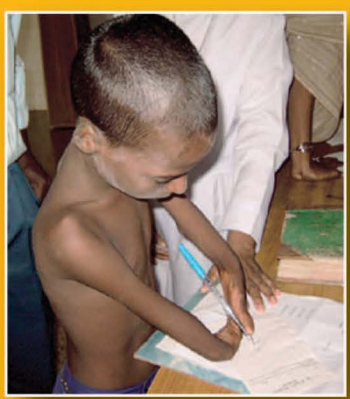
4th Edition

Textbook of REHABILITATION



S Sunder

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Community-based Rehabilitation

INTRODUCTION

Community-based rehabilitation (CBR) is a strategy within the community for the rehabilitation, equalization of opportunities and social integration of people with disabilities in low-income and middle-income countries, by making optimum use of local resources. All members of the community—the disabled people themselves, their families, their friends, the local health, educational, and socio-vocational services, partner with the rehabilitation professionals in the common goal of achieving self-dependence among the groups of disabled individuals. CBR is currently implemented in over 90 countries.

Community-based rehabilitation (CBR) was initiated by the World Health Organization (WHO) following the Declaration of Alma-Ata in 1978. In recognition of this, the ESCAP (Economic and Social Commission for Asia and the Pacific) had declared the decade 1993-2002 as the Asia and Pacific decade for the disabled. Later key recommendations were made in 2003 at the International Consultation in Helsinki to Review Community-based Rehabilitation.

The guidelines that evolved out of these recommendations focus on empowerment through the inclusion and participation of disabled people, their family, and communities in all rehabilitation-related development and decision-making processes. Earlier, CBR was a service delivery method using primary health care and community resources, in low-income countries. They were mainly focused on physiotherapy, appliances, and medical or surgical treatment.

With the involvement of other UN agencies, such as the International Labour Organization (ILO), United Nations Development Programme (UNDP), and United Nations Children's Fund (UNICEF) an international meeting in Helsinki decided to focus on reducing poverty, and promoting community involvement and ownership, involving disabled people's organizations in their programs. Later in 2004, the definition of CBR was reworded to include **"poverty reduction, equalization of opportunities and social inclusion of all people with disabilities"**.

The goals of CBR are to ensure that the benefits enshrined in the Convention on Rights of Persons with Disabilities reach the majority by:

- Supporting people with disabilities to maximize their physical and mental abilities.
- Helping them access regular services and opportunities, and to become active contributors to the community and society at large.
- Activating communities to promote and protect the rights of people with disabilities by removing barriers to participation, improve awareness about disability and lobby for their inclusion in society.
- Empowering PWD and their families.

The community-based rehabilitation (CBR) matrix consists of five components (Health, Education, Livelihood, Social, and Empowerment) (Fig. 3.1).

There is a difference between CBR projects and CBR programs. While projects are usually small scale and have specific outcomes in one area of CBR, programs tend to be large scale, complex and without specific outcomes.

The programs in CBR broadly aim at:

- Prevention of disabilities
- Identification of high-risk infants and mothers
- Early detection of disability and management
- Assessment of felt needs of the people with disability and the family
- Home-based or neighborhood-based programs
- Parental involvement
- Play groups and integrated schooling for children
- Organizations for and by the people with disability.

India is a vast country with a huge rural-based population. Mahatma Gandhi has said that India lives in its villages. It is not possible to provide professional expertise across the length and breadth of the land at the doorstep of the people with disability. Hence, we have to take up an approach which is simple and benefits a larger population.

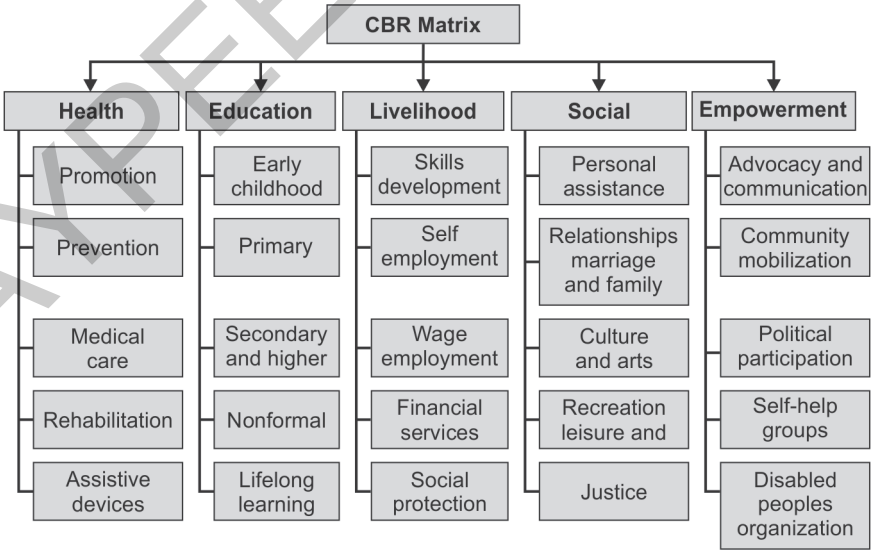

Fig. 3.1: Community-based rehabilitation (CBR) matrix.
Source: CBR summary, WHO.

The basic concept inherent in the multi-layered approach to CBR is the ***decentralization*** of responsibility and resources, both human and financial to community level organizations. Those with disabilities are enabled to participate fully in the social, economic and political life of the community.

CBR is the appropriate rehabilitation program for the rural people with disability delivered at their doorstep with the use of local resources and with the involvement of local people (Fig. 3.2). CBR is a need-based rehabilitation done in the community at the community level by utilizing the contribution of the community. The people with disability and their families are intensively involved in the decision making process, as are the members of the community.

Fig. 3.2: Community-based rehabilitation—an amputee being rehabilitated in his house in a village.

CBR is a self-help movement based on:

- Awareness and concern of the community
- Initiatives from the community
- Planning from the community
- Resources from the community
- Implementation by the community
- Evaluation by the community
- Modification by the community
- Benefits to and from the community.

Sustainable CBR programs are initiated by very large organizations or by the government. They need **good leadership**, usually good CBR program managers. The programs network with other organizations as **Partnerships**. Successful CBR programs have a strong **participation of the community**. **Local resources** are used with ample consideration of **cultural factors**. Stakeholders are empowered to plan, and manage CBR programs, so that they become **sustainable**. **Money** also has to be provided by government funding (grants), or donor funding. Sometimes, income is generated by selling products, or services. For a long standing CBR program, there must be **political will,** and support from the government. Disabled people's organizations are a great resource for strengthening CBR programs, and many play meaningful roles in them.

CRITERIA

CBR programs must coordinate service delivery at the local level, and people with disabilities must be included in CBR programs; at all stages, they must have distinct decision-making roles.

ASPECTS OF CBR

CBR has four important aspects:

- Medical
- Educational
- Economical
- Social

The medical aspect usually starts with evaluation of the disability by a group of professionals. A comprehensive program is charted out, which is followed up by diligent grassroots level trained personnel. Usually the relatives of the patient are also trained. Whenever required, education is imparted to those who need basic knowledge and skills. This gains more significance in children suffering from cerebral palsy. The educational vocational and avocational skills imparted will provide a springboard for the patient to register himself for a job, or open up opportunities for self-employment, and avenues for economic betterment.

Society needs to be involved in CBR: The success of any CBR program depends upon factors like cost-effectiveness, individualized values as well as social acceptability.

MEMBERS OF THE CBR TEAM

First and foremost, **the patient** has to be involved in all decision-making processes, because he is the recipient of the services. People with disabilities can be more effective than nondisabled people as role models for and counselors of other people with disabilities. Local people, like families of people with disabilities, and members of the community who know the lie of the land, its economy and the local environmental conditions, are in the best position to implement the program. Support will be given by the governments (local, regional, national), nongovernmental organizations and medical inputs by the medical professionals. Allied health science professionals, educators, social scientists, and other professionals are often used in their capacity as educators. The corporate sector, comprising of profitable companies and industries have recently coined a term **corporate social responsibility (CSR)**, implying an obligation to plough back some of the benefits of its operations to the community, in which it operates.

The other members are locally available skilled workers, e.g. carpenters who could be trained to make appliances and aids, local leaders who can lobby for barrier-free environment, the school teacher, who contributes her spare time for children with special needs, the multipurpose rehabilitation worker: (a trained person who can identify disability, and give the basic physiotherapy and prescribe orthotics), and the PHC staff. The medical officers and workers of the PHC need to be trained in identifying handicap and managing it. One of the largest orientation programs of its kind in the world was introduced by the Rehabilitation Council of India for PHC doctors all over India, to orient them toward rehabilitation.

ROLE OF THE REHABILITATION PROFESSIONAL IN CBR

The rehabilitation professional, whether he is medical, paramedical or socio-vocational, is seen as a **leader, teacher and guide** instead of as a health provider. He imparts training, demystifies the rehabilitation concepts, solves specific problems, organizes the set up and generally functions as an advisor.

MODELS OF CBR

WHO model uses trainers and distributes booklets on health conditions.

Neighborhood model: A resource center in the community adopts another center, trains the personnel, and in due course this becomes another resource center.

DRC models: The District Rehabilitation Scheme (DRC) was launched by the Government of India in January 1985 on a pilot basis in collaboration with the National Institute of Disability and Rehabilitation Research, the US Department of Education and UNICEF as an outreach activity for providing comprehensive services to the persons with disabilities at the grass root level. The infrastructure and capacity building of rehabilitation professionals was also taken up.

The DRCs surveys disabled population, and works on all aspects of rehabilitation like prevention, early detection and medical intervention. Deformities are corrected surgically, physiotherapy occupational therapy and speech therapy are given and amputees are provided with artificial limbs. The entire gamut of socio-vocational rehabilitation like facilitation of disability certificate, barrier-free environment, training, job placement, and self-employment opportunities to PWD is also catered to under this scheme.

Textbook of REHABILITATION

Salient Features

- Comprehensive textbook of rehabilitation by renowned physiatrist
- For all rehabilitation professionals
- Conforms to the syllabus of major universities in India
- Brings in new insights to frontiers of rehabilitation and includes new subjects like ergonomics and interventional aspects of rehabilitation.

S Sunder is a Medical Graduate from Stanley Medical College, Chennai, Tamil Nadu, India, and holds a postgraduate degree (MD) in the field of Physical Medicine and Rehabilitation. He specializes in ergonomics and in rehabilitating the handicapped. He is the Founder Medical Director of the **PREM Center for Physiotherapy and Rehabilitation Medicine** in Chennai, which is one of the largest centers of its kind in the city.

He was until recently Senior Consultant and Head, Department of Physical Medicine and Rehabilitation in Global Health City. He has been visiting faculty in the subject of rehabilitation to several colleges, and has been the editor of the bulletin of the Indian Association of Physical Medicine and Rehabilitation.

He is one of the few physiatrists in the field of ergonomics and has done more than four hundred programs on Office Ergonomics among computer professionals. He has been industrial medical consultant to several companies, and has served as President of the Indian Association of Occupational Health, Tamil Nadu branch.

He has presented several papers and chaired several scientific sessions in national and international conferences and has delivered several prestigious national orations.

He founded the **Freedom Trust** under which banner he conducts regular camps for the physically disabled and gives away mobility aids. Over 25,000 physically challenged persons all over India have received mobility aids from the trust. In recognition of his services, he received the coveted **Presidents award for Best Individual in Social Service in the year 2008, and the Tamil Nadu State award for Best Doctor**. In 2017 on World Disability Day, he was awarded the Lifetime Achievement award by the Chief Secretary, Tamil Nadu. Several other organizations have honored him for his valuable contributions to the society.

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