.un.org/divisions/sdd/news/GlobalSurvey_Report_Jan30_07_ReadOnly.pdf).

(20) Mainstreaming disability in the development agenda.New York, United Nations, 2008 (www.un.org/disabilities/default.asp?id=708).

(21) EFA global monitoring report: reaching the marginalized, Paris, United Nations Educational Scientific and Cultural Organization, 2009 (http://unesdoc.unesco.org/images/0018/001866/186606E.pdf).

(22) Facts on disability in the world of work, Geneva, International Labour Organization, 2007 (www.ilo.org/public/english/region/asro/bangkok/ability/download/facts.pdf).

(23) Disability and the MDGs. Brussels, International Disability and Development Consortium 2009 (www.includeeverybody.org/disability.php).

This publication deals with the multisectoral strategy that aims to promote and strengthen community-based rehabilitation in the SEA Region in order to improve the quality of life of people with disabilities and their families through access to health and rehabilitation services in Member States of the Region.

The strategy focuses on the key areas under WHO's mandate, particularly health and rehabilitation. It includes promotion of disability-inclusive health policies and legislation, promotion of access to quality health and rehabilitation services in a barrier-free environment, promotion of participation and empowerment of persons with disabilities and their families/communities in all aspects of health care, development of relevant partnerships with other sectors for CBR and of knowledge management and information systems in its health component.

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