

WCPT COMMUNITY BASED REHABILITATION CONSULTATION

Summary of responses to survey and discussion paper

1. INTRODUCTION

A motion was passed at the 14th General Meeting of the World Confederation for Physical Therapy (WCPT) in May 1999 that WCPT develop a plan to recognise and promote the role of physical therapists in Community Based Rehabilitation (CBR). The Africa Region of WCPT helped in developing a discussion paper and questionnaire to send to WCPT's Member Organisations (MOs). This was done in June 2002 and circulated to all MOs and provisional MOs (n=87). WCPT subgroups and regions also received it.

1. RESULTS

2.1 Respondents

There were responses from fifteen MOs and one provisional MO (each MO = one country) to the survey. One country returned eight responses from various constituencies; the WCPT project manager amalgamated these into one response for the purpose of analysis. While the response rate of 18.4% is low there was a cross-section of responses from countries, which could be considered to be developing and developed. Responses were received from MOs in the Asia Western Pacific, Europe and North American Caribbean regions of WCPT. The lack of responses from the Africa region may be in response to the original involvement of this region in the development of the WCPT discussion paper. There were no responses from the South America region.

Care needs to be taken in interpreting the results given the low response rate and also in response to the different interpretations of CBR expressed (see below).

2.2 Definition

CBR has been defined as "a strategy within community development for the rehabilitation, equalisation of opportunities, and social integration of all People with Disabilities (PWD). CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, educational, vocational, and social services." (Joint Position Paper from ILO, UNESCO, and WHO, 1994)

Thirteen (81.3%) respondents either agreed or strongly agreed with this definition and only two (12.5%) either disagreed or strongly disagreed. Points for further consideration in any revision of this definition were:

- Addition of health promotion and prevention – the notion of habilitation not just rehabilitation
- Emphasis on the protection of the rights and responsibilities of disabled persons, promoting their inclusion in mainstream systems
- The concept of sustainability and utilisation of local resources in providing services

2.3 Provision of CBR

Having been provided with this definition, nine (56%) MOs reported that CBR programmes existed in their country (no=4, blank=3).

2.4 Perspectives on CBR in different countries

Given the information provided by respondents to the survey there appeared to be two distinct perspectives, reflecting different interpretations of CBR:

1. The delivery of services at the local community level by people from within the community, including those with disabilities.

“CBR is seen as a concept, an approach and a series of strategies directed towards the inclusion of people who have disabilities in mainstream development and welfare processes and in civil society. It is thereby founded on the principles of the protection of the rights and responsibilities of a marginalized and socially excluded group. CBR is not merely an ideology but is a pragmatic and scientific system.”

Some concern was expressed that persons with disabilities are still treated as passive recipients of services in many CBR programmes. In addition, whilst CBR was initiated to promote integration and inclusion, much care is still provided in centres.

2. The provision of primary health care services, including health promotion, prevention, treatment and rehabilitation, delivered by health care professionals in settings outside of urban institutions including: homes, health centres, special schools, domiciliary services attached to a tertiary hospital, and outpatient services at a community hospital.

2.5 Organisation of CBR

In all of the countries where CBR exists, covered by the MOs responding, the Government is responsible for CBR programmes, this is often in addition to Non-Governmental Organisations (NGOs) (n=5). However, the Governments are reported as the primary funders, with budgets predominantly controlled nationally. In some programmes (n=2) the health care professionals are responsible and 1 MO reported that small private for profit organisations are also involved.

CBR was reported to be provided in both urban and rural areas, but only three MOs reported that their country provided CBR in both urban and rural settings. Service provision appeared to be predominantly organised from CBR centres, community hospitals and step-down institutions.

Most programmes (n=8) do appear to make provision for monitoring and evaluation at a local level, but not nationally. However, these appear to focus on process measures rather than clinical outcomes.

2.6 Population covered

CBR programmes were reported to provide services for children and adults with disabilities. These covered mobility, visual, language, intellectual disabilities, psychiatric and multiple disabilities. Some respondents replied that everyone living in the community was covered, perhaps reflecting the perception that CBR is any health care provided by health care professionals outside of institutions.

Respondents were asked to estimate the percentage of the population in need of CBR that were provided for. Of those who completed this question (n=9) 5 MOs reported that their country only provided services for up to 40% of those in need and two, both representing developed countries, reported over 80% coverage.

2.7 Contribution of physical therapists

Most CBR programmes involve a range of health care professionals, as well as defined CBR workers. Where CBR programmes involve physical therapists they undertake a number of roles:

- Provision of direct care
- Education and training of physical therapists and other health care professionals
- Basic training and technical / professional supervision of other CBR workers
- Programme initiators
- Team leaders and managers
- Advisers to governments, NGOs and local communities on establishing CBR programmes

The role of physical therapists as educators and trainers of others appears to be well supported – making their knowledge and skills available to a larger community.

3. ISSUES FOR FURTHER CONSIDERATION

1. CBR is an internationally recognised model of rehabilitation that is perhaps better understood in this context in developing countries. In many developed countries CBR is seen to refer to any care provided by physical therapists, and other health care professionals, outside of the institutional setting.
2. A major concern expressed by some respondents was the lack of involvement of local communities in CBR planning, service provision and evaluation, impacting on the extent of local ownership.
3. CBR has yet to realise its potential of making rehabilitation a reality for those in need.
4. Funding systems currently do not appear to support the long-term sustainability of programmes.
5. There appears to be a real or perceived lower status conferred on health care professionals who work in rural communities when compared to colleagues in urban institutions. It is not clear if this is reflective of the opinion of the professionals or local communities and individuals. This poses risks in encouraging physical therapists and other health care professionals to work in rural and community environments. This is further compounded by the lack of exposure to work in rural communities during the pre-qualifying education of many physical therapists internationally.
6. Governments and NGOs need to work with each other and with health care professionals to develop different models of delivering CBR. It would appear that there is a need for research and service evaluation that can investigate clinical outcomes to inform the development of CBR and assess the quality of care provided.