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Community-based rehabilitation: opportunity and challenge

Community-based rehabilitation (CBR) is the main way in which disabled people in most of the world have any chance of accessing rehabilitation services.¹ CBR was first promoted by WHO in the mid-1970s to address the shortage of rehabilitation assistance by providing services in the community with use of local resources.² The strategy drew on the principles of primary health care, accepted international rehabilitation practices of the time, and also existing local practices.

Over the decades, development of CBR has been influenced by concerns of disabled people at the community level and by disabled people's organisations. These concerns have contributed importantly to the evolution of the CBR concept and resulted in increased recognition of discrimination and exclusion, and the need to address social and political aspects of disability. As a result, the medically orientated individualised model, on which CBR was originally based, has expanded and now includes socially orientated rights-based approaches.³ This process of change caused confusion over the definition of CBR but in 2004 it was clarified as "a strategy within general community development for rehabilitation, equalization of opportunities, and social inclusion of all people with disabilities...implemented through the combined efforts of people with disabilities themselves, their families and communities, and the appropriate health, education, vocational, and social services".⁴ The objectives of CBR are not only to maximise physical and mental ability but also to support access

to regular services and opportunities and assist people with disabilities to actively contribute to their own communities as well as encouraging communities to promote and respect their human rights. Its community orientation aligns with the UN Convention on the Rights of Persons with Disabilities⁵ and its breadth of scope is consistent with the conceptual base of the International Classification of Functioning, Disability, and Health.⁶

Although no comprehensive database of CBR implementation is available, global CBR networks are emerging in Africa, Asia, and South America. From their activities we now know, for example, that there are 280 registered CBR programmes in 25 African countries;⁷ about half are run by non-governmental organisations, including disabled people's organisations, and half by governments which involve ministries of social services, health, and disability.

Because CBR cannot be described as a discrete intervention, and the expected outcomes are not standardised, its effectiveness is hard to establish. A summary of published research in the past decade⁸ noted that CBR-type programmes have been described as effective or highly effective. Outcomes reported included: increased independence, enhanced mobility, and greater communication skills for people with disabilities. CBR activities were linked to positive social outcomes, enhanced social inclusion, and greater adjustment of people with disabilities. The summary noted that livelihood interventions integrated into

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CBR have resulted in increased income for people with disabilities and their families, and are linked to increased self-esteem and greater social inclusion. In educational settings, CBR assisted in the adjustment and integration of children and adults with disabilities. The review also found several indications that CBR was cost effective.

However, there are also several critiques of CBR, mainly the dearth of robust research procedures and the paucity of systematic outcomes.⁹ Critiques include the unmet need for medical rehabilitation,¹ failure to maximise the participation of people with disabilities,¹⁰ and neglecting the psychosocial dimensions of disability.¹¹ The community-orientated model has been criticised for relegating people with disabilities to the place where they experience most stigma and discrimination, and increasing the burden for women with the expectation that they will provide care for people with disabilities.

Rapidly growing research interest in CBR theory, interventions, outcomes, and evidence is apparent. It is reflected in calls for improvement of the rigour and reporting of CBR in research and project evaluations,¹² and more innovative methodologies.¹³

CBR recognises the complexity of disability and seeks to address it. This point and responsiveness to its critiques are reflected in the new WHO, UNESCO, ILO, and IDDC CBR guidelines and matrix.⁸ CBR is now ready to be examined more rigorously, applied more consistently, and integrated more effectively into national and international policy making. While its application in developing countries is established, the potential for greater implementation in economically developed

countries remains a challenge which would need further commitment and require shifts in workforce, training, policy, and structural realities.¹⁴

Future research will need to incorporate best practices in rehabilitation and draw eclectically from qualitative, emancipatory, systematic review, and complex intervention methodologies. Future structural and management frameworks in CBR should emphasise networks and partnerships, especially with disabled people's organisations and governments. Future policy and planning strategies should emphasise the connections between CBR and inclusive development globally.

*Sally Hartley, Harry Finkenflugel, Pim Kuipers, Maya Thomas

Institute of Health, Norwich, Norfolk NR4 7JT, UK (SH); Erasmus University, Rotterdam, Netherlands (HF); Joint Centre of Flinders and Charles Darwin Universities, Alice Springs, NT, Australia (PK); and Asia Pacific Disability and Rehabilitation Journal, Bangalore, India (MT)
s.hartley@uea.ac.uk

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