Mapping report of physical rehabilitation services in Afghanistan, Bangladesh, Odisha (India) & Sri Lanka
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Eligibility criteria
These are conditions required to fulfill 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
Refer 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.

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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
GHS  Ghasanfar 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
P&O Prosthetist and Orthotist
SLSOT Sri Lanka Society of Occupational Therapists
SLMA Sri Lanka Medical Association
SLMC Sri Lanka Medical Council
SLSPO Sri Lanka School of Prosthetists and Orthotists
UNICEF United Nations International Children’s Emergency Fund
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 life1.

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

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). Some data on financing of service delivery have been gathered but no in-depth analyses of the remaining data on financing of service delivery have been made.

Six building blocks of health systems:
- Service delivery (physical rehabilitation services)
- Health workforce (rehabilitation professionals)
- Leader ship and governance (regulatory system and legislative framework)
- Health financing
- Medical technologies
- Health information

Physiological 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 physiological rehabilitation, will have important impacts on the whole health system and has to be thought of as a comprehensive reform within the health sector4.

**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.

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 stakeholders living far away from Kabul for example and the instability 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. 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, 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 focuses 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


7 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”.

Rehabilitation and health-related rehabilitation in the CRPD

Article 26 Habituation 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—recognize 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

and by 2030, the top ten causes of disease will be conditions that require physical rehabilitation8. 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 disabilities9. 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 countries10. Commonly known as the cycle of poverty and disability11, 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 halved almost since 199012, still 2 million women a year acquire a disability from pregnancy and childbirth, and experience exclusion and abandonment, which affects their economic and social lives13. 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 ongoing 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 system 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 rehabilitation15.

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


19 DFID. 2010).


23 DFID. Disability, Poverty and Development, Department for International Development, (United Kingdom: 2008).


Global facts on the access to physical rehabilitation globally:

• Only 3% of individuals who need rehabilitation globally are estimated to actually receive support16.

• One third of countries globally did not allocate any specific budget to rehabilitation services in 200517.

• An estimated 105 million people across the world need an appropriate wheelchair18.

• 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 school19.
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 Odisha 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 plan22 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.

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.

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.”

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.”


1. INTRODUCTION

Afghanistan, a landlocked country situated in South Asia is bordered by Pakistan, Iran, Turkmenistan, Uzbekistan, Tajikistan and China. The exact size of the population is not known but the latest figures from the Central Statistics Organisation estimates that 25.5 million people live in Afghanistan, the majority residing in rural areas (even though the country is experiencing an increasing urbanisation)\(^1\). A large part of the population, 42%, are getting their income from agriculture, either as farmers or as agricultural workers, depending on wages from the farming sector\(^2\).

Decades of wars, the persistence of a conflict situation and chronic insecurity, lack of skilled human resources and poor infrastructure, intertwined with poor governance and dependency on foreign assistance\(^3\) are some of the reasons why Afghanistan remains one of the poorest countries in the world\(^4\).

The national poverty rate is estimated as 36% but more than half of the population is highly vulnerable to unexpected external shocks, which could easily push them into extreme poverty. Illiteracy and gender inequalities are additional challenges in Afghanistan. The literacy rate for women aged 15 to 24 is 22%, compared to 51% for men. Similarly, school enrolment rates for girls aged six to nine are 28% lower than for males (31% compared to 43%)\(^5\). This lack of schooling, coupled with cultural barriers, means that women are ill equipped to participate in the labour market. Indeed, labour force participation of women is almost half that of men (40% against 80% of men), and the gap is even more striking in rural areas where only 19% of women actively participate in the labour market.

Poverty reduction is a priority objective of Afghanistan’s National Development Strategy and there has been important investment both in the education and health care sectors. Even though many indicators are of great concern, there are some improvements that need to be highlighted. Enrolment rates in education have increased by 40% between 2005 and 2008, and full immunization rates of children have tripled. Since the reform of the health sector, which was initiated in 2003, the percentage of the population living in districts where the Basic Package of Health Services (BPHS) is being implemented increased from 9% in 2003 to 82% in 2006\(^6\).

Situation of persons with disabilities

A national disability survey was carried out in 2005 and it concluded that the prevalence of persons with

\(^1\) http://cso.gov.af/en/page/6440


\(^3\) For example, international donors provide funds up to 85% of the country’s health care costs.

\(^4\) Trani, J-F and Baillot, P. Challenges for assessing disability prevalence: The case of Afghanistan. ALTER, Revue européenne de recherche sur le handicap 2, (2008), 44-64.


disabilities was 4.8% of the total population and 2.7% (close to 750,000 persons) have severe disability. These figures should be interpreted cautiously, as suggested in the survey, depending on the context and purpose for what they are going to be used. For example, if the state wants to know the abilities of persons with disabilities in the everyday functioning (self-care needs, perform household chores and carry out tasks outside of the house/in the field), the prevalence of people with very severe or severe difficulties to perform such tasks is at 10.8%, more than 2.7 million persons. This implies that there are actually more than 4.8% of the population who are excluded from participation in livelihood activities or community life. The survey suggests that percentage of people without any difficulty to perform the tasks defined is only at 41.1% of the total population in Afghanistan.

The survey also looked at the overall access to health care and it showed that both persons with and without disability have challenges to access health care services; 51% of persons with disabilities have a health centre available (compared to 54.3% for persons without disability). For access to a hospital, only 32.4% of persons with disabilities and 30.5% of persons without disability reported to have access. The survey though does not look at what people think about the quality or functioning, neither the acceptance of these health facilities, which all can be a challenge specifically for persons with disabilities in order to receive adequate health care. Persons with disabilities appear to seek health care more often than others, but the type of barriers that limits access is similar for both persons with and without disabilities. Payment for services, medication and transport were defined as key barriers together with the absence of transport possibilities and persons with disabilities thus pay between 3.6–5.5 times more for health services.

1. Overview of Afghanistan’s health care system

Afghanistan’s health system went through a major reorientation in 2003 in order to fight the disastrous health challenges, and the Ministry of Public Health (MoPH) together with bilateral donors, defined the BPHS program. This program aims to provide more equitable access to basic health care to the most vulnerable people as well as those living in rural and remote areas. Many international and national non-governmental organisations (NGOs) had been providing health services during the years of war and conflict, prior to this major reform. However for BPHS contracting, an open tendering process was launched to select the implementers that would work in coordination with the public health care centres and hospitals. Through this mechanism, the MoPH intended to build its capacity of stewardship and ensure coordination of services to reduce overlaps and provide more equitable provision of services. It was also designed to allow for more stable and long-term funding from the three key donors, USAID, the European Commission and the World Bank. External donors still fund 85% of the program.

This strategy was complemented with the Essential Package of Hospital Services (EPHS) in 2005, which aims to:

1. Identify a standardized package of hospital services at each level of hospital,
2. Provide a guide for the Ministry of Public Health, private sector, NGOs, and donors on how the hospital sector should be staffed, equipped, and provided materials and drugs,
3. Promote a health referral system that integrates the BPHS with the hospital sector.

In the National Priority Program ‘Health for All Afghans’ from 2012, three main components are defined which should improve the access to qualitative care: (1) Strengthen and expand existing health service delivery, (2) Increase and improve Human Resources for Health, and (3) Improve health financing. Scheme 1 illustrates the organisation of the health system and the link between the Basic Package of Health Services and hospital care.

1. Primary health care:
   i. Health Posts—village level, operating from community health workers own house, covering between 1,000–1,500 inhabitants.
   ii. Health Sub-Centres—village level, covering between 3,000–7,000 inhabitants. Supposed to bridge between health posts and Basic Health Centres
   iii. Basic Health Centres—larger village level, covering 15,000–30,000 inhabitants. Awareness on prevention of disability and referral for physiotherapy or rehabilitation. Identification of physical anomalies among newborn babies.
   iv. Comprehensive Health Centres—smaller towns, covering 30,000–60,000 inhabitants. Basic physiotherapy assessment and orthopaedic assessments should be done via outreach teams from District Hospitals.

2. Secondary health care:
   i. District hospitals—located at district levels, covering 100,000–300,000 inhabitants, handle all services included in the BPHS and monitors Basic Health Centres. It should provide outpatient and inpatient rehabilitation for persons who need physiotherapy with referrals for more specialised treatment when needed. Minimum requirement of the policy is to have two physiotherapists (male and female).

3. Tertiary care:
   i. Provincial hospitals—serves one province and provide additional services to the district hospitals, or where no district hospitals are available, provincial hospitals fill that function. Should provide physiotherapy and rehabilitation services.
   ii. Regional hospitals—serve several provinces and have most specialisations. Should provide physiotherapy and rehabilitation services.

Scheme 1 Organisation of the BPHS and EPHS system in Afghanistan

2 Ibid.
3 Ibid.
4 Ibid.
7 Ibid.
or trauma. The lack of disability-disaggregated data about the prevalence of disabling diseases and/ or trauma. There is, until now, only limited data available and age of the population that might benefit from understanding type and amount of needs for services. Afghanistan is not very well defined in terms of the need for physical rehabilitation services in Afghanistan. Since its establishment in 2009, the Department of Health in Afghanistan. Following, similar guidelines on the way forward in terms of spinal cord injury management in Afghanistan. Following, similar guidelines on the management of cerebral palsy will also be developed.

### 2. Governance and Legal Frameworks

This section looks at existing policies in health and social welfare, and more specifically policies on disability and physical rehabilitation.

22 WHO and ISPO. 2005. The P&O technician CAT III fabricates and assembles devices and takes part in their maintenance, repair and replacement. The technician is not involved in direct P&O services to the users.

**1.2 Physical Rehabilitation**

Physical rehabilitation services are identified in the BPHS and EPHS. Afghanistan was one of the first and is still one of the few countries among fragile states to include physical rehabilitation in health policies. However, when BPHS was first developed, the inclusion of physical rehabilitation came rather late in the policy development process and budget for the provision of rehabilitation services were not fully included in the per capita cost calculations which were used to fund BPHS rollout. Instead, physical rehabilitation either got funded separately by donor NGO projects or not at all. Meanwhile, the HMSI developed indicators and measurement systems to track performance on other public health priorities. Thus, physical rehabilitation sits only partially within the focus of the public health sector, although efforts are underway to try to address this gap.

The Disability and Rehabilitation Department (DRD) is responsible for developing and coordinating physical rehabilitation within the Ministry of Public Health in Afghanistan. Since its establishment in 2009, as an upgrade from a disability unit, the department has advanced considerably in defining policies and plans for physical rehabilitation, developed manuals and guidelines as well as awareness material. Still however, most physical rehabilitation services are provided by international and national NGOs that were, in their majority, set-up in an emergency setting in Afghanistan. The need for continuous physical rehabilitation services, and it is estimated that the prevalence is between 2–4.5% per 1000 live births. Using the crude birth rate data from the World Bank in 2012, between 2,379–2,739 children could be born with cerebral palsy each year in Afghanistan. The majority of these children would highly benefit from continuous physical rehabilitation services, including technical aids and specifically orthotic appliances.

**Spinal cord injuries:**

In conclusion, cerebral palsy is another group that benefit extensively from physical rehabilitation services and it requires a production of around 42,000 appliances yearly. To satisfy these needs, ideally around 155–160 P&O technicians (CAT I and II) and 600 bench workers (CAT III) should be available in the country. The Disability and Rehabilitation Department estimates that approximately 25 CAT II professionals are currently working in the country.

**Spinal cord injuries:**

Persons with spinal cord injuries are in need of continuous physical rehabilitation services as well as technical aids. It is estimated that somewhere between 93–147 persons per one million populations might have a spinal cord injury, based on studies in Asia. In Afghanistan this means that between 2,325 and 4,350 people could be in need of continuous rehabilitation service for improving and maintaining their functioning after their injuries. At the moment, the health system does not answer the needs of these patients, leaving them without proper treatment. In order to respond to this gap, the MoPH started a ‘Spinal Cord Injury’ Task Force in June 2013.

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The government of Afghanistan has developed a number of important policy documents and strategies relating to poverty, health, disability and physical rehabilitation. Afghanistan ratified the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2012 and the Law on Rights and Benefits of Disabled People (issue no 1037) from 2010 is now under revision. Afghanistan was also a signatory to the Asian and Pacific Decade of persons with disabilities (2002–2012) and is now a party to the new Asian and Pacific Decade of Persons with Disabilities, 2013–2022, during which the Incheon strategy will monitor the advancement of 10 disability-inclusive development goals aiming at increasing the rights of persons with disabilities in Asia and the Pacific.

An overview of the key documents related to poverty reduction and national development shows that disability and the needs of persons with disabilities are most often mentioned within the category of ‘poor and vulnerable people’. The approach towards persons with disabilities is largely charitable and based on assistance and subventions rather than measures relating to empowerment, such as encouraging participation, employment and livelihood support and inclusion in society. Disability is mainly addressed linked to health care needs, cash transfers or support to persons disabled due to war.

The Afghanistan National Development Strategy, ending in 2013, provides for the following benefits to persons with disabilities:

- **Social protection**: Cash transfer benefits are available for martyr’s families and persons with disabilities due to war.
- **Inclusion**: The strategy sets as a high priority sector ‘to support persons with disabilities access to facilities, including specialised institutions, and to adjust schools and universities to meet their needs’.

The Ministry of Labour, Social Affairs, Martyrs and Disabled (MoLSAMD) is the responsible ministry for disability affairs and for ensuring the implementation of the National Disability Action Plan and monitor the Law on Rights and Benefits of Disabled Persons. So far though, disability seems not to have been mainstreamed within all other social welfare policies or programmes.

The Ministry of Public Health has defined a number of health policies, among which the overarching National Priority Program (2012) ‘Health for All Afghans’, which sets the key priorities for implementing the national health strategy. This program includes the development and reinforcement of physical rehabilitation services within the BPHS. Expanding human resources in physiotherapy is another focus area defined in the second component, ‘to increase and improve human resources’, where the training of community physiotherapists is defined as a priority. Subsequently, physical rehabilitation is also defined within the EPHS. Unfortunately the plan has not identified any specific targets or indicators for measuring the outcomes linked to disability and rehabilitation.

Disability is also included in the Health and Nutrition Sector Strategy as one cross cutting theme, which sets out the following objectives:

- **Early detection of disabilities**: appropriately diagnostics of new born and small children with disabilities; early treatment to counteract disabling developments such as clubfeet and Developmental Dysplasia of the Hip.
- **Barrier free access to general health care services for people with disabilities and access to health staff that is knowledgeable about disability and rehabilitation.
- **Barrier free access to special services such as audiology and orthopaedic services.**

2.1 Disability policies

Afghanistan defined its first law on the Rights and Benefits of Disabled Persons (issue no 1037) in 2010. The law is currently being analysed in comparison with the CRPD in order to see which revisions have to be made as some of its articles are in direct conflict with the CRPD. In February 2013, MoLSAMD did a comparative study of the law and made a presentation to the Disability Stakeholder Coordination Group, established in 2002 which is composed of Disabled People’s Organisations (DPOs), local and International NGOs working in the field of disability alongside with representatives from the Ministry of Education and the MoPH. Preceding this law, a Draft National Disability Policy had already been developed in 2003 and was revised in 2007, in frame of the mine victim assistance Program, but was never approved.

The Afghanistan National Disability Action Plan for 2008–2011 was elaborated to implement the 2007 policy. This action plan was developed under the coordination of the MoLSAMD, as a response to the obligations in the Anti-Personnel Mine Ban Convention, and thus, influence from Mine Victim’s Assistance is noticeable as the needs of persons with physical disabilities are predominant. In addition to the six traditional components included in mine victim assistance, the disability policy integrated two more areas, inclusive education and Community Based Rehabilitation (CBR) and policies, which are not actually obligations of the Anti-Personnel Mine Ban Convention and go beyond the victim assistance focus. MoLSAMD has now taken on the responsibility to coordinate the drafting of a new national disability policy in consultation with members of Disability Coordination Group and other stakeholders. It has been agreed, through a decision of the Deputy Minister of MoLSAMD, that the new national disability policy needs to be in place before reviewing of National Disability Action Plan.

In addition, the MoLSAMD has a global budget for war victims, which entitles victims of war or their families an allowance of 1500 AFN per month. Apart from this, persons with disabilities not arising from war are not entitled to any social welfare benefits. The Afghan disability law was sent to the parliament with recommendation from persons with disabilities and their representatives to review this and include all persons with disabilities in these entitlements but this amendment was rejected.

Results from Handicap International’s KAP survey in 2012 suggest that while some people have been informed about the schemes they are entitled to through government led information campaigns or directly from the local government, others have not obtained any help from the government and are not aware of the existence of government schemes. This happens in urban as well as rural areas.
Annex 1 provides furthermore a summary on the legal framework and policies linked to disability in Afghanistan, compiled by UN Economic and Social Commission for Asia and Pacific (UNESCAP).

2.2 Physical rehabilitation policies

Physical rehabilitation services in Afghanistan were created more than three decades ago and substantially developed after 1990, mostly with the technical and financial support international organisations and donors, to respond to the need of refugees and war victims. While these organisations have made significant efforts over the past years, through conflict and changing authorities, and are now reaching a coverage of 21 out of 34 provinces, the fact is that physical rehabilitation services remain unevenly distributed over the country and large parts of the population have no access to it, or have to travel long distances to reach such services. Some districts might only have one or two physiotherapists for their entire population, while others have orthopaedic centres as well as physiotherapists available in the district hospitals. Two physiotherapists is the minimum requirement of the BPHS and at this point, there are not enough trained people to provide more. Currently only one key donor has integrated physiotherapy into their BPHS activities while EPHS has yet to integrate physiotherapy and prosthetics/orthotics officially so there are constraints in increasing provision.

Since the set-up of the Disability and Rehabilitation Department in the MoPH, responsible to coordinate, develop and monitor the sector, a number of strategic documents, guidelines and manuals have been developed:

- Guidelines on Physical Rehabilitation Services

1392–1395: Basic Package of Health Services Implementers (revised 2012, pending approval).

Several documents are still pending approval and would afterwards need to be translated and widely distributed together with training and awareness sessions. Feedback during the consultation process for the mapping report indicates that the knowledge about these documents among NGOs as well as BPHS implementers is limited. They remain also to be translated.

Disability and Rehabilitation strategy

The National Disability and Rehabilitation strategy seeks improve disability and rehabilitation services and thus to contribute to the Ministry of Public Health’s mission, to the Millennium Development Goals (MDGs) and to the goals of the Mine Ban Convention. The strategy will also support the implementation of the CRPD and other national and international treaties and obligations, and aims to raise awareness for the prevention of disabilities.

‘To work effectively with communities and development partners to improve the health and nutritional status of the people of Afghanistan, with a greater focus on women and children and underserved areas of the country’

(Ministry of Public Health’s mission)

On a longer term, the strategy states that the reinforcement and enhancement of the service provision for both persons with disabilities and persons with temporary impairments will depend on the fulfillment of the following objectives:

- To increase the capacity of the Disability and Rehabilitation Department for coordination, monitoring and reporting on Ministry and NGO implemented rehabilitation services including Community Based Rehabilitation.
- To develop a long-term Ministry of Public Health plan for the oversight and integration of rehabilitation services within the BPHS and EPHS, including budgeting, referral systems, standards of care, service implementation, and quality management.
- To improve physiotherapy and orthopaedic services through increased numbers of professionally trained practitioners at the provincial and community level.
- To improve the psychological and social inclusion of persons with disabilities through cross sector links and referrals.
- To enhance provision of early treatment of children with severe disabilities and care for persons with spinal cord injury and through research, strengthening of rehabilitation services, coordination among key ministries, the development of care policies and guidelines for both medical and non-medical practitioners.
- To increase prevention measures that target avoidable disabilities due to accidents and preventable diseases.

This strategy has been broken down in a three-year operational plan with and responsibilities defined. The plan initially appears to focus more on strengthening the capacity of the Disability and Rehabilitation Department to monitor and gather data as well as defining mechanisms to promote the integration of physical rehabilitation in the overall health sector. It remains unclear how the department plans to support for example the increase of number of rehabilitation professionals and the geographical coverage of services, which are key points for persons with disabilities to really notice improvement in their daily life. While this has been highlighted as an urgent need in the actual strategy, it is less developed in the operational plan.

Guidelines on Physical Rehabilitation Services for implementers of BPHS and EPHS

The two guidelines, still pending approval, for physical rehabilitation services specifically aim to support BPHS and EPHS implementation of physical rehabilitation services through the following points:

- An established and enforceable minimum standard for technical implementation of physiotherapy, orthopaedic and orthotic services in Afghanistan.
- Help to establish accessible high quality physiotherapy services nationwide.
- Guidance to implementers of BPHS and EPHS in planning of physiotherapy, orthopaedic and orthotic services to meet the patient demand nationwide.
- Provision of information on where current services exist to ensure referrals and treatment.
- Guidance to implementers of BPHS in establishing services to cope with the demand and supply of physiotherapy, orthopaedic and orthotic services nationwide.

These guidelines provide a comprehensive description of how these two health packages can integrate two of the key aspects of physical rehabilitation (the only ones available so far in Afghanistan), physiotherapy and orthopaedic services. Up to now, the Ministry of Public Health has been minimally involved in providing and/or managing physical rehabilitation services, but it is planned that the ministry will increasingly integrate these services in the BPHS and EPHS through the sub-contracted implementers or new organisations. Therefore a gradual transition should take place that requires increased coordination and communication between the NGO providing rehabilitation services and the central and provincial health representatives. As the Ministry of Public Health is currently revising the EPHS, the guidelines for physical rehabilitation services...
Implementers services 1392–1395: Basic Package of Health Services (BHPS)

Ministry of Public Health.

Physical rehabilitation as well as a chapter on understanding and description of disability and rehabilitation. A revision was made in 2013 to complement the guidelines for the BPHS and EPHS in order to facilitate the integration of these services in the public health system. The manual provides a comprehensive and human right-based understanding and description of disability and physical rehabilitation as well as a chapter on so far missing aspect of the system, the importance of proper referral mechanisms.

Disability and Physical Rehabilitation Reference Manual for the Health Sector

This reference manual was developed with the aim of raising the awareness of general health professionals and health providers on disability and rehabilitation. A revision was made in 2013 to complement the guidelines for the BPHS and EPHS and the DPO has planned to organise training on the manual for the implementers of BPHS and EPHS in order to facilitate the integration of these services in the public health system. The manual provides a comprehensive and human right-based understanding and description of disability and physical rehabilitation as well as a chapter on so far missing aspect of the system, the importance of proper referral mechanisms.

2.3 Participation of persons with disabilities in policy making

Participation of persons with disabilities in policy making has developed and improved in the past decade in Afghanistan. Consultation with representatives of persons with disabilities and other civil society organisations by MoPH and MoLSAMD has increased with the ongoing development of the capacities of these actors. For example, the process of the Afghan National Disability Action Plan began in 2006 with workshops and sub-groups that brought together civil society actors and persons with disabilities and the Disability Stakeholders Coordination Group (‘DSCG’) is a further forum for engaging persons with disabilities. The multi-stakeholder workshop conducted for this report was again an opportunity for representatives from the three key sectors came together to discuss the situation on disability and physical rehabilitation; decision makers (from Ministry of Public Health and MoLSAMD), physical rehabilitation service providers as well as CBR organisations and representatives of DPOs. It was an important opportunity to share information, understand the different opinions and needs, and a key outcome was the recognition of the gap that persons with disabilities experience between the policy development and the actual improvement in their daily lives. Advocacy and public representation among persons with disabilities is relatively recent among DPOs and they still have limited organisational capacities and struggle to increase their membership base, contributing to the challenge to raise the voices of persons with disabilities in local decision-making. The Disability and Physical Rehabilitation Technical Taskforce in the MoPH, which was set-up in 2002/2003, is composed of persons with technical and managerial expertise in rehabilitation. It was formed to facilitate the exchange of information between rehabilitation service providers, and when needed, the task force tackles specific technical issues such as development of manuals and guidelines and other general resource materials. It also draws representation from BPHS and EPHS implementers. Some of the key achievements

2.4 Regulatory framework of physical rehabilitation service delivery

A regulatory framework can be defined as a set of interrelated laws that are needed to control, coordinate and improve the provision of public services, in this case, physical rehabilitation services. Such instruments and frameworks should be defined and ultimately supervised by central authorities but can be implemented and monitored by either central and/or local authorities or agencies mandated to do so. This framework could regulate: (a) the demand for, and access to, services, (b) the supply of these services by various providers, and (c) the actual provision of physical rehabilitation services.

This mapping exercise involved most of the key stakeholders that are concerned about regulating and improving the access to physical rehabilitation services in Afghanistan. Through its two key health services delivery programs, the MoPH has already initiated some regulatory mechanisms through the contracting-out of the BPHS delivery, where the non-governmental sector forms part of a sort of public-private partnership. While it might have not been a strategic decision based on a long-term plan, it was probably the best solution during the start of the reconstruction period in Afghanistan in 2003, where NGOs had already been involved in providing health care services independently from the MoPH throughout the years of war and conflict. With these new mechanisms though, the Ministry of Public Health started to re-gain the stewardship of the health system, while not necessarily being the actual implementer of the package, in the first time. An assessment of the BPHS in 2010 showed several health improvements, but also challenges, regarding the sustainability, geographical coverage and the quality of the services provided. For the physical rehabilitation sector, a number of regulations have been defined but all are not yet implemented, while others are still to be developed (table 1). Until now, the majority of physical rehabilitation services have been provided and funded by international and national NGOs and made available in parallel to the Ministry of Public Health’s budget. Lately, some of the organisations started to define agreements with the Ministry and with the process of integrating physical rehabilitation into the BPHS and EPHS; there is a need to work on a handover strategy of these centres to the Afghanistan government. MoPH is the responsible Ministry for provision of physical rehabilitation services in Afghanistan. In addition, MoLSAMD is involved in supporting CBR programs, DPOs as well as providing vocational training and some livelihood activities for persons with disabilities.

Table 1 provides an overview of the situation in Afghanistan regarding some of the key regulatory mechanisms that are necessary to have in place to ensure a fair and equitable access to physical rehabilitation services.

3. DELIVERY OF PHYSICAL REHABILITATION SERVICES

Service delivery, one of the most important pillars of access to health, requires that sufficient services, of adequate quality and affordable, should be available where people need them. In terms of physical rehabilitation services it means that basic services should be available close to where people live and more comprehensive services at an acceptable distance. As any other health related service, physical rehabilitation should be available at primary health care level (closely linked to existing CBR and welfare/livelihood programs at community


Table 1: Overview of the regulatory system of physical rehabilitation in Afghanistan 2013

<table>
<thead>
<tr>
<th>Regulatory mechanism</th>
<th>Responsible entity</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gate-keeping mechanisms (information, referral and access)</td>
<td>Ministry of Public Health, DRD</td>
<td>There is no centralised system of assessing needs and demands or developing territorial maps of services.</td>
</tr>
<tr>
<td>Evaluation of needs and demands (macro level)</td>
<td>National and de-centralised Ministry and Directorate of Public Health</td>
<td>There are no official criteria to access services. People can access physical rehabilitation directly and staff in each centre defines treatment. Guidelines as to what impairments benefit from physical rehabilitation are available within BPHS/EPHS.</td>
</tr>
<tr>
<td>Access criteria to physical rehabilitation services (including orthopaedic devices and mobility aids)</td>
<td>Ministry of Public Health, DRD</td>
<td>DRD has defined guidelines on types of diagnosis that benefit from physical rehabilitation services and how to make referral, but not yet implemented. Each physical rehabilitation centre makes their own assessments and provides treatment, or refers to other services based on their own procedures.</td>
</tr>
<tr>
<td>Assessment of individual needs and orientation to services (micro level)</td>
<td>Individual service providers</td>
<td></td>
</tr>
<tr>
<td>Service provider authorisation and funding</td>
<td>Ministry of Public Health International donors and NGOs</td>
<td></td>
</tr>
<tr>
<td>Licensing and/or authorisation</td>
<td>Ministry of Public Health</td>
<td>Licensing and/or authorisation procedures are not yet in place. Physical rehabilitation providers should have an agreement with the Ministry but this is not linked to minimal standards or a license. The Ministry of Public Health supposes that the NGOs provide quality services but there is no control of this.</td>
</tr>
<tr>
<td>Government funding</td>
<td>Ministry of Public Health</td>
<td>Ministry of Public Health manages 2 physical rehabilitation centres from its own budget (although funds are provided by international donors to the ministry). Some EPHS implementers have physiotherapists employed in hospitals.</td>
</tr>
<tr>
<td>International and National organisations and donor funding</td>
<td>Swedish Committee for Afghanistan (SCA), Handicap International, ICRC, IAM, ICOD, DAO</td>
<td>International donors and NGOs fund the majority physical rehabilitation centres and services and most of the Prosthetic Orthotic workshops are dependent of external funds on a project basis. In the past, there have been some trials of starting a handover process but the lack of clear EPHS strategy has impeded such transfer.</td>
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<td>Ministry of Public Health, DRD</td>
<td>DRD in consultation with Disability and Physical Rehabilitation Taskforce has recently developed guidelines and monitoring tools for quality standards in physical rehabilitation, that will be annexed to the guidelines for BPHS and EPHS. These are still awaiting approval from MoPH centres that are managed by international and national organisations have their own quality performance indicators.</td>
</tr>
<tr>
<td>Service quality standards</td>
<td>Ministry of Public Health</td>
<td></td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>Ministry of Public Health International donors and NGOs</td>
<td>DRD has developed data collection tools on physical rehabilitation, but these are yet to be integrated in the general Health Management Information System. Data is collected at hospital and centre levels, and NGO managed orthopaedic centres also collect data, but all this is not yet centralised. There are no formal evaluation mechanisms in place or monitoring of quality or users satisfaction. International and national NGOs have their own separate monitoring processes and are evaluated by their donors. For funding provided by the European Commission, the MoPH is in charge of reviewing the project proposal and of the monitoring and evaluation of activities implemented. For other donors, the MoPH is generally not involved in the processes.</td>
</tr>
<tr>
<td>Data and statistics collection procedures</td>
<td>Ministry of Public Health through the general Health Management Information System</td>
<td></td>
</tr>
<tr>
<td>Information system</td>
<td>Ministry of Public Health MoLSAMD Physical rehabilitation providers</td>
<td>A physiotherapy services directory was published in 2011 but not yet well disseminated. It is planned that it will be printed and distributed at the end of 2013 and annexed to the future EPHS and BPHS guidelines as well as the Disability and Physical Rehabilitation Resource Manual. Referral process and forms are developed and approved but need to be disseminated among BPHS, EPHS and physical rehabilitation centres. DRD has information on existing service and location of services. It is unclear how much of this information is available at provincial and district level though.</td>
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level) where much of the needs can be met. At secondary level, both acute and long-term physical rehabilitation should be offered, and at tertiary level, more comprehensive and specialised physical rehabilitation should be available both in hospitals and specialised national centres. These services should be provided under a clear mandate of the relevant and responsible line Ministries.

One of the central issues regarding physical rehabilitation is that the sector is well provided for at policy level, but implementation of these policies remains limited. There are gaps in terms of geographical coverage, shortage of trained workers and unclear referral mechanisms between public health services and NGO-run rehabilitation services. Many regions in Afghanistan have huge challenges in terms of accessibility and the infrastructure is poorly developed. Due to the security situation in some regions, organisations are not able to expand their services, which hinder access for many people. With most services being provided and funded by international donors and organisations, the sustainability of the few services existing is at risk.

3.1 Identification and early intervention of physical impairments

This mapping concludes that there are very few services available at community level for identifying both children and adults in need of physical rehabilitation. Although a more thorough assessment of the CBR programs was not done, the mapping found that there are relatively few CBR programs in place, and most of them could actually be considered as sort of out-reach programs from the physical rehabilitation centres, and therefore not fully based in the more rural and inaccessible communities. In Handicap International’s KAP study, persons with disabilities told that with the help of neighbours they usually obtained information about services and that the first identification was made by the families themselves34. This certainly delays in many situations the useful start of rehabilitation, provisions of orthopaedic devices or early stimulation for access to education as well as re-integration in livelihood.

Under the BPHS program, Community Health Workers have responsibilities for identification and referral for persons with disabilities. This mapping indicates though, that for the moment, many Community Health Workers are unable to fulfil these functions as they are not trained in these subjects. Several organisations have been working in creating links with Community Health Workers and some have provided simple trainings on disability identification and referrals in some districts. Even though Basic Health Centres should provide information and referral of persons with disabilities in need of physical rehabilitation, as outlined in the BPHS, today, a district or provincial hospital is probably the closest facility where most people would get initial information and support, as some of them have physiotherapists available35. This indicates that identification and early intervention is most surely delayed for children with disabilities, which, as mentioned earlier will affect their chances to develop, and later onto access school and other social activities. This will further on have an impact on their opportunities for employment and securing livelihood.

In March 2013, the DRD organised a one day workshop to discuss how community based health care can work together with CBR programmes. At the end of the workshop, a recommendation to strengthen the relationship between Community Health Workers and CBR networks was made. Follow-up meetings are planned for September 2013.

3.2 Rehabilitation medicine, therapy and assistive devices

Rehabilitation medicine and therapy span from surgical interventions to acute and long-term therapies such as physiotherapy, occupational therapy or speech therapy. Modifications to the close environment as well as support and counselling is usually also included in physical rehabilitation, and can be important factors for supporting inclusion in daily life activities. Assistive devices, such as prosthetics, orthotics and other mobility aids, are also crucial components of physical rehabilitation and sometimes necessities for going to school or engaging in livelihood activities.

Physical rehabilitation at primary health care level (within BPHS)

The result of the mapping shows that basic physical rehabilitation is seldom available at community level and that most people have to travel to the nearest district hospital or provincial hospital to access physiotherapy. A few BPHS implementers have started to include outreach activities and even disability services within their services although these are still the minority. Furthermore, in a number of districts, physiotherapy is not yet available and, among the District Hospitals that do provide physiotherapy treatment, several still lack sufficient female staff. This is an important barrier for access of women and girls with disabilities due to social and cultural restrictions. Physiotherapy services are available in 21 out of 34 provinces and in 81 out of 364 districts36. A number of international and national NGOs provide home-based rehabilitation services through CBR and out-reach programs, but the scope and coverage of such activities is not well documented37. According to the Strategy for Disability and Rehabilitation, CBR activities are implemented in only 16 out of 34 provinces (and 80 out of 364 districts)38.

Since the guidelines for physical rehabilitation for BPHS and the awareness manual are just recently adopted, only very limited referral of persons with disabilities from BPHS implementers to physical rehabilitation services is yet happening. Moreover, even if they do identify people in need of services (after being trained by BPHS implementing organisations), the services are usually very far from where the patients live.

Physical rehabilitation at secondary health care level

At secondary health care level, which in Afghanistan covers the level of district hospitals39, few physical rehabilitation services are available. According to the latest mapping of the Disability and Rehabilitation Department in 2011, 44 districts out of the current 364 have some kind of physiotherapy services either at district hospitals or in a very limited number, in the Comprehensive Health Centres. Certain organisations such as Handicap International and the Swedish Committee for Afghanistan also provide out-reach orthopaedic services, which reaches some of the neighbouring districts close to the orthopaedic centres from where they operate.

Physical rehabilitation at tertiary health care level

Under the draft EPHS guidelines for physical rehabilitation, the comprehensive orthopaedic centres at provincial level would be considered to fall under the competence of the EPHS. As the EPHS is under-going a major revision it is not yet clear how the future funding and contracting to implementers will be managed. There are some suggestions that the MoPH should be responsible for all the funding and that the implementers instead should apply to the ministry and not receive the money directly from the donors. These regulatory mechanisms though are still under discussion. Up to now, 13 out of 34 provinces have such orthopaedic centres, among which two are managed by the Ministry of Public Health and the rest are externally funded and managed by international and national NGOs under their own programmes. There are a few pilot experiences where international NGOs are supporting EPHS providers with the provision of physiotherapy services, such as the
In the reference manual on physical rehabilitation there is a chapter highlighting the necessity of proper referral mechanisms. Such system should make sure that the patients are guided to physiotherapy units or other community support closer to the homes once being discharged from the acute treatment at provincial or national level. Many of these impairments will lead to a disability and therefore need regular follow-up or intermittent rehabilitation and maintenance of assistive devices in order to support reintegration and inclusion in daily life, education and other livelihood activities.

An effective referral system ensures a close relationship between all levels of the health systems and helps to ensure people receive the best possible care as close to home as possible. A referral system also assists in making cost-effective use of hospitals and primary health care services. Support to health centres and outreach services by experienced staff from the hospital or district health post helps build capacity and enhance access to better quality care for all.40

Please note that the numbers below are only representative of the availability of services at provincial level but do not illustrate the distribution of these services within the province. In several provinces, facilities are concentrated in city centres and thus are not easily accessible to people living in remote and rural areas.

The ISPO and WHO guidelines on service coverage for prosthetics and orthotics suggest that Afghanistan needs at least one orthopaedic workshop in each province, which should produce the most commonly needed appliances. Knowing that the costs for setting-up a centre is quite high, the development of new centres has to be done in phases. Four new provinces have been identified to be suitable for establishing orthopaedic centres during a five years period. The selection was based on population cluster, under coverage of services and strategic relationship between all levels of the health systems. ‘An effective referral system ensures a close relationship between all levels of the health systems and helps to ensure people receive the best possible care as close to home as possible. A referral system also assists in making cost-effective use of hospitals and primary health care services. Support to health centres and outreach services by experienced staff from the hospital or district health post helps build capacity and enhance access to better quality care for all.’40

<table>
<thead>
<tr>
<th>Region</th>
<th>Province</th>
<th>Physiotherapy services</th>
<th>CBR**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Total number of facilities providing physiotherapy services</td>
<td>Number of orthopaedic centres only*</td>
</tr>
<tr>
<td>Northern</td>
<td>Balkh</td>
<td>6</td>
<td>2 (ICRC and SCA)*** Yes</td>
</tr>
<tr>
<td>region</td>
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<td>2</td>
<td>0 Yes</td>
</tr>
<tr>
<td></td>
<td>Fayyab</td>
<td>1</td>
<td>1 (AM) Yes</td>
</tr>
<tr>
<td></td>
<td>Jawzjan</td>
<td>2</td>
<td>0 Yes</td>
</tr>
<tr>
<td></td>
<td>Baghlan</td>
<td>1</td>
<td>0 Yes</td>
</tr>
<tr>
<td></td>
<td>Kunduz</td>
<td>4</td>
<td>0 Yes</td>
</tr>
<tr>
<td></td>
<td>Takhar</td>
<td>6</td>
<td>1 (SCA) Yes</td>
</tr>
<tr>
<td></td>
<td>Badakhshan</td>
<td>3</td>
<td>1 (ICRC) Yes</td>
</tr>
<tr>
<td></td>
<td>Sari Pul</td>
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</tr>
<tr>
<td>Central</td>
<td>Kabul</td>
<td>14</td>
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<td>Parwan</td>
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<tr>
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<td>Nangarhar</td>
<td>8</td>
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<tr>
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<td>1 (MoPH) No</td>
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<tr>
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<td>Kunar</td>
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<td>1 (DAO) Yes</td>
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<td>1 (SCA) Yes</td>
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</tr>
<tr>
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</tr>
<tr>
<td>Southern</td>
<td>Wardak</td>
<td>4</td>
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</tr>
<tr>
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<td>Helmond</td>
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<td>1 (ICRC) No</td>
</tr>
<tr>
<td></td>
<td>Nimroz</td>
<td>0</td>
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<tr>
<td></td>
<td>Unzagan</td>
<td>0</td>
<td>0 No</td>
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<tr>
<td></td>
<td>Zabul</td>
<td>1</td>
<td>0 No</td>
</tr>
<tr>
<td></td>
<td>Kandahar</td>
<td>2</td>
<td>1 (PR) Yes</td>
</tr>
<tr>
<td>Western</td>
<td>Herat</td>
<td>10</td>
<td>1 (ICRC) No</td>
</tr>
<tr>
<td>region</td>
<td>Badghis</td>
<td>0</td>
<td>0 No</td>
</tr>
<tr>
<td></td>
<td>Farah</td>
<td>0</td>
<td>0 No</td>
</tr>
<tr>
<td></td>
<td>Ghor</td>
<td>0</td>
<td>0 No</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>83</td>
<td>17 n.a.</td>
</tr>
</tbody>
</table>

*Includes orthopaedic centres that provide prosthetic and orthotic production and fitting as well as physiotherapy treatment and their number are therefore included in the total of physiotherapy centres listed in the 3rd column of this table.
**Information comes from the physical rehabilitation reference manual of the DRO as well as from consultation of rehabilitation implementers in Afghanistan.
***These two centres do not duplicate activities, ICRC making mainly prostheses and SCA orthosis.

The information is gathered from the Disability and Rehabilitation Department, Handicap International and the draft version of the EPHS, during May-June 2013. Some data though might not be updated and should be interpreted with caution as there might be more services available or some that perhaps have stopped providing services.

Improving the availability, accessibility, accountability and quality of rehabilitation services is largely dependent on ensuring the rehabilitation workforce exist, is adequately prepared and mobilised. WHO World report in 2006 is looking at the development of the health workforce in a life span perspective, which covers both the workers perspectives and the policy and governance through state action42.

**Entry**: planning, preparing and producing the required workforce through strategic investments in education and effective and ethical recruitment practices.

**Workforce**: enhancing worker performance through better management of workers in both the public and private health sectors, this includes adequate financial planning to ensure retention of trained health workers and human resource information management systems to make rational human resource allocation decisions.

**Exit**: managing migration and attrition to reduce wasteful loss of human resources.

This mapping has not done a detailed analysis of the whole process from entry to exit, but it does provide relevant information on key perspectives and highlights gaps that need to be further investigated. The data presented in this chapter is gathered from policies and guidelines of the Disability and Rehabilitation Department, from interviews with professional associations and DPOs as well as information provided by key actors participating in the national workshop (Annex 1).

### 4. HUMAN RESOURCES IN PHYSICAL REHABILITATION

Physical rehabilitation professionals are integral part of the human resources for health, and at the same time closely linked to the social and vocational sectors. While this report emphasises on the health and social sector, the need for professionals in the vocational and education sector is also important to meet all the rehabilitation needs of persons with disabilities (including them in education and the workforce). Physical rehabilitation is a pre-condition for many people to access education and employment, and for example physiotherapists or speech therapists have an important role in schools and vocational training institutions.

Physiotherapists

The very first physiotherapy training was set-up in partnership with the Ministry of Public Health in 1984 by support of the International Assistance Mission. Starting out as a two-year training in physiotherapy, the Physical Therapy Institute is now a department in the Ghazanfar Institute of Health Science and runs, since 2008, a three-year diploma course, with the financial and technical support from international donors, mainly International Assistance Mission (IAMA)43 (who are funded under the Mine Victim Assistance framework). The institute has also provided a complementary one-year course for 106 physiotherapists that had two-years training.

On an average, 15–20 students are supposed to graduate annually as physiotherapists and 40% of the students so far have been female44. In total 316 students (including both those with two and three years training) had graduated up to 2011, and of those, 285 are currently working. There is still no clear decision on how these two levels of physiotherapy professionals should be harmonised, and currently, the Ministry of Public Health does not make any difference neither in salary scale nor in job description. It is estimated that around 60% of the physiotherapists work in urban clinics or hospitals and the majority, an estimated 80% are working with NGOs while remaining 20% work in government centres or hospitals or in private clinics. One of the reasons is that most public or private facilities do not have physiotherapy units and are sometimes not aware of the needs of such service, often by lack of information of the benefits and importance of physical rehabilitation. Efforts have been made to promote the recruitment of students from more rural provinces and districts but have proved to be a challenge.

In the guidelines for BPHS and EPHS, the Disability and Rehabilitation Department has defined the minimal need for physiotherapists at the different

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43 The three-year curriculum is recognised by the World Confederation of Physical Therapy.

health care levels, following the Ministry of Public Health’s standards of one bed per 5,000 people. In total, the Ministry of Public Health estimates the minimum number of diploma physiotherapists required will consequently grow 45. Of physiotherapists required will consequently grow. In total, the Ministry of Public Health estimates the minimum number of diploma physiotherapists required will consequently grow. In total, the Ministry of Public Health estimates the minimum number of diploma physiotherapists required will consequently grow. In total, the Ministry of Public Health estimates the minimum number of diploma physiotherapists required will consequently grow. In total, the Ministry of Public Health estimates the minimum number of diploma physiotherapists required will consequently grow. In total, the Ministry of Public Health estimates the minimum number of diploma physiotherapists required will consequently grow. Of physiotherapists required will consequently grow. 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Table 5: Overview of training schools of physical rehabilitation professionals in Afghanistan

<table>
<thead>
<tr>
<th>Profession</th>
<th>Training school</th>
<th>Program and degree</th>
<th>License</th>
<th>Annual graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapist</td>
<td>Physiotherapy Institute in Ghazni</td>
<td>3 years including 3672 hours of theoretical classes including clinical practice in labs and 1224 hours of practical hours with patients</td>
<td>PT need license to work in government sector, not in NGO sector</td>
<td>15–20 PTs</td>
</tr>
<tr>
<td></td>
<td>University of Health Science</td>
<td>Degree: Diploma in Physical Therapy, recognised by WCPT in 2007</td>
<td></td>
<td></td>
</tr>
<tr>
<td>P&amp;O Technicians</td>
<td>Course organised by ICRC in coordination with the Ghazni Institute of Health Science</td>
<td>3-year course ISPO certified Degree: CAT II</td>
<td>Not yet licensed</td>
<td>18</td>
</tr>
</tbody>
</table>

Summarising the analysis of the existing situation of educational programs for physical rehabilitation professionals put evidence on the need to scale up the training capacities and, preferably, looking into a de-centralisation of training opportunities. Current training programs cannot provide the necessary rehabilitation professionals required in the Strategy for Disability and Rehabilitation, as the annual production is only between 30–50 professionals in physiotherapy and prosthetics and orthotics. For example, if the current physiotherapy training can graduate 20 students per year in Kabul, the required minimal amount of 775 physiotherapists is not feasible to meet within a reasonable time frame.

Another challenge that the sector faces is to recruit students from other provinces or districts outside of Kabul and the main cities, something that would increase the chances of people come back and work in their home provinces. Due to poor infrastructure and security problems together with more difficult access to quality primary and secondary education, it remains difficult to recruit students from several of the provinces, especially women, of which there is a great need. While it is debated whether or not to train physiotherapy assistants (which is a shorter training), this might be one option to investigate for Afghanistan. Such training might be easier to implement, is less costly and can have great impact at local level, for example among BPHS implementers. However the risk is that these assistants might lack proper and necessary supervision by physiotherapists.

5. CONCLUSION AND RECOMMENDATIONS

In line with WHO’s recent project of defining guidelines for rehabilitation48, the interpretation of the mapping outcomes and suggestions for moving forward are presented in relation to the key criteria for ensuring an equal access to physical rehabilitation services for persons with disabilities, and others in need for such services in Afghanistan.

5.1 Availability

Availability refers to having functioning and sufficient physical rehabilitation services in a balanced and equitable geographical distribution. Services should also strive to answer to the diversity of needs for services, i.e. age, gender, type of impairment etc. There must also be a long-term strategy of ensuring sustainability of services, financial as well as in terms of quality, including staff availability and adequate competence.

As the mapping outcomes show, even though there is a number of orthopaedic centres and physiotherapy units available in Afghanistan, there is an important shortage of services in many districts, especially in rural areas and regions where insecurity and persisting violence is high. Starting from the community level, there are basically only a handful of organisations that are providing physical rehabilitation and promoting inclusion and participation of persons with disabilities in education, employment or other livelihood activities. The CBR programs, which are in place in 16 provinces (out of 34), are trying to address this gap, but there is a need for better coordination and more involvement of the Afghan authorities to support the wider dissemination of CBR in the country. It is also important to link CBR programs with the BPHS, especially when the process of integrating physiotherapy services at this level takes off.

At the EPHS level, there are a few district hospitals that have physical rehabilitation service available; an estimated 81 districts out of 364 have some kind of physiotherapy. In some hospitals though, there is only one person to serve the whole province and a lack of female staff severely restricts access to women and young girls. Female workforce though is not only a problem for the physical rehabilitation sector, the whole health sector has trouble to recruit and retain female health professionals49. For example, during the first quarter of 2013 the violence and insecurity got worse and many health facilities have been affected, leading to their temporary closure or reduction of staff and services50. This coupled with lack of female staff are important obstacles for the access to even basic health services for women and young girls.

On the encouraging side though, it is important to see that actually one or two comprehensive orthopaedic centres or physiotherapy units are available in 22 of the 34 provinces. In 13 districts there is at least one centre providing orthopaedic devices and physiotherapy. This experience and knowledge constitute a rich learning experience for scaling up service provision.

In the recently revised guidelines on physical rehabilitation for BPHS and EPHS implementers, there is clear guidance on how to integrate physical rehabilitation (initially focusing only on physiotherapy and orthopaedic services) in the mainstream health care system. All necessary details about setting up and including physiotherapy and orthopaedic services are clearly defined, such as, definitions of concepts, job descriptions, costs, referral mechanisms, organisation and monitoring among others. To put this in practice though needs long-term commitment from the Ministry of Public Health and MoLSAMD as well as international donors and organisations currently involved in service provision.

One important challenge now is to make sure that there is budget made available to train and hire the necessary staff at these levels and an important obstacle seems to be the availability of physiotherapists at BPHS but also EPHS levels outside the main cities. What should be clarified and where the disability taskforce probably have a key role, is to urgently define a plan to address the human resource shortage. The Disability and Rehabilitation Strategy does not provide a comprehensive plan for this aspect while it is a key for scaling up services.

Discussions with representatives of persons with disabilities and organisations working at community level indicate that very little improvements in terms of accessing physiotherapy or other rehabilitation services changes are actually seen at this level. While this certainly is due to many factors, such as lack of capacity at provincial health levels and scarce economic resources, it is important that the policies start to be translated into actions. An additional important challenge that was highlighted during
Moving forward

- Implement projects for reaching full implementation of the BPHS and EPHS guidelines through improved collaboration between MoPH, BPHS and EPHS implementers and international and national NGO-run physical rehabilitation. Evaluate and assess the result before disseminating the experience more widely, including in any new rehabilitation facilities opened in the country, through workshops, on-the-job trainings and study visits.
- Put in practice the guidelines on physical rehabilitation in BPHS, and, once being approved, the EPHS, and set priority in training the key stakeholders on disability and physical rehabilitation:
  - BPHS implementers,
  - Community Health Workers: disability identification, referral and information,
  - General medical doctors and nurses,
  - CBR workers
- Develop a coordinated human resource capacity development plan among the relevant line ministries, the disability task force, professional associations and donors, but also provincial health authorities. Current capacities are far from being able to produce the necessary physiotherapists and P&O technicians. Assessment of possibilities to conduct training in other provinces should be studied, with the objective of recruiting personnel from more rural districts. This can ensure a better geographical coverage of rehabilitation professionals and willingness to work outside of main cities.
- Encourage and facilitate for female students to apply for both physiotherapy and P&O training and of equal importance, ensure that they pursue their first employment, in particular through the provision of a positive environment for retention. This being a generalised challenge in the health sector, the MoPH needs to include rehabilitation professionals in the overall human resource strategy that ensures that women are both being trained and employed as health professionals, which also means considering the specific barriers that the exam entry represents for women.
- Include indicators on physical rehabilitation and disability in the Health Management and Information System. The reluctance of the monitoring unit to add indicators due to increased costs could be revised as the MoPH actually under spends their budget; ways should be explored to add financial resources for this aspect.32 Once in the system there is much more opportunities to advocate for more and better services, as the gaps will be visible when measured.
- A CBR training curriculum should be developed and coordination should be strengthened among government and non-government actors within health, education, employment, and social affairs.
- A centralised monitoring and evaluation mechanisms for CBR programs should be developed under the competent authority.

5.2 Accessibility

Accessibility implies that services can be reached and used by the person who needs them. It has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability), and information accessibility.

Disabled People’s Organizations defined three key obstacles to access physical rehabilitation at community level:

1. Poverty, the economical situation of persons with disabilities and their families is very low and the cost for transport, accommodation, and medicine etc. are often preventing people from accessing needed services, even if they are aware about their availability.
2. The information about the benefits that physical rehabilitation and assistive devices can bring to people is not easily available or understandable. Health staff or traditional healers in the communities often have no knowledge on rehabilitation or disability and do not explain the situation so that people can understand and actually act.
3. Poor infrastructure and lack of accessibility at community level coupled with a social and cultural environment that often discriminates against persons with disabilities make access to services more difficult. This also affects the self-confidence of people and can increase their isolation.
4. Insecurity and on-going conflict in some provinces also restricts the freedom of movement and affects persons with disabilities, especially against women and young girls, access to physical rehabilitation.

Physical rehabilitation service providers and representatives of the MoPH and the MoLSAMD identified that the key obstacle was the lack of coordination among the actors involved and the scarcity of funds and technical and human resources.

The project aims to expand CBR activities and strengthen the physical rehabilitation sector through implementation of continuing disability education sessions and trainings strengthening awareness on rehabilitation policy. For more information on the project, please refer to H-Office in Kabul.

53 Information about the under spending of the health budget was provided by Ms. Susan Helshet during the workshop, technical advisor to the Disability and Rehabilitation Department in Ministry of Public Health.

52 The project aims to expand CBR activities and strengthen the physical rehabilitation sector through implementation of continuing disability education sessions and trainings strengthening awareness on rehabilitation policy. For more information on the project, please refer to H-Office in Kabul.

There seems to be an overall agreement that the actual implementation of policies and guidelines must be given priority attention, especially in increasing service provision coverage and training more professionals. A crossing problem is also the security situation, which essentially hinders many programs and projects to be rolled out at national level. Despite the difficulties described, facilitating elements to improve access to services were also identified. DPOs and community organisations put forward the role that local Imams and religious leaders can play in informing and convincing families to look for physical rehabilitation services. They can also be key facilitators in promoting a positive image of disability at local level. This is being implemented in some pilot projects, for example, Handicap International’s rehabilitation project in Kabul. There was also a strong agreement on the comprehensive policies in place being strong facilitators for improvement; plans and manuals in place are crucial for the good development of the sector. The inclusion of physical rehabilitation in the BPHS and EPHS programs can be mentioned as an important success. This will have an impact on the access to services at district level once being approved, and also understood and practically implemented.

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- Roll out the awareness raising training to BPHS and EPHS on physical rehabilitation through training of trainers approach. This can be done in coordination and with support of the international and national NGOs involved in the sector.
- Develop a better understanding of the needs for physical rehabilitation in order to find out how the needs at community level in rural areas can best be addressed. What is the capacity of the CBR programs to be more involved, which physical rehabilitation needs can be answered through trained CBR workers or physiotherapy assistants and which needs referral? What could be the role of Community Health Workers in the BPHS? As it will take time to train physiotherapists that can and are willing to work at district level, a mid-term solution needs to be thought of.
- Increase the awareness of local communities and groups of persons with disability about the benefits that physical rehabilitation can bring and importance of early identification as well as secondary prevention. It is important though that such awareness comes parallel to increasing the access to services in areas that are not yet covered.
5.3 Accountability

Accountability concerns both the transparency and efficiency of the regulatory framework implemented from authority level, as well as accountability from service providers themselves. It refers not only to financial management of services, but also to the overall organisation of the service: clear manuals of policies and procedures, internal regulations, and a qualitative and transparent staff management system, and the active involvement of users in both treatment and service delivery. Key words are: person-centred, user involvement, community partnership, continuity of service and result-outcome oriented.

The mapping has not done any qualitative analysis or review of the actual service delivery of the orthopaedic centres or physiotherapy units, neither of the Physical Therapy Institute. It is therefore not meaningful to make any comments on their accountability. It is though recommended to make a more in-depth analysis of all the physical rehabilitation services in order to see to what extent they are using, or not, similar internal procedures, job descriptions, salary scales, monitoring and evaluation tools as well as logistical processes, purchase procedures and types of material used. For a future handover of services to the MoPH, it is important to harmonise procedures and work towards a user and rights centred approach to service delivery.

A positive step towards increased accountability is the existence of professional associations. Even if they are still new they are slowly taking a stronger role within the sector and can advocate for the working conditions and status of the rehabilitation professionals. Professional association are also important for promoting ethics and values among professionals and could influence the training programs to introduce user participatory assessment and treatment plans among many other things.

Similarly, the availability of a few DPOs and organisations working for the rights of persons with disabilities is another important aspect of accountability. They would represent the users and future users and once growing stronger, will be an important third part in developing the physical rehabilitation sector.

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- Finalise the revision of the Law on the Rights and Benefits of Disabled Persons no. 1037 in-line with the CRPD. Pay specific attention to the rehabilitation sector.
- Conduct an assessment of current physical rehabilitation provision, including orthopaedic centres. To facilitate a progressive handover to the relevant line ministry, it is important to understand which procedures in terms of staff recruitment and job descriptions, salary scales, monitoring and evaluation tools, quality standards, as well as logistical processes, purchase procedures and types of material used. A harmonisation of procedures and processes will facilitate a handover and should respect the human rights of persons with disabilities.

A regulatory framework is slowly being developed for the physical rehabilitation sector in Afghanistan so it is too early to assess its accountability in that sense. Both physical rehabilitation service providers and DPOs though consider the recent policies and guidelines to be important tools but want to see that the full implementation of integrating physical rehabilitation in both the BPHS and EPHS is taken seriously. The roll out of the strategies needs to be done in coordination with all concerned actors. It is thus important for the authorities and the international organisations to show transparency about their plans and time frame to implement the integration of physical rehabilitation into the BPHS and EPHS. Governance is a vital aspect of accountability towards the population in particular in conflict affected countries that are going through a transition and reconciliation process such as Afghanistan.

5.4 Quality

While availability of, and accessibility to, services are crucial, the quality of the services provided is equally important. If the physical rehabilitation centres or units do not provide services satisfactory to the users or do not respect and value the users, persons with disabilities will stop using them or can be even harmed by the interventions. Therefore quality standards and monitoring tools are regulatory procedures that have to be implemented and supervised by adequately trained local and central authorities. In addition, physical rehabilitation services should have their internal procedures in place, which should be transparent and understandable for users, as well as a complaint system where people can give their feedback on services for improvement. All this has to be developed with the principle of acceptability in terms of gender, capacity, culture and life cycle requirements.

In this mapping, the quality aspect of physical rehabilitation has been looked at mainly from a technical point of view. As earlier mentioned, there has been no analysis of service providers’ performances and service delivery or direct questions about quality asked to users, instead the available data can tell some aspects of quality.

As earlier mentioned, the lack of indicators on physical rehabilitation and disability in the Health Information System impedes the responsible ministry to monitor and make informed decisions about human resource development, budgeting and coverage of services. The absence of common quality standards is another challenge. Each service provider has defined its own quality and monitoring procedures and so far, the Ministry of Public Health has no means to monitor or ensure quality of services provided. There is thus a need for improving transparency from the NGO-run physical rehabilitation services but also to build the capacity of the Ministry of Public Health to monitor and invest in these services.

As previously said, the lack of trained human resources in physical rehabilitation is an urgent issue that needs to be addressed. Poorly trained or not enough staff affects quality of services, and hinders the development of new, or the expansion of existing services.

- Strengthen the capacity of the two professional associations of physiotherapy and P&O technicians. They need to develop skills in policy making and advocacy, as well as having a stronger capacity to promote Continuous Professional Education in collaboration with training institutes.
- Strengthen the capacity of DPOs for taking part in policymaking and advocacy in the field of physical rehabilitation and disability rights.
- CBR programs should enhance their support for self-help groups or interest groups to strengthen the voice of persons with disabilities at community level. Such groups have been shown crucial for peer counselling and raising the awareness around health, rehabilitation and access to other services, especially in smaller towns and villages.
- This requires a long term planning knowing that current capacities are weak.
- Improve the coordination and sharing of roles and responsibilities between International and national NGOs, MoPH and MoIAMD. The orthopaedic centres should apply the suggested monitoring tools in the BPHS and EPHS and report to the MoPH. Accountability in terms of technical and financial resources applied is crucial for a long-term hand over strategy.
• Include indicators on physical rehabilitation and disability in the Health Management and Information System so that performance can be measured and monitored.
• Continue and improve the coordination between the international and national NGOs providing physical rehabilitation services, the EPHS/BPHS implementers and the MoPH through greater follow-up and leadership of DRD within the task force group and greater coordination among concerned Ministries.
• Build the capacity of the Ministry of Public Health and the Health Management Information System on monitoring and evaluation, as well as assessment of quality standards. This is crucial for taking over the role and responsibility of monitoring quality and performance of physical rehabilitation service provision.
• Train physical rehabilitation providers on quality management and how to define internal procedures.
• Curricula of physical rehabilitation professionals have to reflect the functions required in the BPHS and ePHS guidelines on physical rehabilitation.
• Elaborate a consistent human resource plan and budget, for training of physical rehabilitation professionals in accordance with estimations of need. Such plan has to be linked to service needs and supported by budget and future retention policy as well as salary payment planning.
• Monitoring of standards of practice for physical rehabilitation professionals: There is need to strengthen internal capacities of professional associations to develop and monitor/reinforce quality standards of practice for each designated field.

Moving forward

BIBLIOGRAPHY


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### Annex 1.1: List of participants in the national workshop

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### Annex 1:3 Country report from UNeSCAP

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#### 1/ Background Statistics

| Human development index rank | 155 (1) |
| GNI per capita (PPP in US$) | 1,419 (1) |
| Life expectancy at birth (years) | 44.6 (1) |
| Mean years of schooling (years) | 3.3 (1) |
| Expected years of schooling (years) | 8.0 (1) |
| Total population | 31,412,000 (2) |

#### 2/ Disability Statistics

| Population of persons with disabilities | 800,000 (3,a) |
| Proportion of persons with disabilities to total population | 2.7 per cent (3) |
| Employment rate of persons with disabilities | 70 per cent of persons with disabilities aged over 15 years are unemployed (3) |
| Access to education | 73 per cent of persons with disabilities above six years of age do not receive any education (3) |

#### 3/ Definitions

- **Definition of disability**
  WHO International Classification of Functions Guidelines (39)
  ‘Disability is the outcome of the interaction between a person with an impairment (which can be acquired or congenital), the environment (for example architectural barriers) and cultural attitudes (prejudice). Disability is a state that may be modified, by reducing impairment, changing attitudes or adapting the environment.’

- **Definition of persons with disabilities**
  ...

- **Categories of impairment**
  ...

#### 4/ Commitment to International Instruments on Disability

- **Ratification or signatory of the Convention on the Rights of Persons with Disabilities (CRPD), and its Optional Protocol**
  Ratified the CRPD in Sep 2012 (49)

- **Ratification or signatory of the Convention on Cluster Munitions**
  Signed Convention on 3 December 2008

- **Ratification or signatory of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction**
  Ratified Convention on 11 September 2002 (7)

#### 5/ Legal Framework

- **Constitutional provisions**

- **Disability-specific laws**
  Comprehensive No
  Sectoral ...
  Disability-inclusive laws Cover: education

#### 6/ Policy Framework

- **Disability-specific policies**
  Sectoral No
  Disability-inclusive Cover: national development strategy; education; labour; social protection; health.

#### 7/ Institutional Framework

- **The national coordination mechanism or disability focal point**
  Ministry of Labour, Social Affairs, Martyrs and Disabled

**Sources:**

**Notes:**
Based on the 2006 National Disability Survey estimate.
1. INTRODUCTION

The People’s Republic of Bangladesh forms the Bengal delta region in the Indian subcontinent. It is bordered by India to its north, west and east, by Myanmar to its southeast and by the Bay of Bengal to its south. It lies also very close to Nepal and the Kingdom of Bhutan, only separated by the Indian Siliguri Corridor. Bangladesh is a densely populated country with an estimated 150 million large population, with 1,050 people living per each square kilometre. Bangladesh is divided into seven administrative divisions: Barisal, Chittagong, Dhaka, Khulna, Rajshahi, Rangpur, and Sylhet. Each division is further on divided into Zilas, and each Zila into Upazilas. Each urban area in an upazila is divided into wards. These divisions allow the country as a whole to be easily separated into rural and urban areas.

Over more than four decades since its independence, Bangladesh has achieved important development progress, reducing its poverty rate by 60% and is on the way to achieving most of the Millennium Development Goals (MDG) targets. Economically, the country has undergone a structural transformation and the garments sector has become an important export sector providing new employment opportunities, often for women. At the same time, the garment sector has a lot of problems and has been heavily criticised for unsafe working conditions, minima salaries and regular working hazards have been reported. The country also has grown more resilient to natural disasters and is building up disaster risk management capacities.

The incidence of poverty has been declining at an annual ratio of 2.47% during 1991–2010, according to the Household Income and Expenditure Survey 2010 data, which is higher than the MDG target of 2.12%. Nonetheless, Bangladesh remains a low-income country ranking 146 out of 186 in the Human Development Index in 2013, with substantial poverty, inequality and deprivation. An estimated 47 million people, around 43% of the total population are still living below the national poverty line of 1,25 US$ per day. A significant proportion of these poor are living in households in remote areas and/or consisting of marginalized groups of the population, such as ethnic minorities or persons with disabilities.

While poverty is decreasing, there is a difficulty with child malnutrition in the country. Although the level of underweight children has decreased, it is not a steady gradual decrease over time. 41% of children below five years of age are stunted and 16% are wasted. Fifty-one percent of children between 6–59 months are anaemic and only 35% of women in the lowest wealth quintile are food secure, compared to 90% in the highest wealth quintile.

Situation of persons with disabilities

Comprehensive data on disability and specifically on the situation of persons with disabilities in Bangladesh is still scarce. From the Bangladesh Bureau of Statistics and the sample vital registration system report from 2010 says that 10.8% of the population are persons with disabilities. Previous studies and surveys have

provided figures on the disabled population from 1.6% by the Government of Bangladesh in 1998, 5.6% by The Innovators, and 13.3–14.4% in a baseline survey made by Action Aid Bangladesh during 1995–97. Due to the use of different disability definitions and a tendency to primarily measure impairments rather than functional and participation limitations, these figures should only be used as indications and not taken as national representative figures.

The most updated international references on disability prevalence are from the WHO, presented in the World Disability report in 2011, considering that globally 15% of the world’s population could have some kind of disability. Looking at the different figures provided, the number of persons with disabilities in Bangladesh could be between 2.4 million up to 21 million persons. Although numbers alone do not provide sufficient information on how to define policies, develop adequate services, or to know the barriers of exclusion and discrimination, but the figures can guide discussions, as will be shown later on in the mapping report.

Together with the survey made by The Innovators in 2005, a Knowledge, Attitude, and Practice (KAP) study on disability was done through a number of focus groups. Questions posed around awareness and access to rehabilitation services indicated at that time a low awareness about availability and usefulness of rehabilitation services, more than 85% of the respondents were unaware about such services in their areas of residence. Equally, very few of the participants interviewed knew about the policies and programs implemented by the authorities and even less regarding what type of support programs or services could be available for persons with disabilities.

1.1 Overview of Bangladesh’s health care system

Upazilla Health Complex is the main health service delivery point at sub-district level in Bangladesh. It has good downward and upward linking to mainstream health services. Under the Upazilla Health complex there are Union Health and Family welfare Centre at Union level, Community Clinic at Ward level, which provides primary health care services to the patients. Complex diseases or health problems, if not manageable to serve, are referred to district level hospitals, and they in turn refer to divisional level Medical Colleges and national reference hospital for specialised treatment:

- Primary health care—Than/Upazila level:
  - Community clinics, satellite units: Village level—minimum care on monthly basis. Health and sanitation awareness.
  - Union Health and Family Centres and Union Sub Centres: Union level—first level of static centres. Minor treatment, awareness and prevention.
  - Thana Health Complex/Upazila Health Complex: Thana/Upazila level. Core of the primary health care system. Serves as referral for union health centre and have an average bed capacity of 30. These centres provide all primary health services and are the first instance for simple diagnostics or specialist referral.

- Secondary health care—Zila (district) level:
  - District hospitals, school health clinics, tuberculosis clinics and urban dispensaries: Provide general medical services but limited diagnostic and laboratory services. Handle referrals from Thana levels and provide both in- and outpatient services. Physical rehabilitation is not present at this level but some district level facilities identify disability and make referrals to other hospitals or organisations.

3. Tertiary care—Divisional level:

- Medical college hospitals: Currently 22 medical colleges and hospitals in Bangladesh, which also function as teaching hospitals. These provide a wider range of specialists and better laboratory facilities for the treatment of more difficult and complicated diseases. Among these 22, there are some with available rehabilitation services for example Dhaka Medical College, Rajshahi Medical College. In addition to government-run colleges, there are about 30 private medical colleges in Bangladesh.

- National referral specialist hospitals: NITOR in Bangladesh has rehabilitation services for orthopaedics and Bangabandhu Sheikh Mujib Medical University provides rehabilitation services for neurological problems. Technicians, under the management of rehabilitation doctors, generally run these services.

1.2 Physical rehabilitation

There is no official definition or strategy of physical rehabilitation as a discipline among other health services neither in Bangladesh National Health Policy 2011 nor in the Health, Population and Nutrition Sector Development Program (HPN) 2011–2016. Historically, acute physical rehabilitation has almost been absent under the Ministry of Health and Family Welfare (MoHFW) whilst long-term rehabilitation has been provided under the Ministry of Social Welfare (MoSW) and NGOs. There is a lack of coordination between these health and social welfare services.

Only very limited data is available regarding types of impairments and needs in the different administrative regions of the country. Hardly any prevalence or incidence of disabling diseases and/or trauma are available and the lack of disability disaggregated data in both health and social sector constitutes an important challenge. Knowing that many villages and towns are short of basic infrastructure and often situated far from health services, combined with inaccessible transportation means, suggest that chronic impairments and consequences of trauma will be disabling in such difficult environment.

A rough idea about the needs for physical rehabilitation can be drawn from estimated prevalence of some diseases in other countries, but there is a need for more robust studies and data to have a better understanding of the specific situation in Bangladesh:

- Prosthetic and Orthotic (P&O) devices and related rehabilitation services: WHO and International Society of Prosthetics and Orthotics (ISPO) estimate that 0.5% of the population is in need of Prosthetic and Orthotic (P&O) services, which would represent approximately 750,000 persons in Bangladesh. It requires a production of around 750,000 appliances yearly. To satisfy these needs, ideally, according to ISPO recommendations, around 930 P&O technicians (CAT I and II) and an additional 1300 bench workers (CAT III) should be available across the country.

- Spinal cord injuries: Persons with spinal cord injuries are in need of continuous physical rehabilitation services as well as technical aids. It is estimated that somewhere between 93–174 persons per one million populations might have a spinal cord injury, based on studies in Asia. Persons with spinal cord injuries are in need of continuous physical rehabilitation services as well.
well as technical aids. In Bangladesh this means that between 14,000 and 22,000 persons could be in need of continuous rehabilitation service for improving and maintaining their functioning after their injuries or illnesses. At the moment, the health system does not have the capacity to answer the needs of these patients, leaving them without proper treatment and possibilities to reintegrate into their communities. The Centre for the Rehabilitation of the Paralysed (CRP) made a study on the survival of persons with spinal cord injuries in 2001, which showed that more than 50% of patients passing through the rehabilitation centre died within a five years period. This shows the urgent need for both rehabilitation and community support to persons with disabilities.

- **Cerebral Palsy:** Children with cerebral palsy is another group that benefit extensively from continuous physical rehabilitation services and it is estimated that the prevalence is between 2.12–2.45 per 1,000 live births. Using the crude birth rates from the Bangladesh Demographic and Health Survey from 2011, between 7,187–8,306 children could be born with cerebral palsy each year in Bangladesh. The majority of these children would highly benefit from continuous physical rehabilitation services, including technical aids and specifically orthotic appliances. The ISPO considers cerebral palsy to be the most common disabling condition seen by child health professionals, and suggests a similar prevalence of 2.0–2.5 per 1,000 live births, a prevalence which has remained quite stable over many decades.

- **Stroke, a cerebral-vascular accident,** is another condition that is a leading cause of disability in many countries. Until now there are no surveys on incidence or prevalence of stroke in Bangladesh but a recent study in Non-Communicable Diseases (NCD) highlights that some of the risk factors, such as smoking, diabetes, lack of physical activity (mainly in urban area) and high blood pressure are on the rise. One can therefore assume that there is a rise in the number of persons surviving a stroke and where physical rehabilitation is essential for recovery and reintegration in daily activities, employment or other livelihood activities.

- **Violence and injury** globally cause more than death from HIV, malaria and tuberculosis combined, according to WHO. This is pertinent to Bangladesh, where an improvement in the socio-economic situation will enable people to buy motorbikes and cars resulting in more traffic accidents and other injuries. A lack of appropriate health care, including physical rehabilitation, will hamper the inclusion and participation of victims: for example, amputations left without rehabilitation and appropriate follow-up care, can result in further complications and worse health outcomes and consequently reintegration in society.

These are only a handful of impairments that people can have and where physical rehabilitation plays an important role for restoring functions and removing barriers that supports the access to education, employment and facilitate social inclusion. This kind of data can provide guidance as to what rehabilitation services should be available and/or developed in Bangladesh.

2. **GOVERNANCE AND LEGAL FRAMEWORKS**

This section looks at existing policies in health and social welfare, and more specifically policies on disability and physical rehabilitation.


During the past 3–4 years, a draft of a new disability law has been developed, which was passed in parliament in October 2013 as the Disability Rights and Protection Act 2013. As per the text of the Act, the Disability Rights and Protection Act will require to be enacted by a government circular, following which; there is a plan to update the National Policy on Disability.

Bangladesh was also a signatory to the Asian and Pacific Decade of persons with disabilities (2002–2012) and is a party to the new Asian and Pacific Decade of Persons with Disabilities, 2013–2022, during which the Incheon strategy will monitor the advancement of 10 disability-inclusive development goals aiming at ensuring the rights of persons with disabilities in Asia and the Pacific.

23. http://www.unescap.or.kr/disability. The Incheon Strategy is a pioneering regional framework that will guide national and regional action in the new Decade. It is derived from the experiences of the ESCAP region and based on the principles of the CRPD and comprises 10 specific time-bound disability-inclusive development goals, 27 targets and 62 indicators similar to the MDG structure.


Poverty where the strategy aims to improve both disability prevention and treatment of persons with disabilities. Even if a clear strategy and comprehensive understanding of disability and physical rehabilitation is not defined, it does state the following points:

- **Strengthening the early detection of disabilities,**
- **Provide primary medical rehabilitation,**
- **Appoint trained doctors, nurses and caregivers to deal with persons with disabilities,** and support services of assistive devices and equipment at health centres.

**Health**

The Ministry of Health and Family Welfare 2011–2016 Strategic Plan does not describe any aspect of developing the physical rehabilitation system. There is a paragraph on persons with disabilities, recognising their difficulties in accessing health care and the overall socio-economic challenges they face, but it does not specify anything on their right to physical rehabilitation. The only section of the strategic plan where rehabilitation is mentioned is under Non-Communicable Diseases (NCD), which says that actions are required that span from primary prevention to treatment and rehabilitation. Improved resource allocation for the most marginalised groups, including persons with disabilities is mentioned as a priority.

**Social protection and safety nets**

The Ministry of Social Welfare (MoSW) is the ministry responsible for disability and for ensuring the implementation of the CRPD and national legislation on disability. In addition there are two further government bodies that officially cater to the needs of people with disabilities: the Department of Social Services and the National Foundation for Development of the Disabled Persons. A National Monitoring Committee was set up after the ratification of the CRPD and consists of representatives of other ministries and Disabled People’s Organisations (DPOs). To date


29. http://www.unescap.or.kr/disability. The Incheon Strategy is a pioneering regional framework that will guide national and regional action in the new Decade. It is derived from the experiences of the ESCAP region and based on the principles of the CRPD and comprises 10 specific time-bound disability-inclusive development goals, 27 targets and 62 indicators similar to the MDG structure.


31. Article 45 Paragraph 1 of the CRPD, May 2010.
Physical rehabilitation remains underdeveloped as a priority within these government bodies. The MoSW provides various services and social safety nets, including cash allowances for people with disabilities. This includes:

- **Social service facilities**: 84 government hospitals have social service facilities, with the main aim of supporting the most vulnerable through providing treatment free of cost.

- **Education** for children with disabilities: run by the government: 64 integrated schools for children with visual impairments exist in 64 districts and, alongside five special schools for children with visual impairments in five divisional cities (Dhaka, Chattagram, Rajshahi, Khulna, Barishal); 100 schools for basic education and vocational training for children with intellectual disabilities exist; seven educational institutes for children with speech and hearing impairments.

- **Employment and Rehabilitation Centre** for Physical Handicap—this is a training and employment centre under the MoSW especially for persons with physical and sensory disability. It provides training, employment, and rehabilitation.

- **Programmes** providing interest-free loans for women affected by acid burns and people with disabilities and distributing awareness posters.

- **Allowances** for elderly persons with disabilities: 350 taka monthly; educational stipend for students with disabilities according to their class (e.g. monthly rates include: primary level 300 taka, secondary level 450 taka, higher secondary level 600 taka and university level is 1000 taka).

### 2.1 Disability policies

As mentioned previously, the first time persons with disabilities received statutory recognition of their rights was with the Disability Welfare Act in 2001. Although amended in 2008, the 1995 policy has not been further revised to ensure compatibility between the Act and Policy. In 2006 a five-year National Action Plan on Disability was approved (2006–2011), which set up the procedures for implementing the Disability Welfare Act. Once the CRPD and its Optional Protocol were ratified in 2007, it became clear that the Disability Welfare Act and the National Action Plan were not fully in-line with the principles and articles of the CRPD. The UN Committee on the Rights of Persons with Disabilities conducted an analysis of the Bangladesh legal framework on disability, as compared with the CRPD clearly indicating the need for a revision.

In 2009, the Government of Bangladesh set up a committee for drafting a new disability Act, the Disability Rights and Protection Act 2013, which has been widely circulated and prepared in a participatory manner and was finally passed in the Parliament in October 2013. As stated earlier, this Act requires to be enacted through a government circular before it becomes effective. Section 8 of the Act describes the access to habilitation and rehabilitation:

- Adoption of family or community based rehabilitation and encouragement of private initiatives,
- Measurement, using defined methods, physical, sensorial and intellectual growth,
- As required, establishment of a considerable number of institutions to ensure institution based rehabilitation for persons with disabilities, especially those with intellectual disabilities deprived of special care in their family environment; take measures to reform existing institutions,
- Set up minimum standards of care per type of disability and take measures on specific methods to develop professional caregivers,
- According to the government policy, take measures to appoint or transfer the parents of children with disabilities who are working in government, non-government organisations, statutory agencies and institutions under local authority to relevant areas where their children are studying, receiving training.

Results from Handicap International’s KAP survey in 2012 suggest that persons with disabilities have not been well informed about protection schemes to which they are entitled. Most schemes are also geared towards financial benefits and less towards access to services.

Annex 3 provides a summary on the legal framework and policies linked to disability in Bangladesh, compiled by UN Economic and Social Commission for Asia and Pacific (UNESCAP).

### 2.2 Physical rehabilitation policies

Physical rehabilitation services in Bangladesh have existed since 1972 with the establishment of the NITOR. This is an orthopaedic hospital and undergraduate & post-graduate training institute, situated at Sher-e-Bangla Nagar, Dhaka, Bangladesh. It was established after the liberation war of Bangladesh, and is the first rehabilitation institute in the country. It is surrounded by many other specialised hospitals, such as the National Institute of Cardiac and Vascular Disease, the National Institute of Ophthalmology, National Institute of Kidney Diseases & Urology and the National Institute of Mental Health. However, there has been a quite slow development of the physical rehabilitation sector until the past few years. Recently there is more interest from the government to start regulating and investing more in physical rehabilitation. Non-Governmental Organisations (NGOs) and charities have so far been the most active in developing and providing physical rehabilitation, often with financial support from international donors and organisations, but these few organisations cannot cover the vast existing needs in the country.

A key dilemma for these types of services to be further developed is the lack of a clear policy, which would make physical rehabilitation a discipline fully recognised as a health discipline and part of the social service sector. There is no description of physical rehabilitation services in the Health Strategic plan; there are only general paragraphs on the need for rehabilitation, mainly linked to deafness, Autism and Non Communicable Diseases. On the other hand, while the mapping could not access the key strategies and policies of the Ministry of Social Welfare, the feedback from interviews and workshops show that here has been a recent investment, supported by World Bank funding, in setting up so called Integrated Disability Service Centres at district level. More about this project will be described in chapter 3.

### 2.3 Participation of persons with disabilities in policy making

Participation of persons with disabilities in policy making has developed and improved in the past decade in Bangladesh and the consultation with representatives of persons with disabilities for the development of the new Disability Rights and Protection Act was wide.

The National Forum of Organisations Working with the Disabled (NFOWD) is a national body of NGOs working in the field of Disability in Bangladesh. NFOWD works in three areas: (a) coordination among its members, (b) raising national level awareness and sensitization on disability issues, and (c) policy advocacy and lobbying work, and its principal working relationship is with the government of Bangladesh. As such, over the years it has gained the reputation and recognition within the country as an example of an interface between the government and the NGOs in this field.

Despite this, there is concern about the lack of initiative of the National Monitoring Committee and the Districts Disability Committees (in 64 districts).
who are considered to work in an ad hoc manner and without real representation of persons with disabilities. Civil society organisations were not satisfied with this, and therefore created their own national Disability Rights Watch Group in 2009, to follow-up the implementation of the CRPD. They released their first Disability Watch report in 2010; an alternative assessment to the Government’s report on the CRPD to the UN Committee on the Rights of Persons with Disabilities.

2.4 Regulatory framework of physical rehabilitation service delivery

A regulatory framework can be defined as a set of interrelated instruments meant to control, coordinate and improve the provision of public services, in this case, physical rehabilitation services. Such instruments and frameworks should be defined and ultimately supervised by central authorities but can be implemented and monitored by either central and/or local authorities or agencies mandated to do so. This framework could regulate: (a) the demand for, and access to, services, (b) the supply of these services by various providers, and (c) the actual provision of physical rehabilitation services.

This mapping exercise involved several of the key stakeholders that are concerned about regulating and improving the access to physical rehabilitation services in Bangladesh. Due to the political disruptions in the country which affected large meeting plans, the mapping exercise was split into four separate workshops with specialised groups consisting of the following: DPOs and service users, Government and NGOs/NGOs, Rehabilitation Professionals and Associations (Annex 1–2). Further clarification was made through personal interviews ranging from telephone to face-to-face meetings.

For the physical rehabilitation sector, there are very few regulations in place; the sector is mostly unregulated (table 1). Until now, the majority of physical rehabilitation services have been provided and funded by international and national NGOs and made available in parallel to the MoHFW and MoSW. Only recently, a World Bank funded project in the MoSW is piloting 68 Integrated Disability Service Centres (IDSCs) in 64 districts. These centres provide both information and rehabilitation services and function as a resource for persons with all types of disabilities. It is also planned that they will facilitate income-generating activities for persons with disabilities (see chapter 3.2).

Table 1 provides an overview of the situation in Bangladesh regarding some key regulatory mechanisms that are necessary to have in place to ensure a fair and equitable access to physical rehabilitation services.

3. DELIVERY OF PHYSICAL REHABILITATION SERVICES

Service delivery, one of the most important pillars of access to health, requires that sufficient services, of adequate quality and affordable, should be available where people need them. In terms of physical rehabilitation services it means that basic services should be available close to where people live and more comprehensive services at an acceptable distance. As for any other health related service, physical rehabilitation should be available at primary health care level (closely linked to existing CBR and welfare/livelihood programs at community level) where much of the needs can be met. At secondary level, both acute and long-term physical rehabilitation should be offered, and at tertiary level, more comprehensive and specialised physical rehabilitation should be available both in hospitals and specialised national centres. These services should be provided under a clear mandate of the relevant and responsible line Ministries.

One of the central issues regarding physical rehabilitation in Bangladesh is that the sector lacks regulatory mechanisms and a clear framework within which to operate. Neither the MoSW nor the MoHFW have any clear definition of these services in the

<table>
<thead>
<tr>
<th>Regulatory mechanism</th>
<th>Responsible entity</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gate-keeping mechanisms</td>
<td>MoHFW</td>
<td>No centralised system of assessing needs and demands or developing territorial maps of services.</td>
</tr>
<tr>
<td>Evaluation of needs and demands (macro level)</td>
<td>Thana Health Complex</td>
<td>There are no official criteria to access services. People can access physical rehabilitation directly and staff in each centre defines treatment.</td>
</tr>
<tr>
<td>Access criteria to physical rehabilitation services (including orthopaedic devices and mobility aids)</td>
<td>MoSW</td>
<td>There are no official needs assessment guidelines and a lack of proper referral and orientation procedures. Each physical rehabilitation centre or provider gives treatment, or refers to other services based on their own procedures.</td>
</tr>
<tr>
<td>Assessment of individual needs and orientation to services (micro level)</td>
<td>Individual service providers</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Overview of the regulatory system of physical rehabilitation in Bangladesh 2013

58 Munir Ahmed Chowdhury. Member Committee on the Rights of Persons with Disabilities of the UN CRPD.
This mapping concludes that there are very few CBR worker per district\(^{34}\).

- **Centre for Disability and Development**—The CDD and NFOWD program of rolling out CBR in 10 districts in partnership with NFOWD, targeting the lowest level of union councils is planned to strengthening human resource capacity and promoting an inclusive approach to community development. CDD has around 300 partners called Community Based Organisations across Bangladesh. Each of these organisations has a trained community worker, here called Community Handicap and Disability Resource Persons who conducts home visits and Primary Rehabilitation Therapy.

- **Centre for the Rehabilitation of the Paralysed**—CRP is primarily providing specialised physical rehabilitation services in Dhaka, Savar, Chittagong and Barisal and has set-up a CBR network in a number of districts, covering for example reintegration of Rana Plaza victims in Savar, awareness around road safety in Comilla, and access to livelihood in Barishal, Manikgonji and Dhaka, Chittagong and Rajshahi. Around 13 CBR workers are available in these districts.

In Handicap International’s KAP study (2012), persons with disabilities said that information about services was primarily given through neighbours and persons with disabilities, including Community Based Rehabilitation (CBR) programs at this level are implemented by NGOs and charities. It is not clear though how these CBR programs coordinate with local health structures in terms of referral to more specialised care after identification has been done.

Community Based Rehabilitation activities are implemented by, among others, following organisations: CRP, CDD, Bangladesh Protibondhi Kallyan Somity (BPKS), Disabled Rehabilitation and Research Association, Leprosy mission, Lepra international, World Vision, Caritas, Action Aid and CBM. Examples of work of some of these CBR programs are:

- **Bangladesh Protibondhi Kallyan Somity**—BPKS is working through two main structures, Persons with Self Initiation to Development centres and Disabled People’s Organisations to Development. They are active in 32 districts with at least one CBR worker per district\(^{34}\).

- **Centre for Disability and Development**—The CDD and NFOWD program of rolling out CBR in 10 districts in partnership with NFOWD, targeting the lowest level of union councils is planned to strengthening human resource capacity and promoting an inclusive approach to community development. CDD has around 300 partners called Community Based Organisations across Bangladesh. Each of these organisations has a trained community worker, here called Community Handicap and Disability Resource Persons who conducts home visits and Primary Rehabilitation Therapy.

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In Handicap International’s KAP study (2012), persons with disabilities said that information about services was primarily given through neighbours and that the families themselves often made the first identification\(^{35}\). This can delay in many situations the useful start of rehabilitation, provisions of orthopaedic devices or early stimulation for access to educational, as well as finding, or be reintegrated into livelihood opportunities. .

### 3.2 Rehabilitation medicine, therapy and assistive devices

Rehabilitation medicine and therapy span from surgical interventions to acute and long-term therapies such as physiotherapy, occupational therapy or speech therapy. Modifications to the close environment as well as support and counselling is usually also included in physical rehabilitation, and can be important factors for supporting inclusion in daily life activities. Assistive devices, such as prosthetics, orthotics and other mobility aids, are also crucial components of physical rehabilitation and sometimes necessities for going to school or engaging in livelihood activities.

#### Physical rehabilitation at Upazila/Thana level

The result of the mapping shows that there is no comprehensive rehabilitation program except an identification service, which refers to district and divisional levels and specialised level hospitals at primary health care level within the health system, and that most people have to travel to the nearest district hospital or one-stop centre (also at district level) to access some kind of physical rehabilitation service. There are a few NGOs or charities that provide physical rehabilitation through its CBR programs but during this mapping, such level of details could not be reached.

#### Physical rehabilitation at district level

At secondary health care level, which in Bangladesh covers the level of district hospitals at Zila level, few physical rehabilitation services are available. Health care services have minor surgery provision but more complicated health problems are referred to divisional and national level. These hospitals though do not provide any physiotherapy or P&O services. According to the description of services provided at district hospitals, and the type of staff assigned, physical rehabilitation professionals, such as physiotherapists or occupational therapists are not included.
An interesting development is the project implemented by the MoSW, with funds from the World Bank, where so-called Integrated Disability Service Centres (IDSC), also referred to as Jatiya Protibondhi Unnayan Foundation centres (JPUF), have been set up at district level. The funding with the World Bank on this project will continue until 2016.

At this moment 68 centres are functioning throughout Bangladesh. Each such centre should have the following type of professionals employed and as is described below, the staffing is still in process:

- 1 Centre manager—all centres have one manager in place.
- 1 Consultant senior physiotherapist and 1 clinical physiotherapist—each centre has a senior physiotherapist in place but only 34 centres have a clinical physiotherapist36.
- 1–2 Assistant physiotherapist—120 assistant PTs are currently in place.
- 1 Clinical occupational therapist—only three OTs are currently in place due to lack of trained professionals.
- 1 Clinical speech and language therapist—only one speech and language therapist is employed due to lack of trained professionals.
- 1 technician for vision test (ophthalmologist)—60 low-level technicians are in place but no ophthalmologists are yet available due to lack of trained professionals.
- 1 technician for hearing test (audiologist)—60 low-level technicians are in place but no audiologists are yet available due to lack of trained professionals.
- 1 Accountant—50 accountants are in place and the rest are supposed to be hired based on governmental quota.
- 1 office assistant—68 office assistants are in place.

Rehabilitation professionals are equally working in a number of NGOs across Bangladesh. Some specialized government hospitals at national level have posts for rehabilitation professional, such as PTs and OTs, but other medical professionals sometimes hold those posts. Table 2 presents a situation where the vast majority of physical rehabilitation professionals are working in the NGO and charity sector and where the governmental services are almost absent in this field.

As these centres are at district level it is difficult for persons with disabilities living far from the centres to access the services, both due to their socio-economic situation and inadequate transport facilities. For that reason, the IDSCs plan to start 32 mobile clinics using adapted buses, equipped with therapeutic equipments. Each mobile therapy van will cover two districts and will focus on children with disabilities, referral linkages to district level IDSCs and raising awareness on disability.

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### Table 2: Organisations and hospitals providing physical rehabilitation in Bangladesh 2013

<table>
<thead>
<tr>
<th>Name of organisation</th>
<th>PT</th>
<th>OT</th>
<th>P&amp;O</th>
<th>SLT*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Against Hunger</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apollic Hospital</td>
<td>7</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autistic well fare foundation</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Bangladesh Protibondhi Kollan Somity</td>
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<tr>
<td>Bangladesh Medical and Research Council</td>
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<td>Bondhu Kollan Foundation</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beautiful mind (school for children with autism)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidzee international school(schools for children with autism)</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LAMB hospital—Integrated Rural Health and Development</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practical Action Bangladesh</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proyash (school for children with autism)</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shishu polli plus (the Sreepur Village Bangladesh)</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Society for the Welfare of autistic children</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sylhet private clinic</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>United Hospital, Dhaka</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>323</td>
<td>83</td>
<td>37</td>
<td>19</td>
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</tbody>
</table>

**Table**

<table>
<thead>
<tr>
<th>Name of organisation</th>
<th>PT</th>
<th>OT</th>
<th>P&amp;O</th>
<th>SLT*</th>
</tr>
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<td>Bangladesh University of Health Sciences</td>
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<tr>
<td>Centre for the Rehabilitation of the Paralysed</td>
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<td>4</td>
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<tr>
<td>Disabled Rehabilitation and Research Association</td>
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<td></td>
<td></td>
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<tr>
<td>Endolite Bangladesh</td>
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<td>Handicap International</td>
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<tr>
<td>Hope for Life</td>
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<td></td>
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<tr>
<td>International Centre for Diarrheal Disease Research Bangladesh</td>
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<td></td>
<td></td>
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<tr>
<td>Integrated Disability Service Centres (working in 64 district)</td>
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<td>3</td>
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<td>Jivita Bangladesh</td>
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</tr>
<tr>
<td>BRAC Limb and Brace Centre (Dhaka)</td>
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<td></td>
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<tr>
<td>Dynamic Limb Centre</td>
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<td></td>
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<tr>
<td>Save the Children</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Society for Assistant to Hearing Impaired Children</td>
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<td></td>
<td></td>
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<tr>
<td>Social Service institute</td>
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<tr>
<td>Social Assistance and Rehabilitation for the Physically Vulnerable</td>
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<tr>
<td>Tauni foundation (school for children with autism)</td>
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<td></td>
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<tr>
<td>Christian Medical College and Hospital</td>
<td>1</td>
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<tr>
<td>Nalta Hospital</td>
<td>1</td>
<td></td>
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</tr>
<tr>
<td>Danish Bangladesh Leprosy Mission</td>
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<tr>
<td>Modern Limb Centre</td>
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<td>Impact foundation</td>
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<tr>
<td>International Committee of the Red Cross</td>
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<tr>
<td>Kidzee international school(schools for children with autism)</td>
<td>1</td>
<td>1</td>
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<tr>
<td>LAMB hospital—Integrated Rural Health and Development</td>
<td>1</td>
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<tr>
<td>Practical Action Bangladesh</td>
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<tr>
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<tr>
<td><strong>Total</strong></td>
<td>323</td>
<td>83</td>
<td>37</td>
<td>19</td>
</tr>
</tbody>
</table>

SLT—Speech and Language Therapist

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36 One reason for the lack of recruitment is there is a government quota to have employed in each post 5% of staff to be freedom fighters or persons with disability. The availability of this quota to be qualified at many of these posts is limited.
Physical rehabilitation at divisional and national level
At tertiary health care level, located at divisional and national level, there is only NITOR that provides specialised physical rehabilitation services in Bangladesh today under the government scheme. In addition, a few NGOs have P&D production units, for example CRP, CDD, BRAC Limb and Brace Centre, LAMB Hospital, Nilphamari Leprosy Mission. This service is subsidised depending on client funding availability. On the other hand some P&D devices are available in the local market mostly imported from China. At national level, mainly in Dhaka, there is private P&D device productions but they are costly and rarely accessible for majority of persons with disabilities.

4. HUMAN RESOURCES IN PHYSICAL REHABILITATION
Physical rehabilitation professionals are an integral part of human resources for health, and at the same time closely linked to the social and vocational sectors. While this report puts the emphasis on the health and social sector, the need for professionals in the vocational and education sector is also important to meet all the rehabilitation needs of persons with disabilities (including them in education and the workforce). Physical rehabilitation is a pre-condition for many people to access education and employment and, for example, physiotherapists or speech and language therapists have an important role in schools and vocational training institutions.

Improving the availability, accessibility, accountability and quality of rehabilitation services is largely dependent on ensuring the rehabilitation workforce exist, is adequately prepared and mobilised. WHO World report in 2006 is looking at the development of the health workforce in a life span perspective, which covers both the workers perspectives and the policy and governance through state actions35.

Entry: planning, preparing and producing the required workforce through strategic investments in education and effective and ethical recruitment practices.

Workforce: enhancing worker performance through better management of workers in both the public and private health sectors, this includes adequate financial planning to ensure retention of trained health workers and human resource information management systems to make rational human resource allocation decisions.

Exit: managing migration and attrition to reduce wasteful loss of human resources.

This mapping has not done a detailed analysis of the whole process from entry to exit, but it does provide relevant information on key perspectives and highlights gaps that need to be further investigated. The data presented in this chapter is gathered from the few available documents on the topic and from interviews with professional associations and DPOs as well as information provided by key actors participating to the national workshop (Annex 1–2).

4.1 Training of physical rehabilitation professionals
The types of physical rehabilitation professionals included in this mapping are doctors, physiotherapists (and assistants), occupational therapists (and assistants), Prosthetic and Orthotic technician and CBR workers. Ideally there are other professional groups that should be involved in physical rehabilitation, such as speech therapists, social workers or counsellors as well as specialised nurses. This mapping has concentrated on the first groups of professionals, in order to provide some solid recommendations on starting to regulate the sector and defining the first steps of a policy or action plan.  

Doctors specialised in physical rehabilitation
There are 200 doctors specialised in physical medicine. These have completed five years MBBS (Bachelor of Medicine, Bachelor of Surgery) plus the Fellow of the College of Physicians and Surgeons for five years. Bangabandhu Sheikh Mujib Medical University runs this course.

Physiotherapists
The very first physiotherapy training in Bangladesh was set up in 1973 at the National Orthopaedic hospital but only two groups ever graduated. It was not until 1994 that a more sustainable training was initiated at the Bangladesh Health Professions Institute (BHIPI) in affiliation with Dhaka University. Later on, other institutes also started to offer training courses in physiotherapy, and today there are in total six training institutes providing recognised physiotherapy courses with Bachelor of Science or diploma level (table 2.). On an average, 465 students are admitted annually to study physiotherapy at different levels.

A Bachelor of Science in physiotherapy is a five years course, including one year of internship while diploma level course runs for four years, including one year of internship. In NITOR, where physiotherapy courses are conducted, and which is the only governmental institute for training rehabilitation professionals, only one full time physiotherapist is working as a course coordinator, other physiotherapists (5 or 6) are working as guest lecturers and are not government employees.

The Bangladesh Physiotherapy Association has registered around 1,300 physiotherapists as currently active, a majority of them (80%) in urban areas while only 20% are supposedly working in more rural settings, mostly with NGOs. The distribution of these physiotherapists among the public and the private sector reflects well the situation of an almost absence of physical rehabilitation in the health sector, only 10% are estimated to work in governmental structures, 60% in private sector and the remaining 30% works with different NGO and charities. According to the information provided during the mapping, salaries in the private sector for a physiotherapist can be up to five times higher than in the public sector. Many physiotherapists, an estimated number of 200, are working as private practitioners mainly in Dhaka city, in private clinics or their own private chamber

While the number of training institutes is growing and more and more physiotherapists graduate, the training of professionals for a country with a population of 150 million is very limited. A majority of the training institutes are based in Dhaka, which could surely pose a problem of recruiting students from other regions of the country, and to ensure that they return and find work in their original areas.

Physiotherapy assistant is another category that is still being trained in Bangladesh but only BHIPI provide this course currently. It is a two-year training with lower entry-level criteria, and around 20 students graduate annually. This mapping estimates that around 600 physiotherapy assistants are working in the country, the majority of them in urban settings.

Occupational therapists
The profession of occupational therapy was initiated at the same time as physiotherapy at the National Orthopaedic hospital in 1973, but was equally discontinued after two generations had graduated. In 1995, the BHIPI re-started occupational therapy training and today they offer three course levels: Bachelor of Science, which is a five year course, including one year internship; Diploma level, which is a four years course, including one year internship; and an assistant level course, which is an 18 months training course, given based on needs of organisations. The Bangladesh Occupational Therapy Association has around 150 members, and it is supposed that all of them are actively working in the country. The vast majority are employed in the NGO sector, which is probably due the lack of physical rehabilitation services in the public sector so far.

Palna Mental Hospital is the largest public psychiatric hospital in Bangladesh and it has nine occupational therapist posts but at this moment unqualified therapists fill these posts. Moreover, a number of occupational therapists also left the country, the association estimates that around 30 graduates are now working abroad.

Speech and Language Therapists
This is a very new profession in Bangladesh and the BHIPI (affiliated with Dhaka University) is the only
BSc course teaching this. The course was established in 2003 and there are currently 33 graduates plus another 101 in various years of study. The Bangladesh Speech and Language Therapy Association is also very new and its constitution is being developed as a preparation for registration.

**Prosthetic and Orthotic technicians**

There are very few P&O technicians in Bangladesh, as there is no accredited training for this in the country. **Only 18 P&O technicians** CAT II were identified, and all of them have studied abroad, for example in India or Vietnam. Most of these P&O technicians are working in Dhaka, in the few workshops available such as the CDD, CRP; and NITOR and ICRC centres and some workshops are available in other districts.

There are also around 60 bench workers working in Bangladesh, most of them trained by NGOs that provide on-the-job trainings in their workshops. These figures shows an important shortage of P&O professionals in the country, and BHPI are planning to start a P&O on-the-job trainings in their workshops. These figures shows an important shortage of P&O professionals in the country, and BHPI are planning to start a P&O workshop in Dhaka. In the centres that they are funding.

**Community Based Rehabilitation**

A national CBR Strategy is under preparation, lead by National Forum of Organisations Working on Disability (NFOWD). Consultation meetings with different stakeholders are ongoing and should be finalised by mid 2014.

### Table 3: Prosthetic and Orthotic workshops in Bangladesh 2013

<table>
<thead>
<tr>
<th>P&amp;O workshops</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>NITOR</td>
<td>Dhaka</td>
</tr>
<tr>
<td>Centre for Disability and Development</td>
<td>Dhaka</td>
</tr>
<tr>
<td>Centre for the Rehabilitation of the Paralysed</td>
<td>Dhaka</td>
</tr>
<tr>
<td>ICRC P&amp;O centre</td>
<td>Dhaka</td>
</tr>
<tr>
<td>Brail Press and Artificial Limb Centre—MoSW</td>
<td>Tongi, Dhaka</td>
</tr>
<tr>
<td>Christian Memorial Hospital—private</td>
<td>Chittagong</td>
</tr>
<tr>
<td>Endolight Bangladesh—private</td>
<td>Chittagong, Sylhet, and Dhaka</td>
</tr>
<tr>
<td>Bangladesh Rural Advancement Committee—NGO</td>
<td>Moynemensing, Dhaka</td>
</tr>
<tr>
<td>Nalta Hospital—private</td>
<td>Sathishira, Khulna</td>
</tr>
<tr>
<td>Danish Bangladesh Leprosy Mission</td>
<td>Nilphamari</td>
</tr>
</tbody>
</table>

CBP, CDD and BPKS are disability related NGOs who conduct CBR-related courses. The course curriculum is not affiliated to any government authority. Mainly those organisations are conducting/producing these type of community workers to fulfil needs in the vicinity of their organisational working areas. As per collected data the following has been found. There might also be other organisations (NGO/INGO) may provide their own in house community corder courses at a smaller scale that have not been captured during this mapping:

### Table 4: Examples of CBR training courses in Bangladesh 2013

<table>
<thead>
<tr>
<th>Name of organisation</th>
<th>Name of course</th>
<th>Duration</th>
<th>Completed till date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDD</td>
<td>Community Handicap and Disability Resource Person Certificate</td>
<td>90 days course, 6 month practical, 10 days refresher</td>
<td>800</td>
</tr>
<tr>
<td>CRP</td>
<td>Community Rehabilitation Technician course</td>
<td>2 years (1 year theory, 1 year practical)</td>
<td>Approx 75</td>
</tr>
<tr>
<td>BPKS</td>
<td>Grassroots Therapy Providers</td>
<td>3 months course</td>
<td>Approx 50</td>
</tr>
</tbody>
</table>

### Table 5: Overview of training schools of physical rehabilitation professionals in Bangladesh 2013

<table>
<thead>
<tr>
<th>Profession admission</th>
<th>Training school</th>
<th>Program and degree</th>
<th>License</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHIPI Dhaka</td>
<td>BSc in physiotherapy</td>
<td>5 years incl. 1 year internship. Diploma in physiotherapy: 4 years incl. 1 year internship Physiotherapy assistant: 2 years</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>NITOR, Dhaka</td>
<td>BSc in physiotherapy</td>
<td>5 years incl. 1 year internship</td>
<td>35</td>
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</tr>
<tr>
<td>People's University of Bangladesh, Dhaka</td>
<td>BSc in physiotherapy</td>
<td>5 years incl. 1 year internship</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Institute of Health Technology, Dhaka, Chittagong, Rajshahi, Khulna, Sylhet, Barisal and Bogra</td>
<td>3 year diploma course in seven divisional level institutes</td>
<td>175 (25 from each institute)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BHIPI Dhaka</td>
<td>BSc in occupational therapy</td>
<td>5 years incl. 1 year internship</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>People's University of Bangladesh, Dhaka</td>
<td>Degree: Bachelor in Speech &amp; Language therapy</td>
<td>5 years incl. 1 year internship</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>BHIPI, Dhaka</td>
<td>Degree: Bachelor in Speech &amp; Language therapy</td>
<td>None</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

66 MAPPING REPORT OF PHYSICAL REHABILITATION SERVICES

67 BANGLADESH
Summarising the analysis of the existing situation of educational programs for physical rehabilitation professionals provides evidence for the need to scale up training capacities and, preferably, to look into a de-centralisation of training opportunities. Current training programs cannot provide the necessary rehabilitation professionals required to cover the needs of physical rehabilitation and assistive devices of persons with disabilities in Bangladesh.

Another challenge that the sector faces is to recruit students from other provinces or districts outside of Dhaka, something that would increase the chances that people come back and work in their home provinces. While it is debated whether or not to train physiotherapy assistants (which is a shorter training), it could be an option to expand such shorter training in other areas of the country, as it is often easier to implement, is less costly and can have great impact at local level, for example if rehabilitation is introduced at Thana Health complexes or secondary health care level hospitals. However the risk is that these assistants might lack proper and necessary supervision by fully qualified therapists and hence dilute and damage the reputation of the professions.

5. CONCLUSION AND RECOMMENDATIONS

In line with WHO’s recent project of defining guidelines for rehabilitation, the interpretation of the mapping outcomes and suggestions for moving forward are presented in relation to the key criteria for ensuring an equal access to physical rehabilitation services for persons with disabilities, and others in need for such services in Bangladesh.

### 5.1 Availability

**Availability** refers to having functioning and sufficient physical rehabilitation services in a balanced and equitable geographical distribution. Services should also strive to answer to the diversity of needs for services, i.e. age, gender, type of impairment etc. There must also be a long-term strategy of ensuring sustainability of services, financial as well as in terms of quality, including staff availability and adequate competence.

As the mapping outcomes show even though there is a number of physical rehabilitation centres available in Dhaka, there is an important shortage of services in many districts, especially in rural areas. Physical rehabilitation is practically absent from at primary and secondary health care level and even tertiary health care rarely have physical rehabilitation included as a service at hospital level. Only a handful of specialised hospitals and clinics offer this in Dhaka, such as NITOR, CRP and CDD.

Starting from the community, while there are some CBR programs (which was also highlighted as an opportunity in the mapping) implemented by NGOs in a number of districts, there is a lack of accessible services providing physical rehabilitation to where people can get properly referred. Feedback from DPOs during the mapping process suggests that lack of transportation means, lack of economic means and also lack of information around such services are important obstacles to receive such services. On the other hand, decision-makers and professional associations added to this feedback that there is a lack of human and material resources for providing services at community level. NGOs consider that their funds are not enough and that project based funding may interrupt well functioning services for the rural population. Having said this, the health system does have structures and centres down to Upazila level, which brings about opportunities to introduce physical rehabilitation, or at least raise the awareness of professionals to refer children and adults with disabilities to such services.

At district level, the establishment of the IDSCs is an important advancement that has improved accessibility especially because they have a mandate to address multiple needs of persons with disabilities, and are able to provide basic physical rehabilitation treatment. The lack of physical rehabilitation staff in district level hospitals is a concern but the very existence of these hospitals is an opportunity to reach a better coverage of rehabilitation if rehabilitation units are developed later on. A physiotherapist and/or occupational therapist could be integrated into the medical team, and could provide acute and chronic care plus technical support and referrals to CBR programs, the IDSCs as well as referrals for more specialised treatment such as P&O services etc.

The development of therapy in these hospitals can also address the preventative side of rehabilitation i.e. working in the acute setting helping to prevent disability which often occurs as a secondary complication to many conditions such as fractures, post surgical complications etc.

An additional important challenge that was highlighted during this mapping, and equally identified in Handicap International’s KAP study from 2012, is the lack of awareness among persons with disabilities and their families about the availability and importance of physical rehabilitation.

There is also a large network of DPOs in the country, some of which provide basic rehabilitation therapy via community workers, though very few provide more comprehensive therapy via a part time qualified therapist.

**Suggestions for moving forward**

- Establish a physical rehabilitation task force/working group to define a physical rehabilitation strategy, including the key actors of the physical rehabilitation sector: MoHFW, MoSW, rehabilitation hospitals and centres, professional associations, DPOs, international and national NGOs involved in the disability and rehabilitation sector and representatives of CBR programs.

- Such strategy has to define the key elements of making sure that services are available as close as possible to the home of persons with disabilities:
  - CBR programs should be further developed to cover all districts using NGOs and the extensive DPO networks throughout the country.
  - Basic physical rehabilitation should be integrated at primary, secondary and tertiary health care structures. This is linked in with acute physical rehabilitation services to be under the umbrella of the Ministry of Health.
  - Awareness raising of rehabilitation and the importance of therapy should be integrated into medical and nursing college curricula. A referral system between all levels of rehabilitation services from grass root CBR to tertiary level should be defined.
  - Location of service providers (especially rehabilitation services) should be made so that all levels of actors from community to tertiary systems are aware of what is available and where.
  - Minima quality standards for each level of service should be defined.
  - Coordination and responsibilities of key ministries should be well defined. Information and monitoring system should also be developed, linked to already existing health and social monitoring mechanisms.
  - Financial and technical resources to implement the strategy/action plan should be clearly defined.

- A more in-depth study on the availability of rehabilitation professionals should be made, covering both private and public sectors. Based on the findings, a coordinated human resource development plan should be planned among the relevant line ministries. Make sure to include provincial divisional and district health authorities. Assessment of possibilities to conduct training in other provinces should be studied, with the objective of recruiting personnel from more rural districts. This can ensure a better geographical coverage of rehabilitation professionals and willingness to work outside of Dhaka.

- CBR programs should become officially included within a ministry, most probably the MoSW. This could improve funding of programs and only with such endorsement; these programs could be rolled out on a national scale. An official CBR training curriculum should be standardized and developed plus coordination should be strengthened among government and non-government actors within health, education, employment, and social welfare.

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29 Handicap International. KAP survey. Attitudes and awareness around physical rehabilitation in Bangladesh, Orissa [India] and Sri Lanka, October 2012.
5.2 Accessibility

Accessibility implies that services can be reached and used by the person who needs them. It has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability), and information accessibility.

Disabled People’s Organisations defined three key obstacles to accessing physical rehabilitation at community level:

1. Poverty, the economical situation of persons with disabilities and their families is very low and the cost for transport, accommodation, and medicine, are often preventing people from accessing needed services, even if they are aware about their availability.

2. The information about the benefits that physical rehabilitation and assistive devices can bring to people is not easily available or understandable. Health staff and traditional healers in the communities often have no knowledge on rehabilitation or disability and do not explain the situation so that people can understand and actually act.

3. Poor infrastructure and lack of accessibility at community level coupled with a social and cultural environment that often discriminates against persons with disabilities make access to services more difficult. This also affects the self-confidence of people and can increase their isolation.

Physical rehabilitation service providers and representatives of decision-makers considered that the key obstacle was the scarcity of funds and technical and human resources. They also mentioned that the absence of a policy and strategy hinders the development of the sector.

Despite the difficulties described, facilitating elements to improve access to services were also identified. DPOs and community organisations highlighted the increasing number of self-help organisations and groups and an increased focus on inclusive development by mainstream NGOs and international donors. The availability of some good quality physical rehabilitation services in Dhaka was also highlighted as an opportunity for further development.

Disabled People’s Organisations defined the lack of physical rehabilitation at primary health care level as a major obstacle to access services close to where they live. This contributes to the late identification of disability, registration and support, which could prevent or delay the recovery and restoration of function for many persons with disabilities. On one hand, there is a lack of awareness among persons with disabilities and/or their families about their rights to health and social services, including the benefits of physical rehabilitation. The limited availability of physical rehabilitation services in many rural areas implies long travel distances, which has an important impact on many persons with disabilities that already have a difficult socio-economic situation.

Where public and NGO-provided services are available, they are in some cases provided for free, or at a minimal cost depending on the economic situation of the beneficiary and based on criterion such as income level and present assets. Some assistive devices and technical aids have to be paid for by the individual though there are cases when these also are subsidized dependant on the economic situation of the client.

Representatives of the professional associations and decision makers in turn consider that the poverty most persons with disabilities experiences is the key obstacle for accessing necessary services in both health and social welfare, including access to physical rehabilitation. They also highlight the lack physical rehabilitation within the public health system as a key problem of access. Sigma and negative community attitudes towards persons with disabilities and their families are additional challenges that should be addressed according to decision makers, professionals and service providers.

Suggestions for moving forward

- Train health professionals on disability, rehabilitation and CBR. The increased awareness of health professionals will improve the health care in general for persons with disabilities and facilitate timely and adequate referral where necessary.
- Improve the coordination between the MOSW and the MoHFW both at state and district level. Scarce resources have to be well utilised and the roles and responsibilities of key actors defined.
- Define minima quality standards for physical rehabilitation services, including clear job descriptions for each professional group. Such standards should also include mechanisms for user participation in service delivery and monitoring, as well as ensuring a user centred treatment and service.
- Develop a better understanding of the needs for physical rehabilitation in order to find out how the needs at community level in rural areas can best be addressed. What is the capacity of the CBR programs to be more involved, which physical rehabilitation needs can be identified and answered through trained CBR workers and which needs referral? How best is it to promote qualified therapists to work in the rural areas.
- Increase the awareness of local communities and groups of persons with disability about the benefits that physical rehabilitation can bring and importance of early identification as well as secondary prevention64. It is important though that such awareness comes parallel to increasing the access to services in areas that are not yet covered.

5.3 Accountability

Accountability concerns both the transparency and efficiency of the regulatory framework implemented from authority level, as well as accountability from service providers themselves. It refers not only to financial management of services but also to the overall organisation of the service: clear manuals of policies and procedures, internal regulations, and a qualitative and transparent staff management system, and the active involvement of users in both treatment and service delivery. Key words are: person-centred, user involvement, community partnership, continuity of service and result-outcome oriented.

64 Early identification means to identify early if children, or adults, have impairment where physical rehabilitation and/or assistive devices would have a positive impact on the function of the person. Secondary prevention means that people with disabilities can have need for physical rehabilitation to avoid a worsening of their impairment and thus a more severe disability.
A regulatory framework for physical rehabilitation needs to be developed. Among the key procedures to ensure equal access to these services, only a handful is in place. Therefore the accountability of the government to ensure the right to rehabilitation and health-related rehabilitation, mobility aids and assistive devices, as stipulated in Articles 3, 25 and 26 of the CRPD.

The mapping has not done any qualitative analysis or review of the actual service delivery of the orthopaedic centres or physical rehabilitation centres. It is therefore not meaningful to make any comments on their accountability. It is, however, recommended to make a more in-depth analysis of all physical rehabilitation services in order to see to what extent they are using, or not, similar internal procedures, job descriptions, salary scales, monitoring and evaluation tools as well as logistical processes, purchase procedures and types of materials used. If the line ministries will become more involved in ensuring physical rehabilitation in Bangladesh, it would be important to have such information ready so that it is easy to make calculations and propose funding mechanisms for service delivery that can be assured by the government.

A positive step towards increased accountability is the existence of professional associations. Even if they are still new they are slowly taking a stronger role within the sector and can advocate for the improved working conditions and status of the rehabilitation professionals. Professional associations are also important for promoting ethics and values among professionals and could influence the training programs to introduce user participatory assessment and treatment plans among many other elements.

Similarly, the availability of DPOs and organisations working for the rights of persons with disabilities is another important aspect of accountability. They represent the users and future users and once growing stronger, will be an important third part in developing the physical rehabilitation sector. Until now though, persons with disabilities declared that they are not sufficiently involved in planning and monitoring of services. Their influence both at service provision level and policymaking has been weak until now but the interest to be consulted is strong. There is a need for raising the awareness among persons with disabilities about their rights, and among DPOs on how to advocate and formulate policies in the field of social and medical services, including physical rehabilitation.

Suggestions for moving forward

- Define procedures for implementation of the newly adopted Disability Rights and Protection Act. Pay specific attention to the rehabilitation section.
- The respective line ministries responsible for physical rehabilitation should start to define a comprehensive regulatory framework for the accountability of the physical rehabilitation sector. Key mechanisms to be defined or improved are:
  - Needs assessment and territorial maps of available services41.
  - Minima quality standards and licensing procedures, including processed for user participation in services delivery, monitoring and evaluation as well as complaint mechanisms.
  - Gate-keeping mechanisms, such as entry criteria and list of services that should be available for free or at affordable costs for all persons with disabilities.
  - Monitoring and evaluation system, include disability and physical rehabilitation in both social welfare and health monitoring systems.

54 Needs assessment refers here to analysing the need of services at geographical/administrative levels. 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.
Moving forward

- Include indicators on physical rehabilitation and disability in the Health Management and Information System so that performance can be measured and monitored.
- Train physical rehabilitation providers on quality management and how to define internal procedures.
- Elaborate a consistent human resource plan and budget, for training of physical rehabilitation professionals in accordance with estimations of need. Such plan has to be linked to service needs and supported by budget and future retention policy as well as salary payment planning.

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Protibondy
Chairman

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Secretary

Annex 2.1: List of participants in the workshop

<table>
<thead>
<tr>
<th>Name of participants</th>
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</tbody>
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### Annex 2.2: Consultations for the mapping

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<thead>
<tr>
<th>Name</th>
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<th>Position</th>
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<tr>
<td>Dr. Rajib Hasan</td>
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### Annex 2.3: Country report from UNESCAP on CRPD

<table>
<thead>
<tr>
<th>Country</th>
<th>Bangladesh</th>
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<tr>
<td><strong>Background Statistics</strong></td>
<td></td>
</tr>
<tr>
<td>Human development index rank</td>
<td>129 (1)</td>
</tr>
<tr>
<td>GNI per capita (PPP in US$)</td>
<td>1,587 (1)</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>66.9 (1)</td>
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<tr>
<td>Mean years of schooling (years)</td>
<td>4.8 (1)</td>
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<tr>
<td>Expected years of schooling (years)</td>
<td>8.1 (1)</td>
</tr>
<tr>
<td>Total population</td>
<td>148,692,000 (2)</td>
</tr>
</tbody>
</table>

| **Disability Statistics** |            |
| Population of persons with disabilities | At least 7,000,000 (3,a) |
| Proportion of persons with disabilities to total population | 5.6 per cent (3,b) |
| Employment rate of persons with disabilities | .. (c) |
| Access to education | Access of education for the children with disabilities is less than 4 per cent (4) |

| **Definitions** |            |
| Definition of disability | Disability Welfare Act (2001, sect. 3, para. 1) |
| Definition of persons with disabilities | 'Disability means any person who is physically crippled either congenitally or as result of disease or being a victim of accident, or due to improper or maltreatment or for any other reasons became physically incapacitated or mentally imbalanced, and as a result of such crippledness or mental impairedness, has become incapacitated, either partially or fully; and is unable to lead a normal life.' |

| **Commitment to International Instruments on Disability** |            |
| Ratification of ILO Convention 159 | No 6 |
| Ratification or signatory of the Convention on Cluster Munitions | No 7 |
| Ratification or signatory of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction | Signed Convention on 7 May 1998; Ratified Convention on 6 September 2000 (8) |

| **Legal Framework** |            |

| **Policy Framework** |            |
| Disability-specific laws | Disability Welfare Act (2001) |
| Comprehensive | Rules for distribution of disable allowance |

| **Institutional Framework** |            |
| The national coordination mechanism or disability focal point | National Coordinating Committee under the Ministry of Social Welfare |

Sources:

Notes:
Based on the 2006 National Disability Survey estimate.
Odisha
(India)
1. INTRODUCTION

Odisha state (formerly known as Orissa) is situated at the Indian east coast, by the Bay of Bengal. It is the 9th largest state in India with a population of close to 42.5 million. Over the last decade, the state has witnessed a 14% growth in its population. Most of the population in Odisha is concentrated in the rural areas with the urban population constituting only 17%.

Data from 2009 on the poverty headcount ratio was 57.2%, which is higher than in all other Indian states and considerably above the national average of 37.2%. If factors beyond income are considered (Multidimensional Poverty Index), about 63.2% of the people in Odisha live below the poverty line. Rural poverty, at 60.8%, is also significantly higher than the urban poverty, which is 37.6% and much more prevalent among the lower cast and disadvantaged groups. In terms of other human development indicators such as health, the state faces several challenges. The percentage of women in Odisha with Body Mass Index less than 18.5, which is 41.1, is higher than the national average of 35.6%; and the state's under-five mortality rate of 90.6 per thousand is also among the bottom five. The proportion of underweight children 40.7% however is lower than the national average of 42.5% in India.

Situation of persons with disabilities

Comprehensive data on disability and specifically on the situation of persons with disabilities in Odisha is scarce. From the 2001 census, 2.1% of the population were identified to have some type of disability. This is probably an underestimation if comparing to the latest data presented by the WHO in the World Disability report from 2011, which gives an estimation of 15% of the population to have a disability. It also depends on the disability definition used and how questions were asked as well as the awareness of both enumerators and families on how to identify disability. In the Odisha Health Vision 2010, a figure of 4-5% of the total population having a disability is provided as a reference but apart from the number of In any case, there is no reliable recent data on disability in the state of Odisha.

If defining disability in line with the UN Convention on the Rights of Persons with Disabilities (CRPD) and using the figures of the WHO, the number of people with disabilities could be around 6.3 million in Odisha. Now, numbers alone does not provide sufficient information on how to design policies or to know the barriers of exclusion and discrimination, but some important information can be drawn as will be shown later on.

The Indian health care system has its pillar in community and primary preventive and curative health care, secondary hospitals care and tertiary specialised care but as the figures presented earlier on shows, the Ministry of Health and Family Welfare in Odisha faces important constraints in providing equitable health services to its entire population. Recruitment of qualified and experienced staff is a problem, for covering also the rural territories of Odisha. There are also wide disparities among different populations, where the tribal population's health indicators are far worse than the general population. With the majority of the population living in rural areas, as earlier mentioned more than 80% of the population in Odisha lives in rural areas, this is of course a major difficulty that the Odisha government is trying to address.

1.1 Physical rehabilitation

The need for physical rehabilitation services in Odisha state is not very well defined in terms of understanding the of needs of different rehabilitation services. There is no data available regarding type of impairments and needs in the different regions or districts or the age span of persons with disabilities. Hardly any the prevalence would
or incidence of disabling diseases and/or trauma is available and the lack of disability disaggregated data in both health and social sector constitutes an important challenge. Knowing that many villages and towns are short of basic infrastructure and are situated far from health services, combined with poverty and inaccessible transportation means, suggest that chronic impairments and consequences of trauma will be disabling in such difficult environment.

A rough idea about the needs for physical rehabilitation in Odisha can be drawn from estimated prevalence of some diseases in other countries, although it is necessary to conduct more robust epidemiological and socio-economic studies to have a better understanding of the specific situation in Odisha:

- **Prosthetic and Orthotic devices and related rehabilitation services**: WHO and International Society of Prosthetic and Orthotic (ISPO) estimate that 0.5% of the population in need is of Prosthetic and Orthotic (P&O) services, which is approximately 212,500 persons in Odisha. It requires a production of around 70,000 devices yearly. To satisfy these needs, ideally, around 250 trained Prosthetists and Orthotists (CAT I and II) and an additional 1,200 P&O technicians (bench workers CAT III) should be available across the country.

- **Spinal cord injuries**: persons with spinal cord injuries are in need of continuous physical rehabilitation services as well as technical aids. It is estimated that the prevalence of spinal cord injury is somewhere amid 93-174 persons per one million population, based on studies in Asia might have a spinal cord injury. This means that somewhere between 3,950 and 7,400 in Odisha persons could be in need of continuous rehabilitation service for improving or maintaining their functioning after their injuries. At the moment, the health and social welfare systems do not answer the needs of these persons, leaving them without proper treatment.

- **Cerebral palsy**: children diagnosed with cerebral palsy are in majority in need of continuous physical rehabilitation services. Estimated incidence in different countries is between 2.1 to 4.5 per 1000 live births. Using the crude birth rate data from the 2010 annual health survey, between 1,700-2,040 children could be born with cerebral palsy each year in Odisha. The majority of these children would require from continuous physical rehabilitation services, including technical aids and specifically orthotic appliances. The ISPO considers cerebral palsy to be the most common disabling condition seen by child health professionals, and suggests a similar prevalence of 2.0-2.5 per 1000 live births, a prevalence which has remained quite stable over many decades.


20. Ibid.

21. P&O CAT I is responsible for direct user services and management of orthopaedic workshops, usually at reference centres or training institutions. P&O CAT I advise on the design of devices, and design and production of components of the device and make adjustments as necessary. The P&O CAT may supervise and conduct training and education of other P&O staff and CAT I, if required. P&O CAT II is responsible for direct patient care and provision of services, and management of the orthopaedic workshops if a CAT I professional is not available. The tasks are similar as a CAT I specialist, but they are usually not involved in research and evaluation activities. The P&O CAT II provides and produces services for the more common levels of P&O devices. This is often the highest category of specialist at a mid-term period until CAT I professionals have been trained.

22. WHO and ISPO, 2005. The P&O technician CAT III fabricates and assembles devices and takes part in their maintenance, repair and replacement. The technician is not involved in direct P&O services to the users.


24. Stroke, a cerebral-vascular accident, is another disease that is a leading cause of disability in many countries. More than 80% of global deaths from stroke occur in low- and middle-income countries and it is estimated that the rate of stroke mortality will increase even faster in these countries in the coming years relative to high-income countries. Until now there are no surveys on incidence or prevalence of stroke in Odisha but cardiovascular diseases have been defined as a rapidly emerging challenge in India due to longer life expectancy, increasing prevalence of diabetes as well as change in life styles. Stroke is today among the 10 most common death causes in Odisha. Many stroke survivors will need physical rehabilitation, which is often essential for recovery and reintegration in daily activities, employment or other livelihood activities.

25. Violence and injury globally cause more death than HIV, malaria and tuberculosis combined, according to WHO. With poverty rates reducing and increasing economic opportunities, more people in India, and equally in the state of Odisha, will have access to vehicles and motorbikes which certainly will lead to higher number of traumatic injuries, of which many can lead to temporary or permanent disabilities. A lack of appropriate health care including medical rehabilitation, will hamper the inclusion and participation of the persons: for example, the amputation of one extremity of a person, which is not followed-up with adequate rehabilitation and social support, can result in further complications and worse health outcomes and consequently reintegration in daily life and society.

These are only a handful of impairments that people can have and where physical rehabilitation plays an important role for restoring functions and removing barriers that hinder the access to education, employment and facilitate social inclusion. This kind of data can provide guidance as to what rehabilitation services should be available and/or further developed in Odisha.

2. **GOVERNANCE AND LEGAL FRAMEWORKS**

This section looks at existing policies in health and social welfare, and more specifically policies on disability and physical rehabilitation.

India has developed a number of policy document related to health, social welfare and also disability. India ratified the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2007 and has a disability rights act in place since 1995, the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full participation) Act. India was also a signatory to the Asian and Pacific Decade of persons with disabilities (2002-2012) and is a party to the new Asian and Pacific Decade of Persons with Disabilities, 2013-2022, during which the Incheon strategy will monitor the advancement of 10 disability-inclusive development goals aiming at ensuring the rights of persons with disabilities in Asia and the Pacific.

An analysis of the key documents related to poverty reduction and human development as well as the overall health and social welfare policies shows that disability is still often considered as a welfare issue, not yet as a matter of human rights and equal opportunities. On the other hand it is positive that disability is actually included in key health and social policies. For example, in the draft 12th Five Year Plan (which is a national plan of growth and development), the focus on vulnerable and excluded groups, among them persons with disabilities has a clear focus.


collection of data that are disaggregated on categories of vulnerable populations is for instance proposed in order to improve the evidence and monitoring of their access to services and living situation. Other improvement proposed is the training of health and rehabilitation professionals on the needs and expectations of ‘differently-abled’ persons.

2.1 Disability policies

India’s law on disability rights dates from 1995 and is considered the main reference to the rights and welfare of persons with disabilities: the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full participation) Act (Persons with disabilities Act). A new bill is currently being drafted, which will be in line with the CRPD.

The National Policy for Persons with Disabilities was developed in 2006 and has been adopted as well by the state of Odisha. The Persons with disabilities Act and the national disability policy are under the responsibility of Ministry of Social Justice and Empowerment at national level and the Ministry of Women and Child Development at Odisha state level. A state coordination committee is monitoring the implementation of the policy according to the 2003 adoption of the Persons with Disabilities Act.

Other legislation linked to disability:

- The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disability Act 1999.
- Mental Health Act 1987.

The Odisha state policy on persons with disabilities from 2006 defines the concept of rehabilitation as ‘socio-economic rehabilitation’, replacing the earlier understanding of rehabilitation as mainly medical. This is an important advancement as it goes away from the medical model of disability towards a more social model. It also specifies that rehabilitation measures can be classified into three distinct groups: physical rehabilitation, educational rehabilitation and economic rehabilitation.

The strategies defined for physical rehabilitation include:

- Early detection and intervention—aimed to minimize the impact of disabilities, with a special focus on providing and developing these services in both rural and urban areas.
- Counselling and medical rehabilitation—measures include: strengthening capacities of persons with disabilities and their families, physiotherapy, occupational therapy, surgical correction, audio logical rehabilitation and inclusive education which shall be extended to cover all the districts of the state. The strategy foresees the involvement of government institutions as well as local and corporate bodies, national institutions, and NGOs (including parents and persons with disabilities).
- Increase coverage of rehabilitation services in rural areas. One way will be to establish new District Disability Rehabilitation Centres in all districts and sub centers at the block level near the CHCs so that they are easily accessible. Privately owned centres shall be regulated to ensure quality and accountability. Any health worker can identify (referral service and management of disabled with appropriate capacity building inputs)
- Convergence with National Health Mission to utilise the services of Accredited Social Health Activist on early identification and medical rehabilitation of persons with disabilities in rural areas.
- Development of rehabilitation professionals—human resource requirement for rehabilitation will be assessed and a plan developed so that rehabilitation programs do not lack human resource. Effective steps shall also be taken for inclusion of rehabilitation education in medical courses in graduation and post-graduation level.

There are two additional schemes that are important for the physical rehabilitation sector:

- The Assistance to Disabled Persons Scheme (ADIP), a national scheme for provision of technical aids and appliances and to cater for surgical needs of persons with disabilities23. The national government provides support to state governments as well as NGOs that are engaged in such work.
- Assistive devices—state government shall ensure budget provision for supply of aids and appliances and coordinate with organisations under the ADIP scheme. Corporate bodies as well as philanthropic organisations will also be invited to increase coverage.

Deendayal Disabled Rehabilitation Scheme (DDRS), a national scheme providing grant-in-aid to NGOs that work with services of rehabilitation for persons with disabilities, such as Community-Based Rehabilitation (CBR), early intervention for children, developing man power, support for research on technical aids and assistive technologies, among others24.

Annex 3 provides a summary on the legal framework and policies linked to disability in Sri Lanka compiled by the UN Economic and Social Commission for Asia and Pacific (UNESCAP).

2.2 Physical rehabilitation policies

The Rehabilitation Council of India (RCI) was set up in 1986, and in 1992, the RCI Act was enacted by the parliament and became a statutory body25. The mandate of the RCI is to regulate and monitor services related to persons with disabilities, to standardise educational syllabi and to maintain register of all qualified professionals working in the field of rehabilitation and inclusive education (physiotherapists and occupational therapists are not under the registration of the RCI, they are in process of setting up their own council). It also has the power to implement punitive actions against unqualified persons delivering services to persons with disabilities.

The RCI Act was amended by the Parliament in 2000 to make it more broad based. While there is no specific policy on physical rehabilitation neither at national nor state levels, as earlier mentioned, physical rehabilitation forms part of the policy on disability rights. In Odisha, the government is in process of preparing a state policy on disability based on the National Disability Policy and in line with the CRPD. The Director of the Welfare for the Persons with Disabilities has formed a core committee, which has been engaged for this mapping exercise and for the drafting of a State Vision document on rehabilitation. This State Vision document will be shared among the key actors before being presented to the drafting committee of the State disability policy.

There is also State Institute of Disability Rehabilitation (SIDR) in Bhubaneswar under the MoWCD, based in the campus of the Capital Hospital (which is one of the most important public hospitals in Odisha), which is responsible to support and monitor the network of DDRCs. Until now the SIDR has had a low profile and not yet assuming its full function. A separate department with adequate resource allocation in each district with a nodal officer like a district Disability officer should be appointed like a district evacuation officer.

2.3 Participation of persons with disabilities in policy making

Official mechanisms for the participation of persons with disabilities in policy-making and other decision-making processes are not well defined. As persons with disabilities are getting more organised and claim more participation, the MoWCD has started to conduct more consultation with these organisations.

The establishment of a State Commissioner for persons with disabilities, as required by the Persons with Disabilities Act, provides also more possibilities for claiming rights and denouncing violations. During this mapping, it was said that the State Commissioner is receiving more and more complaints from persons with disabilities in Odisha. Once the new bill comes into force the state commission for people with Disabilities should have a 6 member bench to approve of different proposals and schemes.

2.4 Regulatory framework of physical rehabilitation service delivery

A regulatory framework can be defined as a set of interrelated instruments meant to control,
coordinate and improve the provision of public services, in this case, physical rehabilitation services. Such instruments and frameworks should be defined and ultimately supervised by central authorities but can be implemented and monitored by either central and/or local authorities or agencies mandated to do so. This framework could regulate: (a) the demand for, and access to, services, (b) the supply of these services by various providers, and (c) the actual provision of physical rehabilitation services.

This mapping involved a number of key stakeholders that are concerned about regulating and improving the access to physical rehabilitation services in Odisha. Through the national workshop organised as an opportunity to debate and gather information and further complemented by specific consultation, the situation of the regulatory framework of the physical rehabilitation system has been identified. The public physical rehabilitation services are, in majority, under the responsibility of the Odisha Ministry of Women and Child Development (MoWCD). The Ministry of Health and Family Welfare (MoHFW) has recently started to include physical rehabilitation within its scope of services but ideally Rehabilitation services should be converged with this Department for better delivery.

Thus, the definition of roles and responsibilities and the coordination between these two ministries remain to be regulated.

There are also various Non Governmental Organisations (NGO) and charities that are supporting CBR programs, and private companies and clinics providing physical rehabilitation. Public services are automatically authorised for delivering services and until now, there are no unified quality standards for physical rehabilitation, neither any system that controls nor monitors private rehabilitation centres and services or orthopaedic devices. When it comes to the NGOs and charities, they need to register with the Social Welfare Department under the MoWCD (as regulated under the Persons with Disabilities Act). Private for profit companies and clinics though are not obliged to register with any ministry. Rehabilitation professionals though should have a licensed to be able to practice, majority of them with the RCI and the doctors by the Medical Council of India.

Table 1 provides an overview of the situation in Odisha state regarding the key regulatory mechanisms that are necessary to ensure a fair and equitable access to physical rehabilitation services.

The analysis of the regulatory framework for physical rehabilitation services shows that several mechanisms are missing, incomplete or not fully reinforced and those procedures for implementing them are not yet in place. While the MoHFW is only recently starting to work in physical rehabilitation, the welfare department for persons with disabilities is the main responsible within the MoWCD to define and implement regulatory mechanisms. A number of important regulatory mechanisms are to be defined, such as minima service quality standards and a monitoring system of quality and performance. Procedures for licensing (authorisation) of providers that are linked to quality standards should be developed; as this will become important once private providers are more regulated and develop public-private partnership with the government. Equally, the needs assessment at grass root level should be improved. Community based Rehabilitation should be set in a mission mode.

These procedures are fundamental for improving access to services and to develop a long-term human resource plan for training an adequate number of physical rehabilitation professionals. Another important mechanism is the information system, which should be available at all levels to make sure that the people in need of these services receive understandable information. This requires in turn that disability and physical rehabilitation is included in the data gathering and monitoring systems, both in the welfare department of persons with disabilities and the public health system.

<table>
<thead>
<tr>
<th>Regulatory mechanism</th>
<th>Responsible entity</th>
<th>Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of needs and demands (macro level)</td>
<td>MoWCD</td>
<td>There is no centralised system at state level of assessing needs and demands or developing territorial maps of services.</td>
</tr>
<tr>
<td>Access criteria to physical rehabilitation services (including mobility device and technical aids)</td>
<td>MoWCD Physical rehabilitation centres and services</td>
<td>Eligibility criteria for access are not yet standardised, each clinic of rehabilitation centre have its own assessment and treatment protocols. Public services are provided for free (including assistive devices) for persons with disabilities living below the poverty line (ADIP).</td>
</tr>
<tr>
<td>Contracting and funding</td>
<td>MoWCD MoHFW</td>
<td>There is a process of handing over some responsibility of physical rehabilitation to the MoHFW but it is not yet operational.</td>
</tr>
<tr>
<td>Licensing and authorisation</td>
<td>MoWCD</td>
<td>No official licensing/authorisation procedures linked to quality standards exist in any of the ministries and services are thus not continuously evaluated. All NGO providing rehabilitation should register with the Social Welfare Department under MoWCD. Public services do not need any specific licensing or authorisation. Private rehabilitation services are not yet controlled or monitored by any ministry or department.</td>
</tr>
<tr>
<td>Government funding</td>
<td>MoWCD National Ministry of Social Justice and Empowerment</td>
<td>MoWCD funds DDRCs. National ministry of Social Justice and Empowerment provides funding for public services such as SVSVNIRT AR and ALIMCO and also aid-in grants for NGOs that deliver CBR services (annual contract basis).</td>
</tr>
<tr>
<td>International organisations (external donor funding)</td>
<td>International NGOs and donors</td>
<td>International NGOs fund some CBR programs independently and Handicap International supports two DDRCs but the total support is marginal. Corporate sector should be roped in for the active role-play in the delivery of rehabilitation services.</td>
</tr>
<tr>
<td>Service quality standards</td>
<td>MoWCD</td>
<td>There are no official quality standards for the physical rehabilitation sector or the CBR programs. The MoWCD has developed a guideline and manual on how to establish DDRC.</td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>MoWCD MoHFW</td>
<td></td>
</tr>
</tbody>
</table>
at tertiary health care level, more comprehensive and long-term physical rehabilitation should be provided, and at secondary health care level, both acute and long-term physical rehabilitation services it means that basic services should be available close to where people live at an acceptable distance. As any other health related service delivery, one of the most important pillars of access to health, requires that sufficient services, of adequate quality and affordable, should be available where people need them. In terms of physical rehabilitation services it means that basic services should be available close to where people live at an acceptable distance. As any other health related service, physical rehabilitation should be available at primary health care level (closely linked to existing CBR and welfare/livelihood programs at community level) where much of the needs can be met. At secondary health care level, both acute and long-term physical rehabilitation should be provided, and at tertiary health care level, more comprehensive and specialised physical rehabilitation should be available both in hospitals and specialised referral clinics and centres. These services should be provided under a clear mandate of the relevant and responsible line ministries.

Physical rehabilitation is not a priority within the MoHFW, and as earlier mentioned, the MoWCD has the main responsibility to ensure these services, and despite that they are not well equipped or sufficiently capacitated to ensure these services at all levels. There are important gaps in terms of geographical coverage; especially at community level and only eight out of 30 districts have established a DDRC (with five more being planned). Another challenge, also identified in Handicap International’s Knowledge, Attitudes and Practice (KAP) study in 2012, is the lack of awareness among persons with disabilities and their families about the existence and possible benefits of physical rehabilitation, combined with distrust towards doctors and medical staff. A different difficulty is the lack of long-term follow-up at community level, which may result in people abandoning their rehabilitation plan or stop using their assistive device. Recruiting physical rehabilitation staff to DDRCs is said to be problematic due to limited number of trained cadres and difficulties to attract staff to work in rural districts. This affects both availability and quality and hinders the set-up of new physical rehabilitation units.

3. DELIVERY OF PHYSICAL REHABILITATION SERVICES

Service delivery, one of the most important pillars of access to health, requires that sufficient services, of adequate quality and affordable, should be available where people need them. In terms of physical rehabilitation services it means that basic services should be available close to where people live at an acceptable distance. As any other health related service, physical rehabilitation should be available at primary health care level (closely linked to existing CBR and welfare/livelihood programs at community level) where much of the needs can be met. At secondary health care level, both acute and long-term physical rehabilitation should be provided, and at tertiary health care level, more comprehensive and specialised physical rehabilitation should be available both in hospitals and specialised referral clinics and centres. These services should be provided under a clear mandate of the relevant and responsible line ministries.

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3.1 Identification and early intervention of physical impairments

This mapping concludes that there are limited services available at community level for identifying children as well as adults that require physical rehabilitation. The Anganwadi workers should identify children with disabilities but the mapping indicates that this is not yet well implemented in all districts. Particularly when it comes to identifying children in need for physical rehabilitation. Inclusive Education Volunteers (IEVs), depending on the Education Department, should do home-based intervention for children with severe or multiple disabilities. The role of the IEVs is to prepare children for school or to be equipped with life-skills that facilitate their inclusion in their communities. They should also provide training to families or other care supporters. Equally to the Anganwadi workers though, they are always trained in basic rehabilitation therapy and about

31 Anganwadi workers are women from the same village/ward, trained in performing various functions linked to women and child health, awareness on social welfare programs and gathering of data on their communities. They should also identify children with disabilities.
32 Inclusive Education Volunteers (IEVs) are to provide home-based education for children with severe/profound disabilities with the objective of either preparing them for schools or for life by imparting to them basic living skills. The Inclusive Education Volunteers give training to caregivers and regularly conduct follow up with them to check on the progress. The planning and intervention includes general assessment, community assessment, monitoring and setting of short-term, medium and long-term goals. Along with the above work mandate, the IEV also maintains a database at the gram Panchayat level and extends support to the education facilities at the grass roots level. An IEV also counsels the parents and teachers to develop the child with disabilities and documents the proceedings to later assess the percentage of progress.

Handicap International. KAP survey. Attitudes and awareness around physical rehabilitation in Afghanistan, Bangladesh, Orissa (India) and Sri Lanka, October 2012.
is usually also included in physical rehabilitation, and can be important factors for supporting inclusion in daily life activities. Assistive devices, such as prosthetic, orthotic and other mobility aids are also crucial components of physical rehabilitation and sometimes necessities for going to school or engaging in livelihood activities.

Physical rehabilitation at district level

The result of the mapping shows that basic physical rehabilitation is seldom available at district level and especially in more rural communities and tribal areas, and that most people have to travel to the nearest DDRC or to regional medical colleges to access physiotherapy or other services, or to pay for private services.

So called 'single-window camps' are being organised by Odisha government at block level, where persons with disabilities are invited and will have access to a screening process to identify and orient people towards relevant services. If there is a need for assistive devices or P&O appliances for example, measurements are taken. Based on the requirements of the custom made devices and pre-fabricated aids, there is another camp organised later on, where devices are distributed and some follow-up is done. It is a permanent activity, although the MoWCD expressed a concern about their capacity to financially sustain this service. It is nevertheless an important opportunity for persons with disabilities living in rural areas to get information about possible benefits of physical rehabilitation services and other schemes and access some services. The challenge though regarding the long-term follow-up of the situation of the people that has received services still remains, as the camps are not organised at the same location on a regular basis. Basic physical rehabilitation needs to be available at primary health care level or at least at each district level for a better long-term follow-up.

While the MoHFW does not have any physical rehabilitation at primary health care level, there are a few NGOs that implement CBIR programs and/or that provide physiotherapy services at community level.

Information provided through interviews and service providers indicate that these services function quite well but are scarce in number and are funded either through external donors or on annual basis through aid-in grant schemes.

Physical rehabilitation at regional level

District Disability Rehabilitation Centres have been set-up in eight of the 30 districts of Odisha and the MoWCD has planned for another five centres to be established. These are multiuse services (often known as ‘one-stop-shop’) that should offer information and guidance on schemes and subsidise available to persons with all types of disabilities and provide a range of services, among them:

- Providing disability certificate.
- Encouraging early identification and intervention and support referral to more specialised rehabilitation centres as well as vocational, educational or social institutions.
- Providing comprehensive rehabilitation services such as physiotherapy, occupational therapy, assistive devices assessment, fitting and repair.
- Counselling.
- Implementing outreach services through ‘single-windows’ camps to follow up the services it rendered, identify new clients, and refer them for other services.

The feedback of the consultations and interviews during the mapping suggest some concern about the quality of services provided in some of these DDRCs. First of all they are not sufficient in numbers, they do not cover all districts, and secondly, the centres have difficulties in finding enough qualified staff, thus services that should be delivered are not yet available. The DDRCs are managed and funded by Odisha MoWCD, with additional funds from the national Deendayal Ability and Rehabilitation Scheme for Voluntary Actions for persons with disabilities (DDAR) for persons with disabilities (DDRS). Hospitals at secondary health care level are located at the district head quarters and provide a limited amount of services for persons with disabilities, but do not provide for example physiotherapy or P&O devices. They provide immunisation services, identification of disability, some surgeries for cataract, reconstruction surgery of leprosy-affected persons, minor orthopaedic surgeries for clubfoot and for persons with polio.

Physical rehabilitation at state level

The lack of precise information regarding physical rehabilitation services in Odisha makes it difficult to map out what is actually available at state level. According to key informants, there are more possibilities to access specialised treatment in the twin city of Cuttack and Bhubaneswar, as the nationally managed rehabilitation centres are operating there: the Artificial Limbs Manufacturing Corporation of India (ALIMCO) and the National Institute of Rehabilitation Training and Research (SVNIRTAR).

ALIMCO produces a range of orthopaedic devices such as prosthesis and orthosis and other types of mobility aids such as crutches and wheelchairs. It also provides hearing aids and devices for visual disabilities such as Braille equipment. SVNIRTAR in its turn also produces orthopaedic devices but is also a training and research institute (see further under chapter 4). SVNIRTAR has 100-beds for in-patients that require physical rehabilitation, with a team of physiotherapists, occupational therapists and P&O professionals.

The three medical colleges, situated in each of the three regions, should provide physiotherapy and occupational therapy services but so far only two of them have sufficient human resources to do so.

One important challenge, which is actually crosscutting throughout the health and social welfare system in Odisha, is the absence of a referral system. For persons with disabilities that can afford, and has

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34 These eight districts are: Sambalpur, Kalahandi, Khordha, Mayurbhanj, Koraput, Nabarangapur, Ganjam and Kenduimal (Phulbain). The five new DDRCs will be established in Jajpur, Balasore, Bhadrak, Sambalpur and Puri districts.


36 In other states of India, DDRCs are sometimes managed by NGOs although still funded by state and national schemes.

37 These figures have been provided by rehabilitation professionals in SVNIRTAR and from the training institutions during interviews during the months August-September 2013. These are estimations and should be interpreted as giving an orientation to the situation of physical rehabilitation in Odisha. The real figures might be either slightly higher or lower.

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Table 2: Physical rehabilitation centers and hospitals with rehabilitation units (2013)

<table>
<thead>
<tr>
<th>Region</th>
<th>Public physical rehabilitation centres</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PT</td>
</tr>
<tr>
<td>Central region</td>
<td></td>
</tr>
<tr>
<td>National Leprosy Eradication Programme</td>
<td>5</td>
</tr>
<tr>
<td>ALIMCO regional centre (Bhubaneswar)</td>
<td>1</td>
</tr>
<tr>
<td>DDRC (2)</td>
<td>1</td>
</tr>
<tr>
<td>SVNIRTAR (Cuttack)</td>
<td>10</td>
</tr>
<tr>
<td>Sriram Chandra Bhanja Medical College (Cuttack)</td>
<td>2</td>
</tr>
<tr>
<td>Regional Spinal Cord Injury Centre (Cuttack)</td>
<td>4</td>
</tr>
<tr>
<td>Northern region</td>
<td></td>
</tr>
<tr>
<td>SVNIRTAR Sub Centre</td>
<td>1</td>
</tr>
<tr>
<td>DDRC</td>
<td>0</td>
</tr>
<tr>
<td>Veer Surenda Sa) Medical College (Burla)</td>
<td>0</td>
</tr>
<tr>
<td>National Leprosy Eradication Programme</td>
<td>6</td>
</tr>
<tr>
<td>Southen region</td>
<td></td>
</tr>
<tr>
<td>DDRC (5)</td>
<td>3</td>
</tr>
<tr>
<td>Maharaja Kushna Chandra Medical College</td>
<td>1</td>
</tr>
<tr>
<td>College (Berhampur)</td>
<td>1</td>
</tr>
<tr>
<td>National Leprosy Eradication Programme</td>
<td>3</td>
</tr>
<tr>
<td>SUBTOTAL</td>
<td>38</td>
</tr>
</tbody>
</table>
the opportunity to travel to Bhubaneswar/Cuttack or the main cities to receive treatment, there is no system of follow-up on treatment and progress once they are back home. Consequently, the effect of the treatment could be minimal. Equally if the maintenance of mobility aids is not followed up and repairs done to damages, people might decide that they are not useful, or stop using them when not knowing how to find a place to repair them. This further undermines the trust in public health care and specifically physical rehabilitation services.

As mentioned above, there are two public companies that produce orthopaedic aids and assistive devices, ALIMCO and SVNIRTAR, which are located in Bhubaneswar and Cuttack. Some of the DDRCs also produce a limited number of prosthetic and orthotic devices. In addition there is one private company that produce P&O devices, Endolite India Limited.

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Although this mapping could not map out all the workshops in each district, which should produce the ortho-prosthetic devices and technical aids production and fitting.

Although this mapping could not map out all the workshops in each district, which should produce the ortho-prosthetic devices and technical aids production and fitting, the production capacity of the centres but one can conclude from the estimated ratio of professionals in relation to the number of persons with disabilities that needs are not covered by the public services and that there is unequal geographical distribution.

The distances are large and transportation can be both difficult and expensive for persons with disabilities to reach Bhubaneswar or the few major cities that provide such services. The ISPO and WHO guidelines on service coverage for prosthetics and orthotics suggest that Odisha needs at least one orthopaedic workshop in each district, which should produce the most commonly needed appliances.

Table 3: Public and private centres producing and delivering P&O devices (2013)

<table>
<thead>
<tr>
<th>Region/District</th>
<th>Ortho-prosthetic device and technical aids production and fitting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central/Cuttack</td>
<td>SVNIRTAR, Regional Spinal Injury Centre</td>
</tr>
<tr>
<td></td>
<td>Perfect orthotic and orthotic centre (private)</td>
</tr>
<tr>
<td>Central/Khurda</td>
<td>DDDR, SIDR, ALIMCO Regional Centre, Bhubaneswar</td>
</tr>
<tr>
<td></td>
<td>Loco—Rehabilitation centre (private)</td>
</tr>
<tr>
<td></td>
<td>Chakradhar Institute of rehabilitation Science, Bhubaneswar (private)</td>
</tr>
<tr>
<td></td>
<td>Bhagwan Mahaveer Viklang Seva Samiti, Jaipur (private)</td>
</tr>
<tr>
<td></td>
<td>Endolite India Ltd., Bhubaneswar (private)</td>
</tr>
<tr>
<td>Northern/Sambalpur</td>
<td>DDDR, Rama Jyoti Orthopaedics (private)</td>
</tr>
<tr>
<td>Southern/Ganjam</td>
<td>DDDR, Ortha Aid (private)</td>
</tr>
<tr>
<td></td>
<td>Omt Viklang Kendra (private)</td>
</tr>
<tr>
<td>Southern/Kalahandi</td>
<td>DDDR, Ortha Aid (private)</td>
</tr>
<tr>
<td>Southern/Kandhamal</td>
<td>DDDR, Ortha Aid (private)</td>
</tr>
<tr>
<td>Southern/Koraput</td>
<td>DDDR, Ortha Aid (private)</td>
</tr>
<tr>
<td>Southern/Nabarangpur</td>
<td>DDDR, Ortha Aid (private)</td>
</tr>
</tbody>
</table>

* PT—Physiotherapist; OT—Occupational therapist; P&O—Prosthetic and Orthotic professional; Other—special educators, mobility instructors, psychologists etc.
Improving the availability, accessibility, accountability and quality of rehabilitation services is largely dependent on ensuring the rehabilitation workforce exist, is adequately prepared and mobilised. WHO World report in 2006 is looking at the development of the health workforce in a life span perspective, which covers both the workers perspectives and the policy and governance through state actions38:

Entry: planning, preparing and producing the required workforce through strategic investments in education and effective and ethical recruitment practices.

Workforce: enhancing worker performance through better management of workers in both the public and private health sectors, this includes adequate financial planning to ensure retention of trained health workers and human resource information management systems to make rational human resource allocation decisions.

Exit: managing migration and attrition to reduce wasteful loss of human resources.

This mapping has not done a detailed analysis of the whole process from entry to exit, but it does provide relevant information on key perspectives and highlights gaps that need to be further investigated. The data presented in this chapter is gathered from policies and documents of the national and states ministries involved in physical rehabilitation, as well as from interviews with professional associations and DPOs as well as information provided by key actors participating to the national workshop (Annex 1).

Due to the absence of centralised data within the MoHFW as well as MoWCD, the accuracy of the information has to be taken with some caution. The data presented in this chapter is gathered from policies and documents of the national and states ministries involved in physical rehabilitation, as well as from interviews with professional associations and DPOs as well as information provided by key actors participating to the national workshop (Annex 1).

4.1 Training of physical rehabilitation professionals

The types of professionals included in this mapping are physiotherapists, occupational therapists P&O professionals, physiatrists, speech therapist, audiologist, psychologists as well as the CBRWs/ RWs. Ideally there are other professional groups that should be involved in physical rehabilitation, such as counsellors, specialised nurses or social workers. In Odisha though those professional groups are yet to be integrated into physical rehabilitation, but the key professional available can ensure a substantial aspect of the rehabilitation process.

Physiatrists specialised in physical medicine and rehabilitation

In India there is a specialisation in physical rehabilitation (called Physical Medicine and Rehabilitation in India), and physicians that complete this training are called physiatrists. It is a branch of modern (allopathic) system of medicine that aims to enhance and restore functional ability and quality of life to those with physical impairments or disabilities. That is, a medical specialty that emphasizes prevention, diagnosis and treatment of patients who experience limitations in function resulting from any disease process, injury or symptom39. The physiatrist is the coordinator of the physical rehabilitation team who emphasis prevention, diagnosis and treatment of patients through the team work.

The outcome of this assessment suggests that there are very few physiatrists working in Odisha, at least in the public sector. About 3 physiatrists (PMR Specialists) are working in SVSNITRAR. Every year two students are admitted at SVSNITRAR to pursue DNB-PMR which is a post graduate programme after MBBS registered by DNB counsel of India. This specialisation is still not available in Odisha.

Physiotherapy and occupational therapy

Both the national government and Odisha government provide Bachelor degrees in physiotherapy and occupational therapy. Both courses are provided by SVNITRAR during 4 and a half years course recognised by the Utkal University. There are about 5 private PT colleges in Bhubaneswar that provides degrees in physiotherapy by govt of Odisha and affiliated to Utkal university of Bhubaneswar

The annual intake of students in Odisha is 65 seats per course. Physiotherapists and occupational therapists are not licensed by the RCI. There are on-going negotiations around which council that should license the physiotherapists and occupational therapists. These professionals consider themselves to be closer to the medical field and are advocating for establishing their own council.

There are also a number of private colleges and institutes that offer physiotherapy and occupational courses, but during this mapping, specific details could not be obtained. Diploma and certificate level courses are being provided in other states of India but not in Odisha.

The most important professional associations are:

- The Indian Associations of Physiotherapists, established in 1956 with around 30,000 members. A branch exists in Odisha.
- All India Occupational Therapy Association, established in 1952 with around 3,300 members. A branch exists in Odisha.

Continuous Professional Education is not mandatory for renewing licenses of any health professional. SVNITRAR is officially organising regular training for physiotherapists and occupational therapists that are paid for by the professions themselves. The respective professional associations also provide continuous education, but these are not officially validated.

Prosthetic and Orthotic

Currently there are four levels of P&O training in India:

- Certificate level in prosthetics and orthotics—a one year course.
- Diploma level in prosthetics and orthotics (called Prosthetists and orthotists)—a two years course + six months internship.
- Bachelor degree in prosthetics and orthotics—a four years course.
- Master degree in prosthetics and orthotics—two years post-graduate course.

All training courses in P&O in India are recognised by the RCI, which is the responsible agency to certify training institutes. In Odisha, the only public training institute for prosthetics and orthotics is SVNITRAR. They provide a Bachelor degree of four years with a yearly intake of 46 students.

The main professional P&O association is the Orthotic and Prosthetic Association of India that has 660 members from all over India40. This organisation organises some Continuous Professional Education for their members during executive meetings or annual conferences but such courses are not recognised by the RCI. Most P&O professionals in Odisha participate to courses organised by SVNITRAR, which are recognised by the RCI.

Community Based Rehabilitation

A one-year CBR diploma program was developed in 2007 to respond to the vast need of services in rural areas of India. These multi-purpose CBR workers are trained in the identification and rehabilitation of persons with different types of disabilities and in promoting their rights and empowerment. CBR workers can be employed in DDCs or NGO managed CBR programs. In Odisha there is no registry of the number or workplaces of CBR workers and it is not clear if a proper training at diploma level is actually being implemented.

4.2 Number and geographical distribution of physical rehabilitation professionals

Despite that the training of physical rehabilitation professions has been in place since several years in Odisha, there are not yet sufficient numbers of professionals available for the public sector. One reason might be that while students receive training in

39 http://www.iapmr.org/physiatryandpmr.html
40 http://www.prothetica.org
41 http://www.opai.org.in
Table 4: Overview of training institute of physical rehabilitation professionals in Odisha (2013)

<table>
<thead>
<tr>
<th>Profession</th>
<th>Training School</th>
<th>Program and degree</th>
<th>License</th>
<th>Graduation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy</td>
<td>SVNIRTAR National Ministry of Social Justice and Empowerment</td>
<td>Bachelor in physiotherapy: 4.5 years</td>
<td>Master in physiotherapy: 2 years</td>
<td>Courses are recognised by Ursalk University</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PTs are not yet licensed</td>
<td>Master: 15 per year</td>
<td></td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>SVNIRTAR National Ministry of Social Justice and Empowerment</td>
<td>Bachelor in occupational therapy: 4.5 years</td>
<td>Master in occupational therapy: 2 years</td>
<td>Course is recognised by Ursalk University</td>
</tr>
<tr>
<td></td>
<td></td>
<td>OTs are not yet licensed</td>
<td>Master: 15 per year</td>
<td></td>
</tr>
<tr>
<td>Prosthetic &amp; Orthotic</td>
<td>SVNIRTAR Ministry of Social Justice and Empowerment</td>
<td>Bachelor in Prosthetics &amp; Orthotics: 4 years</td>
<td>Licensed by RCI</td>
<td>Bachelor: 46 per year</td>
</tr>
</tbody>
</table>

Bhubaneswar they might later feel reluctant to work in rural areas where the conditions are very different. The private sector also attracts the newly graduates whom find it more promising, and those companies are mainly located in big cities. Estimations made by the participants in the national mapping workshop indicate that the majority are working in urban areas. As table 5 presents, the number of rehabilitation professionals as compared to the total population and the population of persons with disabilities is very low. For example, the northern region of Odisha state has only 10 physical rehabilitation professionals employed in the public sector, for a population of more than 12 million.

All the physiatrists are employed in SVNIRTAR. On the opposite, only 5% of physiotherapists, who are estimated to be around 1,000 in Odisha, are working in public rehabilitation services. The majority of them are thus working in private hospitals, clinics or as independent workers. A similar situation can be described for occupational therapists, where an overwhelming majority, around 90%, are employed in the private sector. The remaining occupational therapists are working in SVNIRTAR and the DDRCs. A total of 100-150 occupational therapists are professionally active in Odisha according to members of the All India Occupational Therapy Association in Odisha.

An estimated number of 100 P&O professionals are working in Odisha, in public and private services, with the majority (80-85%) working in urban areas. The few that are available in more rural areas are working for NGOs. Estimations provided from the professional association suggest that 75% of the P&O professionals are working in public centres, most of them in ALIMCO and SVNIRTAR. Others are employed in DDRCs or in multi-national companies. If looking back at the approximate need of P&O professionals based on SGP and WHO recommendations, around 250 P&O professionals (Master, Bachelor and diploma levels) should be available together with approximately 1,200 bench workers (certificate level).

During this mapping it was not possible to get precise information regarding professionals employed in the private sector, thus it is difficult to estimate how many are actually working and if there is a gap or not in terms of ensuring coverage of needs. What is evident though is that the geographical distribution of the available physical rehabilitation professionals is limited to the main cities, thus depriving the rural population from the benefitting from services.

Table 5: Physical rehabilitation professionals in the public health sector in Odisha (2013)42

<table>
<thead>
<tr>
<th>Province</th>
<th>Population</th>
<th>Estimated number of persons with disabilities</th>
<th>PT</th>
<th>OT</th>
<th>P&amp;O</th>
<th>OTHER</th>
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<tbody>
<tr>
<td>Central</td>
<td>18,265,853</td>
<td>477,958</td>
<td>26</td>
<td>12</td>
<td>36</td>
<td>20</td>
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<tr>
<td>Northern</td>
<td>12,063,679</td>
<td>275,987</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Southern</td>
<td>11,617,826</td>
<td>267,390</td>
<td>16</td>
<td>3</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Total public</td>
<td>41,947,358</td>
<td>1,021,335</td>
<td>49</td>
<td>15</td>
<td>47</td>
<td>31</td>
</tr>
</tbody>
</table>

42 The estimated number of persons with disabilities in each region as well as the total population per region is taken from the 2001 national census, around 2.6% of the population. This might be an understatement though, the WHO World Disability report provides a general figure of 15% of persons with disabilities, and 2.2-3.8% of persons with severe disabilities (such as quadriplegia, blindness, severe depressions etc).

5.1 Availability

Availability refers to having functioning and sufficient physical rehabilitation services in a balanced and equitable geographical distribution. Services should also strive to answer to the diversity of needs for services, i.e. age, gender, type of impairment etc. There must also be a long-term strategy of ensuring sustainability of services, financial as well as in terms of quality, including staff availability and adequate competence.

As the mapping outcomes show and even though there is a number of physical rehabilitation centres available in Odisha, there is an important shortage of services in many districts, especially in rural areas. Physical rehabilitation is practically absent from at primary and secondary health care level.

Starting from the community, there are some programs in place that target children with disability, such as CBR and educational programs involving the Inclusive Education Volunteers, these programs are few in numbers and cover a limited geographical area. It was said as well that some community workers lack sufficient skills and incentives to provide basic rehabilitation therapy and proper referral for children with physical disabilities. At the same time, the existence of these programs and IEVs are potential for improving and widening the scope of coverage by increasing their numbers and capabilities. As such, identification and early intervention of disability could step by step be improved and adequate referral to more specialised treatment increase. For adults with disabilities there is practically no support at community level as of today.

At district level, the establishment of the eight DDRCs is an important advancement that improved availability; especially because they have a mandate to provide also the most commonly needed P&O devices. It is essential though to improve the quality of services and to ensure the availability of sufficient number of rehabilitation professionals/officials/Doctors.

The absence of physical rehabilitation professionals in primary, and to a large extent in secondary health care services in Odisha, is another challenge. Recently though, the Ministry of Health and Family Welfare has started to recognise the importance of physical rehabilitation, thus the possibilities to improve the availability services at community and district levels could be huge if incorporated in MoHFW.

Another important challenge, linked of course to the lack of services availability, is the absence of a comprehensive crosscutting referral system. The health sector does not have these services within
its referral system and does not refer to the welfare department’s services. While the MoWCD do have referral cards and files in place, the system and practices could be improved. Non Governmental Organisations providing rehabilitation services are not yet included in any referral system.

More specialised and advanced physical rehabilitation is mainly located in the twin-city of Cuttack and Bhubaneswar and in some major cities in the southern region. Two specialised rehabilitation centres, SVNIRTAR and ALIMCO provide specialised services but only SVNIRTAR has beds for hospitalisation (100 beds). While information regarding the availability of physical rehabilitation at tertiary level is incomplete, one can conclude that the key services exist only in Cuttack and Bhubaneswar. The public system, where services are provided for free for the poor population, cannot today respond to the needs for comprehensive specialised rehabilitation and proper follow-up. This means that people have to travel far to get treatment and for those needing longer-term hospitalisation and rehabilitation, for example after a stroke or a spinal cord injury, physical rehabilitation treatment is very limited. There is only one public hospital for spinal cord injuries in Odisha. If the most needed services were available closer to where people live, people would have less need to travel to the provincial capitals for support.

An additional important challenge that was highlighted during this mapping, and equally identified in Handicap International’s KAP study from 2012, is the lack of awareness among persons with disabilities and their families about the availability and importance of physical rehabilitation.

On the encouraging side, there is an on-going process to develop a state action plan on physical rehabilitation, and where the responsibilities of each of the ministries need to be clearly defined, as well as at what level and what type of physical rehabilitation services should be available at the different administrative divisions. The MoWCD is also planning to open five new DDRCs.

Suggestions for moving forward

- Establish a physical rehabilitation task force to work on a physical rehabilitation strategy, including the key actors of the physical rehabilitation sector such as: Ministry of Health and Family Welfare, Ministry of Women and Child Development, rehabilitation hospitals and centres, professional associations, Disabled People’s Organisations, international and national NGOs involved in the disability and rehabilitation sector and representatives of CBR programs.
- Such strategy has to define the key elements of making sure that services are available as close as possible to persons with disabilities home:
  - CBR programs should be further developed to cover all districts and should closely coordinate with the educational department and the IVEs.
  - Basic physical rehabilitation should be integrated at primary, secondary and tertiary health care in close coordination with the DDRCs and the ISDR.
  - Minimum quality standards for each level of service should be defined.
  - Coordination and responsibilities of key ministries should be well defined.
  - Financial and technical resources to implement the strategy/action plan should be clearly defined.
  - A more in-depth study on the availability of rehabilitation professionals should be made, covering both private and public sectors. Based on the findings, a human resources development plan could be developed and integrated into the state strategy/action plan for physical rehabilitation. Make sure to include provincial health authorities.

Assessment of possibilities to conduct training in other provinces should be studied, with the objective of recruiting personnel from more rural districts. This can ensure a better geographical coverage of rehabilitation professionals and willingness to work outside of main cities.

- An official CBR training curriculum should be developed and coordination should be strengthened among government and non-government actors within health, education, employment, and social affairs.
- Include physical rehabilitation professionals in the strategy of human resources for health and retaining policies in rural areas.
- Define indicators on physical rehabilitation and disability to be integrated in the Health Information System. There is a need to have concrete data on disability and rehabilitation in both Ministry of Health and Ministry of Social Services. Once data is available in the national monitoring systems there is much more opportunities to advocate for more and better services, as the gaps will be visible when measured.
- Adequate financial budget should be allocated for the physical rehabilitation sector and clearly appear in the final actions plan.
- Include disability and awareness around physical rehabilitation in the trainings for Inclusive CBR workers, Anganwadi workers and the Accredited Social Health Activists (of the National Health mission program).

5.2 Accessibility

Accessibility implies that services can be reached and by the person is user friendly and can use it with dignity who uses them. It has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability), and information accessibility.

Disabled People’s Organisations defined the lack of physical rehabilitation at primary health care level as a major obstacle to access services close to where they live. This contributes to the late identification of disability, registration and support, which could prevent or delay the recovery and restoration of function for many persons with disabilities. While the establishment of the eight DDRCs is seen as a facilitating element, DPOs think that they are still too few and that they are not yet fully functioning in terms of providing the required services. On one hand, there is a lack of awareness among persons with disabilities and/or their families about their rights to health and social services, including the benefits of physical rehabilitation. On the other hand, the limited availability of services implies long travel distances to access physical rehabilitation, which has an important impact on many people with disabilities that already have a difficult socio-economic situation.

Where public services are available, they are in theory provided for free, or at a minimal cost depending on the economic situation of each person with disabilities.

Some assistive devices though have to be paid. The availability of train concession and a deputy disability commissioner at district level were seen as facilitating elements to access physical rehabilitation. One important issue that was mentioned in the mapping was the difficulties to ensure continuation of treatment and the lack of follow-up possibilities once being discharged from a hospital. Physical rehabilitation is often provided more as acute treatment and the longer-term hospitalisation is limited due to a shortage of beds, thus the need for a well-defined referral system between the health care levels as well as from DDRCs to specialised rehabilitation centres is urgent. Equally, the referral process back to CBR programs and IVEs has to be integrated in such system. Crucial for improving accessibility though, is to increase the availability of services closer to where the person lives.

Persons with disabilities declared that they are seldom involved in planning and monitoring of services. Their influence both at service provision level and policymaking has been weak until now but the interest to be consulted is strong. There is a need for raising the awareness among persons with disabilities about their rights, and among DPOs on how to advocate and formulate policies in the field of social services, including physical rehabilitation.

Representatives of the professional associations and decision makers in turn consider that the poverty most persons with disabilities experiences is the
key obstacle for access necessary services in both health and social welfare, including access to physical rehabilitation. They also highlight the lack of awareness of persons with disabilities and their families about the benefits of physical rehabilitation. Stigma and negative community attitudes towards persons with disabilities and their families are additional challenges that should be addressed according to decision makers, professionals and service providers.

To access services at district level, professionals and decision makers underline similar obstacles as DPOs, absence of proper transport and limited financial resources, but they added also the lack of manpower in hospitals and DDRCs. On the positive side, all actors involved in rehabilitation consider the various disability schemes and programs as strong facilitators that are valuable for improving and strengthening the access to physical rehabilitation services.

**Suggestions for moving forward**

- A future physical rehabilitation strategy/action plan should incorporate key regulatory mechanisms and provide guidance as to which types of services should be available at what level, the estimated need for human resources and a plan for training and retaining workers. A comprehensive referral system should also be suggested.
- **Trained rehabilitation professionals on disability and rehabilitation.** The increased awareness of health professionals will improve the health care in general for persons with disabilities and facilitate timely and adequate referral where necessary.
- Improve the coordination between the Ministry of Health and Family Welfare and the Ministry of Women and Child Development, both at state and district level. Scarce resources have to be well utilised and the roles and responsibilities of key actors defined, especially as the MoHFW is showing interest to take on more responsibility to provide physical rehabilitation.
- Define minima quality standards for physical rehabilitation services, including clear job descriptions for each professional group. Such standards should also include mechanisms for user participation in service delivery and monitoring, as well as ensuring a user centred treatment and service.
- Increase the awareness of local communities and groups of persons with disability about the benefits that physical rehabilitation can bring and importance of early identification as well as secondary prevention.

The accountability of the authorities in terms of ensuring qualitative physical rehabilitation services to persons with disabilities in Odisha can be improved through defining a comprehensive regulatory framework. Some mechanisms are already in place and there is thus a base to build upon. So far though, it is impossible to evaluate the effect or impact of the services, as regular data collections is not done and the MoHFW does not include any indicators on disability and physical rehabilitation in its monitoring system. Unmet needs are most probably large. Moreover, the information system to inform people about the benefits of physical rehabilitation and the availability of services is not in place. Referral cards and files have been developed in the women and child department, and are in use but not yet centralised in a regular way. Through raising the awareness and building capacity of both IEVs and DDRC staff, a more comprehensive referral system could be defined without too much investment. As the MoHFW gets more involved in providing physical rehabilitation, the coordination and harmonisation of referral procedures between community services and hospitals care have to be ensured.

A positive step towards increased accountability is the existence of professional associations. Even if they are still not very strong in Odisha, their role to advocate for the working conditions and status of the rehabilitation professionals is important, and needs to be strengthened. Professional associations are also vital for promoting ethics and values among professionals and could influence the training programs to introduce user participatory assessment and treatment plans and advocate for more opportunities of continuous professional education opportunities among many other things.

Another important advancement regarding accountability is the establishment of a State Disability Commissioner, which could facilitate the involvement of DPOs in policy making. With a possibility to denounce violation of rights, the voice of persons with disabilities and their families has been strengthened. Persons with disabilities and their families can now file complaints and even denounce the lack of physical rehabilitation services (which according to article 25 and 26 of the CRPD, ratified by India in 2007, is an obligation to provide).

The availability of DPOs and organisations working for the rights of persons with disabilities is another crucial aspect of accountability. They represent current as well as future users of physical rehabilitation services and with increased capacity and voice; they should be considered an important third part in developing the sector.

**Suggestions for moving forward**

- The respective line ministries responsible for physical rehabilitation should start to define a comprehensive regulatory framework for the accountability of the physical rehabilitation sector. Key mechanisms to be defined or improved are:
  - Needs assessment and territorial maps of available services^47^.
  - Minima quality standards and licensing procedures, including processed for user participation in services delivery, monitoring and evaluation as well as complaint mechanisms,
  - Gate-keeping mechanisms, such as entry criteria and list of services that should be available for free or at affordable costs for all persons with disabilities,
  - Monitoring and evaluation system, include disability and physical rehabilitation in both social welfare and health monitoring systems,
  - Clear financing procedures for developing physical rehabilitation services,
  - An information management system.
- **Strengthen the capacity of the professional associations of physiotherapy, occupational therapy, and Prosthetists and Orthotists.** They need to develop skills in policy making and advocacy, as well as having a stronger capacity to promote Continuous Professional Education in collaboration with training institutes.
- **Strengthen the capacity of DPOs for taking part in policymaking and advocacy in the field of physical rehabilitation and disability rights.**

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46 Early identification means to identify early if children, or adults, have impairment where physical rehabilitation and/or assistive devices would have a positive impact on the function of the person. Secondary prevention means that people with disabilities can have need for physical rehabilitation to avoid a worsening of their impairment and thus a more severe disability.

47 Needs assessment refers here to analysing the need of services at geographical/administrative levels. 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.
• DPOs equally have an obligation to raise the awareness among its members about the possible benefit of physical rehabilitation. They should also encourage the creation of self-help groups at community level, perhaps in coordination with the CBR program, to enhance the awareness on rights and available benefits in general.

• CBR programs should enhance their support to self-help groups or interest groups to strengthen the voice of persons with disabilities at community level. Such groups have been shown crucial for peer counselling and raising the awareness around health, rehabilitation and access to other services, especially in smaller towns and villages.

This programme requires a long term planning knowing that current capacities are weak.

• Improve the coordination and sharing of roles and responsibilities between the MoHFW, MoWCD, national NGOs and charities as well as the private sector.

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motivation.org.uk/what-we-do/our-programmes/mobility

WHO Ministry of Health and Family Welfare. ‘National Family Health Survey (NFHS 3)—Vol 1’


5.4 Quality

While availability of, and accessibility to, services are crucial, the quality of the services provided is equally important. If the physical rehabilitation centres or departments do not provide services satisfactory to the users or do not respect and value the users, persons with disabilities will stop using them or can be even harmed by the interventions. Therefore quality standards and monitoring tools are regulatory procedures that have to be implemented and supervised by adequately trained local and central authorities. In addition, physical rehabilitation services their internal procedures in place, which should be transparent and understandable for users, as well as a complaint system where people can give their feedback on services for improvement. All this has to be developed with the principle of acceptability in terms of gender, capacity, culture and life cycle requirements.

In this mapping, the quality aspect of physical rehabilitation services has only been discussed during the national workshop. An assessment of the service providers has not been done neither have the mapping conducted any larger set of questions with users of services. The analysis is therefore based on the workshop discussion and the available data and information, which can only give a general point of view on the quality of physical rehabilitation services in Odisha.

As earlier mentioned, the lack of clearly identified indicators on physical rehabilitation and disability in the management and information system of both health and women and child development departments impedes the responsible ministry to monitor and make informed decisions about human resource development, budgeting and coverage of services. The absence of common quality standards is another challenge.

The identified lack of trained human resources in physical rehabilitation and their availability to work outside the main cities are urgent issues that need to be addressed, and especially to define some kind of incentives for recruiting students from other provinces, or decentralise training structures. Poorly trained or not enough number of staff affects quality of services, and hinders the development of new, or the expansion of existing, services.

Suggestions for moving forward

• Continue and improve the coordination between the MoHFW and the MoWCD as well as the Ministry of Education. For the development of a physical rehabilitation strategy/action plan, a multi-stakeholder task force could be established, including all concerned ministries as well as representative of professional organisations, service providers and DPOs. International organisations could also bring in experience from other countries and present lessons learned from similar practices. This regional mapping is just one example.

• Include indicators on physical rehabilitation and disability in the Health Information System as new services would be introduced in the public health system, so that quality and performance can be measured and monitored.

• Develop a set of minimum quality standards for physical rehabilitation.
Annex 3.1: Attendance list national workshop Odisha

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr. Dilip Ku. Singh</td>
<td>SIDR</td>
</tr>
<tr>
<td>Mr. Pradyum Kumar Rath</td>
<td>Aaina</td>
</tr>
<tr>
<td>Mr. Hemant Ku. Subudhi</td>
<td>OVM</td>
</tr>
<tr>
<td>Mr. Ranjit Mohapatra</td>
<td>SADHANA</td>
</tr>
<tr>
<td>Mr. Basant Nanda</td>
<td>SVNIRTAR</td>
</tr>
<tr>
<td>Mr. Niranjan behera</td>
<td>OVM</td>
</tr>
<tr>
<td>Mr. Ajay Jena</td>
<td>PARIVAR</td>
</tr>
<tr>
<td>Mr. K. Anand Rao</td>
<td>ODPM</td>
</tr>
<tr>
<td>Mr. B.B. Pattanayak</td>
<td>SIDR</td>
</tr>
<tr>
<td>Mr. R.K.Sharma</td>
<td>VRC</td>
</tr>
<tr>
<td>Mr. Satya Mohapatra</td>
<td>I.H.S</td>
</tr>
<tr>
<td>Mr. Deepak Sahoo</td>
<td>Prosthetic and Orthotic Association</td>
</tr>
<tr>
<td>Dr. Narayan Pati</td>
<td>Chetna</td>
</tr>
<tr>
<td>Mr. Umesh Patra</td>
<td>ekta</td>
</tr>
<tr>
<td>Ms. Dipti Dash</td>
<td>SADHANA/ODPM</td>
</tr>
<tr>
<td>Puruna Khatai</td>
<td>Aaina</td>
</tr>
<tr>
<td>Mr. Akshya Barik</td>
<td>ODPN</td>
</tr>
<tr>
<td>Mr. Bhubanananda Pani</td>
<td>PT Association</td>
</tr>
<tr>
<td>Mrs. Pragyan Singh</td>
<td>OT Association</td>
</tr>
<tr>
<td>Mr. Ashutosh Hota</td>
<td>RARE</td>
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<tr>
<td>Mr. Gauranga Patra</td>
<td>SVNIRTAR</td>
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<tr>
<td>Mr Nandan Acharya</td>
<td>SIDR</td>
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<td>Mr. Debashish Pramanik</td>
<td>ODPN</td>
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<td>Mr. Subhash Ch. Sahoo</td>
<td>SIDR</td>
</tr>
<tr>
<td>Mr. Sanyasi Behera</td>
<td>Swabhiman</td>
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</table>

Annex 3.2: List of consultative meetings

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<thead>
<tr>
<th>Institution/association</th>
<th>Persons consulted</th>
<th>Date of meeting</th>
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<tbody>
<tr>
<td>Director of welfare of persons with disabilities, Government of Odisha</td>
<td>Mr. B.B Pattanaik</td>
<td>26-02-2013</td>
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<tr>
<td>Director of Health, Government of Odisha</td>
<td>Mr. Nalini Kanta Dash</td>
<td>07-03-2013</td>
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<tr>
<td>Indian Association of Physiotherapy Utkal Branch,</td>
<td>Executive members</td>
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<tr>
<td>All India Occupational Therapy Association</td>
<td></td>
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<td>Odisha Branch and Orthotic &amp; Prosthetic Association of India, Odisha Branch.</td>
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### Country: India

<table>
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<td>Human development index rank</td>
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<tr>
<td>GNI per capita (PPP in US$)</td>
<td>3,337</td>
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<td>Life expectancy at birth (years)</td>
<td>64.4</td>
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<tr>
<td>Mean years of schooling (years)</td>
<td>4.4</td>
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<tr>
<td>Expected years of schooling (years)</td>
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<td>Total population</td>
<td>1,224,614,000</td>
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<table>
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<tbody>
<tr>
<td>Population of persons with disabilities</td>
<td>(a) 21,900,000 (2002)</td>
</tr>
<tr>
<td>Proportion of persons with disabilities to total population</td>
<td>(a) 2.13 per cent (2002)</td>
</tr>
<tr>
<td>Employment rate of persons with disabilities</td>
<td>(a) 34 per cent (2002)</td>
</tr>
<tr>
<td>Access to education</td>
<td>47.5 per cent in the rural area and 44.4 per cent in the urban area</td>
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</table>

<table>
<thead>
<tr>
<th>3/Definitions</th>
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<tbody>
<tr>
<td>Definition of disability</td>
<td>The Persons with Disabilities Act (1995) provides the following definition of ‘disability’:</td>
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<tr>
<td>- blindness;</td>
<td></td>
</tr>
<tr>
<td>- low vision;</td>
<td></td>
</tr>
<tr>
<td>- leprosy-cured;</td>
<td></td>
</tr>
<tr>
<td>- hearing impairment;</td>
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</tr>
<tr>
<td>- locomotor disability;</td>
<td></td>
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<tr>
<td>- mental retardation;</td>
<td></td>
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<td>- mental illness.</td>
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<tr>
<td>Definition of persons with disabilities</td>
<td>The Persons with Disabilities Act (1995) defines ‘person with disability’ as ‘...a person suffering from not less than forty per cent of any disability as certified by a medical authority.’</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>4/Commitment to International Instruments on Disability</th>
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<tbody>
<tr>
<td>Ratification or signatory of the Convention on the Rights of Persons with Disabilities (CRPD), and its Optional Protocol</td>
<td>Signed Convention on 30 March 2007; Ratified Convention 1 October 2007</td>
</tr>
<tr>
<td>Ratification or signatory of the Convention on Cluster Munitions</td>
<td>The Optional Protocol has not been signed</td>
</tr>
<tr>
<td>Ratification or signatory of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction</td>
<td>No</td>
</tr>
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</table>

### Legal Framework

<table>
<thead>
<tr>
<th>5/Legal Framework</th>
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<tbody>
<tr>
<td>Constitution of India (1996, part. IV, art. 41)</td>
<td></td>
</tr>
<tr>
<td>Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act (1995); Mental Health Act (1987)</td>
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<th>6/Policy Framework</th>
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<tr>
<td>National Policy for Persons with Disabilities (2006)</td>
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<tr>
<th>7/Institutional Framework</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>The national coordination mechanism or disability focal point</td>
<td>Central Coordination Committee and Central Executive Committee, under the Ministry of Social Justice and Empowerment</td>
</tr>
</tbody>
</table>

### Definitions

**Definition of disability**

The Persons with Disabilities Act (1995) provides the following definition of ‘disability’:

i. blindness;

ii. low vision;

iii. leprosy-cured;

iv. hearing impairment;

v. locomotor disability;

vi. mental retardation;

vii. mental illness. (India 2005, art. 2, para. i)

**Definition of persons with disabilities**

The Persons with Disabilities Act (1995) defines ‘person with disability’ as ‘...a person suffering from not less than forty per cent of any disability as certified by a medical authority.’

### Ratification or signatory of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction

Signed Convention on 30 March 2007; Ratified Convention 1 October 2007. The Optional Protocol has not been signed.
Sri Lanka
1. INTRODUCTION

Sri Lanka, with a population of over 21 million, has during the last decades shown important development achievements and is estimated to reach most of the Millennium Development Goals by 2015\(^5\). A sustained economic growth boosted after the end of the conflict and more important, an investment in universal access to health care and education has enabled many Sri Lankans to move out from poverty. At the same time, there are worrying figures that show increasing inequalities and also regional disparities indicating unequal distribution of this economic growth. The Poverty Gap index which measures the depth of poverty varied among districts from 0.7 in Colombo and Gampaha, 5.1 in Batticaloa, 2.6 in Jaffna and 2.8 in Moneragala.\(^6\) The Northern and Eastern provinces have fewer public health structures available, partly due to a lack of investment during the years of conflict. Several districts in these provinces will in fact not reach the MDGs, for instance in maternal and child mortality or poverty.

Data on disability and on the situation of persons with disabilities is very scarce in Sri Lanka. The only official figures come from the 2001 census, and indicate a disability prevalence of 1.6%\(^7\). This is most probably an underestimation, due perhaps to the definition of disability used in the census as well as to how questions were asked, and also the capacity of enumerators to identify disability. In addition the census enumeration was only partially carried out in Mannar and Vavuniya districts in the Northern province and Trincomalee and Batticaloa districts in the Eastern province; in Jaffna, Mullaitivu and Kilinochchi districts enumeration was not conducted due to the conflict.\(^8\) Recent figures from the ‘World Report on Disability’ indicate that 15% of the world’s population lives with some kind of disability\(^9\). Within this estimate the number of people with disabilities in Sri Lanka would be around 3 million. This is considered by some to be too high an estimate. Numbers alone do not provide sufficient information on how to design policies and services because they do not indicate acceptability, availability and accessibility of services, the barriers to participation including the causes of discrimination and exclusion of this group of the population. However it may serve to draw some analyses as will be shown later on.

Data from the Household Income and Expenditure Survey 2009/2010 indicates that 14.4% of households have a member with a disability or with chronic illness\(^10\). People with disabilities or households with a disabled family member, often face higher poverty and low employment.

1.1 Overview of the health system in Sri Lanka

Sri Lanka’s health delivery system comprises a network of Health Units and Medical Institutions.

Health Units: The Medical Officer of Health Area is the smallest Health Unit in a health district and is tasked with preventive health and Mother and Child (Family) Health Care (MCH).\(^11\) Each district is made up of between seven to twenty Health Divisions. There are 331 MOH areas spread throughout the country. Each Medical Officer of Health Area is managed by a Medical Officer of Health (MOH) supported by a team of public health personnel comprising of Public Health Nursing Sisters (PHNS), Public Health Inspectors (PHI), Supervising Public Health Midwives (SPHM) and Public Health Midwives (PHMs). The Public Health Midwife (PHM) is the ‘front line’ health worker and provides domiciliary family care with a focus on mothers and children within the community. The PHM is given a well-demarcated area having a population ranging from about 2000 to 5000.\(^12\)

1\(^5\) http://www.lk.undp.org/content/srilanka/en/home/mdgoverview.html
2\(^6\) CBSL HIES 2013
3 Data related to disability from the 2011 Census is due to be released end 2013
4\(^7\) http://www.statistics.gov.lk/PopHouSat/PDF/docs%20Disabled%20Chapter.pdf
5\(^8\) ‘World Report on Disability’, WHO and The World Bank, 2011
10 Health units and divisions differ from administrative districts and divisions.
Medical Institutions: These deliver services at primary, secondary and tertiary levels.

Primary Care Institutions or Divisional Hospitals include Peripheral Hospitals, Rural Hospitals and Primary Medical Care Units (previously called Central dispensaries and Maternity Wards). Divisional Hospitals provide both inpatient and outpatient care including the provisions of basic health facilities for the treatment of minor ailments. Referral to secondary and tertiary care institutions for further treatment, provision of perinatal care and follow-up of referrals from secondary and tertiary care. On the other hand Primary Care Units concentrate on outpatient services.

Secondary Care Institutions include District General Hospitals and District Base Hospitals. They generally offer four common specialities such as Medicine, Surgery, Paediatrics, and Obstetrics & Gynaecology. They sometimes offer Eye, ENT and Dermatology. Essential back up services are available at these institutions including laboratory services and basic radiological services. Increasingly physiotherapy is being introduced in these hospitals.

Tertiary Care Institutions include Teaching Hospitals and Provincial Hospitals. A range of specialties and support services are available at the tertiary level. Specialized Hospitals also deliver services at the tertiary level.

Within the institutional system all rehabilitation therapies are available at all tertiary institutions, while some aspects of rehabilitation are generally available in most secondary institutions. Assistive devices including prosthetic and orthotic services and seating and positioning services are available at some tertiary and a small number of secondary level institutions. These are also made available by a few NGOs and private institutions.

Access to services and referral to rehabilitation may typically involve a consultation with a private Doctor, general practitioner or Doctor in an outpatient department and onwards to either a specialised Doctor or to the rehabilitation department. At tertiary and secondary levels for some specialties such as neurology, orthopaedics, paediatrics and rheumatology and rehabilitation there may be a dedicated rehabilitation department who receive rehabilitation referrals and surgeons may directly refer a person with an amputation for prosthetic rehabilitation depending on availability of services. People who have an existing prosthesis who require review may be able to directly access P&O services as a returning client. There is no established system for referral back to community level for follow up as there is no provision for outreach rehabilitation under the MoH structure and community based rehabilitation is not widespread or delivered in coordination with health services.

Sri Lanka took steps to equalise access to health care in the 1930s when the country adopted policies for universal health care and free education. This resulted in remarkable achievements in child and maternal mortality. Sri Lanka now has a life expectancy of 75 years and an individual can expect to live 62 years free from disability. There has been a strong emphasis on increasing access to basic health care at community level and on providing accessible ante and post-natal care. Most women today receive ante-natal care and almost all deliver their children at the hospital.

1.2 Physical rehabilitation

The extent of the need for physical rehabilitation services in Sri Lanka is not well known. There is little data available about the prevalence of disabling diseases and impairments and of persons that may need such services at national and local levels. The lack of disability disaggregated data in both health and social sectors constitutes an important challenge in terms of planning and monitoring service needs and provision. With physical rehabilitation services being provided by different stakeholders including government hospitals, not-for-profit national and international NGOs and the private sector information is not easily obtained. This is in most part due to the absence of procedures for collecting and registering such data and for related regulatory procedures.

A rough idea about the needs for physical rehabilitation in Sri Lanka can be drawn from estimated prevalence of some diseases in other countries although it is necessary to conduct more robust studies and collect data to have a better understanding. These estimates must be considered with caution.

- Spinal cord injuries: persons with spinal cord injuries are in need of on-going access to physical rehabilitation services as well as assistive devices. Studies carried out in other countries in Asia estimate a spinal cord injury prevalence of between 93–174 persons per one million population. The Spinal Cord Injuries Association of Sri Lanka estimates that between 3,000–4,000 persons have spinal cord injuries and could be in need of long term rehabilitation services for improving function. They estimate an annual incidence of spinal cord injury due to accident or other trauma to be 250–300 persons. These figures are expected to increase in the absence of an effective prevention strategy. Traffic congestion for instance is rapidly increasing.

- Cerebral palsy: children diagnosed with cerebral palsy are another group in need of long-term physical rehabilitation services. Estimated incidence in different countries vary between 2.12–2.45 per 1000 live births. Using data from


Sources
2007 in Sri Lanka on live births, around 1,000 children could be born with cerebral palsy each year, and many of them will be in need of long-term physical rehabilitation services, including positioning and mobility devices. The International Society for Prosthetics and Orthotics (ISPO) say that cerebral palsy is usually identified as the most common physically disabling condition seen by child health professionals. They suggest a similar prevalence of 2.0–2.5 per 1,000 live births, a figure has remained quite stable over many decades.18

- **Stroke, a cerebral-vascular accident**, is another health condition that is a leading cause of disability in many countries. Until now there are no epidemiological studies on incidence and prevalence of stroke in Sri Lanka but stroke was defined as the third most common cause of death in the Health Master Plan.19 One can therefore assume that there is a significant population that survives a stroke and where physical rehabilitation is essential for recovery and reintegration in daily activities, employment or other livelihood and social activities.20

- **Diabetes mellitus** is a risk factor for stroke. In addition people with diabetes tend to be more at risk of amputation due to complications of diabetes including peripheral neuropathy, vascular disease and infection. A study conducted between 2005–6 identified one in five adults in Sri Lanka has either diabetes or pre-diabetes and one-third of those who have diabetes are undiagnosed.21

- **Violence and injury** are causes of many deaths worldwide and resulting injuries can lead to permanent disability.22 Sri Lanka, a country in post-conflict and a country in economic transition demonstrating a rapid increase in the purchase of motor vehicles, will most probably see an increase in traumatic injuries. In 2011 2,721 casualties of road traffic accidents were recorded.23 Many of these injuries can lead to temporary or permanent disabilities. A lack of adequate health care including physical rehabilitation will potentially constrain economic and social participation after injury. An amputee for example, who does not have satisfactory follow-up care and rehabilitation may face secondary complications and consequent unnecessary barriers which delay and impede participation in society.

**Assistive devices**

Assistant devices are included in this section because they constitute a vital component of physical rehabilitation for people with conditions described above. Assistive devices include wheelchairs, seating aids and other positional devices, crutches, walking frames, wheeled walkers, tricycles, prosthetics and orthotics. Such devices are used to enhance an individual’s abilities, improve their function, and enable them to be better able to live independently and to participate in their families and communities.24 WHO states that in many developing countries only 5–15% of people who require assistive devices have access to them. This may be the situation in Sri Lanka where production of such devices is limited and not easily accessible. These devices are provided free of cost by the State but availability is significantly limited by budgetary constraints and potentially their effective use limited due to skills in assessment and provision. NGOs and the private sector do manufacture devices, but costs are often prohibitive and beyond the reach of the majority of people in need of physical rehabilitation who are poor. Costs and financial support are critical if the device and make adjustments as necessary. The P&O CAT I may supervise and conduct training and education of other P&O staff (Cat II and III) and is involved in research and evaluation programs. The P&O CAT II is responsible for direct patient care and provision of services, and management of the orthopaedic workshop if a CAT I professional is not available. The tasks are similar as a CAT I specialist, but they are usually not involved in research and development activities. The P&O CAT II provides and produces services for the more common levels of P&O devices. This is often the highest category of specialist at a mid-term period until CAT I professionals have been trained.25

WHO and ISPO, 2005. The P&O technician CAT II fabricates and assembles devices and takes part in their maintenance, repair and replacement. The technician is not involved in direct P&O services to the users.

**National Policy on Disability 2003, Ministry of Social Services**

0.5% of the population is in need of P&O services, which is approximately 105,000 persons in Sri Lanka.26 This requires production of around 35,000 appliances yearly. To satisfy these needs around 140 trained Prosthetists and Orthotists (CAT I and II)27 and an additional 560 bench workers (CAT III)27 should be available in the country.

**2. GOVERNANCE AND LEGAL FRAMEWORKS**

This section looks at existing policies in health and social services, and more specifically at laws and policies on disability and physical rehabilitation. Health and rehabilitation are provided free of cost by the state.

Whilst the National Policy on Disability28 is rights-based, an analysis of other key policies related to poverty reduction and human development as well as overall health and social policies shows that disability may still too often be considered to be a medical and/or welfare issue, and not adequately a matter of human rights and equal opportunities. As a shift towards the latter, disability is included in some key health and social policies. Disability is mentioned in the main policy for social protection and development, the Samurdhi programme run by the Ministry of Economic Development. The Samundhi programme identifies families who are poor and vulnerable and eligible for economic support. These families are at the same time supported to start livelihood activities for poverty reduction.29 The Samundhi programme was set-up in 1994. It is fully financed by the Sri Lankan Government. Evaluations by Government and others including the World Food Program have shown positive benefits and impact. The Ministry of Social Services provides many welfare benefits for persons with disabilities which are described later in this report.

‘Physical disability’ has also been defined as a priority area that needs focused attention in the Health Master Plan 2007–12. The following sections include a program on Disabled Health under the Directorate of Youth Elderly and Disabled. A draft National Action Plan for Disability (described later) is now (November 2013) before the Cabinet of Ministers awaiting approval. This includes strategies to improve access to and availability of physical rehabilitation.

**2.1 Disability laws and policies**

Sri Lanka enacted its first disability law called the ‘Protection of the Rights of Persons with Disabilities ActNo.28’ in 1996. The Ministry of Social Services took steps to draft a new “Disability Rights Bill” in 2006 to provide the local law for implementation of the CRPD. This is yet being processed.30 Although the country signed the UNCRPD in 2007, it is not yet ratified it or signed the optional protocol. A National Policy on Disability was enacted in 2003 (based on the then draft UN CRPD) and the National Action Plan for Disability (NAPD, based on the UNCRPD) is awaiting Cabinet approval (see above). The NAPD has seven components to provide a rights-based long-term multisectoral framework within seven thematic areas. These are:

21 Ibid.
22 P&O CAT I is responsible for direct user services and management of orthopaedic workshops, usually at reference centres or training institutions. P&O CAT I advise on the design of devices, and have skills necessary to assess the fit and function of the device and make adjustments as necessary. The P&O CAT I may supervise and conduct training and education of other P&O staff (Cat II and III) and is involved in research and evaluation programs. The P&O CAT II is responsible for direct patient care and provision of services, and management of the orthopaedic workshop if a CAT I professional is not available. The tasks are similar as a CAT I specialist, but they are usually not involved in research and development activities. The P&O CAT II provides and produces services for the more common levels of P&O devices. This is often the highest category of specialist at a mid-term period until CAT I professionals have been trained.
24 20 WHO disabilities and rehabilitation who.int/disabilities
25 20 WHO and ISPO, 2005. The P&O technician CAT II fabricates and assembles devices and takes part in their maintenance, repair and replacement. The technician is not involved in direct P&O services to the users.
26 20 National Policy on Disability 2003, Ministry of Social Services
1. Empowerment
2. Health and rehabilitation
3. Education
4. Work and employment
5. Mainstreaming and enabling environments
6. Data and research
7. Social and institutional cohesion

Social Services: The Ministry of Social Services provides the following welfare support for persons with disabilities and their families:

- Construction of a new house, maximum SLR 250,000
- Improvements to own house SLR 150,000
- Improve accessibility of house and toilet SLR 35,000
- Self-employment assistance SLR 25,000
- Medical assistance SLR 20,000
- Cost of medicines and transport to hospitals SLR 20,000
- Assistive devices to those from low-income groups—tricycles, wheelchairs, crutches, hearing aids, spectacles,
- Cash transfers under Mahinda Chinthana, per month

The Ministry of Social Services has a limited provision for assistive devices; they are planned and budgeted for under centralized and decentralized processes (see section 3.2). However there is limited coordination among sectors for assistive devices, which are planned and budgeted for under centralized and decentralized processes (see section 3.2).

The Ministry also conducts courses in sign language, Braille and orientation on mobility for government officers. The Department of Social Services runs a National Community-Based Rehabilitation Programme and five Special Vocational Training Centres for people with disabilities.

Sri Lanka has a number of welfare measures in place to support people who are poor and their families: at societal level disability is most often seen in a charitable context. At the same time, since the National Policy on Disability was approved in 2003, the state sector has been slowly moving towards inclusion and rights. The Ministry of Education is striving to achieve the MDG goal of primary universal education by 2015 which should improve possibilities on the ground for the inclusive education of children with disabilities. The Ministry of Child Development and Women’s Affairs is taking positive steps to encourage inclusive preschools. The University Grants Commission is encouraging more universities to make them open to students with disabilities. The Ministry of Economic Development includes people with disabilities in their community development programmes. It is soon to have a legal mandate for including disability in all aspects of their work. People with disabilities are increasingly visible in wage employment in the corporate sector and supported through initiatives such as the Employers Federation of Ceylon disability network which matches employers with employees with disabilities.

Annex 3 provides a summary on the legal framework and policies linked to disability in Sri Lanka compiled by the UN Economic and Social Commission for Asia and Pacific (UNESCAP).

2.2 Physical rehabilitation policies
Physical rehabilitation started on a small scale in Sri Lanka when the WHO first introduced physiotherapists to the health system around 1957. It has been growing slowly over the decades until it has recently received greater attention from the state. Whilst the first ‘Rheumatology and Rehabilitation Hospital’ was started in Ragama in the Western Province in 1971, the Ministry of Health today runs five smaller rehabilitation hospitals in 5 provinces. The Ministry of Health has short-term plans to have at least one rehabilitation hospital per province and to upgrade at least 11 hospitals with facilities for physical rehabilitation. Prosthetics and Orthotics services are mostly managed by local and international NGOs, particularly in conflict-affected areas where there are many people with physical impairments.

The draft National Plan for Disability (NAPD) names health and rehabilitation as one of its seven thematic areas. Implementation and monitoring of this component is the responsibility of the Ministry of Health. The NAPD allocates roles and responsibilities to stakeholders, so any confusion that may exist is clarified while representing the Ministry of Social Services’ clear remit to maintain physical and health professionals; ensure access to specialized services and health care facilities required/used by people with disabilities; strengthen strategies for specific impairments including physical impairments; sustain improvements to costs, affordability and to indigenous medicine. The Ministry of Social Services will continue to distribute mobility devices to individuals who have physical impairments at the grass-roots and follow-up and support their community living.

Rehabilitation is defined in the NAPD as ‘a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environment’. This definition is derived from the World Report on Disability (2011). The NAPD draws on the World Report on Disability to adapt evidence-based actions for Sri Lanka. Actions to improve access to, and use of physical rehabilitation in the health sector identified in the NAPD include:

- Setting up rehabilitation units in all teaching, provincial and district general hospitals for short and medium-term care in a phased manner, with orthotists and rehabilitation specialists, specialized nursing, physiotherapy, occupational therapy, speech and language therapy and social work.
- Setting up dedicated Rehabilitation hospitals for long-term care in each district, starting with one per province.
- Developing the Ragama Rehabilitation Hospital as the National Centre of Excellence for children and adults.
- Making available and accessible appropriate assistive technologies and devices required by people with disabilities for their education, work and independent living within their communities.
- Assess requirements of existing cadres to provide optimal disability-related health care and rehabilitation work.
- Review and revise basic and continuing education curricula of rehabilitation personnel and other personnel working in rehabilitation and ensure their continuing professional and career development.
- Determine new categories and cadres required (i.e. social workers, psychologists etc.) and carry out/facilitate their training.

The Development of professional standards, minimum standards of work and ethical practice in disability work is included in the thematic area on ‘Social and Institutional Cohesion’ of the NAPD. Within this, the development of a Regulatory Framework for Physical Disability will be the responsibility of the Ministry of Health.

2.3 Participation of persons with disabilities in policy making
In line with the Protection of the Rights of Persons with Disabilities Act No 28 of 1996, the National Council for Persons with Disabilities (NPCD) was established in 1996 together with the National Secretariat for Persons with Disabilities (NSPD). The role of the Council is to promote, advance and protect the rights of persons with disabilities in Sri Lanka and to...
advise the government on issues pertaining to persons with disabilities. The Minister of Social Services is the Chairman of the Council which consists of 21 members appointed by the President on the recommendation of the Minister. The Council includes representatives of Disabled People's Organisations (DPOs), and is expected to maintain at least 51% representation from them together with other organisations working in the field of disability. Other members include relevant ministries, departments, professionals and non-governmental organisations. While the intention of 51% representation is that it would ensure the participation of persons with disabilities in decision-making processes, there were concerns raised from persons with disabilities during this mapping process who doubted the adequacy of their representation and how much influence their involvement has in reality.

The National Secretariat for Persons with Disabilities was established to implement the decisions of the Council. They also receive allocations from the government budget to carry out welfare programmes for the Ministry of Social Services listed earlier.

2.4 Regulatory framework for physical rehabilitation service delivery

A regulatory framework for public and private services can be defined as a set of interrelated instruments meant to control, coordinate and improve the provision of public services, and in this case for physical rehabilitation services. They should be defined and ultimately supervised by central authorities but can be implemented and monitored by either central and/or local authorities or agencies mandated to do so. This framework could regulate: (a) the demand for, and access to, services, (b) the supply of these services by various providers and (c) the actual provision of physical rehabilitation services. 37

This mapping exercise actively involved representation of many key stakeholders that are concerned about regulating physical rehabilitation services in Sri Lanka.

During discussions about the regulatory framework for physical rehabilitation, participants identified the lack of coordination between the Ministry of Health and the Ministry of Social Services as a significant impediment to the development of a regulatory system. With the Ministry of Health increasingly being involved in providing physical rehabilitation services, its role clarified in the National Action Plan for Disability, and with its intention of developing a national strategy for physical rehabilitation, the opportunity has risen for the development of a regulatory framework for physical rehabilitation service delivery. At present, the functions of the Ministry of Social Services include the following in relation to physical rehabilitation:

- Providing assistive devices, mainly mobility aids but also support for prosthetic devices.
- Running a centre for child guidance services at Navinna, Maharagama for children with disabilities under the Department of Social Services. 38
- Implementing a National CBR program. However key informants of this mapping were of the view that basic rehabilitation therapy including referral is very limited within the CBR programme.

To add to the challenges of coordination, there are national and international NGOs as well as private health companies and hospitals delivering physical rehabilitation services. The Ministry of Health is currently working on strengthening the regulation of private health care providers. However, it is still unclear how private companies producing assistive devices or physiotherapy centres will be regulated and supervised. Due to the lack of information about their numbers, type and geographic location, they have not been considered in this mapping. The focus has been on public services and a few aspects of some NGO programs.

Table 1 gives an overview of the situation in Sri Lanka regarding some of the key regulatory mechanisms that are necessary to ensure fair and equitable access to physical rehabilitation services.

The analysis of the regulatory framework is based very much on discussions at the national workshop under the study. It presents an ad hoc development of a number of actions rather than a planned strategy.

<table>
<thead>
<tr>
<th>Regulatory mechanism</th>
<th>Responsible entity</th>
<th>Situation</th>
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<tbody>
<tr>
<td>Gate-keeping mechanisms (information, referral and access)</td>
<td>Ministry of Health, Ministry of Social Services (national and devolved/ decentralised)</td>
<td>There is no centralised system for assessing needs and demands or for developing territorial maps of services.</td>
</tr>
<tr>
<td>Evaluation of needs and demands (macro level)</td>
<td>Ministry of Health, Ministry of Social Services (national and devolved/decentralised)</td>
<td>Access criteria are not yet standardised, each centre or service makes its own assessment and decides on treatment. Ministry of Social Service has criteria for providing mobility devices which are available at divisional level where they are mostly distributed.</td>
</tr>
<tr>
<td>Access criteria to physical rehabilitation services (including mobility and other assistive devices)</td>
<td>Ministry of Health, Ministry of Social Services</td>
<td>Physical rehabilitation centres and services</td>
</tr>
<tr>
<td>Contracting and funding</td>
<td>Ministry of Health, Ministry of Social Services</td>
<td></td>
</tr>
<tr>
<td>Licensing and authorisation</td>
<td>Ministry of Health, Ministry of Social Services</td>
<td>No quality standards of official licensing/authorisation procedures linked to quality standards exist in any of the ministries. Services are not continuously evaluated according to any standards. All NGOs have to register with the National NGO Secretariat (under Ministry of Defence) and, depending on where they work, locally at district or divisional secretariats. NGOs working in disability should register with the National Secretariat for Persons with Disabilities within the Ministry of Social Services. Those providing physical rehabilitation should also have an agreement with Ministry of Health at national/provincial level. Some NGOs do not follow these regulations. Presidential Task Force approval is needed to work in the Northern Province, and an agreement with Ministry of Health facilitates this process. Information around registration of providers and who does what and where is not centralised and thus difficult to access.</td>
</tr>
<tr>
<td>Government funding</td>
<td>Ministry of Health, Ministry of Social Services</td>
<td>Ministry of Health includes physical rehabilitation in its budgets for teaching, provincial and specialised hospitals. Provincial authorities include physical rehabilitation services in District and Base Hospitals.</td>
</tr>
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</table>
A number of important regulatory mechanisms are still missing, such as authorisation or licensing of physical rehabilitation services based on common minimal quality standards and a regular monitoring of quality and performance by health and social service authorities. Such regulations are important in order to build credibility and transparency of services.\(^{40}\) Regular needs assessment at geographical levels is also missing, meaning that the Ministry of Health does not have any centralised mechanisms of defining the number and types of physical rehabilitation services required at each administrative level. This is fundamental both for improving access to services and for developing a long-term human resource plan for training rehabilitation professionals. Another important mechanism is to have a well-established information system available at all levels and to make sure that the people in need of these services get the proper information. This requires in turn that disability and physical rehabilitation is included in the health monitoring and evaluation system at national and provincial levels. Much of these components have been taken into account in the NAPD.

Teaching hospitals and primary health care institutions are centralised under the Ministry of Health; provincial hospitals are decentralised. The Ministry of Social Services is decentralised for budgeting and procurement, there are often personnel from central and provincial level working alongside one another within divisions.

### 3. DELIVERY OF PHYSICAL REHABILITATION SERVICES

Service delivery, one of the most important pillars of health, requires that sufficient services should be available where people need them, of adequate quality and be affordable. In terms of physical rehabilitation it means that basic services should be available close to where people live. As any other health related service, physical rehabilitation should be available at primary health care level (closely linked to existing CBR and other development and welfare programs at community level) where many of the needs can be met.\(^{43}\) At secondary level, both acute and long-term physical rehabilitation should be offered, and at tertiary level, more comprehensive and specialised physical rehabilitation should be available, both in general hospitals and national referral hospitals and clinics. These services should be provided under a clear mandate of the relevant and responsible line Ministries.

This mapping revealed a gradually developing system of physical rehabilitation services with increasing commitments coming from the Ministry of Health and Ministry of Social Services. There are remaining gaps in terms of geographical coverage, especially at community level and an unequal service distribution among districts, a lack of capacity among existing providers and shortage of trained workers as well as unclear referral mechanisms between public health facilities and physical rehabilitation services.\(^{42}\) Another important challenge, also identified in Handicap International’s KAP study in 2012, is the lack of awareness among persons with disabilities about the existence and importance of physical rehabilitation. Yet another difficulty is the lack of long-term follow-up at home and community level, which may result in people abandoning their rehabilitation or stop using their assistive device. Recruiting physical rehabilitation staff to tertiary and secondary level hospitals in some provinces is said to be problematic due to limited number of trained cadres and difficulties to retain staff in these provinces. This affects both availability and quality and hinders the setting-up of new physical rehabilitation units. In spite of these concerns having been expressed by some, at present at least 332 physiotherapists are employed in more than 72 state hospitals taking them into peripheral areas of districts. The Ministry of Health

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\(^{41}\) Handicap International. [KAP survey. Attitudes and awareness in the CBR program through the Department of Social Services.](http://www.who.int/disabilities/cbr/en)

\(^{42}\) A study done by the Rheumatology and Rehabilitation Hospital showed that community members and not a health facility or social service office referred 56% of patients coming to their hospital demonstrating a valuable and different perspective.

\(^{43}\) Handicap International. [KAP survey. Attitudes and awareness around physical rehabilitation in Afghanistan, Bangladesh, Orissa (India) and Sri Lanka, October 2012.](http://www.who.int/disabilities/cbr/en)
is also at present taking steps to start the placement of physiotherapists at Medical Officer of Health level.

3.1 Identification and early intervention

The Ministry of Health, through its mother and child health programme implemented by the Family Health Bureau (FHB) has an effective strategy for the early identification of impairments in children, and of the risk of impairment. Questions and simple tests are included in the Child Health Development Record (CHDR used by public health midwives) to identify delayed development and impairments. Two interventions follow thereafter. One, the child is referred to the Medical Officer of Health and then onward when necessary. Two, the public health midwife interacts with the child and family for early stimulation and support at home. At the same time the FHB is researching, developing and expanding this system to improve home-based care with the setting up of child guidance centres at Medical Officer of Health level with secondary referral facilities at Base Hospitals.\(^{44}\)

Impairments in adults are perceived by them or their families in the first instance. Medical advice is most often sought, either from allopathic practitioners in general practice or in hospital or from practitioners of indigenous medicine.

Although an assessment of the national CBR program was not part of this mapping exercise key informants held the view that knowledge of CBR community workers on identifying these impairments and of dealing with them are limited.

General Practitioners (both indigenous and allopathic) and District and Base Hospitals are the places where adults go to be assessed by a medical officer. In Handicap International’s KAP study, families themselves or community members were said to make most identification and it was common to get information from neighbours or relatives of where to seek help.\(^{45}\) With increased knowledge of disability in communities there is a greater possibility of early detection.

Increasingly where infants and young children are concerned parents share their concerns about their child with public health midwives (see above) who visit their homes. Or the public health midwife herself detects impairment when she monitors each infant’s growth and development using the child health development record (CHDR). Increasingly therefore identification is made early and interventions start immediately in the homes and through referral to the Medical Officer of Health and onward if necessary to relevant health institutions. This increases chances for children with physical disabilities, of more normal development and later on to access school and other social activities. This will further on have a positive impact on their opportunities for employment and securing a livelihood.

3.2 Rehabilitation medicine, therapy and assistive devices

Rehabilitation medicine together with surgical interventions for physical impairments is combined with short and long-term courses of therapies such as physiotherapy, occupational therapy or speech and language therapy.\(^{46}\) Modifications to the home environment as well as support and counselling is usually also included in physical rehabilitation, and can be important factors for supporting inclusion in daily life activities. These may not be addressed adequately in the absence of community and home-based programmes. Assistive devices, such as P&O appliances and other mobility aids, are also crucial components of physical rehabilitation and sometimes necessities for going to school or engaging in livelihood activities.

Physical rehabilitation at primary health care level

The mapping indicates that basic physical rehabilitation is seldom available at community level. As a matter of policy, physiotherapy has not yet reached health units (Medical Officer of Health areas). This will surely change with further development of the health system. For instance, the Ministry of Health is at present taking steps to start the placement of physiotherapists at Medical Officer of Health level. At present, people have to travel to the nearest district hospital or base hospital (secondary institutions) where physiotherapy is available. In line with Handicap International’s KAP study, this mapping showed that secondary level physical rehabilitation facilities mainly provide services for acute conditions, and that longer term physiotherapy together with occupational therapy ad increasingly speech and language therapy is available in tertiary institutions. This may often lead to situations in which people are discharged after acute trauma or diseases could have secondary complications that result in or worsen their disability. Most informants agree that an accessible and efficient referral system for physical rehabilitation is not yet in place. Other barriers identified were the costs for transportation and accommodation at provincial hospitals, as poverty remains high among persons with disabilities in Sri Lanka.

The Ministry of Social Services implements a National CBR program. Mapping results show both positive and negative aspects of the program. The lack of an effective support system from the division upwards with a consequent high turnover of community volunteers was a major problem. So were the variations of program effectiveness and quality between different districts. While the Ministry of Social Services used a cascade effect by first training all their Social Services Officers in CBR who in turn were training volunteers, the continuous follow-up of work varied widely even between different divisions. Where NGOs run CBR projects, opportunities for continuous training and incentives are higher. NGO coverage is however rather limited. A key challenge expressed during the mapping process was the high volunteer turnover. According to the Ministry of Social Services around 8,000 of the 14,000 volunteers that were trained are said to be currently active in the field.

Mobility aids are disbursed centrally through the National Council for Persons with Disability and the Secretariat, as well as at provincial level as part of the CBR programme. Their availability in terms of quantity though is grossly limited by budget compared to needs. The draft National Action Plan for Disability calls for the Ministry of Social Services and the Ministry of Health to review jointly past CBR experiences each has had separately and to come together to develop a rights-based, sustainable, multisectoral CBR strategy.

In addition to the public system there are a few NGOs that implement CBR programs and/or provide physiotherapy services at community level. Information provided through interviews and service providers indicate that these services function satisfactorily on the whole, but have limited coverage. They are dependent on external funds and are project based; activities can be changed or stopped with short notice. These rehabilitation centres are primarily located at provincial and district levels and deliver out-reach services. Some may provide support for travel and accommodation.

Physical rehabilitation at secondary institutions

At secondary institution level, five out of the total 25 administrative districts have a rehabilitation hospital\(^{47}\) where medium term physical rehabilitation is provided. Some assistive devices including prefabricated prosthetics and orthotics devices might also be available but there is no production at this level. Around 50 Base Hospitals and District Hospitals also have smaller physiotherapy units. The capacity of these hospitals has not been recorded, although believed to be limited. There are 8 physical rehabilitation centres in 6 districts producing assistive devices including prosthetics and orthotics devices within the Ministry of Health.\(^{48}\) International donors fund most of these centres. Other (NGOs and the private sector) produce assistive devices in parallel to the public health system (e.g.Tangalle, Colombo, Kandy, Jaffna).

44 Annual Action Plan for Child Health Programme, Ministry of Health, 2010
45 Ibid.

47 These five rehabilitation hospitals are available in the following districts: Kandy, Polonnaruwa, Galle, Jaffna and Badulla. No specific information about their capacity or staff composition could be found through.
48 Colombo (3), Kilinochchi, Vavuniya, Mannar, Trincomalee and Batticaloa.
Physical rehabilitation at tertiary institution level

Tertiary Hospitals (teaching and provincial general hospitals) of the Ministry of Health provide acute and some long-term rehabilitation care. The tertiary rehabilitation hospital, namely the Rheumatology and Rehabilitation Hospital Ragama, is located within Colombo district just outside the city and provides comprehensive long-term rehabilitation care. The tertiary rehabilitation hospitals (teaching and provincial general hospitals) of the Ministry of Health provide acute and some long-term rehabilitation care.

As presented in Table 2, the number of professionals in the three categories of physical rehabilitation professions working in Sri Lanka today varies significantly between different provinces. In this mapping, physical rehabilitation units and centres were not visited and thus the quality or capacity treatment has not been assessed. Information provided during the workshop and interviews with DPOs and professional associations suggest that the capacity of providers is limited and that many hospitals have vacancies for rehabilitation staff.

Three Ministry of Health hospitals in Colombo produce assistive devices. As mentioned before, a few national and international NGOs have set-up rehabilitation centres that include P&O workshops, with funding from international donors. As Table 3 shows, 12 centres are situated in 5 provinces. Of these, 4 are in the western province, 4 in the northern province, 2 in the eastern and 1 each in the central and southern provinces. Information regarding capacity and production is not easily available. Questions remain about whether outputs are adequate. Geographical coverage is very uneven. Applying the ISPO and WHO guidelines on service coverage determines Sri Lanka cannot deliver the quantity of treatment necessary to meet the needs of persons with disabilities and others in need of these services. At the same time, highlighted as something positive, is the recent decision to invest in developing one rehabilitation hospital per province in the short-term, with plans to upgrade a further 11 hospitals with facilities for physical rehabilitation. Added to this is the planned initiative of the Ministry of Health and the Ministry of Social Services to come together to develop CBR initiatives of the Ministry of Health and the Ministry of Social Services to come together to develop CBR.

In summary, even if there is a lack of official data on the needs for physical rehabilitation services, it is clear that the capacity of service providers in Sri Lanka cannot deliver the quantity of treatment necessary to meet the needs of persons with disabilities and others in need of these services. At the same time, and highlighted as something positive, is the recent decision to invest in developing one rehabilitation hospital per province in the short-term, with plans to upgrade a further 11 hospitals with facilities for physical rehabilitation. Added to this is the planned initiative of the Ministry of Health and the Ministry of Social Services to come together to develop CBR.

The figures provided should be interpreted cautiously. They are provided from the Health Master Plan but the data has not been verified or cross-checked. It can still provide an understanding about the shortages of staff.

Table 2: Sample of Government hospitals and teaching units with rehabilitation therapists available at present (2013)

<table>
<thead>
<tr>
<th>Hospitals (does not include all tertiary level hospitals)</th>
<th>PT</th>
<th>OT</th>
<th>S&amp;LT*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Province</td>
<td>58</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>National Hospital of Sri Lanka, Colombo</td>
<td>11</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Teaching Hospital, Colombo North Ragama</td>
<td>15</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Central Province</td>
<td>17</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>General Hospital, Kandy</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Teaching Hospital Peradeniya, Kandy</td>
<td>16</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>General Hospital, Matara</td>
<td>8</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>General Hospital, Hambantota</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Northern Province</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Teaching Hospital, Jaffna</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Base Hospital, Vavuniya</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Western Province</td>
<td>11</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Teaching Hospital, Kurunegala</td>
<td>7</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>General Hospital, Trincomalee</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>General Hospital, Ampara</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>North Central Province</td>
<td>7</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Teaching Hospital, Anuradhapura</td>
<td>9</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Provincial General Hospital, Ratnapura</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Uwa province</td>
<td>9</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Subtotal</td>
<td>189</td>
<td>52</td>
<td>19</td>
</tr>
</tbody>
</table>

Special hospitals and treatment units

<table>
<thead>
<tr>
<th>Hospitals (Including those listed above)</th>
<th>PT</th>
<th>OT</th>
<th>S&amp;LT*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Province</td>
<td>13</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Lady Ridgeway Hospital for Children, Colombo</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Castle Street Hospital for Women, Colombo</td>
<td>5</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Cancer Institute, Maharagama</td>
<td>21</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Rehabilitation Hospital, Ragama</td>
<td>4</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>National Institute for Mental Health, Angoda</td>
<td>2</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>National Institute of Nephrology, Dialysis and Transplantation, Maligawatte, Colombo</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tuberculosis and Respiratory Disease Control Programme (Cheet Hospital), Wellisara</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Teaching staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School of Physiotherapy &amp; Occupational</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy</td>
<td>01+01</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>University of Colombo</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>University of Kelaniya</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Subtotal</td>
<td>57</td>
<td>28</td>
<td>8</td>
</tr>
<tr>
<td>OTHER GOVERNMENT HOSPITALS (INCLUDING THOSE LISTED ABOVE)</td>
<td>246</td>
<td>80</td>
<td>35</td>
</tr>
<tr>
<td>TOTAL NUMBER OF THERAPISTS IN GOVERNMENT HOSPITALS</td>
<td>117</td>
<td>27</td>
<td>0</td>
</tr>
<tr>
<td>HOSPITALS (INCLUDING THOSE LISTED ABOVE)</td>
<td>363</td>
<td>107</td>
<td>35</td>
</tr>
</tbody>
</table>

| * PT—Physiotherapist; OT—Occupational therapist; S&LT—Speech and Language therapist |
| ** 32 recently qualified diploma holders are due to get appointments soon. List does not include them or approximately 180 degree holders who are yet awaiting issues regarding recruitment to government cadres to be sorted out. |
Disability[90] [2011] looks at the development of the health workforce in the context of a life span perspective. This covers both the workers perspectives and policy and governance through state actions.51

**Entry:** Planning, producing and preparing the required workforce through strategic investments in education and effective and ethical recruitment practices.

**Workforce:** Enhancing worker performance through better management of workers in both the public and private health sectors. This includes adequate financial planning to ensure retention of trained health workers and human resource information management systems to make rational human resource allocation decisions.

**Exit:** Managing migration and attrition to reduce wasteful loss of human resources.

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Table 3: Ministry of Health hospitals and NGO centres with ortho-prosthetic (mobility assistive device) workshops

<table>
<thead>
<tr>
<th>Ortho-prosthetic device and technical aids production and fitting (excluding those for the Forces)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Western province</strong></td>
</tr>
<tr>
<td>Lady Ridgeway hospital, Colombo—supported by Handicap International</td>
</tr>
<tr>
<td>Rheumatology and Rehabilitation Hospital, Ragama</td>
</tr>
<tr>
<td>National Hospital, Colombo</td>
</tr>
<tr>
<td>Friend-in-Need Society, Colombo</td>
</tr>
<tr>
<td>Rehab Lanka, Colombo (produce wheelchairs and tricycles, no assessment, fitting or training services)</td>
</tr>
<tr>
<td><strong>Central province</strong></td>
</tr>
<tr>
<td>Kandy Centre for the Handicapped</td>
</tr>
<tr>
<td><strong>Southern province</strong></td>
</tr>
<tr>
<td>Navajeewana, Tangalle—supported by CBM</td>
</tr>
<tr>
<td><strong>Northern province</strong></td>
</tr>
<tr>
<td>District General Hospital in Kilinochchi—supported by Handicap International</td>
</tr>
<tr>
<td>Jaffna Jaipur Centre for Disability</td>
</tr>
<tr>
<td>General Hospital, Vavuniya—supported by the Sri Lanka School for Prosthetics and Orthotics</td>
</tr>
<tr>
<td>Base hospital, Mannar—supported Merthna Foundation Centre for Disabled, Mannar—supported by Caritas Valvuthayam and Motivation</td>
</tr>
<tr>
<td><strong>Eastern province</strong></td>
</tr>
<tr>
<td>Teaching Hospital, Batticaloa—supported by Handicap International</td>
</tr>
<tr>
<td>General Hospital, Trincomalee—supported by the Sri Lanka School for Prosthetics and Orthotics</td>
</tr>
</tbody>
</table>

(In addition to the above, the private sector also produces prosthetics and orthotics)

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This mapping was not a detailed analysis of the whole process from planning to exit, but it does provide relevant information on key perspectives and highlights gaps that need to be further investigated. The data presented in this chapter is gathered from the Annual Action Plan 2010 of the Ministry of Health, from interviews with professional associations and information provided by key informants during the workshop session (Annex 1, Annex 2). Due to the absence of centralised data in the Ministries of Health and of Social Services, accuracy of information has to be taken with some caution. Even so, the data presented will be useful for further strategy planning, donor contributions and for both decision makers and professionals that wish to improve the quantity, capacity and quality of human resources in the physical rehabilitation sector.

### 4.1 Preparing and training physical rehabilitation professionals

The professions included in this mapping are medical officers specialised in physical rehabilitation, physiotherapists, occupational therapists, speech and language therapists and prosthetists and orthotists. Together, all these key professionals can implement a substantial proportion of the physical rehabilitation process.

Ideally there are other professional groups that should participate in physical rehabilitation, such as psychologists, counsellors, specialised nurses and social workers. In Sri Lanka though, those professionals groups are yet to be developed.

**Medical officers specialised in physical rehabilitation**

In Sri Lanka there is a specialisation in rheumatology and rehabilitation at the Post-Graduate Institute of Medicine of the University of Colombo for medical officers with a medical degree. They are then called rheumatologists and rehabilitation consultants and have board certification to practice both specialized fields of medicine. Depending on the condition of the patient, other specialists may also be involved in the team, such as orthopaedic surgeons, neurologists, general surgeons, general physicians, paediatricians etc.

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Continental Professional Education is not mandatory for renewing licenses of any health professional. They are mostly organised on an ad hoc basis by professional associations or by international NGOs involved in the physical rehabilitation sector. Both physiotherapists and occupational therapists have their respective professional associations. These work on professional development and the status of the physical rehabilitation workers as well as promoting more evidence-based practice. Up to now though, they have not been much involved in policy making. With an increasing number of members they have the opportunity to change this situation in the future. Among the associations are,  
- Sri Lanka Society of Physiotherapists (SLSP, professional association)  
- Government Physiotherapy Association Sri Lanka (trade union)  
- Sri Lanka Society for Occupational Therapist (SLSOT, professional association)  
- Sri Lanka Association of Occupational Therapists (SLAOT, trade union)  

Prosthetics and Orthotics

In 2004, the Cambodia Trust, with financial support of the Nippon Foundation, developed a partnership. In 2004, the Cambodia Trust, with financial support from the Nippon Foundation, developed a partnership with the Ministry of Health to set up the Sri Lanka School for Prosthetics and Orthotics. Previously a few students had been trained in Cambodia supported by the Ministry of Defence or international NGOs. In 2004, a project for the setting up of a training school was initiated. Around 15 students are accepted each year, and on successful completion of three years training (including one year clinical practice under supervision), they graduate as Prosthetists and Orthotists CAT II. The International Society for Prosthetics and Orthotics, ISPO, has certified the course.

According to the information provided during this mapping, from the 51 qualified Prosthetists and Orthotists that have been trained in Sri Lanka, around 34 (1 who upgraded outside Sri Lanka to CAT I and 33 in CAT II) are currently working in Sri Lanka. The majority are in urban areas, predominantly in the NGO sector and in Ragama Hospital. Many are in rehabilitation institutions run by the Ministry of Defence for the Forces.

The profession of Prosthetist and Orthotist was recognised by the Ministry of Health in 2012 and a license is required to practice. There are two professional associations established, the Sri Lanka Association for Prosthetics and Orthotics (SLAPO), which was set-up during the development of the school in 2004 and recently in 2012, the Sri Lanka Federation of Prosthetists and Orthotists (SLFPO). SLFPO is a trade union.

Speech and language therapy

The Disability Studies Unit (DSU) at Kelaniya University now Department of Disability Studies (DDS), in collaboration with the University of London Centre for International Child Health and the Hospital for Children, Great Ormond Street set-up a two-year diploma course in speech and language therapy in 2006. The Ministry of Health supported the initiative. All diploma holders added a one-year module at the DDS and were awarded a degree. In 2010 the diploma was then up-graded to a four-year degree program. They are licensed by the Sri Lanka Medical Council (SLMCC). Very recently, a professional association was established named the Sri Lankan Government Working Speech and Language Pathologists/Therapists Union.

As the profession is still very new in Sri Lanka, there are so far only 25 speech and language therapists actually working in Government hospitals, primarily in Colombo and some of the major towns of the country (see Table 2). A further 35 or so are in the private sector while another 200 or so are in the 4 batches currently following the degree programme.

Community Based Rehabilitation

A CBR program was initiated in Sri Lanka in 1980 by an NGO and in the following year by the School of Social Work of the Ministry of Social Services. It became a national program in 1994 within the Ministry. The CBR program is said to have now expanded to 25 districts and is said to cover 9,321 Grama Niladari divisions with an apparent total number of 10,127 volunteers. While it is said to have a large coverage, key informants expressed some doubts about the efficiency, quality and sustainability of the program in many districts. Handicap International’s KAP study equally indicated that the program faces shortages and challenges. A background analysis of the draft CBR action plan appears to emphasize access to physical rehabilitation. But there are some who criticize the way the programme works currently and propose a review and change in many aspects. This is welcome, as CBR is a key approach to reach persons with disabilities in rural areas. The draft National Action Plan calls for a review of the present strategy and the development of one that is sustainable and multisectoral.

Community workers (volunteers) are said to receive a 3–8 days training through Social Services Officers at district and divisional levels, with very occasional, if any refresher training. It was highlighted in this mapping that there is a high turnover of community volunteers and in some places a lack of motivation as the support is inadequate and not regular. No monetary or in-kind incentives are provided but volunteerism is a cultural phenomenon and is valued and respected in Sri Lanka. Several volunteers spend many years working. Until now, the Ministry of Social Services has not set up an official training structure for CBR although a CBR training package based on the WHO CBR Manual of 1986 is in place and used by the Social Services Officers at district level and by community volunteers working with disabled people and their families.

The section of mapping concerning educational programs of physical rehabilitation professionals suggests a good base for scaling up the training of human resources in physical rehabilitation. While there is a need for training more professionals in all cadres, this has to be followed with a careful planning of their geographical deployment. All schools and universities offering paramedical programmes are situated in Colombo and Kandy. Also to be noted is that if current graduates were employed, government cadres could be increased rapidly and thereafter steadily. Therefore the need for new training institutions must be analysed carefully and their necessity determined before starting any new initiatives. A few young graduates are sometimes reluctant to work in more distant areas. The private health sector growing steadily in Sri Lanka tends to attract physiotherapists, speech therapists and prosthetists and orthotists. While this can be seen as positive as it could increase access to services, a careful balance has to be maintained. Many persons with disabilities and their families do face socio-economic difficulties and will have very limited possibilities to pay for private rehabilitation services. Most private centres, in addition, establish themselves in larger cities and therefore will not meet the needs in rural areas. At the same time increasing numbers of private educational institutions are embarking on the training of rehabilitation professionals which may be more than adequate for the private sector with low demands. Opportunities for foreign employment are decreasing. Caution is necessary or the country may well have a surplus of rehabilitation workers as has been the experience elsewhere.

4.2 Number and geographical distribution of physical rehabilitation professionals

Despite the training of physical rehabilitation professions being set-up quite long ago (physiotherapy in 1957 and occupational therapy in 1972) there are not yet sufficient numbers of professionals employed in the government sector. A major reason was ‘brain-drain’, when western countries, in the past, attracted many physiotherapists. A deliberate current policy in
professionals in the Western Province (Table 2). There appears to be however a concentration of rehabilitation moving closer to the people. While earlier therapists tended to want to stay in smaller towns, they are now working in more distant and difficult districts.

While there is a strong demand for urban placement, the geographical coverage is rather limited. It appears that not many medical officers take to this specialization. By policy, only four common specialties in Medicine, Surgery, Paediatrics, and Obstetrics & Gynaecology are always available in secondary institutions. Sometimes, ENT and Dermatology are also available. Essential back up services are also available at these institutions including laboratory services and basic radiological services. Other key specialists linked to physical rehabilitation, such as neurosurgeons, rheumatologists, and orthopaedic surgeons as well as radiologists are available in tertiary institutions.

5.1 Availability

In line with WHO’s recent project of defining guidelines for rehabilitation, the interpretation of the mapping outcomes and suggestions for moving forward are presented in relation to the key criteria for ensuring an equal access to physical rehabilitation services for persons with disabilities, and others in need for such services in Sri Lanka: Availability, Accessibility, Accountability, and Quality.

Available availability refers to having functioning and sufficient physical rehabilitation services in a balanced and equitable geographical distribution. Services should also strive to answer to the diversity of needs for services, i.e., age, gender, type of impairment etc.

There must also be a long-term strategy of ensuring sustainability of services, financial as well as in terms of quality, including staff availability and adequate competence.

There are several medical professionals; including a shortage of general physicians and paediatricians. With the end of the conflict in 2009 the situation is changing and vacancies in these provinces are being filled. While it is not possible to make an accurate assessment regarding the numbers of professionals needed in each professional category, due to the lack of any international or national standard as reference, using the data provided in the first chapter of the report, it may be fair to say that needs of physical rehabilitation are currently greater than the services and professionals can meet. Applying the recommendations of WHO and ISPO on calculating the need for Prosthetists and Orthotists professionals, Sri Lanka needs to train an additional 106 Prosthetists and Orthotists (CAT I and II) and in total, approximately 560 bench workers should be in place (there is no information available regarding the number of bench workers in the country).

With the current capacity for the training program, another 5–6 years will be necessary to reach 140 professionals. The Ministry of Health sends five Prosthetists and Orthotists every year to Thailand for a bridge course with upgrading to CAT I. 15 are undergoing this training in Thailand at present. At the time of this mapping there was no plan to set up for CAT I training in the country.

5. CONCLUSION AND MOVING FORWARD

Since there are now about 500 rehabilitation professionals in government hospitals (Table 2), and adding to this the number employed in the Forces and Police, an estimated guess would be that this may represent about 80% or more of those working in the country at present. The rest would be working in private hospitals and NGOs. Representatives of the Ministry of Health and the professional associations reported that a number of vacancies are still to be filled in the five rehabilitation hospitals that have been established. The 34 Prosthetists and Orthotists are all distributed in the major towns.

Salaries in the public sector for physical rehabilitation professionals were mentioned as a challenge for retention. The private sector appears to offer better conditions, both in terms of salary and other benefits. On the other hand public service offers security of tenure. Lower costs of living often attract workers to more distant areas. Culturally, most rural people return to live in or near their places of birth. A few decades ago a demand for urban placement was high but now with improvement of peripheral schools, health care and general quality of living, this has changed. In Sri Lanka, unlike many other countries rural-urban migration is negligible.

When it comes to medical specialists involved in physical rehabilitation in the public sector, the geographical coverage is rather limited. It appears that not many medical officers take to this specialization. By policy, only four common specialties in Medicine, Surgery, Paediatrics, and Obstetrics & Gynaecology are always available in secondary institutions. Sometimes, ENT and Dermatology are also available. Essential back up services are also available at these institutions including laboratory services and basic radiological services. Other key specialists linked to physical rehabilitation, such as neurosurgeons, rheumatologists, and orthopaedic surgeons as well as radiologists are available in tertiary institutions.

The northern and eastern provinces in general lack several medical professionals; including a shortage of general physicians and paediatricians. With the end of the conflict in 2009 the situation is changing and vacancies in these provinces are being filled. While it is not possible to make an accurate assessment regarding the numbers of professionals needed in each professional category, due to the lack of any international or national standard as reference, using the data provided in the first chapter of the report, it may be fair to say that needs of physical rehabilitation are currently greater than the services and professionals can meet. Applying the recommendations of WHO and ISPO on calculating the need for Prosthetists and Orthotists professionals, Sri Lanka needs to train an additional 106 Prosthetists and Orthotists (CAT I and II) and in total, approximately 560 bench workers should be in place (there is no information available regarding the number of bench workers in the country).

With the current capacity for the training program, another 5–6 years will be necessary to reach 140 professionals. The Ministry of Health sends five Prosthetists and Orthotists every year to Thailand for a bridge course with upgrading to CAT I. 15 are undergoing this training in Thailand at present. At the time of this mapping there was no plan to set up for CAT I training in the country.

5. CONCLUSION AND MOVING FORWARD

In line with WHO’s recent project of defining guidelines for rehabilitation, the interpretation of the mapping outcomes and suggestions for moving forward are presented in relation to the key criteria for ensuring an equal access to physical rehabilitation services for persons with disabilities, and others in need for such services in Sri Lanka: Availability, Accessibility, Accountability, and Quality.

5.1 Availability

Available availability refers to having functioning and sufficient physical rehabilitation services in a balanced and equitable geographical distribution. Services should also strive to answer to the diversity of needs for services, i.e., age, gender, type of impairment etc.

There must also be a long-term strategy of ensuring sustainability of services, financial as well as in terms of quality, including staff availability and adequate competence.


65 Ibid.


services were available closer, people would have less need to travel to the provincial capitals for support. The mapping emphasises also a lack of coordination between the Ministry of Health and the Ministry of Social Services and equally a lack of coordination from NGO service providers with public authorities. There seems to be an overlap of responsibilities and sometimes overlap of services provided, which need to be clarified in the implementation of the newly drafted policies and strategies, equally at national, provincial and divisional levels. While decentralised Social Service Offices do provide assistive devices, there was a consensus that the number of devices as well as the system of distribution could be improved. The follow-up of the use of devices on a longer-term basis is also missing but a better coordination between Social Services Offices and Regional Health Services could improve such follow-up, especially if including the CBR program and trained health community workers.

Encouragingly, the Ministry of Health is planning to increase the number of rehabilitation hospitals to cover each province and has expressed commitment to define a physical rehabilitation strategy. There is thus a good basis for improving the availability of physical rehabilitation within the health system. Sri Lanka has already invested strongly in community health, and many structures are already in place, which facilitates incorporation of physical rehabilitation into existing primary and community health services. There are also international organisations and donors that are investing in physical rehabilitation, and if there is a good collaboration, these services can be incorporated into the public health sector. This will provide an important improvement, especially in the Prosthetics and Orthotics sector.

5.2 Accessibility

Accessibility implies that services can be reached and used by the person who needs them. It has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability), and information accessibility.

Suggestions for moving forward

- International NGOs that run or support physical rehabilitation services should work in closer coordination with the Ministry of Health and Ministry of Social Services. A strategy of integrating these services into the public health system should be developed in a phased manner. Such integration can be defined in different modalities, they can become public services or there can be sub-contracting mechanisms where the Ministry of Health enters in a public-private partnership with the organisation. Public-Private partnerships require strong stewardship from the State; this should be a pre-condition to move forward with such an initiative.
- Establish a physical rehabilitation task force or physical rehabilitation unit to work on a physical rehabilitation strategy, including the key actors of the physical rehabilitation sector such as: Ministry of Health, Ministry of Social Services, rehabilitation hospitals, professional associations, Disabled People’s Organisations, international and national NGOs involved in the disability and rehabilitation sector and representatives of CBR programs.
- Develop a coordinated human resource development plan between the relevant line ministries, the National Council for Persons with Disabilities (NCPD), physical rehabilitation professional associations and NGOs in line with the draft national action plan on disability. Make sure to include also provincial health authorities. Assessment of possibilities to conduct training in other provinces should be studied, with the objective of recruiting personnel from more rural districts. This can ensure a better geographical coverage of rehabilitation professionals and willingness to work outside of main cities.
- Include physical rehabilitation professionals in the strategy of human resources for health and retaining policies in rural areas.
- Include indicators on physical rehabilitation and disability in the Health Information System in coordination with review of the DoSS lists of people with disabilities at GN level. There is a need to have concrete and harmonized data on disability and rehabilitation in both Ministry of Health and Ministry of Social Services. Once data is available in the national monitoring systems there are much more opportunities to advocate for more and better services, as the gaps will be visible when measured.
- Map data collected including disability prevalence and aetiology, rehabilitation needs including assistive devices to indicate geographical variations to enable more responsive service delivery.
- Conduct a more comprehensive mapping of seating, positioning and mobility devices in terms of availability, accessibility and quality for analysis and service delivery planning.
- Adequate financial budget should be allocated for the physical rehabilitation sector and clearly appear in the final action plan.

Disabled People’s Organisations defined poverty and lack of information as most important obstacles for people to benefit from physical rehabilitation services in Sri Lanka. On one hand, there is a lack of awareness among persons with disabilities and/or their families about their rights to health and social services, including the benefits of physical rehabilitation. On the other hand, the limited availability of services implies long travel distances to access physical rehabilitation, which has an important impact on many people with disabilities that already have a difficult socio-economic situation. An additional obstacle is the inaccessible infrastructure, both roads and public transport, which was highlighted as well among service providers and authorities during this mapping.

Where services indeed are available, persons with disabilities and professionals consider them to be of acceptable quality and they are provided for free, or at a minimal cost. The problem in fact is more linked to the continuation of the treatment and the lack of follow-up possibilities once being discharged from the hospital. Physical rehabilitation
is often provided more as acute treatment and the hospitalisation is limited due to a shortage of beds, thus the need for a well-defined referral system between all health care levels and also CBR programs is urgent. But, at the end, it is also important to increase the availability of services closer to where the person is living.

Persons with disabilities also considered that resource allocation for the sector is insufficient and that the lack of quality standards and the limited number of well-trained professionals are obstacles for improvement. Persons with disabilities also want to be more involved when it comes to planning and monitoring of services, which until now has been minimal. Their influence both at service level and policy level is weak, even as part of the National Council of Persons with Disabilities. There is a need for raising the awareness among persons with disabilities about their rights, and among DPOs, how to advocate and formulate policies in the field of social services, including physical rehabilitation.

Representatives of the professional associations in turn consider that there is a lack of policies and regulations for improving their professional status and the place of physical rehabilitation within the public health system. If the positive outcomes of physical rehabilitation were more known among both other health staff and the health authorities, it could lead to more investment and increased resources to enlarge services in the country.

The Ministry of Health, with the objective to develop a physical rehabilitation strategy has initiated a series of meetings with some of the key stakeholders. Recent changes though within the Ministry of Health have put the process on hold, but it is certainly an important step towards coordinating efforts to improve the accessibility to services.

**Suggestions for moving forward**

- Define a comprehensive physical rehabilitation strategy that incorporates the key regulatory mechanisms and provides guidance as to which types of services should be available at what level, the estimated need for human resources and a plan for training and retaining workers. A comprehensive referral system should also be suggested. Raise awareness about services as well as referral and gate-keeping mechanisms amongst community members through accessible media and messages.
- Train other health professionals on disability and rehabilitation. The increased awareness of health professionals will improve the health care in general for persons with disabilities and facilitate timely and adequate referral where necessary.
- Improve the coordination between the Ministry of Health and the Ministry of Social Services, both at national, provincial, district, divisional and community levels. Scarce resources have to be well utilised and the roles and responsibilities of key actors better defined.
- Define minimal quality standards for physical rehabilitation services, including clear job descriptions for each professional group. Such standards should also clarify the right of user participation in service delivery and monitoring, as well as ensuring a user centred treatment and service.
- Increase the awareness of local communities and groups of persons with disability about the benefits that physical rehabilitation can bring and importance of early identification as well as secondary prevention. It is important though that such awareness comes parallel to increasing the access to services in areas that are not yet covered.
- Enhance civil society involvement (DPOs, user groups, NGOs) to influence governance.

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**5.3 Accountability**

Accountability concerns both the transparency and efficiency of the regulatory framework implemented from authority level, as well as accountability from service providers themselves. It refers not only to financial management of services but also to the overall organisation of the service: clear manuals of policies and procedures, internal regulations, and a qualitative and transparent staff management system, and the active involvement of users in both treatment and service delivery. Key words are: person-centred, user involvement, community partnership, continuity of service and result-outcome oriented.

There is an important concern about the accountability of the authorities in terms of ensuring qualitative physical rehabilitation services to persons with disabilities in Sri Lanka. The regulatory framework is still weak and many procedures are yet to be defined. While physical rehabilitation is to a certain extent regulated in the general health care system, it is not possible today to evaluate the effect or impact of the services, as data is not disaggregated to analyse disability and physical rehabilitation. Unmet needs are most probably large but there is no data collection system in place to measure this or an information system that inform people about the benefits of physical rehabilitation.

Accountability of the physical rehabilitation service providers themselves towards their users one of the important aspects to be considered has not been looked at in-depth in this report however the issue came out in the discussions with user representatives at the stakeholder workshop it goes together with the lack of unified quality standards, which makes it impossible for users to have a reference when receiving treatment. Until now, the concept of user involvement, or user participation, is not applied. Individuals with disability and DPOs are not involved in monitoring or evaluating service providers and have very limited influence in their own process of rehabilitation.

The existence of professional associations is an important aspect of accountability. Even if some of them are still recent, they are slowly taking a stronger role within the sector and could start to advocate for their working conditions and the status of the rehabilitation professionals. Professional association are also important for promoting ethics and values among professionals and could influence the training programs to introduce participatory user assessment and treatment plans and possibilities for continuous professional education opportunities.

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**Suggestions for moving forward**

- Finalise the Disability Rights Bill so that the CRPD may be ratified.
- Conduct an assessment of current physical rehabilitation provision, including orthopaedic centres. To facilitate a progressive handover to the relevant line ministry, it is important to understand procedures in terms of staff recruitment and job descriptions, salary scales, monitoring and evaluation tools, quality standards, as well as logistical processes, purchase procedures and types of material used.
- Strengthen the capacity of the professional associations of physiotherapy, occupational therapy, speech and language therapists and Prosthetists and Orthotists. They need to develop skills in policy making and advocacy, as well as having a stronger capacity to promote Continuous Professional Education in collaboration with training institutes.
- Strengthen the capacity of DPOs for taking part in policymaking and advocacy in the field of physical rehabilitation and disability rights.
- CBR programs should enhance their support to self-help groups or interest groups to strengthen the voice of persons with disabilities at community level. Such groups are often crucial for peer counselling and raising the awareness around health, rehabilitation and access to other services, especially in smaller towns and villages. This requires a long term planning knowing that current capacities are weak.

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69 Early identification means to identify early if children, or adults, have impairment where physical rehabilitation and/or assistive devices would have a positive impact on the function of the person. Secondary prevention means that people with disabilities can have need for physical rehabilitation to avoid a worsening of their impairment and thus a more severe disability.
• Improve the coordination and sharing of roles and responsibilities between international and national NGOs, Ministry of Health and Ministry of Social Services.
• Develop a set of national minimum quality standards for physical rehabilitation. In the future, such standards should be linked to the licensing of new physical rehabilitation centres and a system of monitoring of quality and performance should as well be developed. The perspective of the users and their participation has to be included in such standards.
• DPOs have an obligation to raise the awareness among its members about the possible benefits of physical rehabilitation. They should also encourage the creation of self-help groups at community level, perhaps in coordination with the CBR program, to enhance the awareness on rights and available benefits in general.

5.4 Quality

While availability of, and accessibility to, services are crucial, the quality of the services provided is equally important. If the physical rehabilitation centres or units do not provide services satisfactory to the users or do not respect and value the users, persons with disabilities will stop using them or could even be harmed by the interventions. Therefore quality standards and monitoring tools are regulatory procedures that have to be implemented and supervised by the authorities. In addition, services should have clear internal procedures that are transparent and understandable for users, as well as a complaint system where people can give their feedback on services for improvement. All this has to be developed with the principle of acceptability in terms of gender, capacity, culture and life cycle requirements.

In this mapping, the quality aspect of physical rehabilitation services provided has only been discussed during the national workshop. An assessment of the service providers has not been done and nor has the mapping conducted any larger set of questions with service users. The analysis is therefore based on the workshop discussion and the available data and information, which can only give a general point of view on the quality of physical rehabilitation services.

As earlier mentioned, the absence of indicators on physical rehabilitation and disability in the Health Information System impedes the responsible ministry to monitor and make informed decisions about human resource development, budgeting and coverage of services. The absence of common quality standards is another challenge. Each service provider may have its own quality and monitoring procedures and so far, the Ministry of Health has no means to monitor or ensure quality of services provided. As already mentioned, the lack of trained human resources in physical rehabilitation is an urgent issue that needs to be addressed, and especially to give incentives for recruiting students from other provinces, or decentralise training structures. Poorly trained or not enough number of staff affects quality of services, and hinders the development of new, or the expansion of existing services.

Suggestions for moving forward

• Continue and improve the coordination between the international and national NGOs providing physical rehabilitation services DPOs and the Ministry of Health and Ministry of Social Services through the set-up of a task force group or a physical rehabilitation unit in the Ministry of Health.
• Include indicators on physical rehabilitation and disability in the Health Information System so that quality and performance can be measured and monitored.
• Develop a set of national minimum quality standards for physical rehabilitation including CBR.
• Develop the Health Information System to capture data to monitor, evaluate, and assess quality standards within rehabilitation services delivery.
• Elaborate a consistent human resource plan for training of physical rehabilitation professionals in accordance with estimations of need. Such plan has to be linked to service needs and supported by budget and future staff retention policy as well as salary scales.

Annex 4.1: List of Participants—National Workshop Colombo

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Designation/Position</th>
<th>Institution/Organisation</th>
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<tbody>
<tr>
<td>1</td>
<td>Dr. Priyantha Athapattu</td>
<td>D/YED</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>2</td>
<td>Dr. Indrakumari Fernando</td>
<td>DPCS</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>3</td>
<td>Dr. Geethani Kandaudahewa</td>
<td>DO/YED</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>4</td>
<td>Dr. Shinnomi Maduwage</td>
<td>CCP/YED</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>5</td>
<td>Dr. Roshan Sampath</td>
<td>Formerly CC/YED</td>
<td>Ministry of Health</td>
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<tr>
<td>6</td>
<td>Dr. Kamalani Wanigasinghe</td>
<td>MO/YED</td>
<td>Ministry of Health</td>
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<tr>
<td>7</td>
<td>Dr. Narendra Pinto</td>
<td>Consultant Orthopaedic Surgeon</td>
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<tr>
<td>8</td>
<td>Dr. R.P. Palitha Karunapema</td>
<td>Director</td>
<td>Rheumatology &amp; Rehabilitation Hospital—Ragama</td>
</tr>
<tr>
<td>9</td>
<td>Dr. Lilani Panagala</td>
<td>Consultant Rheumatologist</td>
<td>Ministry of Health</td>
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<tr>
<td>10</td>
<td>Dr. Padma Gunaratne</td>
<td>Consultant Neurologist</td>
<td>Ministry of Health</td>
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<tr>
<td>11</td>
<td>Dr. Duminda Munidasa</td>
<td>Consultant in Rheumatology &amp; Medical Rehabilitation</td>
<td>Ministry of Health</td>
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<tr>
<td>12</td>
<td>Dr. Harsha Gunesekara</td>
<td>Consultant Neurologist</td>
<td>Ministry of Health</td>
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<td>13</td>
<td>Dr. Kanchara Wijesinghe</td>
<td></td>
<td>Ministry of Health</td>
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<tr>
<td>14</td>
<td>Mr. P.K.A. Kithsiri</td>
<td>National Trainer</td>
<td>Sri Lanka Spinal Cord Network National Hospital</td>
</tr>
<tr>
<td>15</td>
<td>Dr. Samanmali Sumanasena</td>
<td>Senior Lecturer and Consultant Paediatrician</td>
<td>Dept of Paediatrics, Faculty of Medicine, University of Colombo</td>
</tr>
<tr>
<td>16</td>
<td>Mr. M. Ramamurthy</td>
<td>Director—Planning</td>
<td>Ministry of Social Services</td>
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<tr>
<td>17</td>
<td>Mr. D.M.S.A.Niroshana</td>
<td>Assistant Director</td>
<td>National Secretariat for Persons with Disabilities Ministry of Social Services</td>
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<tr>
<td>18</td>
<td>Dr. Padmani Mendis</td>
<td>Advisor, Disability Issues</td>
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<tr>
<td>19</td>
<td>Mr. Prasanna Kuruppu</td>
<td>President</td>
<td>Disability Organisations Joint Front</td>
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<tr>
<td>20</td>
<td>Mr. Priyantha Jayakody</td>
<td>Project Manager</td>
<td>Disability Organisations Joint Front</td>
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<tr>
<td>21</td>
<td>Mr. Cyril Sirwardene</td>
<td>Secretary</td>
<td>Sri Lanka Foundation of the Rehabilitation of the Disabled (Rehab Lanka)</td>
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<tr>
<td>22</td>
<td>Mr. Premadasa Dissanayaka</td>
<td>Chairman</td>
<td>Sri Lanka Foundation of the Rehabilitation of the Disabled (Rehab Lanka)</td>
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<tr>
<td>23</td>
<td>Ms. Kumarini Wickramasuriya</td>
<td>Founder/Chairperson</td>
<td>Navajeevana</td>
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<tr>
<td>24</td>
<td>Ms. Shiromi Udurawana</td>
<td>Vice President</td>
<td>National Institute for the Care of Paraplegics Sri Lanka</td>
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<tr>
<td>25</td>
<td>Dr. K. Kandeepan</td>
<td>Programme Coordinator</td>
<td>Centre for Accessibility, Monitoring &amp; Information on Disability (CAMID)</td>
</tr>
<tr>
<td>26</td>
<td>Mr. N. Thileepan</td>
<td>President</td>
<td>Sri Lanka Association of Occupational Therapists</td>
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### Annex 4.2: List of consultative meetings held

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<tr>
<td>Mr. Christy Fernando</td>
<td>Additional Secretary—Ministry of Social Services</td>
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<tr>
<td>Mr. M.D.C. Jayamanna</td>
<td>Director—National Secretariat for Persons with disabilities.</td>
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<tr>
<td>Mr. Shantha Kumara</td>
<td>National Coordinator—CBR, Ministry of Social Services</td>
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<tr>
<td>Dr. P. Athupatu</td>
<td>Director—YED, Ministry of Health</td>
<td></td>
<td>Meeting</td>
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<tr>
<td>Mr. Anura Ranasinghe</td>
<td>Director Planning—Ministry of Economic Development</td>
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<tr>
<td>Mr. Harith</td>
<td>Director—Divi Neguma Programme—Ministry of Economic Development</td>
<td></td>
<td>Phone interview</td>
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<tr>
<td>Mr. N. Thileepan</td>
<td>President—Sri Lanka Association of Occupational Therapist</td>
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<tr>
<td>Mr. P.P.H. Perera</td>
<td>President—Sri Lanka Association of Prosthetists and Orthotists</td>
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<td>Phone interview</td>
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<tr>
<td>Mr. Sanjeewa Thunpattu</td>
<td>Secretary—Sri Lanka Society of Physiotherapists</td>
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<td>Phone interview</td>
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<tr>
<td>Ms. Anita Pearson</td>
<td>Technical Unit Coordinator—Handicap International</td>
<td></td>
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<tr>
<td>Mr. Samal Subabrata</td>
<td>P&amp;O Coordinator—Handicap International</td>
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<tr>
<td>Dr. Niroshan Lokunarangoda</td>
<td>Council member—Sri Lanka Medical Association</td>
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<td>Mr. Prasanna Kuruppu</td>
<td>President—Disability Organisations Joint Front</td>
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<tr>
<td>Mr. Priyantha Jayakody</td>
<td>Project Manager—Disability Organisations Joint Front</td>
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<td>30</td>
<td>Mr. Harsha Perera</td>
<td>Committee member</td>
<td>Sri Lanka Association of Prosthetists and Orthotists</td>
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<tr>
<td>31</td>
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<td>Admin Manager</td>
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<td>Asanga Pragnaratne</td>
<td>Senior P &amp; O</td>
<td>Sri Lanka School of Prosthetists and Orthotists</td>
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<td>Chamila Kariyawasam</td>
<td>Lecturer</td>
<td>Sri Lanka School of Prosthetists and Orthotists</td>
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<td>34</td>
<td>Mr. Malcolm Almeida</td>
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<td>MD Medicals (Pvt) Ltd</td>
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<td>Gunaseka Udawatta</td>
<td>Administrative Officer</td>
<td>Colombo Friend-in-Need Society</td>
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<td>Mr. Herman Wedland</td>
<td>Managing Director</td>
<td>Matamanna Orthopaedic Suppliers Company (Pvt) Ltd</td>
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<td>Dr. Nishirani Lakayusriya</td>
<td>National Professional Officer (NCD)</td>
<td>World Health Organization (WHO) Sri Lanka</td>
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<td>38</td>
<td>Mr. Simone Brotni</td>
<td>Operations Section</td>
<td>European Union</td>
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<td>39</td>
<td>Mr. Ivan Rasiah</td>
<td>Project Management Specialist</td>
<td>United States Agency for International Development (USAID)</td>
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<td>40</td>
<td>Mr. Adam Schmidt</td>
<td>Director Office</td>
<td>United States Agency for International Development (USAID)</td>
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<td>41</td>
<td>Ms. Christine Danton</td>
<td>Program</td>
<td>United States Agency for International Development (USAID)</td>
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<td>42</td>
<td>Mr. Gilles Nouzies</td>
<td>Country Director</td>
<td>Handicap International</td>
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<td>43</td>
<td>Mr. Yuban Malla</td>
<td>Programme Manager</td>
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<td>Mr. Subabrata Samal</td>
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<td>Mr. T. Bhalirathan</td>
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<td>Mr. Jayashanka Basnayake</td>
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<td>48</td>
<td>Mr. Arjuna Erasmusagolla</td>
<td>Programme Officer</td>
<td>Handicap International</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>Ms. Genevieve C. Balolong</td>
<td>PT Trainer</td>
<td>Handicap International</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Ms. Triunu Yasarathne</td>
<td>Communication Coordinator</td>
<td>Handicap International</td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Mr. Vivek Singh</td>
<td>Regional Technical Coordinator</td>
<td>Handicap International</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Ms. Charlotte Axelsson</td>
<td>Consultant</td>
<td>Handicap International</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Mr. Sithsri Liyanage</td>
<td>Project Manager[National Projects]</td>
<td>Handicap International</td>
<td></td>
</tr>
</tbody>
</table>
Annex 4.3: Country report from UNESCAP

<table>
<thead>
<tr>
<th>Country</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sri Lanka</td>
<td></td>
</tr>
</tbody>
</table>

1/Background Statistics

<table>
<thead>
<tr>
<th>Human development index rank</th>
<th>91</th>
</tr>
</thead>
<tbody>
<tr>
<td>GNI per capita (PPP in US$)</td>
<td>4,886</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>74.4</td>
</tr>
<tr>
<td>Mean years of schooling (years)</td>
<td>8.2</td>
</tr>
<tr>
<td>Expected years of schooling (years)</td>
<td>12.0</td>
</tr>
<tr>
<td>Total population</td>
<td>20,860,000</td>
</tr>
</tbody>
</table>

2/Disability Statistics

| Population of persons with disabilities | 274,711 |
| Proportion of persons with disabilities to total population | 1.6 per cent |
| Employment rate of persons with disabilities | .. |
| Access to education | 31.7 per cent |

3/Definitions

Definition of disability

The Protection of the Rights of Persons with Disabilities Act (1996) defines a person with disability as ‘any person who, as a result of any deficiency in his physical or mental capabilities, whether congenital or not, is unable by himself to ensure for himself, wholly or partly, the necessities of life.’ The National Policy on Disability (2003) states that ‘the classification of types of disability used by the Ministry of Social Services and Social Welfare for programme development encompasses people who have visual, speech, hearing, mobility, intellectual, and psychiatric disability and disability arising as a result of epilepsy and other causes. It also encompasses multiple disabilities, which is a combination of two or more of these various disabilities in a single individual.’ (Sri Lanka 2003, p. 10)

The 2001 Population and Housing Census (Sri Lanka 2001) was based on the following classification:

i. Disabilities in seeing
ii. Disabilities in hearing/speaking
iii. Disabilities in hands
iv. Disabilities in legs
v. Other physical disabilities
vi. Mental disabilities

4/Commitment to International Instruments on Disability

| Ratification or signatory of the Convention on the Rights of Persons with Disabilities (CRPD), and its Optional Protocol | Signed Convention on 30 March 2007 |
| Ratification of ILO Convention 159 | No |
| Ratification or signatory of the Convention on Cluster Munitions | No |
| Ratification or signatory of the Convention on the Prohibition of the Use, Stockpiling, Production and Transfer of Anti-Personnel Mines and on their Destruction | No |

5/Legal Framework

| Sectoral | Cover: training and employment; access to built environments |
| Disability-inclusive laws | Cover: poverty alleviation and social welfare |

6/Policy Framework

| Sectoral | Cover: training and employment |
| Disability-inclusive | .. |

Sources:

Notes:


b. According to the Ministry of Social Services and Social Welfare (Sri Lanka 2009), the Census conducted in 2001 has not covered the entire country. Only 18 Districts out of 25 districts were covered.

c. For the Census of Population and Housing 2001, a person with disabilities was defined as 'a person who was unable or limited in carrying out activities that he or she can do due to congenital or long-term physical/mental disabilities.' (Sri Lanka 2001)
Handicap International is an independent and impartial aid organisation working in situations of poverty and exclusion, conflict and disaster. We work alongside people with disabilities and vulnerable populations, taking action and bearing witness in order to respond to their essential needs, improve their living conditions and promote respect for their dignity and fundamental rights.

www.handicap-international.org