Mapping report of
physical rehabilitation services in

Afghanistan, Bangladesh, Odisha (India) & Sri Lanka

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Glossary

Eligibility criteria

These are conditions required to fulfil to receive a service, welfare support or other governmental benefits. In this report it refers to the conditions that persons with disabilities, or others in need of physical rehabilitation services, should have to receive treatment and/or assistive device subsidised by the respective authority.

Gate-keeping

Gate-keeping is the system of decision-making that guides effective and efficient targeting of services for persons with disabilities and other vulnerable groups[1]. In its large sense, gate-keeping mechanisms are referral procedures and processes of guiding and directing users towards services, defined within a legal framework.

Gate-keeping mechanisms

Refers to sets of interrelated instruments meant to control, coordinate and improve the provision of social services at the system, individual and service provider levels. Regulatory mechanisms are defined by central public authorities and implemented by central and/or local authorities or agencies, mandated to do so. They manage: (a) the demand for and access of users to social services, (b) the supply of these services by various providers and (c) the actual provision of social services[2].

Licensing /authorization

A mandatory procedure carried out by authorities, wherein providers are given the permission to deliver social or medical services, after complying with minimum quality standards or criteria determined at the national level in the particular domain of intervention[3].

Territorial maps of services

Territorial maps are charts of existing and needed services at specific geographical levels (e.g., municipality, district, or region and province), renewable within specific intervals of time (e.g., 3–5 years). Any proposal for opening new physical rehabilitation services, or for extending provision of existing ones, is generally analysed in relation with these territorial charts.

[1] Bilson, A, and Gotestam, R. "Improving Standards of Child Protection Services – A Concept Paper", UNICEF Innocenti Centre, (UNICEF and the World Bank: Florence: 2003).

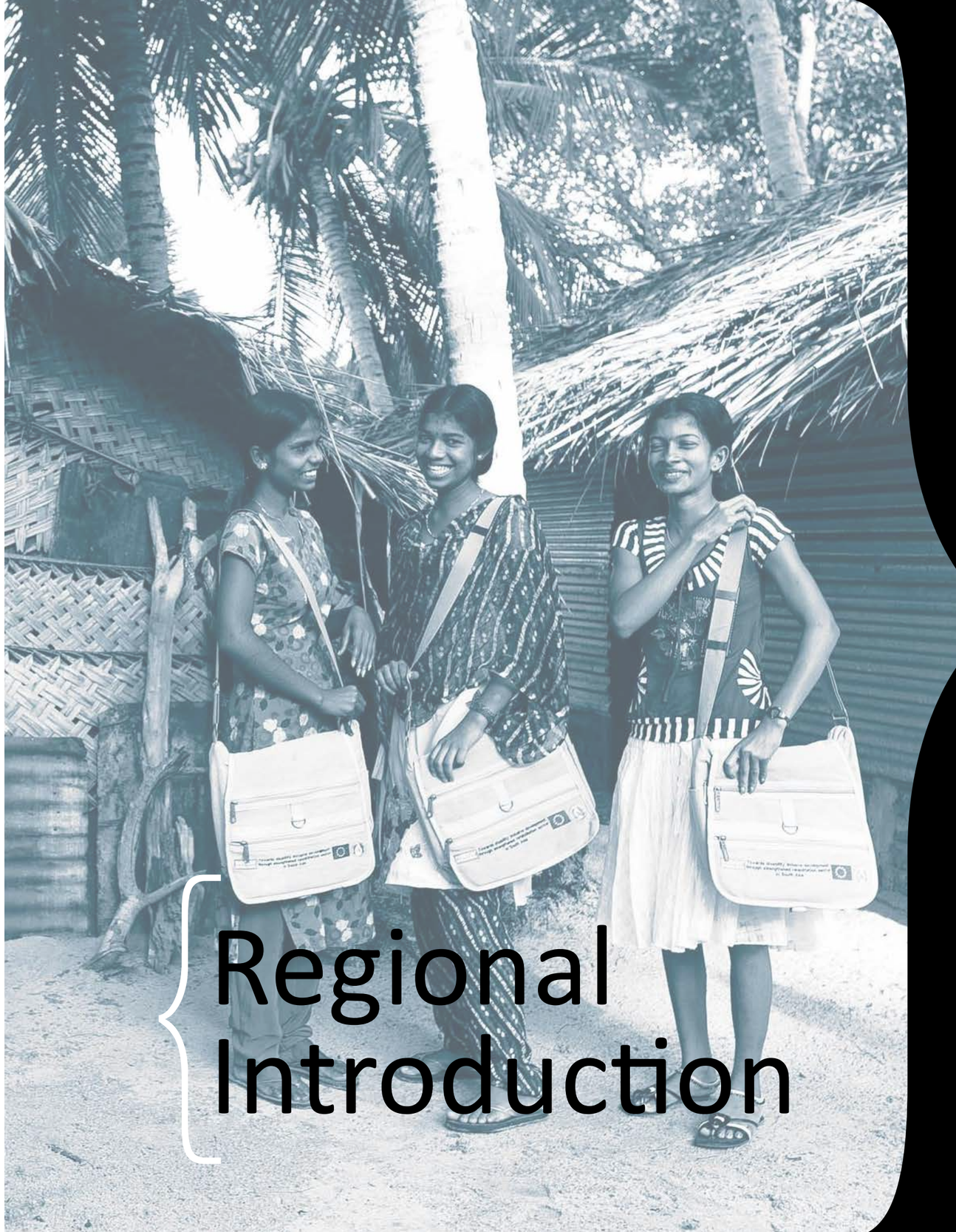
[2] Bilson, A., and Gotestam, R., 2003.

[3] Chiriacescu, D. "Shifting the Paradigm in Social Service Provision: Making Quality Services Accessible for People with Disabilities in South East Europe", (Handicap International: Sarajevo: 2008).

Abbreviations and acronyms

CBR	Community Based Rehabilitation
DPO	Disabled People's Organisation
MDG	Millennium Development Goals
NGO	Non Governmental Organisation
WHO	World Health Organisation
UNPD	United Nations Development Program
UNFPA	United Nations Population Fund
AAPT	Afghanistan Association for Physical Therapy
ANSOP	Afghanistan National Society for Orthotic and Prosthetic
BPHS	Basic Package of Health Services
CRPD	Convention on the Rights of Persons with Disabilities
DAO	Disability & Ability Organisation
DRD	Disability and Rehabilitation Department (of the Ministry of Public Health)
EPHS	Essential Package of Hospital Services
GIHS	Ghazanfar Institute of Health and Science
HI	Handicap International
HMIS	Health Management Information System
IAM	International Assistance Mission
ICRC	International Committee of the Red Cross
KAP	Knowledge Attitude Practice
KOO	Kabul Orthopaedic Organisation
MoLSAMD	Ministry of Labour Social Affairs, Martyrs and Disabled
MoPH	Ministry of Public Health
P&O	Prosthetic and Orthotic
SCA	Swedish Committee for Afghanistan
USAID	United States Agency for International Development
BHPI	Bangladesh Health Professions Institute
BPKS	Bangladesh Protibandhi Kallyan Somity
CDD	Centre for Disability in Development
CIDA	Canadian International Development Agency
CRP	Centre for the Rehabilitation of the Paralysed
DFID	Department for International Development UK

GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
HPNSDP	Health, Population and Nutrition Sector Development Program
IDSC	Integrated Disability Service Centres
JICA	Japan International Cooperation Agency
JPUF	Jatiya Protibondhi Unnayan Foundation
MoHFW	Ministry of Health and Family Welfare
MoSW	Ministry of Social Welfare
NFOWD	National Forum of Organisations Working with the Disabled
NITOR	National Institute of Traumatology and Orthopaedic Rehabilitation
OT	Occupational Therapist
PT	Physiotherapist
P&O	Prosthetic and Orthotic
SLT	Speech and Language Therapist
UN	United Nation
ADIP	The Assistance to Disabled Persons Scheme
ALIMCO	Artificial Limb Manufacturing Corporation of India (Ltd.)
CAT	Category (referring to ISPO category of Prosthetists and Orthotists)
UNCRPD	UN Convention on the Rights of Persons with Disabilities
DDRC	District Disability Rehabilitation Centre
DDRS	Deen Dayal Disabled Rehabilitation Scheme
IEV	Inclusive Education Volunteers
ISPO	International Society of Prosthetics and Orthotics
MoHFW	Ministry of Health and Family Welfare
MoWCD	Ministry of Women and Child Development
SVNIRTAR	National Institute of Rehabilitation Training and Research
PWD Act	Persons with Disabilities Act (Equal Opportunities, Protection of Rights and Full participation) Act
RCI	Rehabilitation Council of India
SIDR	State Institute of Disability Rehabilitation
UNESCAP	UN Economic and Social Commission for Asia and Pacific
CAT	Category (referring to ISPO category of Prosthetists and Orthotists)
CBM	Christian Blind Mission
INGO	International Non-Governmental Organisation
ISPO	International Society for Prosthetics and Orthotics
NAPD	National Action Plan for Disability
P&O	Prosthetist and Orthotist
SLAOT	Sri Lanka Association of Occupational therapist
SLAPO	Sri Lanka Association for Prosthetics and Orthotics
SLMA	Sri Lanka Medical Association
SLMC	Sri Lanka Medical Council
SLSOT	Sri Lanka Society of Occupational Therapists
SLSP	Sri Lanka Society for Physiotherapy
SLSPO	Sri Lanka School of Prosthetists and Orthotists
UN CRPD	UN Convention on the Rights of Persons with Disabilities
UNICEF	United Nations International Children's Emergency Fund



Regional Introduction

Handicap International's regional program in South Asia launched a three-year project in 2011 "Towards Disability Inclusive Development through a Strengthened Rehabilitation Sector in South Asia" in Afghanistan, Bangladesh, Odhisa state in India, and Sri Lanka. The project seeks to improve the provision of physical rehabilitation services for persons with disabilities and empower them to participate in development and policy reform processes.

One component of this project is a mapping (situational analysis) of the physical rehabilitation sector in the three countries and the Odhisa state in India. The aim of this mapping is improve the availability of information on the physical rehabilitation sector and to have an overview of the needs and unmet needs for physical rehabilitation. An appreciation of the human resource situation and the availability, accessibility and geographical distribution of services as well as a better understanding of the governance of the physical rehabilitation system is also an important outcome.

The results of this mapping will allow national and regional appraisal on the situation of service delivery as well as training capacity for physical rehabilitation professionals and permit a comparison among the three countries and Odhisa state. The information and analysis will help stakeholders (like professional associations, ministries, training schools, Disabled People's Organisations (DPOs) and international organisations) to collectively propose priorities and actions to address gaps.

These are countries that are clearly different socially, culturally, politically and economically but with respect to physical rehabilitation service provision and broad-disability issues, have nevertheless many similarities. One important common barrier is the challenge to access affordable and qualitative physical rehabilitation services, services that are essential for many persons with disabilities for active participation in education, labour market and civic life[1].

MAPPING OF PHYSICAL REHABILITATION SECTOR

Handicap International has been present in all four countries for nearly 20 years and has implemented a number of projects to improve the access to rehabilitation services for persons with disabilities together with local partners. Nevertheless, a systematic mapping and analysis of the physical rehabilitation sector at national levels has not been

[1] WHO and World Bank. *World Disability Report*, (WHO Press: Geneva: 2011).

made before and there is limited information available in all four locations on the availability, accessibility and quality of services. This lack of data on disability and rehabilitation is delaying a coordinated development of physical rehabilitation services and human resource. For this reason, Handicap International proposed to carry out a participatory macro level mapping of the sector with the aim to provide information and data allowing the definition of more coherent plans and actions at systemic level.

This analysis presents a snapshot in real time of the situation of the physical rehabilitation in the three countries and Odhisa state in 2013. This assessment has not included a primary research and does not aim to present a directory of physical rehabilitation services. While Handicap International's South Asia regional office is leading the mapping exercise, multi-stakeholder groups have been facilitated in each country, where key actors involved in the sector are represented. These groups have participated in the data collection process and will be working together to suggest further plans and actions based on the mapping outcomes.

This mapping has targeted mainly three out of the six building blocks defined by the WHO as making the pillars of a health system (service delivery, health workforce and leadership and governance)[2]. Some data on financing of service delivery have been gathered but no in-depth analyses of the remaining three blocks have been done.

Six building blocks of health systems[3]:

- Service delivery (physical rehabilitation services)
- Health workforce (rehabilitation professionals)
- Leader ship and governance (regulatory system and legislative framework)
- Health financing
- Medical technologies
- Health information

[2] WHO. *Everybody's business. Strengthening health systems to improve health outcomes. WHO's Framework for Action*, (WHO: Geneva: 2007).
[3] WHO, 2007: p. 14.

Physical rehabilitation has a key role in the health sector, and therefore this mapping is basing its analysis of the sector in accordance with the above-mentioned WHO Framework for Action. These building blocks are interdependent and interventions in one block could affect the others. Therefore, making changes or scaling up specific interventions, such as physical rehabilitation, will have important impacts on the whole health system and has to be thought of as a comprehensive reform within the health sector[4].

METHODOLOGY AND PROCESS

The mapping process has a two-fold objective: contributing to identify strengths and weaknesses of the physical rehabilitation sector in the region, and, at the same time, provide opportunities for strengthening the dialogue among national actors in each of the countries. For this, participatory methods of data collection and identification of strengths and challenges of the physical rehabilitation sector were applied. Before defining the precise tools for the analysis, a review on relevant literature around health and physical rehabilitation as well as disability policies and services. After that a general questionnaire was developed and initially tested in Bangladesh. After relevant adaptations, the questionnaire was circulated to the main stakeholders. A national level workshop was organised in two countries and Odhisa state, and smaller focus group discussions and individual consultations were held in Bangladesh. At these workshops the mapping exercise was presented and information was gathered on key aspects of physical rehabilitation in each country:

- Regulatory mechanisms (governance).
- Availability of services.
- Human resources for physical rehabilitation and the training capacities.
- Identification of the most important obstacles as well as facilitators to access physical rehabilitation services.

[4] De Savigny, D. and Adam, T. (Ed.). *Systems thinking for health-systems strengthening*, (WHO and Alliance for Health Policy and Systems Research: WHO Press: 2009).

In each country workshop, a stakeholder group was invited representing the main actors involved in the physical rehabilitation sector, such as relevant line ministries (usually health and social welfare), service providers, training institutes and school, professional associations, DPOs and representatives of persons with disabilities, Community Based Rehabilitation (CBR) organisations and international and national NGOs providing or funding physical rehabilitation services.

This mapping was implemented in four steps during the period November 2012–August 2013.

- **Phase 1** Literature review and formulation of a data collection questionnaire (November–December 2012).
- **Phase 2** Organisation of national level workshops in each country (February – April 2013). This phase included: identification of the key stakeholders in each country, pre-meeting with ministry representatives, professional associations, DPOs and physical rehabilitation service providers, and conducting a one-day workshop at national level for introducing the mapping exercise and initiate the collection of information.
- **Phase 3** Continuous data collection at country level through individual meetings with key actors.
- **Phase 4** Finalisation of mapping report and consultation with the key actors to share the results and define recommendations.

Upon finalisation of the results, a second national workshop will be organised, which poses an opportunity to review the findings of the mapping and then define priorities and actions for coordinated efforts to improve the access to physical rehabilitation services for persons with disabilities.

As with any mapping and situational analysis there were challenges which put some limitations for producing the data. The security situation in Afghanistan prevented participation of stakeholder living further away from Kabul for example and the instable political situation in Bangladesh impeded the organisation of a national workshop, despite two attempts. Various actions were put in place to counteract these challenges but they may have an effect on the outcomes of the mapping in terms of some information not being made available or missing out on some relevant stakeholders' participation. Despite this, the information gathered is considered to give a rather accurate macro-level understanding of the physical rehabilitation sector in the three countries and Odhisa state.

PHYSICAL REHABILITATION IN THIS REPORT

There is no unified definition of physical rehabilitation at international level. Among the countries included in this mapping, Afghanistan is the only country that has a clear definition of the scope of physical rehabilitation in a policy or legal framework[5]. Sri Lanka is currently drafting its National Disability Action Plan wherein the section on health and rehabilitation proposes a definition of general rehabilitation similar to the one suggested in the World Report on Disability[6], making reference to Article 26 of the Convention on the Rights of Persons with Disabilities (CRPD). Neither Odhisa state nor Bangladesh has any definition of physical rehabilitation yet in an official policy.

While rehabilitation is a wide and comprehensive concept that addresses the areas of health, education and employment, this mapping focus specifically on physical rehabilitation. These rehabilitation services are specifically directed towards people with physical and neurological impairments, which result in mobility challenges. Therefore, this mapping does not include rehabilitation linked to sensorial disabilities, such as visual and/or hearing impairments, or rehabilitation for mental health disorders and intellectual disabilities. The scope was defined taking

[5] In the four years strategy for Disability and Physical Rehabilitation in Afghanistan (1391–1394), rehabilitation is defined as: *"to bring back something to an earlier level of structure or function that is better than the present level. Physical rehabilitation in this context refers to the process aimed at enabling persons with functional limitations because of physical impairment, to reach a level of optimal function. Rehabilitation may include measures to provide and/or restore physical functions, or compensate for the loss or absence of a function or for a functional limitation".*
[6] WHO and World Bank. World Disability Report, 2011, p. 95.

Rehabilitation and health-related rehabilitation in the CRPD

Article 26 Habilitation and Rehabilitation "…to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services…".

Article 25 Health—recognise that persons with disabilities have the "… right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation".

into account human and financial resource available for this mapping and in consultation with key actors.

Physical rehabilitation can be summarised as being effective in five ways:

1. Treating the underlying pathology or injury
2. Reducing the impairment and/or disability
3. Preventing and treating complications
4. Improving functioning and activity
5. Enabling participation

The ultimate aim of rehabilitation is to provide the individual with the best possible opportunity for full and effective participation and inclusion in society, with possibilities to study, work, access services, etc.

Physical rehabilitation—one aspect of disability inclusive development

There are estimates that 92% of the disease burden in the world is related to causes that require health professionals associated with physical rehabilitation[7] and by 2030, the top ten causes of disease will be conditions that require physical rehabilitation[8]. This section provides a brief overview on the importance of making sure that physical rehabilitation services become part of global health and social policies and the human and societal gains that can be achieved.

GLOBAL HEALTH, DISABILITY AND DEVELOPMENT

While global health Millennium Development Goals (MDGs) have focused mainly on reducing specific diseases and mortality, particularly of women and children, with some measurable success, there is a large unmet global health need, which the current health workforce and services are ill-equipped to deal with. Violence and injury cause more deaths than HIV, tuberculosis, malaria combined and for every death, four more are left with permanent physical disabilities[9]. In fact, many of those who survive acts of violence, road traffic accidents, war injuries or suicides are left with permanent or temporary disabilities—16% of all disabilities globally could be caused by injuries. In addition, injuries show a strong social class gradient and are more common in poorer countries[10]. Commonly known as the cycle of poverty and disability[11], this uneven distribution of injuries is another cause and effect of this vicious cycle. A number of factors, such as living, working and travelling in less safe conditions, poorer access to quality emergency and post-emergency health care and rehabilitation services, and lack of access to health insurance schemes contributes to injuries being more prevalent among the more marginalised population of any country.

While it is important to look at mortality reduction, this indicator tells very little about quality of life. While maternal mortality has almost halved since 1990[12], still 20 million women a year acquire a disability from pregnancy and childbirth, and experience exclusion and abandonment, which affects their economic and social lives[13].

The Human Development Report states, *"The objective of development is to create an enabling environment for people to enjoy long, healthy and creative lives"*[14]. Development is not just about survival; it is also about quality of life. Access to rehabilitation, as stipulated in Article 26 of the CRPD, is important to enable persons with disabilities to be independent through supporting their full physical, mental, social and vocational ability, for inclusion and participation in society. Rehabilitation and access to assistive devices and technology are pre-conditions for full inclusion and participation.

There are timely opportunities to promote this development. The on-going process negotiating a post-2015 development framework is bringing discussions on shifting from a disease focus to instead looking at universal access to health, and from mere survival to quality of life. The WHO is also developing international guidelines for physical rehabilitation, using a health systems strengthening framework, which will strongly support the need to consider physical rehabilitation within health systems. For the South Asia region, the new Asian and Pacific Decade of Persons with Disabilities 2013–2022 will be monitored through a set of goals and indicators defined in the Incheon Strategy, which is based on the CRPD and cover equally the access to health and rehabilitation[15].

Global facts on the access to physical rehabilitation globally:

- Only 3% of individuals who need rehabilitation globally are estimated to actually receive support[16].
- One third of countries globally did not allocate any specific budget to rehabilitation services in 2005[17].
- An estimated 105 million people across the world need an appropriate wheelchair[18].
- Only between 5–15% of people in low and middle-income countries who require assistive devices/technologies actually receive relevant equipment.
- Children with disabilities are less likely to start school and have lower rates of staying and being promoted in school[19].

As a result, broader development goals are impacted:

- Economic contribution is lost: rehabilitation related injury is the biggest cause of economic productivity lost from the workplace in the United States[20].
- Poverty reduction opportunities are lost: hampered mobility prevents people from accessing livelihood opportunities for themselves and their families.
- Children are at risk of missing education: children with physical disabilities might have more difficulties to start school without the necessary mobility aids and supportive physical rehabilitation.

Having established that physical rehabilitation is instrumental to global health needs and development

[7] Gupta, N., Castillo-Laborde, C., and Landry, M. D. Health-related rehabilitation services: assessing the global supply of and need for human resources, *BMC Health Services Research* 2011, 11: 276.
[8] WHO. *Injuries and Violence. The facts*, (WHO Press: Geneva: 2010).
[9] Ibid.
[10] Ibid.
[11] DFID. *Disability, Poverty and Development*, Department for International Development, (United Kingdom: 2000).
[12] UNDP. http://www.un.org/millenniumgoals/maternal.shtml
[13] WHO. *World Health Report 2005: Make every mother and child count,* (WHO: Geneva: 2005).
UK All party Parliamentary Group on Population Development and Reproductive Health. *Better o dead? A report on maternal morbidity*, May 2009. Accessed 5th of September 2013 http://www.appg-popdevrh.org.uk/Publications/Maternal%20Morbidity%20Hearings/Maternal%20Morbidity%20Report%20-%20FINAL.pdf
[14] UNDP. http://hdr.undp.org/en/humandev/ accessed 5th of September 2013.
[15] UNESCAP. Accessed on 13 August 2013. http://www.unescapsdd.org/disability/publication/incheon-strategy-%E2%80%9Cmake-right-real%E2%80%9D-persons-disabilities-asia-and-pacific
[16] South-North Centre for Dialogue and Development. *Global survey of government actions on the implementation of the standard rules of the equalisation of opportunities for persons with disabilities*, (Office of the UN Special Rapporteur on Disabilities: Amman: 2006).
[17] WHO and the World Bank. *World Report on Disability*, (WHO Press: Geneva: 2011).
[18] Motivation. (2012). *Mobility: Helping to achieve freedom through mobility*. Retrieved from http://www.motivation.org.uk/what-we-do/our-programmes/mobility
[19] WHO, World Disability Report, 2011.
[20] Jacobs, J. J. et al. *The burden of musculoskeletal diseases in the United States. Prevalence Societal and Economic Cost*, (Bone and Joint Decade: US: 2008). www.boneandjointburden.org

outcomes, how is the situation at global level when it comes to access to physical rehabilitation?

In many low- and middle-income countries, physical rehabilitation is not yet well understood in terms of its contribution to health and socio-economic development outcomes. As a result, physical rehabilitation is not sufficiently included in health policies and plans, which result in the sector being under resourced and funded and appears to be seen more as a welfare issue rather than an essential aspect of health care and development.

Rehabilitation services are, if not absent, only partially available with concentration in urban centres, or exist through Non Governmental Organisation (NGO) initiatives that are often dependent on external funding and support and sometimes set-up in an almost parallel system to, but not part of national public health systems. Due these parallel interventions, they are usually not included in the country's Health Information Management System and are therefore poorly monitored from the responsible line ministry. Nationally defined quality standards are seldom in place, although each physical rehabilitation centre might apply its own quality control system, but it remains outside of the public health monitoring, and quality is therefore not guaranteed.

Another important challenge, which is shared with the general health sector in many countries, is that the rehabilitation workforce is limited in number and quality. Very few training institutions exist and most professional groups either only recently got recognised as governmental health workforce categories or still remain to be recognised. Therefore, in many countries their positions are not funded, or their salaries do not correspond to their professional qualifications. This mapping will contribute to a better understanding of the physical rehabilitation system in the three countries and Odhisa state in India, to enable more informed decision-making and support persons with disabilities to have a better access to these services.

EXECUTIVE SUMMARY OF FINDINGS AND RECOMMENDATIONS

While the context and situation with regard to physical rehabilitation in each country is different, the pages that follow highlight common challenges in physical rehabilitation. There is a general shortage of services and human resources for physical rehabilitation especially in rural areas. At community level, in most countries, only a handful of organisations provide services and promote inclusion of persons with disabilities and in urban settings, even where services exist they usually focus on only part of the physical rehabilitation and do not offer a full physical "rehabilitation pathway". With regard to policy, the situation of policy and planning is improving; countries are at different stages of developing policies and strategies to provide for physical rehabilitation. However responsibilities for provision are divided; sometimes physical rehabilitation falls within public health provision, at other times, social services. A further challenge for policy makers and planners is the lack of clear data relating to prevalence and need as well as an inability to monitor services due to the lack of physical rehabilitation indicators from health management information systems (HMIS).

Since the mapping began, new and conducive international developments have occurred; in May 2013 the World Health Organisation (WHO) at the 66th World Health Assembly adopted a resolution calling for better health care for persons with disabilities and called on all states to make mainstream healthcare available to persons with disabilities and ensure that persons with disabilities have access to rehabilitation services that enable them to fully achieve their potential and have the same opportunities as others to participate fully in society.

In May 2014, the 67th Assembly made a resolution to adopt and endorse the "WHO global disability action plan 2014–2021: Better health for all people with disability". The plan[21] has three objectives,

- to remove barriers and improve access to health services and programmes;
- to strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation;
- to strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services.

The 67th Assembly urges all Member States to implement the proposed actions in the Action Plan as adapted to national priorities and specific national circumstances.

This mapping report supports countries to assess their physical rehabilitation situation against these global resolutions. It also offers specific recommendations which countries can consider, in light of the objectives and recommendations of the Global Action Plan.

A summary of these recommendations of this mapping is below:

Services

- Develop a comprehensive physical rehabilitation strategy that incorporates regulatory mechanisms and guidance as to which services should be available at what level, the estimated human resource needed.
- Where policy provisions exist, implement them fully and provide adequate matching financial budget for delivery of physical rehabilitation services. If needs be, services can be piloted, evaluated and assessed before rolled out further.
- Define minimum quality standards for physical rehabilitation services. Include a user-centred approach.
- Include indicators on physical rehabilitation in the Health Management Information System (HMIS) so that performance can be measured and monitored. Once data is available in national monitoring systems there are more opportunities to plan for more/ better services as gaps will be visible when measured.
- Increase awareness of communities and persons with disability about the benefits of physical rehabilitation and the importance of early identification

These recommendations of the mapping are consistent with recommendation 2.4 of the WHO Global Action Plan: *"Expand and strengthen rehabilitation and habilitation services ensuring integration, across the continuum of care, into primary (including community), secondary and tertiary levels of the health care system, and equitable access, including timely early intervention services for children with disabilities"*[22].

Human Resources

- Ensure that physical rehabilitation professionals are included in human resources for health strategies and retention policies, especially in rural areas.
- Develop a human resource capacity development plan, to produce the requisite HR needed to deliver services. Ensure training of persons in non urban settings, in order to facilitate better geographic distribution of professionals outside cities.
- Ensure that clear job descriptions exist for each group of professionals. These job descriptions should align with the quality standards required to deliver physical rehabilitation services. (Rehabilitation professionals should have the competencies to deliver the required services and this should be reflected in their job descriptions)
- Mainstream physical rehabilitation within other public health disciplines by training public health professionals in physical rehabilitation (what it is, who does what, roles and the role of CBR in physical rehabilitation) either through post graduate 'continuing professional education' or, by inclusion in pre-qualification training curricula of public health professionals. This will increase awareness and facilitate timely and adequate referrals.

[21] The WHO Global Action Plan on Disability, endorsed by the 67th World health Assembly in May 2014 is viewable at: http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_16-en.pdf?ua=1

[22] WHO (2014) "Draft WHO global disability action plan 2014–2021: Better health for all people with disability" http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_16-en.pdf?ua=1 p20. Accessed 27th May 2014

These recommendations of the mapping are consistent with recommendation 2.3 of the WHO Global Action Plan: *"Develop and maintain a sustainable workforce for rehabilitation and habilitation as part of a broader health strategy "*[23].

Leadership and governance

- Establish a physical rehabilitation taskforce to work on physical rehabilitation strategy including key actors such as Ministries of Health, Ministries of Social Services, service providers, users, professional organisations and NGOs involved in physical rehabilitation
- Continue and improve coordination between and among state and non state actors involved in delivery of physical rehabilitation services.
- Enhance civil society involvement (disabled persons organisations, user groups NGOs) to participate in governance.
- Strengthen the capacity of professional associations for taking part in policy making. They need to develop skills in policy making and advocacy.
- Ensure that CBR programs support self-help groups or interest groups to strengthen the voice of persons with disabilities at community level.

These recommendations are consistent with recommendation 2.1 of the WHO Global Action Plan: *"Provide leadership and governance for developing and strengthening policies, strategies and plans on habilitation, rehabilitation, assistive technology, support and assistance services, community-based rehabilitation and related strategies"*[24].

[23] WHO (2014) "Draft WHO global disability action plan 2014–2021: Better health for all people with disability" http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_16-en.pdf?ua=1 p19. Accessed 27th May 2014

[24] WHO (2014) "Draft WHO global disability action plan 2014–2021: Better health for all people with disability" http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_16-en.pdf?ua=1 p16. Accessed 27th May 2014

Afghanistan