



Policy Paper

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# Physical and functional rehabilitation

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Technical Resources Division  
June 2013



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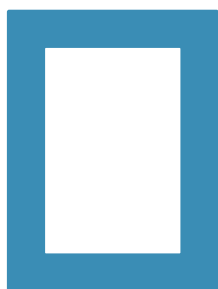
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## Policy Paper

# Physical and functional rehabilitation

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**“Handicap International was created in the 1980s by a handful of practitioners – doctors, physical therapists, occupational therapists and logisticians – appalled at the lack of specific care services for thousands of Cambodians whose limbs had been lost to the landmines infesting the border with Thailand and surrounding the camps where they desperately sought refuge.**

**In the wisdom of the times, physical and functional rehabilitation was not deemed “life-saving.” And so, just when thousands of impoverished families were facing the physical, psychological and social consequences of terrible and unjust mutilations, none of the medical actors working in the refugee camps considered that type of assistance a priority.**

**To the association’s founders, such a denial of rights was incomprehensible and, frankly, unacceptable. Especially since home-made orthopaedic solutions were springing up all around them, thanks to “survival strategy” ingenuity.**

**Handicap International has been fuelled by that determination, and today – whether in the immediate aftermath of a disaster or in situations of great poverty – donors recognise that access to physical and functional rehabilitation is essential to helping people with disabilities rebuild their lives.**

**Naturally, this victory has a cost, but that cost is nothing compared to the quality of life that is being offered, in very real terms, to thousands of individuals and their families across the globe.”**

**Jean-Baptiste Richardier**

**Co-founder and Federal Executive Director of Handicap International, 2013**

# Foreword

For the past thirty years, the fight begun by the organisation's founders has never stopped. Nor, indeed, has the injustice faced by the men and women excluded from a system of assistance – a system that refuses to offer the continuity of surgical and medical care they need to get the orthopaedic fittings that would enable them to have a role in society, and then an occupation, or access to education... and thus embark on the path to autonomy, independence and dignity. Rehabilitation services are still the poor relations of health care systems, often orphans, stuck between Ministries of Health and Social Welfare, or forgotten, receiving international funding that is still woefully inadequate for the challenges to be met and the ever-increasing number of people needing technical support and follow-up (patients with chronic diseases, the elderly, victims of traffic accidents or armed violence, etc.). States and the international community must understand and surmount the challenges of providing essential, continuing lifelong care.

The road already travelled is also dotted with successes – the signing of the Ottawa and then the Oslo Treaties creating a duty to provide assistance to victims without discrimination, the birth and signing of the Convention on the Rights of Persons with Disabilities, the creation of ever-stronger civil society organisations and the emergence of professional associations. The fact of a United Nations high-level meeting devoted specifically to disability in New York is proof of that progress.

Over the years, our knowledge and practices have improved significantly via partnerships with organisations in the South and other international organisations, thanks to links with international and regional professional bodies, strong synergies with business, and the trust we have established and maintained with the main institutional donors. We respond ever better and faster to needs, not just in acute crisis and chronic situations, but in situations of extreme poverty as well.

With this policy paper we offer our teams and partners the basis for understanding what we believe physical and functional rehabilitation covers today. While we can look back and see how far we have come, we are also aware of the changes we have yet to go through. Hence it highlights the directions we will be taking in the coming years, for example the user-centred approach, the quality and sustainability of services in developing countries, improving the professional training process, and connecting with user groups.

We have a small, highly-motivated and ambitious team that, with limited resources (always too limited!), manages daily tours-de-force to improve our practices, capitalise, train, innovate, structure and improve the position of physical and functional rehabilitation in the world. This document follows naturally from that, highlighting how the medical field plays an essential role in enhancing the social participation of people with disabilities. The beneficiary becomes a new participant in his own health, allowing him to be a stakeholder in building the societies of today and tomorrow.

Thanks to all who contributed, and happy reading.

**Ludovic Bourbé**  
**Director of Technical Resources Division**

# Introduction

## Why a Policy Paper for the Unit?

A policy paper spells out the mandate, values and strategy of the Federation in operational terms, as they apply to a given activity sector. Producing a document of this type for the Rehabilitation Services Unit is a complex undertaking, as “rehabilitation” must be narrowed to fit within the unit’s scope of activities.

Yet as a comprehensive process that contributes to health promotion, rehabilitation is a component of most Handicap International projects, no matter what the implementing unit.

In addition, there are numerous international institutional guidelines dealing with rehabilitation in a broader sense of the word. Handicap International – and the Rehabilitation Services Unit, in particular – has contributed to some of these (for example, the World Health Organization’s World Report on Disability<sup>1</sup>, and Community-Based Rehabilitation: CBR Guidelines<sup>2</sup>), and is helping to develop the new WHO Guidelines on health-related rehabilitation, due out in late 2014.

That joint effort with the WHO has not only established Handicap International’s, and the unit’s, credibility, but also helped solidify our own conception of the unit’s scope of activities, centred primarily on physical and functional rehabilitation.

Other challenges with a document like this have to do with the association’s historical, founding commitment – a commitment renewed in its first federal strategy<sup>3</sup> and reflected in numerous international reference standards.

Most of the projects implemented over Handicap International’s more than thirty-year history have included physical and functional rehabilitation activities; the diversity of these activities further complicates the unit’s work:

- There are activities aimed at creating public and private mainstream, specific or support services<sup>4</sup> able to deliver a wide variety of physical and functional rehabilitation services to people with temporary or permanent congenital or acquired impairments or disabilities (due to accident, communicable or non-communicable diseases, chronic or non-chronic diseases, etc.);
- The services require a wide variety of trained, competent professionals;
- Activities are deployed at different levels, from the local to the national to the regional, in different intervention contexts (Emergency – Reconstruction – Development).

This document presents the physical and functional rehabilitation-specific challenges, principles and recommendations for Handicap International. Above all, it sets out the overall framework within which the theoretical underpinnings of the Rehabilitation Services Unit are applied; the primary objective is to ensure consistency between the association’s mandate and the implementation, in its programmes, of projects falling within the unit’s scope of activities.

The secondary objective is to formalise the selection and/or identification of external guidelines for adaptation for internal use.

## What is the primary audience for this document?

This Rehabilitation Services Unit policy paper is aimed primarily at an internal audience of strategy people – that is, Desk Officers, Field Programme Directors and Technical Advisers and Coordinators.

However, the summary (policy brief) may be presented and shared with our operational partners and international and non-governmental (NGO) peer organisations.

Readers are expected to have a fairly thorough knowledge of two other essential documents:

- The practical guide, “Access to services for persons with disabilities”, Handicap International, 2010;
- The World Report on Disability – its short version, in particular, and more specifically, Chapter 4: and Rehabilitation, World Health Organisation, 2011.

## Why is Handicap International taking a position on physical and functional rehabilitation?

### **There is a huge need and demand for physical and functional rehabilitation**

This is evidenced by the many – though still insufficient – numbers and findings, in particular:

- The WHO<sup>5</sup> estimates that “more than one billion people in the world live with some form of disability,” i.e., about 15% of the world’s population.
- In developing countries, an estimated 0.5% of any given population needs prosthetics/orthotics and related rehabilitation services<sup>6</sup>. The WHO estimates that 10% of people with disabilities worldwide need a wheelchair<sup>7</sup>, or 1.5% of any population.
- It is widely acknowledged that the needs of these 105 million people are not being adequately met. The World Health Organisation’s CBR guidelines point out that “in many low-income and middle-income countries, only 5-15% of people who require assistive devices and technologies have access to them. In these countries, production is low and often of limited quality, there are very few trained personnel and costs may be prohibitive”<sup>8</sup>.
- In Africa, there are on average two million people for every orthopaedic device production unit<sup>9</sup>.
- The challenges of an aging population, the increasing incidence and prevalence of disabling, non-communicable chronic conditions and the disabling effects of violence and trauma are enormous. While the need for high quality health care is generally well-understood, there are drastic restrictions regarding the availability of post-acute care services.

The unit’s challenge is to seize upon the need and demand for physical and functional rehabilitation and respond with a specific yet comprehensive approach:

“rehabilitation can contribute to reducing poverty through improving functioning, activity levels and participation. Evidence suggests that difficulties in functioning related to ageing and many health conditions can be reduced and quality of life improved with rehabilitation. Lack of access to rehabilitation services can increase the effects and consequences of disease or injury; delay discharge; limit activities; restrict participation; cause deterioration in health; decrease quality of life and increase use of health and rehabilitation services”<sup>10</sup>.



**Health-related rehabilitation is Handicap International's historical core competency**

The organisation was created in 1980 by two French doctors in Thailand; its first mission was helping Cambodian refugees living in camps along the Thai-Cambodian border. It was at that time that the first orthopaedic services were set up. Thanks to simple, locally-available materials, the association was able to provide immediate, concrete and effective help and train skilled local teams - orthopaedic technicians in the beginning, and later rehabilitation therapists and physical therapists.

That physical and functional rehabilitation-centred approach was then expanded to consider rehabilitation in its broader sense, including the social dimension of the person, leading to more comprehensive care and, ultimately, to the formalisation of Handicap International's other areas of technical intervention, both in the field and at headquarters.

**Rehabilitation remains a priority for Handicap International, as reflected in its 2011-2015 federal strategy"**

- "Access for persons with disabilities to rehabilitation services in reconstruction and development settings".
- "Support the emergence of rehabilitation professions and local training for professionals".
- "Call on institutions and funding bodies to assume their responsibility for providing essential resources [for rehabilitation]".

**Organisation of the document**

This document has two main parts:

- The first part presents the theoretical underpinning of the Rehabilitation Services Unit - the principles, models, approaches and contexts necessary to designing a physical and functional rehabilitation project strategy.
- The second part offers a more operational framework within which the different theoretical elements are laid out. The objective is to guide the selection of - and aid decision-making on - the physical and functional rehabilitation activities to be undertaken.

Lastly, the document presents the different subject areas within the unit's scope that are - or could be - covered by a reference document.

Through its recommendations, this document engages the Rehabilitation Services Unit - and hence Handicap International as a whole - whenever a physical and functional rehabilitation project is being developed. It is therefore essential to limit the scope of the unit's activities and the resulting project strategies consistent with the broad intervention principles defined by the association.



Nepal, 2012

# 1. Principles and benchmarks

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The purpose of this chapter is to present the theoretical underpinnings of the Rehabilitation Services Unit. While the directions defined by the Handicap International Federation provide a general framework for the unit's activities, the principles, models and approaches discussed below are the keys it uses to create a physical and functional rehabilitation project strategy in accordance with its scope of activities.

# 1.1 Intervention principles

All Handicap International-supported projects must respect the association's values and be consistent with its strategic priorities.

As these principles are discussed throughout the document, we wanted to start by introducing them.

The principles outlined below are excerpted from Handicap International founding documents<sup>12</sup> and were approved by the Board of Trustees in February 2010.

We must preface by saying that the design of physical and functional rehabilitation projects must fall within the scope of the Rehabilitation Services Unit's activities (see **1.6** In summary).

All projects supported by the Rehabilitation Services Unit must follow several principles.

## Principles relative to beneficiaries and level of intervention

- Aim to have the greatest possible positive and measurable impact on the lives of our final beneficiaries (see **2.2.2** Service provision / Recommendations & **2.3.2** Occupations promoted by the Unit).
- Focus primarily on the most vulnerable populations and those most exposed to risk, as well as on victims of discrimination and exclusion, in particular regarding issues of gender<sup>13</sup>, childhood and old age.
- Foster participation by beneficiaries, their families and their communities, and support solidarity mechanisms within the community (see **1.3.2** The rehabilitation process).
- Focus primarily on the local level and the services level (see **2.2** Levels of intervention).

## Principles relative to methods of intervention

- Seek solutions that are both realistic and adapted to the context (see **1.4.1** The identification-to-follow-up cycle & **2.3.4** Human resource shortages).
- Take the Relief-Rehabilitation-Development contiguum into account, adapting to the specificities of each situation in accordance with the principle of "operational differentiation" (see **1.5** The context).

## Principles relative to coordination, partnership and sustainability

- Seek to coordinate activities with stakeholders at the local, national and international levels (see **1.4** From the individual to the system & **2.2** Levels of intervention).
- Seek to formalise partnerships to ensure the sustainability of the actions undertaken (see **1.4** From the individual to the system & **2.2** Levels of intervention).
- Include an exit strategy at the design stage (see **1.5.2** Situation analysis).

## Principles relative to quality and impact

- Aim for quality by analysing wants and needs and prioritising them according to the environment and actors present, by providing sufficient resources and choosing appropriate operational approaches, and through knowledge management and proximity to the beneficiaries (see **1.5.2** Situation analysis).
- Be evaluated in order to measure outcomes and, beyond that, the impact on the final beneficiaries (see **2.2.5** Network and advocacy).

### Principles relative to conceptual frameworks, approaches, references and methodological tools

- Promote a global understanding of disability through use of the Disability Creation Process model (see [1.3.1](#) Analysis models).
- Share the approaches, guidelines and standards used with other stakeholders and partners.

### Principles relative to the use of law

- Base their actions on universal human rights instruments and international humanitarian law, while considering the rights and customs of the project country.
- Respect and promote the Convention on the Rights of Persons with Disabilities (CRPD), Articles 11 and 32<sup>14</sup>, in particular.

### Principles relative to testimony and advocacy

- Serve to enrich the association's field experience, which is used to legitimise advocacy actions (see [2.2.5](#) Network and advocacy).

### Principles relative to impartiality

- Commit the association to work on behalf of beneficiary populations in all circumstances, without involvement in existing political struggles.
- Provide assistance without discrimination and without consideration other than the needs of the persons affected, whatever their origin or affiliation.

### Principles relative to responsibility and transparency

- Respect the principles of “do no harm” (measure the consequences of all actions and cause no detrimental effects) and “overlook nothing” (seek to mobilise all suitable means available).
- Send information up the chain so that it can be transmitted to the various stakeholders: beneficiaries, the authorities in project countries, public opinion, donors and supporters, and professional and institutional backers (see [2.2.5](#) Network and advocacy).

The combination of these broad principles has yielded a number of cross-cutting approaches that, taken together, define the “ID card” of the Rehabilitation Services Unit-supported project.

### An inclusive approach to disability

- **Objective:** to help ensure that disability, in whatever form, is addressed so that people with disabilities gain equal opportunities and equal rights in their society (CRPD).

### A participative approach centred on the service user<sup>15</sup>: application of the inclusive approach

- **Objective:** to give service users a central role in the decisions that concern them by developing and facilitating their relationships with service providers and any other actors involved in the person's environment. This approach should be applied at the level of the individual himself, as a user, and/or the service provider (micro), at the level of their interactions, that

is, service provision (meso), and at a broader level affecting the nature of those interactions (macro).

### A non-discriminatory approach

- **Objective:** to care about the most vulnerable in order to restore equal opportunity via access to physical and functional rehabilitation services, without discrimination and without consideration other than the needs of the persons affected, whatever their origin and social, cultural, religious or ethnic affiliation.

This applies to minorities, the poorest social classes, children, the elderly and people living with HIV. There is special attention to gender via access to services, training and employment for women<sup>16</sup>.

This also applies to isolated populations, whether in urban or rural areas, by the promotion of a **community-based approach**<sup>17</sup> aimed at ensuring access to local rehabilitation activities and facilitating referral to more specialised rehabilitation services.

## 1.2 Purpose

**Rehabilitation** is “a set of measures that assist individuals who experience, or are likely to experience, disability [resulting from impairment, regardless of when it occurred (congenital, early or late)] to achieve and maintain optimal functioning in interaction with their environments”<sup>18</sup>.

This definition corresponds to comprehensive process that contributes to health promotion<sup>9</sup> and determines most Handicap International projects. It is therefore necessary to refine this definition to fit the activities developed as part of Rehabilitation Services Unit-supported projects.

- The WHO defines **the individual in his environment** as the centre of the rehabilitation process.  
“Individuals” should be understood to be not just those “who experience, or are likely to experience, disability,” but also their families, who can be helped to become actors in the rehabilitation process and benefit from the results achieved.



Within the scope of its activities, the Rehabilitation Services Unit promotes actions where the individual and his family are at the centre of the rehabilitation process, rather than universal actions (universal access, for example).

- In the WHO report<sup>20</sup>, rehabilitation measures take the form of rehabilitation medicine and therapy.

“**Rehabilitation medicine** is concerned with improving functioning through **the diagnosis and [medical] treatment** of health conditions, reducing impairments, and preventing or treating complications. (...) Can be involved in rehabilitation medicine (...) a broad range of therapists (physiotherapists, occupational therapists, speech and language therapists...)”

The therapy that we will call **physical and functional rehabilitation** « is concerned with **restoring [optimal functioning] and compensating for the loss of functioning**, and **preventing or slowing deterioration in functioning** in every area of a person’s life. (...)

Therapy measures include:

- training, exercises, and compensatory strategies,
- education,
- support and counselling [for the individual and his family],
- modifications to the environment,
- provision of resources and assistive technology » (orthopaedic fitting, mobility aids, aids for daily living and for communication).

To do this, there are a variety of physical and functional rehabilitation techniques and methods, done in individual or group sessions in either specially-adapted and -equipped spaces or in the person’s own living space.



Within its scope of activity, the Rehabilitation Services Unit mainly develops physical and functional rehabilitation-centred actions. However, actions centering on rehabilitation medicine are considered:

- when needed to facilitate the development and coordination of physical and functional rehabilitation actions (see **2.3.2** Occupations promoted by the Unit);
- when required prior to physical and functional rehabilitation activities (e.g., Ponseti method for treatment of clubfoot).

“**Persons with disabilities** include those who have **long-term** physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others”<sup>21</sup>. While there have been a number of association projects targeting mental impairments in the past (Egypt, Romania and Somaliland in the 1990s) and current projects targeting intellectual impairment and disabilities (Kenya), these issues are not within the current scope of Rehabilitation Services Unit activities; they have to be coordinated by the Prevention and Health Unit.

On the other hand, as the rehabilitation approach (see **1.3** The approach and the models) aims to consider the person as a whole, it is inappropriate consider the existence of **associated** mental and intellectual disabilities an exclusion criterion for setting up physical and functional rehabilitation projects. They have to be taken into account when identified, and referred

whenever possible.

If there are no facilities capable of managing this type of disability, the project should include community-based actions aimed at raising awareness of this issue and creating the skills necessary for basic care (see **2.3.4** Human resource shortages).

The CRPD defines the person in a disabling situation as having long-term impairments and disabilities. It is essential that people with **temporary** impairments and disabilities also receive physical and functional rehabilitation, not only because it can allow full recovery but also because it can prevent a temporary disability from becoming long-term.

It is important to note that while impairments and disabilities of all sorts may be treated by physical and functional rehabilitation in a facility, for a long-term disability the “centre of gravity” of the intervention should ultimately be the user and his family, within his community. Indeed, the intervention should aim at a long-term process of life habit adjustments for the person’s optimal functioning and participation, and this can only be done in his own environment (see **2.2** Levels of intervention).



Within its scope of activity, the Rehabilitation Services Unit mainly promotes actions centred on prevention and physical and functional rehabilitation for people with physical and/or sensory impairments and disabilities, whether temporary or long-term.



## 1.3 The approach and the models

Providing someone with physical and functional rehabilitation assumes that that person is in, or is at risk of, a disabling situation due to impairments and disabilities. The latter are analysed in order to establish a therapeutic plan aimed at optimal functioning (autonomy), so that the person can better participate in daily living and social activities.

The goal of optimal functioning means working on impairments and disabilities in order to set off a process of full or partial recovery, the latter aimed at adaptation and compensation.

Regardless of the anticipated outcome, because the initial impairments and disabilities can lead to **complications**, another goal of physical and functional rehabilitation is **prevention**.

However, establishing a therapeutic plan (intervention strategy) requires understanding the disabling situation, which is an interplay between the person's impairments and disabilities, environmental factors and life habits.

The analysis considers not just each professional's specific expertise, but also the viewpoint of the person and his family.

The rehabilitation process can begin from that analysis, using joint decision-making, prioritising and adjustments.

## 1.3.1

### The analysis models

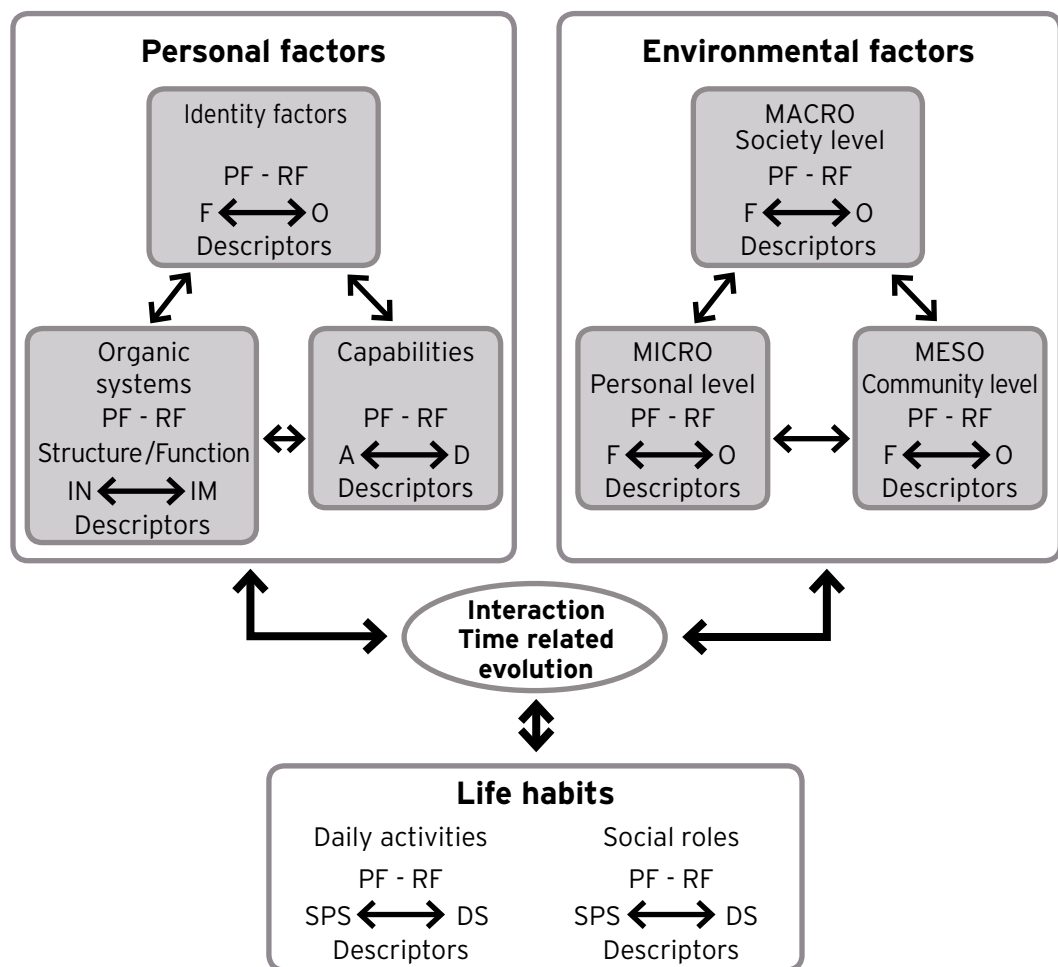
The Rehabilitation Services Unit recommends two models for understanding disability, analysing the situation, putting together a project and evaluating the results.

### Disability Creation Process (DCP)

This analysis model focuses on the **interactions** between personal factors (including health), environmental factors and life habits, with all three given equal weight.

The analysis of the interactions fosters an understanding of the person's overall situation (social model).

### Human Development Model – Disability Creation Process (HDM-DCP 2)



© P. Fougeyrollas, 2010, [www.ripph.qc.ca](http://www.ripph.qc.ca)

#### Legend

PF - RF : Protective factor - Risk factor

F ↔ O : Facilitator ↔ Obstacle

IN ↔ IM : Integrity ↔ Impairment

A ↔ D : Ability ↔ Disability

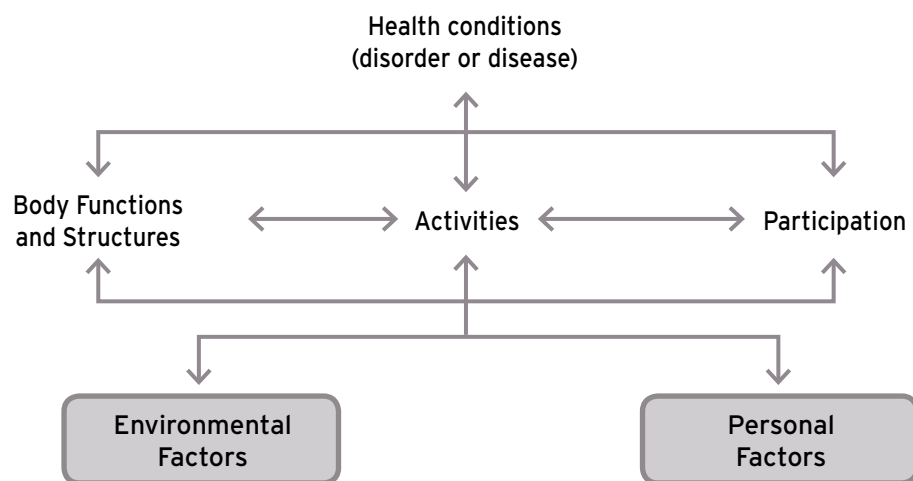
SPS ↔ DS : Social participation situation ↔ Disabling situation

## International Classification of Functioning, Disability and Health (ICF)

This model focuses on the individual's performance (activities performed as part of everyday life), determining a causal link

between that performance and the person's social participation.

The WHO recommends this model as an international standard for describing and evaluating health.



© WHO, International Classification of Functioning, Disability and Health, 2001



According to Handicap International, “our understanding of disability is based on the original model of the Disability Creation Process (DCP)”<sup>22</sup>, which the unit has adopted and recommends as an analysis tool within the actions it promotes.

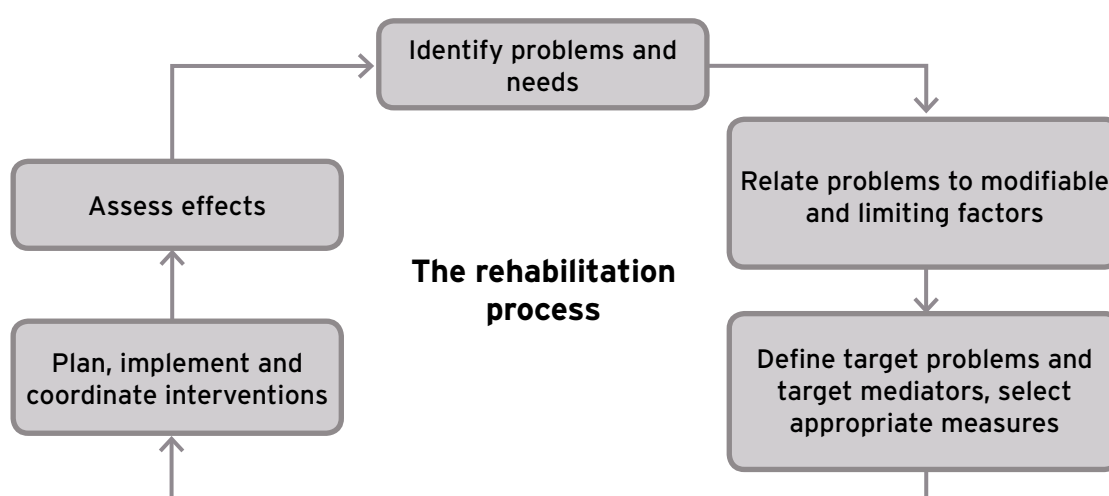
However, because “comparing multiple data sources can provide more robust interpretations, if a common framework like the ICF is used”<sup>23</sup>, the unit recommends using the ICF for communications outside the association, particularly in research contexts.

## 1.3.2

### The rehabilitation process

Using an analysis model allows construction of a well-argued and justified intervention strategy. The strategy is formalised by a

series of actions, starting with identifying and analysing the problems, then planning an intervention and evaluating it so that the initial strategy can, if necessary, be adjusted.



© WHO, World Report on Disability, chapter 4: Rehabilitation, 2011, p. 96.

### The different phases of the rehabilitation process

Using an analysis model, listening to the person and his family and identifying their explicit wants and implicit needs:

- The personal factors, environmental factors, facilitating factors, resources and barriers are analysed and evaluated.
- A multidisciplinary team puts together an intervention plan with the person and his family.

- The plan is implemented in the form of care and advice by one or more rehabilitation professionals and, depending on the situation, training for self-care or family care<sup>24</sup>. It is important to note that “rehabilitation that begins early produces better functional outcomes”<sup>25</sup>.
- Results are monitored and evaluated in terms of life habits and social participation (optimal functioning).
- If necessary, adjustments are made (continuum of care).

## 1.4 From the individual to the system

### 1.4.1

#### The identification-to-follow-up cycle

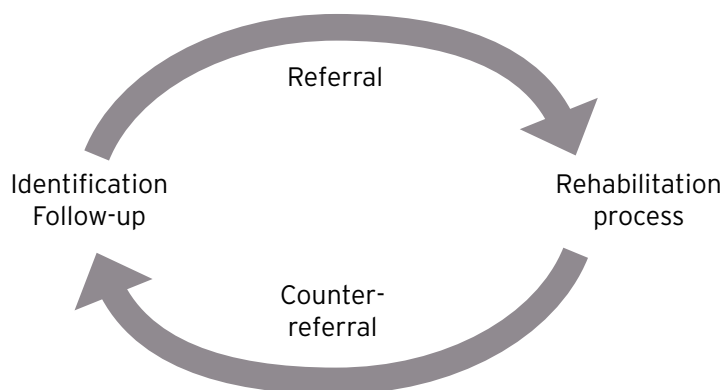
Offering physical and functional rehabilitation assumes the existence of, or risk of developing, **identified** impairments and disabilities.

In **contexts where skilled human resources are plentiful** and health education widespread, **identification** can occur either through an individual's request or complaint to his doctor or by routine screening (maternal and child health, early childhood, school, etc.).

In all cases, the doctor makes a medical diagnosis and/or refers to a specialist (rehabilitation physician), and then issues a medical prescription for physical and functional rehabilitation, identifying the type of professionals required. The prescription takes the place of a **referral**. During the rehabilitation treatment - or once it is over - the individual generally returns to his doctor, who provides **follow-up** and determines whether further care is needed.

**Note:** In some contexts, certain rehabilitation professionals are authorised to diagnose specific problems and provide treatment and follow-up without a doctor's involvement.

#### Identification to follow-up cycle



© Handicap International, 2013

In **contexts where human resources are scarce** or less skilled and the population has limited comprehension of public health issues, each step in the identification/referral/intervention/follow-up cycle is a potential obstacle to the smooth flow of the physical and functional rehabilitation process:

- Does the person have the means to detect that a problem exists?
- Are there local professionals likely to spot the problem?
- If the latter exist, are they able to distinguish a minor problem that can be solved at the local level from a more complex problem that might deteriorate, requiring referral?
- Is there a local or distant facility where physical and functional rehabilitation services could be provided by professionals with the expertise to manage the problem?



- Does the person know that there is a facility that can deal with his problem, and does he have the means to access it?
- Does the person understand the need and will he have the means to return for follow-up of his problem?
- If not, can he get follow-up in his community?

In contexts that are resource-poor and/or lacking skilled human resources, “we seek solutions that are both realistic and adapted to the context. We reject stereotypical approaches, preferring to analyse the specificities of each situation or context and identify the most suitable actions and operating procedures possible”<sup>26</sup>.

Hence all actions aimed at developing rehabilitation activities must first analyse each aspect of the identification-to-follow-up cycle and determine the type and level of service provision, depending on whether there are physical and functional rehabilitation services and professionals. Identifying needs that are impossible to meet as things stand is only pertinent if their prevalence and incidence are used to justify a rehabilitation project, the feasibility of which must be studied (expertise, physical premises, equipment, etc.).

# 1.4.2

## The sectoral approach

As explained earlier, physical and functional rehabilitation is a process centred on the person and his family.

We saw that in order for there to be rehabilitation service provision, the skills had to be available and able to be practiced in a facility or service. In order for that rehabilitation service provision to be appropriate and long-lasting, the skills have to be sufficient, trained and sustainable<sup>27</sup> and be able to be practiced in accessible, viable services<sup>28</sup>.

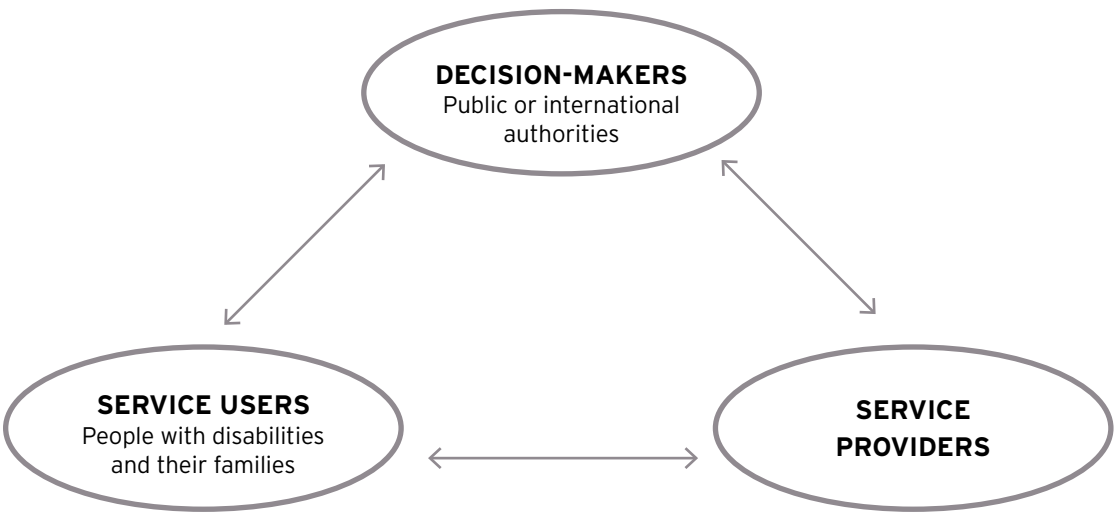
Thus, any potential rehabilitation process aimed at sustainable, high quality service provision must also consider the **rehabilitation system** of which it is a part. That system includes the policies in place and the various rehabilitation sector

organisations, institutions and resources responsible, among other things, for making human resources available and for operating the physical and functional rehabilitation services (see 2.2.3 System: sectoral policies).

The legitimacy of a physical and functional rehabilitation action is based on the existence of a well-run intervention on behalf of the person and his family (direct beneficiaries). Working toward sustainability and reproducibility at the system level will broaden its impact<sup>29</sup>. This requires supporting and creating links between the various sector actors involved in creating a rehabilitation process (indirect beneficiaries).

Hence, the sectoral approach must make it possible to work with all of the direct and indirect beneficiaries of Rehabilitation Services Unit interventions.

### Key actors in providing services to persons with disabilities





Beyond the physical and functional rehabilitation process itself, the intervention with the user and his family should promote their participation in the decision-making process (see figure above). The aim of this capacity-building approach is to encourage people to speak out in an informed way, so they can:

- participate in creating and monitoring individual projects, which should not be forced on users: encourage peer-to-peer exchange so they can benefit from the experiences of others,
- have their voices heard regarding the quality of the services provided: encourage the creation and expression of users' groups,
- lobby decision-makers for continuity and sustainability of services: mobilise and support Disabled People's Organisations (DPOs).

This approach is not unique to the Rehabilitation Services Unit, however, but part of every Handicap International project and overseen by the Support to Civil Society Unit<sup>30</sup>.

As the approach is not specific to the Unit, it will not be discussed in this document. It should be understood, however, that physical and functional rehabilitation projects may include activities centred on community mobilisation and service user capacity-building.

The sectoral approach should also help identify people responsible for:

- selecting and developing quality rehabilitation service provisions;
- ensuring that such provisions are funded;
- putting regulatory mechanisms in place to coordinate the different actors and construct a standardisation process – in particular, by creating a national rehabilitation policy or programme.

“Creating or amending national plans on rehabilitation, and establishing infrastructure and capacity to implement the plan are critical to improving access to rehabilitation. Plans should be based on analysis of the current situation, consider the main aspects of rehabilitation provision – leadership, financing, information, service delivery, products and technologies, and the rehabilitation workforce – and define priorities based on local need”<sup>31</sup>.

Given that this approach is unlikely to produce short-term results, **physical and functional rehabilitation projects** should be developed as part of a larger, long-term strategy formalised by a **national rehabilitation programme or plan**<sup>32</sup>, within which the Handicap International project plays a meaningful role (see **2.2.3** System: sectoral policies).



## 1.4.3

### The intersectoral approach

Physical and functional rehabilitation is not an isolated approach, but rather a link in the overall process of supporting the person with disabilities.

It works in complement with other sectors to provide continuity of services to meet people's wants and needs. To do this, the actors must be interconnected, complementary, and work collaboratively. When properly coordinated, this collaboration ensures a quality effort toward "optimal" social participation.

There is a continuity of service approach between **health care** and physical and functional rehabilitation, as illustrated by the referral/counter-referral cycle presented above. Because the physical and functional rehabilitation sector is an integral part of the health care system, a **special, priority relationship** must be created or strengthened to encourage prevention and early detection of disability-causing congenital and acquired impairments, especially, at a number of levels:

- At the coordination of the medical and social rehabilitation process; led by a physician who, if he or she exists, must be sensitized to the issues and competent.
- In hospitals, especially in post-operative (e.g., trauma) care, through early intervention by physical therapists in particular. In general, if a health care facility has surgeons, it should also have the technical facilities for physical and functional rehabilitation.

- In mother and child protection services:
  - by training health care professionals in the correct techniques for preventing or promptly treating delivery-related problems (such as brachial plexus birth palsy),
  - by detecting maternal or child pathologies requiring early referral to physical and functional rehabilitation facilities (obstetric fistulae, birth defects, delayed psychomotor development, etc.).
- In the management of certain communicable or non-communicable, chronic or non-chronic diseases that, while primarily medical, sometimes require targeted physical and functional rehabilitation to prevent or reduce impacts in terms of impairment and disability (diabetes, cardiovascular and respiratory disease, AIDS, Buruli ulcer, etc.).

Combining physical and functional rehabilitation with **socioeconomic and educational** activities helps increase participation by people with impairments and disabilities. The benefit of rehabilitation service provision is enhanced by support that helps get users quickly back to school or work. Conversely, physical and functional rehabilitation intervention can promote social participation by facilitating access to education and/or employment, intervention that should in some cases be considered prerequisite.

Referral from one service to another is a good illustration of this collaboration; it is greatly facilitated when there is an understanding of each other's issues and the services they offer.

Such a cross-cutting intersectoral approach linking the various actors should be planned from the local all the way up to the national level. The physical and functional rehabilitation sector may be overseen by the Ministry of Social Action via its disability policy, or by the Ministry of Health via a national health policy.

Oversight by the Ministry of Health is particularly advantageous because:

- the issues involved in physical and functional rehabilitation (prevention, chronic illnesses, etc.) extend beyond the scope of the Ministry of Social Action;
- having the national rehabilitation programme be part of the national health policy fosters a continuum of care from identification to follow-up; no matter what the supervising ministry, this continuum requires that a rehabilitation service be **integrated** into the health care system from the primary to the tertiary level.

In terms of intersectoral linkages, the Education Ministry needs to be involved for vocational training, the Employment Ministry for official recognition of the relevant occupations, and the Finance Ministry for implementing a national rehabilitation plan.

# 1.5 The context



“We take the Relief-Rehabilitation-Development contiguum into account, adapting our methods of action, our activities and their duration to the specificities of each situation. The principle of ‘operational differentiation’ enables us to adapt our operating procedures to the context and to the areas of competences concerned, using specific methods and management”.<sup>33</sup>

## 1.5.1

### From emergency to development

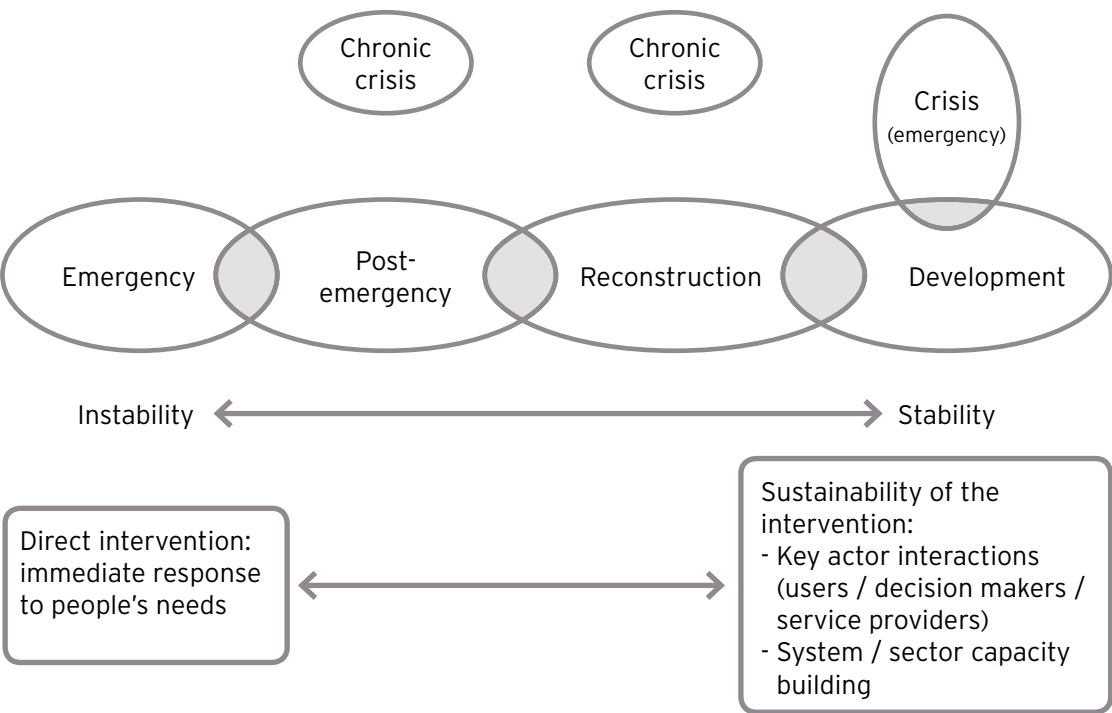
Because the physical and functional rehabilitation approach centres on the individual, it can be implemented no matter what the context.

On the other hand, the design of a rehabilitation project must take into account:

- ▀ people’s environment, which varies depending on the stability of the context;
- ▀ the ability to mobilise resources locally in a fairly sustainable way.

Handicap International has defined five contexts in which its actions are developed<sup>34</sup>.

### The five Handicap International intervention contexts



While Handicap International relies on local human resources to develop its projects in all contexts, in an emergency context the aim of the “have do” approach is to multiply its actions to meet the need, and in a development context the aim is to transfer skills, something that requires a latency period incompatible with a rapid response. “We have to keep in mind that the primary aim of emergency action is not to strengthen local partners but, first and foremost, to meet the needs of vulnerable people and their families affected by the crisis”<sup>35</sup>.

Development Division and Emergency Response Division operating procedures differ<sup>36</sup>, and though the Unit is mainly focused on development strategies, the Emergency Response Division may call upon its rehabilitation expertise in emergency and post-emergency contexts, in particular when:

- cross-disciplinary expertise is needed;
- seeking complementarity in changeable contexts;
- knowledge sharing is needed (strengthening each participant’s knowledge about the specificities of the context).

The Unit may also intervene in reconstruction contexts – considered a transition phase – where, though emergency and post-emergency activities may continue, community initiatives will get more systematic support and participatory and partnership strategies will gradually be introduced with increasingly active involvement by the population in the design, implementation and assessment of actions. The emphasis will also be on restoring community capacity and – when the stability of the environment permits – preparing a paradigm shift toward laying the foundation for the development phase.

The stability of the context and the sustainability of actions are related. In a development context, the physical and functional rehabilitation intervention strategy relies on partnerships aimed at:

- transferring know-how from the association to local actors. This skills transfer requires identifying human resources with long-term availability;
- setting up appropriate, accessible and viable facilities or services.

These two markers of sustainability – which are essential but not sufficient – are only possible in a stabilised context.



### Specific context: the refugee camp

In the context of a refugee camp, which is the epitome of an artificial structure, development projects are not possible. Swinging between emergency and post-emergency, the objective must be an appropriate response to basic and specific needs of vulnerable populations<sup>37</sup>. Some camps last for years or even decades (e.g., Kenya and Thailand) however, making more advanced actions possible, including setting up rehabilitation and training activities (reconstruction). Given the mobility of the population in this context – especially people who have been trained – extreme vigilance in terms of project objectives is essential (the Unit should produce a document on this subject).

# 1.5.2

## Situation analysis

In stabilised contexts, the decision to intervene in physical and functional rehabilitation and the types of service provision anticipated will depend on the country's level of development.

A preliminary situation analysis should help identify the prerequisites and identify existing helps and hindrances to setting up a rehabilitation project. In particular, that analysis should look at the interactions between the various actors and their level of accountability<sup>38</sup>.

Situation analysis preliminary to setting up a physical and functional rehabilitation project		
Level	Things to study	Things to watch for
Users	User wants and needs	Prioritisation (impact)
	Prevalence and repercussions (public health)	
	Comprehension of health problems	Awareness-raising, education
	Participation, community mobilisation and solidarity	
Services	Type, accessibility and viability of services	Basic, mainstream and specific, support <sup>39</sup>
		Funding
		Partnership
		Decentralisation
		Identification to follow-up
		Technology
	Human resources: source and availability, stability, skill type and level, representativeness	Quality, best practices
		Status
		Targeted or transferable skills
		Training and standards
Decision-makers	Legislation, decision-maker commitment and governance, financial capacity	
	Sectoral approach	Supervisory ministry (Health)
		National rehabilitation plan
	Multisectoral coordination	Ties with health sector

Whatever the scope of the project being considered, whether planned at the local level or on a national or even regional (multi-country) scale, it is important to note that:

- the situation analysis should always study all three levels;
- it should ultimately meet the explicit wants and implicit needs of the users;
- it should include an exit strategy negotiated with and agreed to by the local partners. "We plan an exit strategy at the programme or project design stage, planning for appropriate support during the transition period"<sup>40</sup>.

## 1.6 In summary

### Physical and functional rehabilitation and its analysis models

The goal of rehabilitation medicine is to improve an individual's level of functioning via medical diagnosis and treatment of his health problems.

The goal of physical and functional rehabilitation, a process for people with temporary or long-lasting impairments and disabilities (and their families), is to:

- ▀ restore or compensate for functional loss to allow optimal functioning in interaction with the environment;
- ▀ to prevent or slow functional deterioration.

To achieve this, the person is given exercises, advice, and recommendations for educational measures, and technical aids and environmental adjustments may be made.

To ensure that the rehabilitation process is appropriate to people's needs, their situation should be analysed using a disability comprehension model. Handicap International recommends the DCP model. For communications outside the association, however, the unit recommends using the ICF, particularly in research contexts.

### The project development process

Any action aimed at developing quality physical and functional rehabilitation activities centred on the needs of people (the direct beneficiaries) must first analyse each aspect of the identification-to-follow-up cycle. That analysis should help determine the type of intervention and the appropriate level of service provision, depending on whether:

- ▀ there is an existing service whose practices, technologies and accessibility have to be studied;
- ▀ there are rehabilitation professionals.

Given that we want the service provided by the rehabilitation process to be sustainable, the rehabilitation system into which it will fit must be considered. That sectoral approach must be applied to other related sectors as well, and the actors comprising that (those) system(s) (i.e., the indirect beneficiaries) – both decision-makers and service providers – given support and guidance. Ultimately, the preliminary situation analysis should identify the prerequisites to setting up a physical and functional rehabilitation project, as well as any existing helps and hindrances.

Lastly, in order to achieve our goal of pertinence and maximum positive impact, a time-limited **physical and functional rehabilitation project** must be part of a broader, longer-term strategy in the form of a **national rehabilitation programme or plan**. The creation and formalisation of such a programmatic plan can itself be the subject of a project between Handicap International and its institutional partners.



## Scope of activities of the Rehabilitation Services Unit

The Unit:

- puts the principles set forth by the Handicap International Federation into practice in its scope of activities;
- promotes actions aimed primarily at developing physical and functional rehabilitation, rather than rehabilitation medicine, activities;
- promotes actions where the individual and his family are at the centre of the rehabilitation process, rather than universal actions;
- promotes mainly actions centred on prevention and physical and functional rehabilitation for people with physical and/or sensory, rather than mental and intellectual, impairments and disabilities;
- conducts actions aimed at all of the actors involved in promoting physical and functional rehabilitation (service users, service providers and decision-makers) at every level (local or community and sectoral);
- although primarily concerned with development strategies, deploys its actions or expertise, in more or less direct ways, in all contexts, from emergencies to development.





Liberia, 2012



## 2. Intervention modalities

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The aim of this chapter is to present a more operational framework within which the various theoretical elements developed earlier are applied.

The goal here is not to offer a standard project logical framework, but to put the basic physical and functional rehabilitation principles into perspective. The objective is to guide the choice of – and aid decision-making on – actions to be undertaken to promote physical and functional rehabilitation in development contexts.

## 2.1 Reducing the barriers



Given the scarcity of rehabilitation resources relative to the need, the issue is not so much advocating for well-founded rehabilitation strategies, but rather removing the barriers to their development. According to the WHO<sup>41</sup>, “the barriers to rehabilitation service provision can be overcome through a series of actions, including:

- reforming policies, laws, and delivery systems, including development or revision of national rehabilitation plans;
- developing funding mechanisms to address barriers related to financing of rehabilitation;
- increasing human resources for rehabilitation, including training and retention of rehabilitation personnel;
- expanding and decentralizing service delivery;
- increasing the use and affordability of technology and assistive devices;
- expanding research programmes, including improving information and access to good practice guidelines”.

Whatever the chosen theme(s) for developing a physical and functional rehabilitation project, some or all of the WHO-recommended measures must be considered in the design.

## 2.2 Levels of intervention

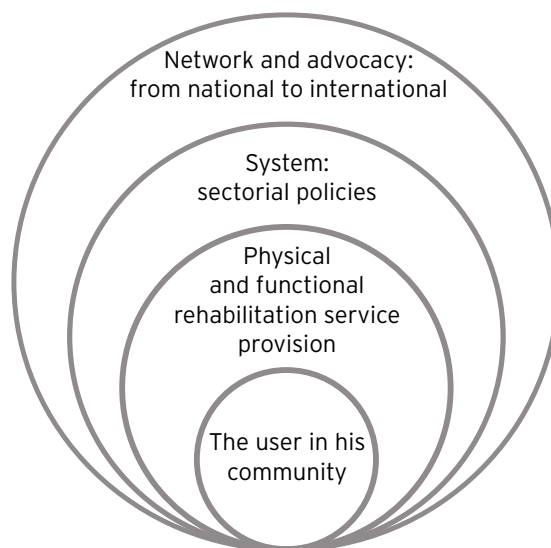


“Our action is implemented primarily at local level and at the services level, alongside the populations, groups and individuals concerned. This groundlevel experience gives us legitimacy in seeking a greater and more lasting impact through working to influence systems and policies”<sup>42</sup>.

“It is important to remember that support is needed for people with disabilities and their families as close as possible to their own communities, including rural areas”<sup>43</sup>.

As we have said, the orientation of a project aimed at providing local physical and functional rehabilitation is based on the diagnosis rendered after a situation analysis of the system into which the proposed project must fit. That diagnosis should be based on a study of the identification/referral/intervention/follow-up cycle. The type of provision being considered will depend on whether a service already exists and the type of activities proposed, the location of that service relative to the community, how it fits into the sectoral and intersectoral network, and the recognition and support it receives to grow and continue.

### The different levels of intervention



© Handicap International, 2013

Intervention  
modalities

35

Because the intended project must produce lasting effects, it is best to intervene at every level to ensure the **quality, viability and sustainability** of the rehabilitation provision. Frequently, however, one or more levels is inaccessible or the project does not have the means to tackle them all. Hence,

prerequisites and conditions to facilitate decision-making on the timetable and choice of intervention level(s) must be defined. It is important to note here that quality must be considered at all levels of intervention; viability is intrinsic to the service level and sustainability to the sectoral level.

### 2.2.1

#### The user in his community

**The general aim of the project strategy** (defined as priority):

People with disabilities have physical and functional rehabilitation provision close to them. Considering the information from the situation analysis, the prerequisites for setting up a physical and functional rehabilitation project at the local or community level are:

- the existence of wants and needs consistent with the Unit's orientations (decision-makers, service providers and users);
- the presence of a physical and functional rehabilitation service, whatever its location, to which users needing specific services can be referred.

**The targeted aim of the project strategy:**

Setting up a community-based physical and functional rehabilitation project (sectoral approach) to develop local human resources capable of identifying, referring and, if need be, following the users of a physical and functional rehabilitation service.

**What the strategy should achieve:**

- The population is informed and aware of the project's ability to meet such expressed wants or needs.
- Community health workers or CBR workers<sup>44</sup> are selected, supported and trained in identifying and, if need be, following project beneficiaries.
- These workers are informed of the existence of a rehabilitation service or services and the nature of the provision, to ensure appropriate referrals.
- The provision is in keeping with the needs of the users referred.
- Local basic provision and user follow-up are monitored by service professionals.

"Community-based workers (...) can work across traditional health and social services boundaries to provide basic rehabilitation in the community [especially regarding environmental accessibility] while referring patients to more specialized services as needed. CBR workers generally have minimal training, and rely on established medical and rehabilitation services for specialist treatment and referral"<sup>45</sup>.

**Risks:**

- Creating expectations that the project cannot meet, due to an identification and referral process that exceeds the capacity of the service.
- Inaccessibility of the service.
- Poor quality of community-based provision, due to a lack of regular support by physical and functional rehabilitation professionals.
- Project set-up is unsustainable.

The location of the physical and functional rehabilitation service – as revealed by the situation analysis – will influence the design of project activities.

### The service is geographically accessible

#### If the service is located within the community:

- The targeted strategy defined in the table above is applied, knowing that follow-up can be done directly by service professionals (consultations and home visits, if necessary).

#### If the service is far from the community:

- “In low-resource, capacity-constrained settings, efforts should focus on accelerating the supply of services in communities through CBR, complemented with referral to secondary services. Examples of measures in community-based rehabilitation include:
  - Identifying people with impairments and facilitating referrals,
  - Delivering simple therapeutic strategies through rehabilitation workers, or taught to individuals with disabilities or a family member,
  - Providing individual or group-based educational, psychological, and emotional support services for persons with disabilities and their families,
  - Involving the community: manage rehabilitation problems collaboratively<sup>46</sup>, and mobilising disabled people's organisations, when they exist.

- “No place too far from services”<sup>47</sup>: the community's primary health care services can provide coordination and reception so that mobile teams of physical and functional rehabilitation professionals can come from the service to work (consultations, onsite provision, if considered possible, referral to the service for specific needs, and follow-up).
- Referral requires measures ensuring that users have access to the service (see **2.2.3** System: sectoral policies and the Financial Access technical sheet<sup>48</sup>). In addition, follow-up activities must be planned and organised.
- Depending on the needs and to ensure continuity of care, **basic rehabilitation provision** can be developed locally by CBR workers. In that case, it is essential that such provision be prescribed and monitored by physical and functional rehabilitation professionals, and that the CBR workers be trained and monitored.

### The service is geographically inaccessible

- Develop community-based prevention activities.
- Advocate for local services and/or to create a service as part of the project: identification/referral/follow-up activities will have to be concomitant with skills development within the service.
- Reconsider the pertinence of the project.

See also Flowchart 1: **From identification to referral: decision tree** (2.2.4 part).

### 2.2.2

#### Physical and functional rehabilitation service provision

**The general aim of the project strategy** (defined as priority in connection with the previous level):

There is a viable physical and functional rehabilitation service offering quality physical and functional rehabilitation appropriate to the wants and needs of users.

Considering the information from the situation analysis, the prerequisites to setting up such a project are:

- sufficient demand and need for rehabilitation services;
- human resource availability;
- the possibility of developing appropriate infrastructure.

**The targeted aim of the project strategy:**

The organisation in the service is efficient and centred on the needs and expectations of users. It facilitates the provision of quality physical and functional rehabilitation by skilled human resources.

**What the strategy should achieve:**

- The adoption by local partners of best practice standards – based on scientific consensus or Evidence-Based Practice whenever possible – guides the internal organisation of the service. It aims to meet these standards by constantly improving quality at both the facility governance<sup>49</sup> and clinical levels.
- The training of service practitioners yields a collection of skills appropriate to the expected level and quality of service provision (expertise and technical). That level is determined based on user needs and wants, the initial educational level of the professionals to be trained relative to international standards (when such exist), and the anticipated scope of the service in which the professionals must practice.
- The viability of the service is ensured by the service provision meeting user needs and wants, the users' ability to access the service, and good financial management aimed at controlling expenses relative to funding.

**Risks:**

- Inability of the human resources to attain the desired skill level, given their initial level of education.
- Financial viability: the cost of the planned service offerings exceeding the funding ability.

## Type of service

Physical and functional rehabilitation service provision can be developed at all three service levels<sup>50</sup>, that is:

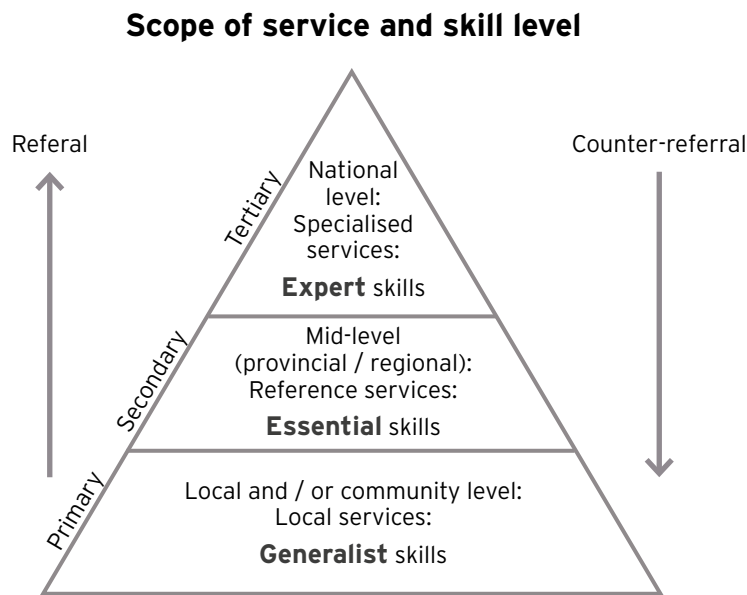
- mainstream services providing physical therapy, speech therapy, occupational therapy, etc. practiced in a hospital or office, in public or private facilities;
- support services providing technical aids, including mobility aids<sup>51</sup>; these can be stand-alone or located within a mainstream or specific service;
- specific services concerning rehabilitation centres offering an entire range of physical and functional rehabilitation services, including not just technical aids, but also social support, etc.

**Note:** supporting the simultaneous development of different types of services improves the physical and functional rehabilitation coverage rate for people with impairments and disabilities, from the simplest to the most complex, temporary to permanent. Large specialised structures, though essential, should not be promoted exclusively at the expense of local services.

## Service level and type of service provided

There is a relationship between the level of coverage or scope of the service and the type of activities developed within it.

- “Medical rehabilitation and therapy are typically provided in acute care hospitals<sup>52</sup> for conditions with acute onset<sup>53</sup>. Follow-up medical rehabilitation, therapy, and assistive devices could be provided in a wide range of settings, including specialized rehabilitation wards or hospitals; rehabilitation centres (...). Longer-term rehabilitation may be provided within community settings and facilities such as primary health care centres, schools, workplaces, or home-care therapy services<sup>54</sup>. (...) Community-delivered rehabilitation interventions are an important part of the continuum of rehabilitation services, and can help improve efficiency and effectiveness of inpatient rehabilitation services<sup>55</sup>”.
- The expertise expected at the tertiary care level (see figure below) assumes in-depth knowledge in a narrow area of specialisation, whereas the generalist practice at the primary care level corresponds to more limited knowledge over a broad range of skills. Thus, two people in the same profession with the same initial training may need to develop different skills, depending on the type of rehabilitation provision being considered and the structure of the existing health care system.



### Recommendations

- Independent of the funding opportunities - which can impact the decision on which type of service to develop - the primary aim of any rehabilitation services set up should be to meet the needs of the greatest number of people (prevalence and public health impact) and/or the need for preventive action.
- The service should be as close as possible to the community (geographic accessibility). Its scope (primary, secondary or tertiary) and type (mainstream, specific or support) will depend, in particular, on the population density in its service area and on any existing services of the same type.
- In development contexts, management of acute conditions must be supported by promoting hospital-based physical therapy, in particular.
- The effort to ensure quality by identifying and adopting best practice standards should result in an efficient, user-centred organisation:
  - Creation and support of user groups, relationship with disabled people's organisations;
  - The head of the service should be a qualified administrator/manager: it is better to teach a generalist the specificities of physical and functional rehabilitation than to divert a specialist with technical expertise from his clinical and training responsibilities.
- The identification/referral/follow-up system must be structured so that:
  - wants and needs that the service can take care of are identified;
  - properly-conducted referral maintains the activity level of the service;
  - follow-up fosters continuity of care (quality) by calling upon community involvement rather than mobile teams from the service (accessibility); mobile teams should be deployed only for highly technical provision and/or supervision of community-based activities.

See also Flowchart 2: **From referral to service provision: decision tree** (2.2.4 part).



## 2.2.3

### System: sectoral policies

**The general aim of the project strategy:**

The service offers sustainable physical and functional rehabilitation having a positive impact on the users' quality of life.

**The targeted aim of the project strategy:**

There is a national rehabilitation plan formalising:

- the system or network into which the service is integrated;
- the regulatory mechanisms necessary to the sustainability of the service, aimed at guiding the quality process, disseminating it and keeping it alive through evaluation;
- the connections between the responsible actors involved (sectoral and intersectoral) and users or their representatives.

**What the strategy should achieve:**

- Rehabilitation needs are identified at the national level, prioritised and formalised in an action plan legitimising the service provision offered.
- The service adopts and contextualises the regulatory and standardisation mechanisms that define:
  - the framework within which internal organisation is designed and services provided;
  - the resources needed to provide services;
  - the practices themselves.The service is also a stakeholder in how these mechanisms evolve, relying on the users' point of view, in particular.
- Service sustainability is ensured by involving decision-makers, who guarantee the allocation and stability of human and financial resources.
- The human resources assigned to the service are dedicated and surplus, rather than diverted from other essential services.
- The training for rehabilitation professionals is validated by the supervisory authorities, and they have formal, recognised status.
- There is a sustainable supply channel for raw materials, appropriate to the service's activities.

### Method: sustainability workshop<sup>56</sup>

All of the physical and functional rehabilitation actors get together to share their short-, medium- and long-term vision for the sector, with a view to designing a joint intervention strategy.

The strategy is based on the analysis and choice of sustainability indicators, determined using the Sustainability Analysis Process.

The aim of the strategy is to create an inter-actor action plan enabling the supervisory ministry to develop or revise a national rehabilitation plan that defines everyone's place and role and prioritises the areas of intervention.

**Note:** Handicap International cannot have final responsibility for the entire sustainability process, given that the challenges will depend on the dynamics requiring long-term involvement by each of the actors, including international cooperation actors.

### Recommendations

The Unit has adopted the following three WHO recommendations:

1. Policies and regulatory mechanisms:
  - "Assess existing policies, systems, services, and regulatory mechanisms, identifying gaps and priorities to improve provision.
  - Develop or revise national rehabilitation plans, in accord with situation analysis, to maximize functioning within the population in a financially sustainable manner.
  - Where policies exist, make the necessary changes to ensure consistency with the CRPD.
  - Where policies do not exist, develop policies, legislation and regulatory mechanisms coherent with the country

context and with the CRPD. Prioritize setting of minimum standards and monitoring."<sup>57</sup>

2. "Policy actions require a budget matching the scope and priorities of the plan. The budget for rehabilitation services should be part of the regular budgets of relevant ministries - notably health - and should consider ongoing needs. Ideally, the budget line for rehabilitation services would be separated to identify and monitor spending"<sup>58</sup>.

3. "Develop funding mechanisms to increase coverage and access to affordable rehabilitation services. Depending on each country's specific circumstances, these could include a mix of:

- Public funding targeted at persons with disabilities, with priority given to essential elements of rehabilitation including assistive devices and people with disability who cannot afford to pay.
- Promoting equitable access to rehabilitation through health insurance.
- Expanding social insurance coverage.
- Public-private partnership for service provision.
- Reallocation and redistribution of existing resources.
- Support through international cooperation including in humanitarian crises"<sup>59</sup>.
- Financial participation by the user should be considered, if the authorities have developed a fee policy. That policy should be defined based on the actual calculated cost of the provision, from free-of-charge to fee-for-service. If it is decided that the user must help pay, the project must strive to ensure fair, affordable access for all users<sup>60</sup>.

The following points must also be considered:

- It is necessary to “pay specific attention to the transfer of knowledge and practices to local actors in the PMR sector, particular during the exit phase of the partnership and make sure to accompany and plan sufficient time for the partners to integrate and appropriate the new skills and knowledge”<sup>61</sup>.
- It is necessary to “anticipate the need for training of PMR professionals both in the initial phase of the project as for the long-term need of the country in question. It is important already from the start to identify partners that can build training programs, or supportive academic institutions that can be part of a longer-term partnership of building **training capacities**, beyond the intervention of Handicap International”<sup>62</sup>.

Anticipating training needs and identifying training partners must be followed by:

- drafting a training curriculum that meets international standards, whenever possible;
- institutional recognition of that curriculum.

Ideally, this first step in a training project should be finalised **before any training actions begin**. In some contexts, however, waiting until these results are achieved to actually begin the training actions needed for provision of physical and functional rehabilitation services is hard to imagine (see [2.3.4](#) Human resource shortages).

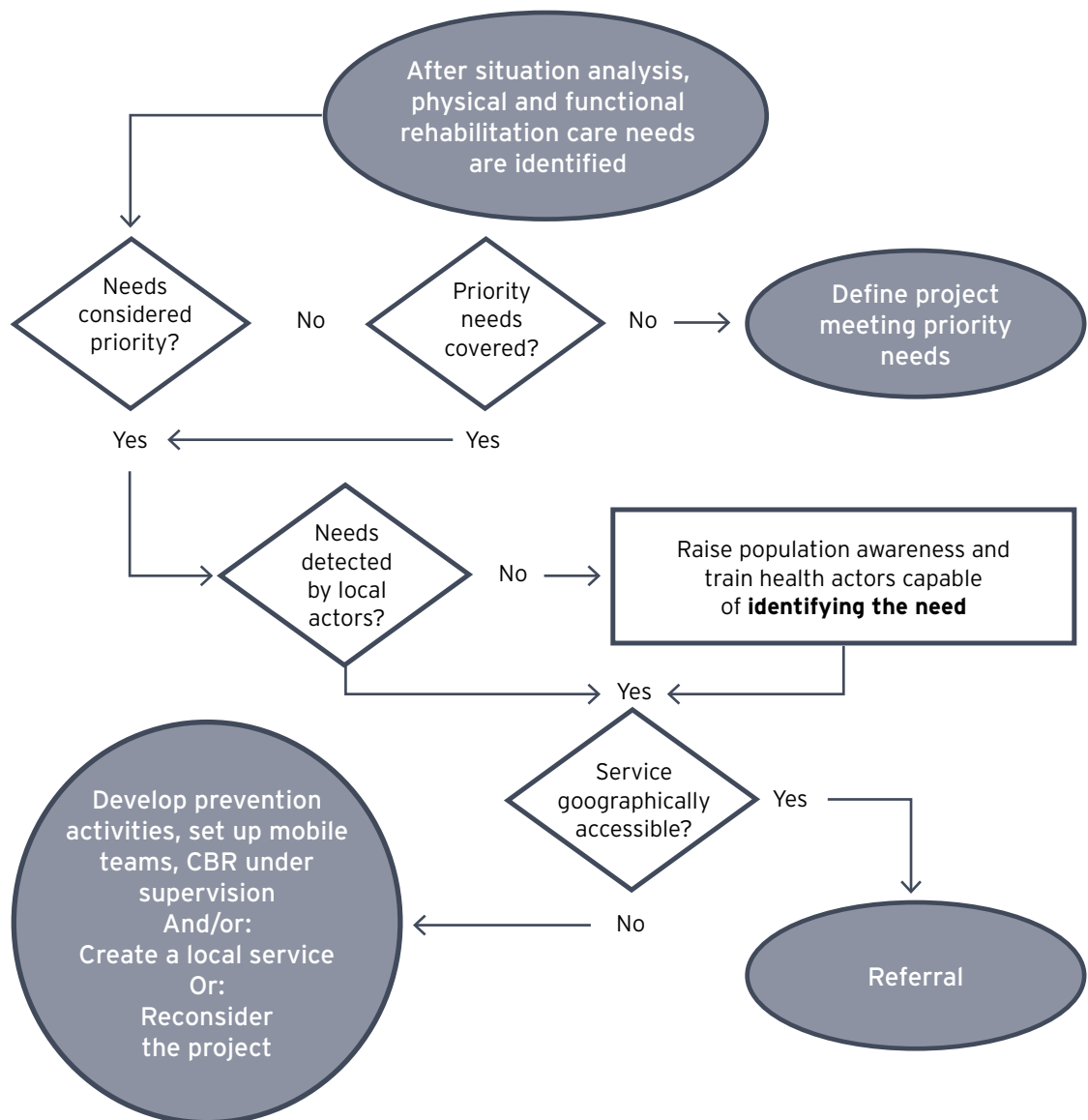
- Once trained, physical and functional rehabilitation professionals should be supported in their practice, in order to reinforce their newly-acquired skills (clinical mentoring and continuing education).
- Their professional identity must be developed not just through the practice of their craft, but also through support for the creation of recognised professional associations.
- Quality of life: more studies on the impact of physical and functional rehabilitation on users' quality of life are needed. A first study of this kind was conducted in Togo in 2009 for Handicap International. That study, which used the DCP as the conceptual basis for analysis, could serve as a model for new studies employing the same methodology, to “produce comparable evidence that could be used to measure impact, plan programmes, and mobilise resources”<sup>63</sup>.

See also Flowchart 3: **From quality to viable, sustainable service provision: decision tree** ([2.2.4](#) part).

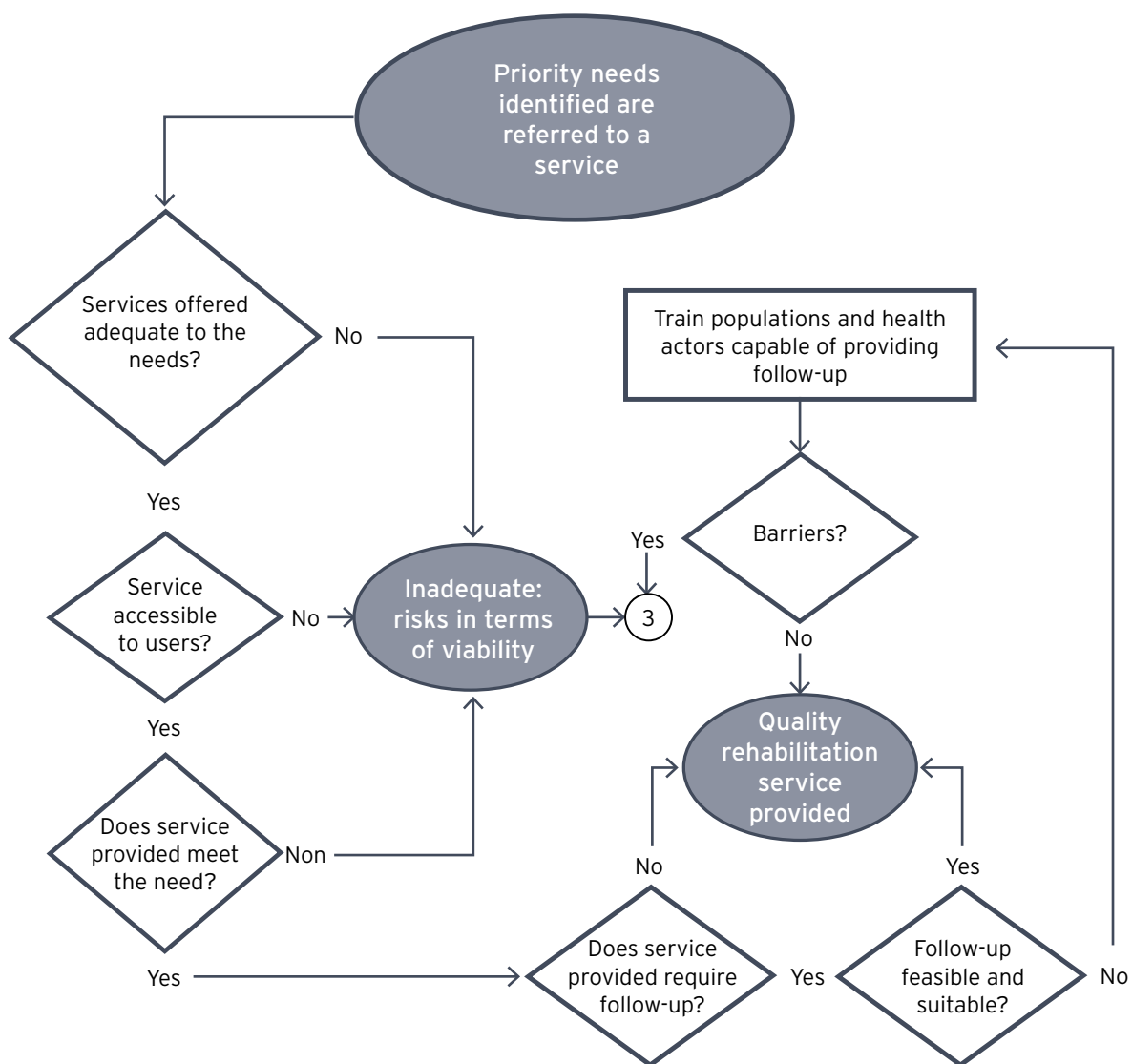
## 2.2.4

### Summary: flowcharts

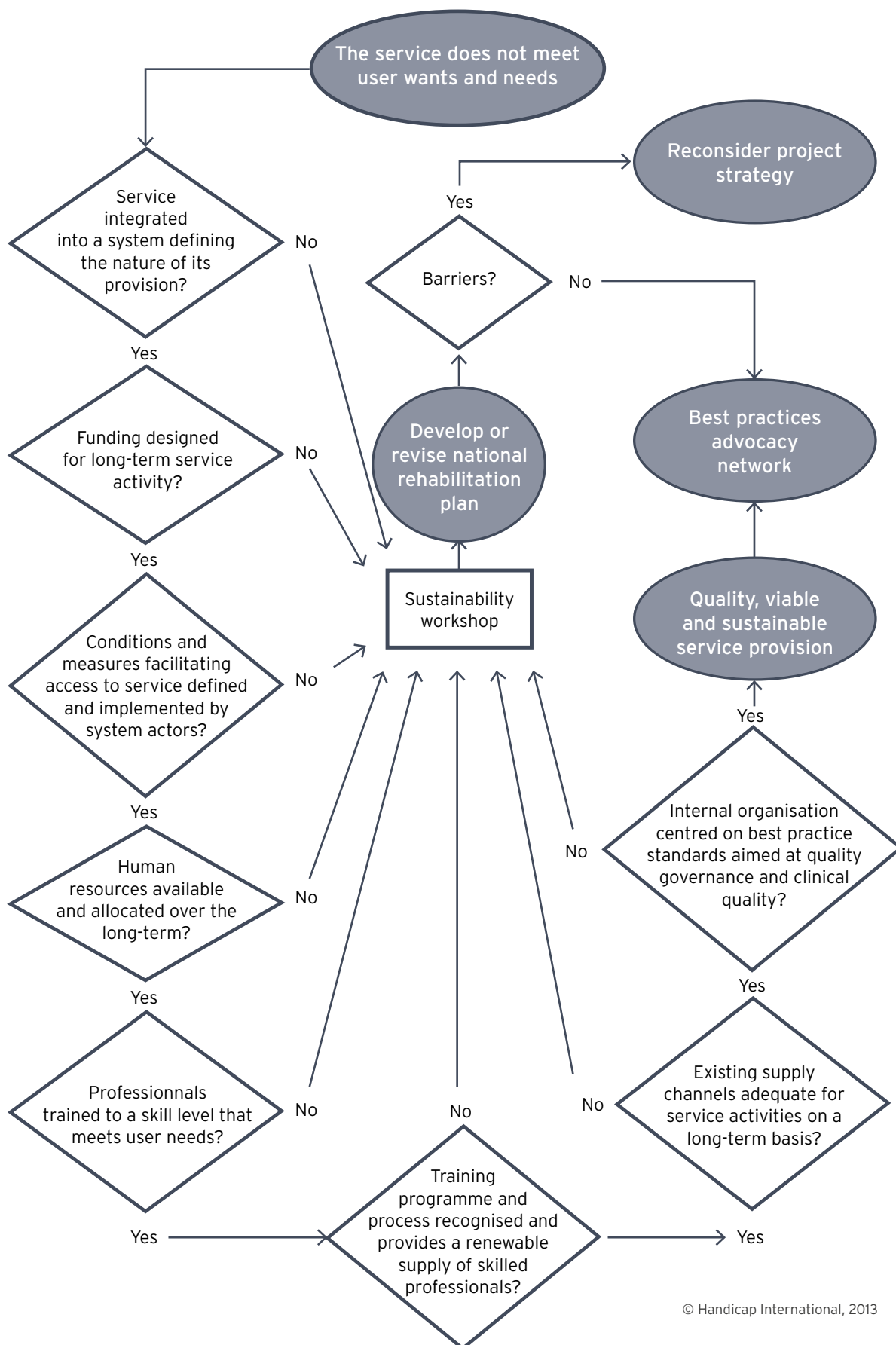
#### 1 From identification to referral: decision tree



2 From referral to service provision: decision tree



## 3 From quality to viable, sustainable service provision: decision tree



## 2.2.5

### Networks and advocacy, from national to international

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In ad hoc networks, Handicap International is positioned as a leader in physical and functional rehabilitation from humanitarian situations to development contexts. Through its regular collaboration in working groups, Handicap International has developed a close relationship with the WHO's Disability and Rehabilitation team, actively participating in the production of the World Report on Disability, a reference tool cited frequently here, the recently-released Joint position paper on the provision of mobility devices<sup>64</sup>, and others. While that collaboration helped establish its influence in pressing for recommendations on broader rehabilitation-related issues, Handicap International now feels it necessary to develop more targeted advocacy promoting **health-related physical and functional rehabilitation**. This requires identifying and getting involved in health networks where advocacy would help ensure continuity of service through better integration of physical and functional rehabilitation, at lower cost and regardless of context.

#### The networks

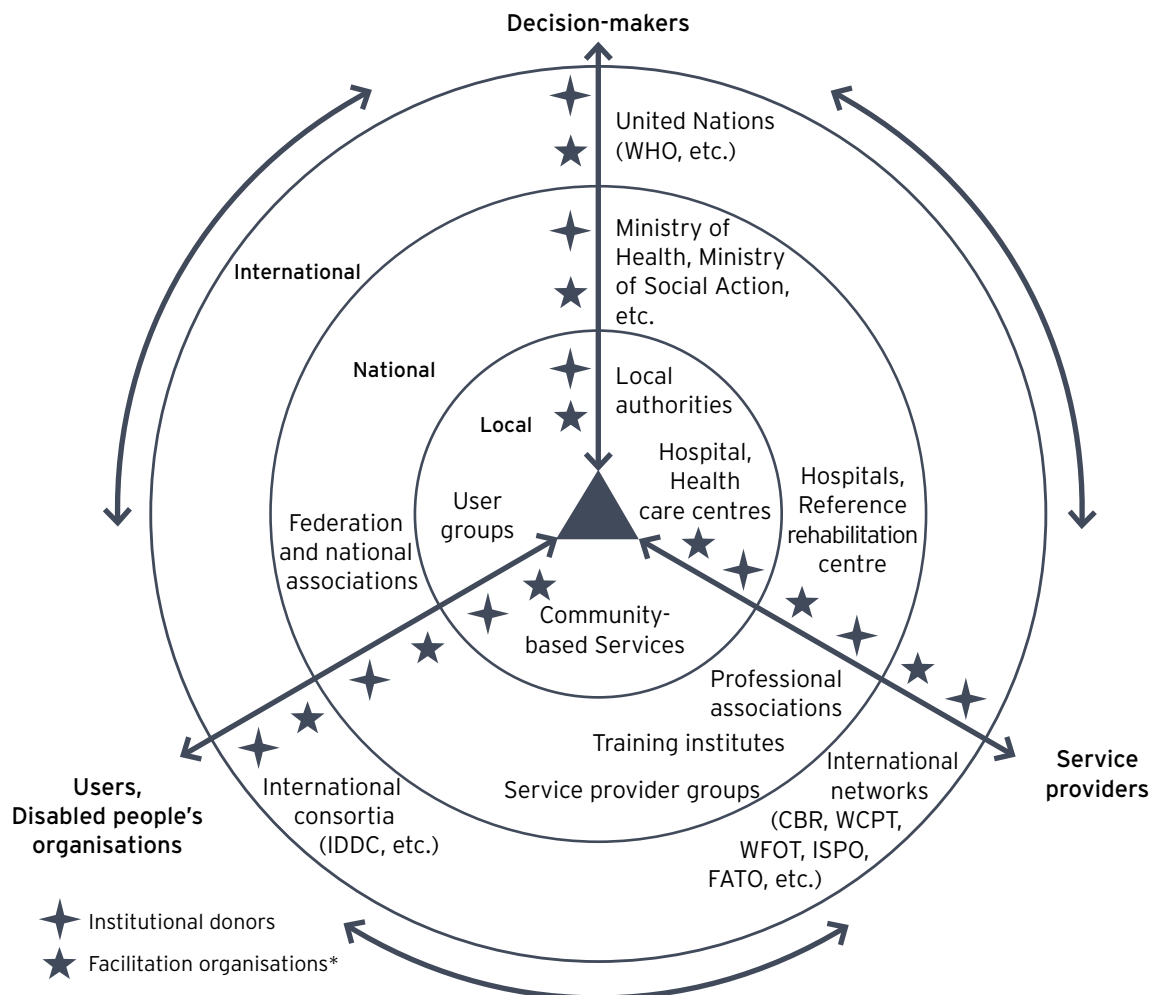
Being visible in networks - being known and recognised - allows a number of actions:

- Disseminating innovations and lessons learned to promote best practices and quality assurance; this presupposes:
    - the ability to collect reliable data that can be used for comparison according to a proven, validated methodology, or even a research effort aimed at validated practices;
  - the willingness and ability to evaluate projects: "we ensure that the outcomes of our actions are objectively evaluated and we measure the impact of our activities on the lives of beneficiaries"<sup>65</sup>;
  - data analysis and synthesis leading to a stated position;
  - opportunities for targeted communication: "we undertake to keep the different stakeholders in our actions informed: beneficiaries, the authorities of the countries in which we work, public opinion, our donors and supporters and our professional and institutional backers"<sup>66</sup>.
- "Better data are needed on service provision, service outcomes, and the economic benefits of rehabilitation. Evidence for the effectiveness of interventions and programmes is extremely beneficial to guide policy-makers in developing appropriate services"<sup>67</sup>.
- Developing collaborations, coordination mechanisms and partnerships to strengthen expertise, facilitate field actions and, possibly, get more and better funding:
    - Seek out joint projects with other rehabilitation actors for technical value-added aimed at greater country impact;
    - Consider closer collaboration with other organisations aimed at headquarters-to-headquarters framework agreements to form strategic alliances;

## Levels of intervention

- Work with universities and research centres and develop research protocols on themes of interest to the Unit to get scientific backing and thus facilitate publication;
- Mobilise academic expertise for developing training programmes and mobilising trainers.
- Weigh in on the debate around issues related to rehabilitation promotion and funding, promote best practices to influence policies that favour access to rehabilitation services and thereby move toward advocacy actions.

### Network: actors that can be mobilised for physical and functional rehabilitation



\* Organisations (IOs, NGOs, etc.), agencies, universities and research centres that facilitate the existence of physical and functional rehabilitation via national or international projects.



The Unit has technical resources specifically positioned to be able to reach the maximum number of network contacts:

- the Technical Coordinator, positioned for local support, representative at the national and potentially regional level;
- the Technical Adviser, positioned at the regional and international level.

The greater the number of connections among network actors – both at a given level and between different levels – the more effective advocacy actions will be.

## Advocacy



“Legitimacy for our testimony and advocacy lies in our field experience and action alongside beneficiary populations. Founded on needs and facts, these activities must be pertinent and potentially useful to these populations. Advocacy is a lever that is complementary to our humanitarian and development work. It aims to promote a political environment that is favourable to improving the living conditions of the beneficiaries of our action and to the exercising of their rights. We undertake direct advocacy at the international level. In the countries where we work, we encourage advocacy by local groups and individuals”<sup>68</sup>.

**The key messages** transmitted in the networks should come from the Unit when they concern specific themes, and from the entire Technical Resources Division and Handicap International when they are more global in scope:

- Rehabilitation care, essential to ensuring complete, continuous and lifelong management of disabled people's health care needs.

- The universal right to health, so that everyone can live in dignity: health care policies should go beyond prevention and life-saving treatments and strive for better quality of life.
- The injustice faced by people with disabilities; raised to promote the necessary respect for the principles of equal access to health care.
- One health care system for all: inclusive, non-discriminatory health care services.

## Advocacy focus areas for physical and functional rehabilitation

- The numerous debates on the shortage of health care personnel (Health Workforce shortage) should include the issue of paramedical personnel working in physical and functional rehabilitation, their training, and their integration in health care systems.
- Health forums on non-communicable or neglected tropical diseases, in particular, should include the needs of people with disabilities in their recommendations and make reference to physical and functional rehabilitation services.
- The post-2015 Millennium Development Goals (MDG) should include the needs of people with disabilities, and ideally make reference to physical and functional rehabilitation services.

## Advocacy themes for the Unit

- National policies and strategies and the position of physical and functional rehabilitation with respect to health priorities: demonstrate that including physical and functional rehabilitation in health strategies and thus getting involved in this area is a way to meet the MDGs while reducing medium- and long-term costs – especially in the management of chronic disability.

- Human resources: advocating for more skilled personnel, recognition of training and status, and incentives favouring the valorisation and retention of physical and functional rehabilitation professionals.
- Promoting quality service organisation and professional practices. Ensuring that the technologies that have to be utilised are quality and appropriate, and that supply channels are reliable and sustainable.
- Funding: a funding opportunity does not in itself justify launching a rehabilitation project. It is not enough that funding address the challenges of promoting physical and functional rehabilitation; funding authorities must also guarantee the resources needed to conduct a long-term project, particularly in contexts of extreme poverty<sup>69</sup>.

### Means of action

#### Networks

- Strengthen ties within the conventional physical and functional rehabilitation network: alliances further guarantees success (see figure on network actors).
- Target networks with influence in physical and functional rehabilitation issues:
  - Health care community (MCH, non-communicable diseases, etc.);
  - World Health Professions Alliance;
  - Rehabilitation and humanitarian networks (emergency, UN clusters);
  - "Disability and civil society" movements;
  - Post-MDG movement.
- It is important to mobilise "South" networks, when they exist, as they are directly concerned and can mobilise efficiently around changing practices in complex contexts (for example, the African Federation of Orthopaedic Technicians, or FATO, on sustainability issues in African countries with no national rehabilitation plan).

#### National rehabilitation plans

- Increase the exchange of best practices between countries with regard to the benefits of drafting national rehabilitation plans; compare these practices to the international standards and international intervention frameworks.
- Mobilise and facilitate a discussion between the actors in a given country around sector sustainability issues, with a view to achieving consensus and an action plan with objectives and indicators. Verify that each actor has a place in the system (see [2.2.3 System: sectoral policies/sustainability workshop](#)).
- Form alliances with professional associations and service groups to lobby governments on the advantages of promoting a national rehabilitation plan.

#### Studies, data collection and research

based on scientific consensus or proof (Evidence-Based Practice) around priority topics for dissemination in the networks:

- Quality of life: analyses should measure the impact of physical and functional rehabilitation service provision – or lack thereof – on the functioning of people with disabilities in their environment.
- Health economics studies or cost-benefit analyses:
  - Cost of physical and functional rehabilitation for the user;
  - Cost of physical and functional rehabilitation within the health care system;
- Human resources.

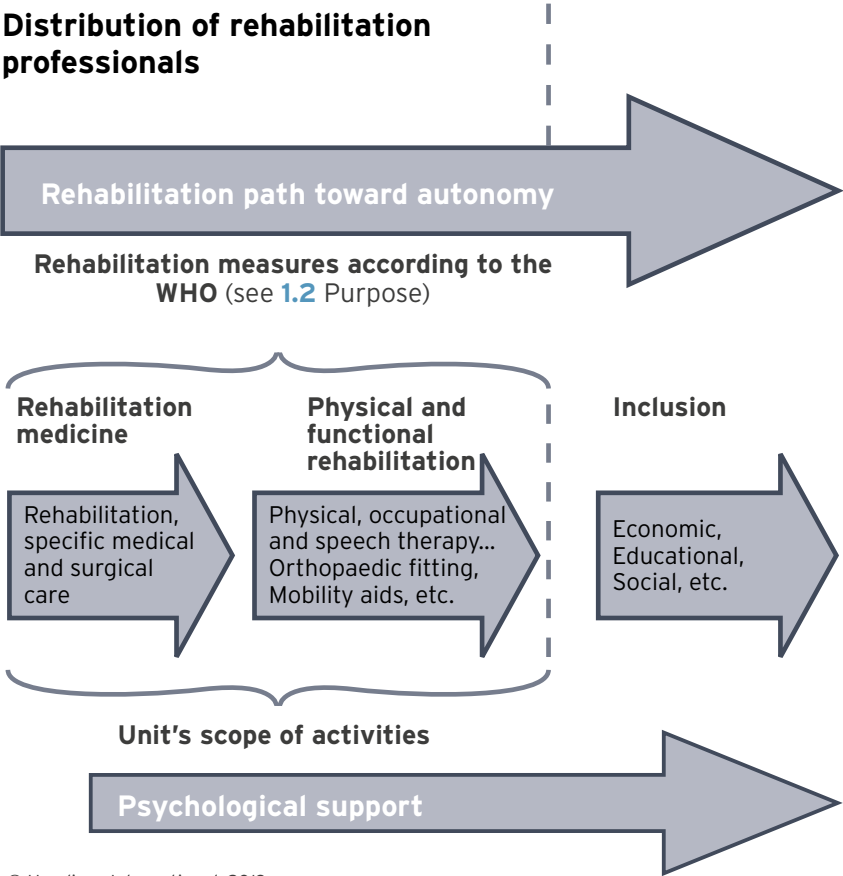
These studies should highlight the public health benefits with regard to the number of people who were able to take advantage of physical and functional rehabilitation.

# 2.3 Physical and functional rehabilitation professionals



“Handicap International supports the emergence of rehabilitation professions and local training for professionals as a means of ensuring sustainable and high-quality service delivery in reconstruction and development settings. The quality and appropriateness of initial training, continuing education and intermediate level

training for rehabilitation professionals will be a growing focus of our field action. Supporting the national and regional professional associations responsible for accreditations (quality control) and recognition of rehabilitation professions will also be a priority over the next five years”<sup>70</sup>.



## 2.3.1

### The different occupations

List of occupations or actors involved in physical and functional rehabilitation, according to the International Standard Classification of Occupations (ISCO)<sup>71</sup>.

ISCO code	Categories	Target occupations	Handicap International units to which they are posted
<b>22</b>	<b>Health professionals</b>		
2211	Generalist medical practitioners		Health
2212	Specialist medical practitioners	Physiatrists	Rehabilitation
		Surgeons*	Health & Rehabilitation
2221	Nursing professionals (or specialist nurses)	Rehabilitation nurses	Health & Rehabilitation
2222	Midwifery professionals		Health
2264	Physiotherapists		Rehabilitation
2265	Dieticians and nutritionists		Health
2266	Audiologists and speech therapists	Speech therapists	Rehabilitation
2269	Health professionals not elsewhere classified	Occupational therapists	Rehabilitation
		Psychomotor therapists	Rehabilitation
		Prosthetists and Orthotists (P&O)**	Rehabilitation
		Pedorthists**	Rehabilitation

\* Usefulness depends on the type of specialty and prioritisation of orthopaedic and reconstructive surgery<sup>72</sup>.

\*\* Not considered health specialists in the ISCO classification.

ISCO code	Categories	Target occupations	Handicap International units to which they are posted
<b>32</b>	<b>Health associate professional</b>		
3214	Medical and dental prosthetic technicians	Orthopaedic Technologists	Rehabilitation
		Pedorthists technologists	Rehabilitation
322	Nursing and midwifery associate profession		Health & Rehabilitation
3253	Community health workers		Health, Rehabilitation & Social Services*
3255	Physiotherapy or rehabilitation technicians and assistants		Rehabilitation

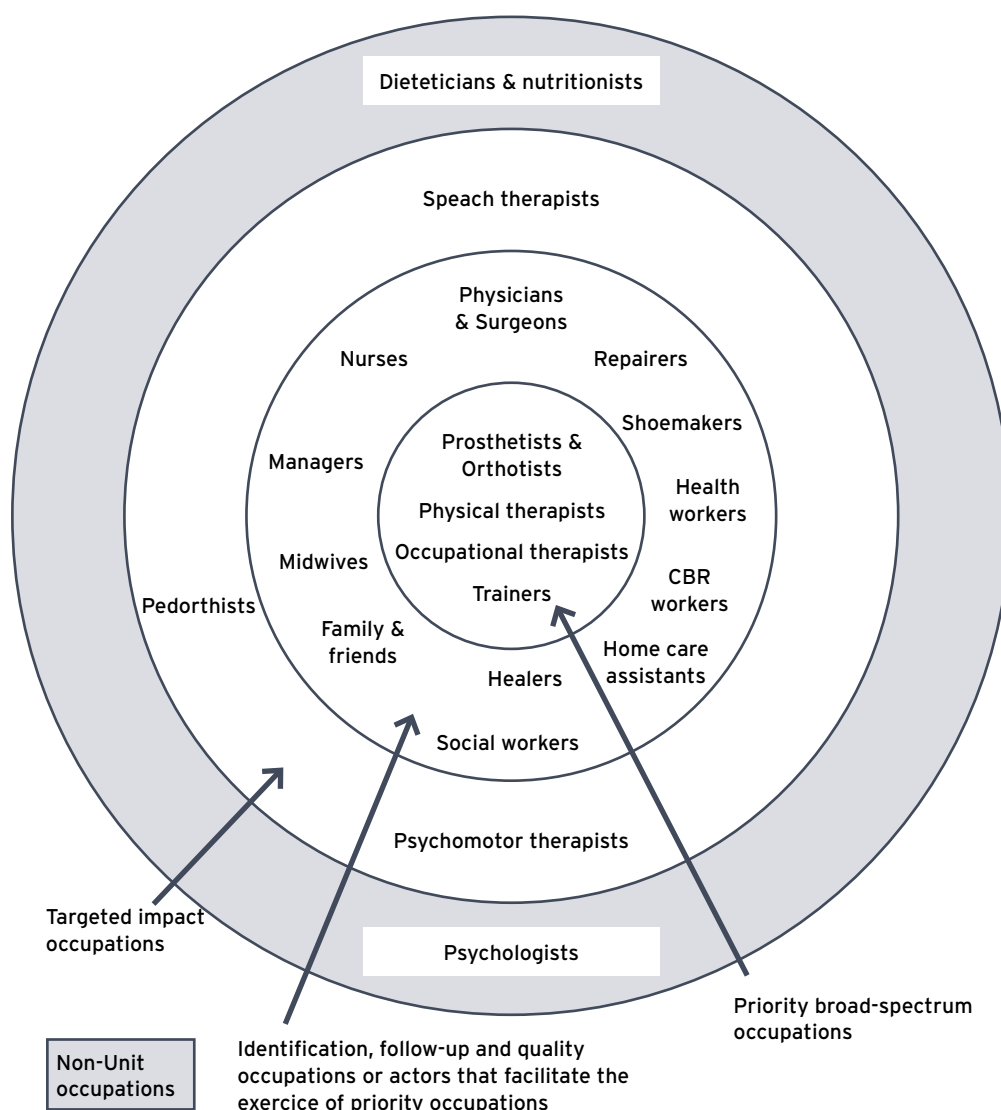
\* Social, Economic and Educational Services Unit.

ISCO code	Categories	Target occupations	Handicap International units to which they are posted
	Support professions		
5322	Home-based personal care workers	Home-based carers	Health, Rehabilitation & Social Services
5329	Personal care workers in health services not elsewhere classified	Healer	Health & Rehabilitation
7... Not referenced	Orthopaedic Technicians (bench workers)		Rehabilitation
7212	Welders and flame cutters	Mobility aid repairers (wheelchairs)	Rehabilitation
7522	Cabinet-makers and related workers		Rehabilitation
7536	Shoemakers and related workers	Orthopaedic shoemaker	Rehabilitation
	Community-based actors		
Not referenced	Community-Based Rehabilitation workers		All units
	Community groups		All units
	Family and close friends	Family & friends	All units
	Additional occupations		
1342	Professional service managers	Health services	Health & Rehabilitation
1343		Aged care services	Health, Rehabilitation & Social Services
2310	University and higher education teachers	Trainers	Health & Rehabilitation
2320	Vocational education teachers		Health & Rehabilitation
2634	Psychologists		Health
3412	Social work associate professionals		Social Services

## 2.3.2

### Occupations promoted by the Unit

#### Hierarchy of physical and functional rehabilitation-related occupations



## “Core target” occupations for Handicap International

Handicap International requires, on principle, that projects have the “greatest possible (...) impact on the lives of our final beneficiaries”<sup>73</sup>.

The occupations that Unit considers priority satisfy this principle and the needs of the greatest number of beneficiaries.

- Working in the areas of promotion, prevention, treatment and rehabilitation, **physical therapists** are concerned with identifying and maximising people's quality of life and **potential for movement**, looking at their physical, psychological, emotional and social well-being. Physical therapy involves interacting with users, their families and other health practitioners to formulate a process for evaluating and analysing user's needs, a diagnosis, and a treatment strategy. It uses manual techniques, treatment exercises and specialised equipment<sup>74</sup> to improve movement. As physical therapists work with all types of conditions, from acute to chronic, they are essential to physical and functional rehabilitation.

- **Occupational therapists** are concerned with **the therapeutic use of activities** of daily living with individuals or groups to enable them to participate in roles and situations at home, school, work, in their community, and in leisure activities. In this wide range of contexts, occupational therapist looks at physical, cognitive, psychosocial and sensory functioning and other performance-related aspects in order to support participation in activities of everyday life. Occupational therapy interventions may involve the person (improving his motor, cognitive and psychosocial abilities), the environment (advice on mobility aids and advice to the family to improve their assistance), social participation (participation in the assessment to improve learning or resume a professional activity), or a combination of the three, depending on the need<sup>75</sup>. Considering the rehabilitation process and its view of disability that is necessarily broader than that focused solely on physical capacities, promotion of occupation therapy is fundamental in our projects.

- **Prosthetists and Orthotists (P&O)** help compensate for disability and correct functional problems and impairments by **making devices to replace** (prosthesis) a limb segment **or assist** (orthosis) **an impaired part of the body** (limbs and trunk)<sup>76</sup>.

They contribute their expertise, in particular, to multidisciplinary consultations by examining the person and establishing a functional and situational body assessment. They accompany the person through the various steps of their orthopaedic fitting, creating a personalised caregiver/patient relationship. Similarly, P&O advise, design, adapt and dispense technical aids. Depending on the context, they may call upon people from other occupations (worker, carpenter or welder).

As P&O make all types of orthopaedic fittings, they are essential to physical and functional rehabilitation.

**Note:** in order to meet the footwear needs in diabetes-endemic contexts and make up for the lack of pedorthists<sup>77</sup>, P&O should acquire their orthopaedic foot fitting skills via continuing education (a standardisation effort for this profession is currently underway in the European Union among the shoe- and boot makers, the pedorthists and the ISPO).

- **Trainers** are essential to preparing and replacing rehabilitation practitioners and to maintaining and improving their skill level. They are one of the key elements in the system for ensuring long-term availability of skilled human resources. For clinical instruction, the trainer belongs to one of the occupations in question.

### Support occupations

These facilitate the work of the core target occupations and improve the quality and impact of their provision (pertinence and continuity of care, etc.).



### Regarding physicians

#### There are two possible levels of intervention:

- General practitioners: raise awareness via initial training, continuing education or in the course of professional practice to promote rehabilitation and improve identification/referral.
- Rehabilitation physicians: promote the development of expertise and support the creation or strengthening of the specialisation through continuing education. Call upon non-Handicap International partners, given that the formal training process is beyond the scope of the Unit. By extension, promote acquisition of target orthopaedic skills by surgeons (for example, the proper amputation level facilitates prosthetic fitting).

### Targeted impact occupations

These occupations work with a limited number of impairments and disabilities; in addition, Handicap International does not have the in-house skills to promote them. A few projects have been developed around speech therapy and psychomotor therapy.



Because promoting an occupation is a difficult process requiring a long-term commitment, any strategy aimed at promoting these occupations must ensure that:

- the broad-spectrum “core target” occupations meeting the most needs and thus likely to have the “greatest possible impact” exist, are recognised, and do not require substantial support;
- the need exists, and has been formalised by a local request;
- there are technical partners to ensure appropriate, long-term expertise.



#### In summary

Occupations that make it possible to meet the broadest needs (impact) – such as physical therapy, occupational therapy and Prosthetic and Orthotic fitting occupations – should have priority. Promotion of any other rehabilitation occupation must be justified by a situation analysis that validates its pertinence, and the so-called priority occupations and quality training courses for them must already exist.

## 2.3.3

### Occupations, competencies and standards

The competencies of some physical and functional rehabilitation occupations are formalised in documents issued by corresponding international professional organisations. These documents establish reference standards that must be met or followed. Not all of these standards meet the challenges of developing countries equally, however. When the desired standard does not exist or is unrealistic, Handicap International must assert its own position and collect best practices from existing projects so that they can be used to influence, via the networks, the development of appropriate reference documents.

#### Occupations for which there are international reference documents appropriate to developing countries:

- Prosthetists & Orthotists are classified into two clinical categories (advanced, or university-trained, and mid-level) and one technical category (entry-level)<sup>78</sup>. It should be noted, however, that they are listed only as mid-level in the International Standard Classification of Occupations (ISCO).
- Occupational therapy, which defines a common base accessible to every context, and to which other qualifications may be added, depending on the country<sup>79</sup>.
- Occupations dealing with mobility aids (wheelchairs) are explained in a reference document that includes training modules<sup>80</sup>.

### Occupation for which international reference documents are difficult to adapt to developing countries:

- Physical therapists, with a recommendation for Master's level training<sup>81</sup>.



#### Clarification

Whenever it is a question of promoting the emergence of an occupation or strengthening its own competencies, Handicap International supports compliance with existing reference documents, validated by ad hoc professional associations. However, because “we seek solutions that are both realistic and adapted to the context”<sup>82</sup>, Handicap International supports the idea that the expected competency level needs to match the contextual reality in the countries where the association works. For that reason, Handicap International is lobbying for the recognition and promotion of mid-level physical therapy in countries where the level of training required by the WCPT is inaccessible<sup>83</sup>. Thus, depending on the context, occupations that Handicap International considers priority can be supported in order to increase competencies at the specialist, mid- and support levels.

## 2.3.4

### Human resource shortages



“We seek solutions that are both realistic and adapted to the context. We reject stereotypical approaches, preferring to analyse the specificities of each situation or context and identify the most suitable actions and operating procedures possible”<sup>84</sup>.

“The training for rehabilitation and other health personnel in developing countries can be more complex than in developed countries. Training needs to consider the absence of other practitioners for consultation and advice and the lack of medical services, surgical treatment, and follow-up care through primary health care facilities. Rehabilitation personnel working in low-resource settings require extensive knowledge on pathology, and good diagnostic, problem-solving, clinical decision-making, and communication skills”<sup>85</sup>.

We therefore face a paradox in some contexts, in that while it is necessary to promote a broad range of physical and functional rehabilitation professional skills to make up for the lack of certain practitioners, in those same contexts human resource shortages are often accompanied by:

- a low level of education;
- comprehension sometimes influenced by traditional beliefs;
- limited understanding of health and disability-centred issues.

Devising solutions to promote physical and functional rehabilitation in such situations will require three things:

- **knowledge and recognition** of physical and functional rehabilitation by the population and health care practitioners;
- professionals with appropriate **competency** in physical and functional rehabilitation;
- realistic, appropriate physical and functional rehabilitation **actions or provision**.

#### Suggested actions

- Raise the awareness of populations and health care practitioners and educate them about the stakes and importance of physical and functional rehabilitation, in terms of well-being and public health; this is a necessary condition to valorising the rehabilitation-related occupations, which are often measured against the prestige of medication.
- “Train non-specialist health professionals (doctors, nurses, primary care workers) on disability and rehabilitation relevant to their roles and responsibilities”<sup>86</sup>.
- Strengthen the identification-referral-service provision-follow-up cycle via a systemic approach in which health professionals – physical and functional rehabilitation practitioners included – must work together.
- To make up for the frequent lack of medical personnel to prescribe physical and functional rehabilitation, encourage multidisciplinary teamwork (joint **intrasectoral** rehabilitation consultation with prosthetists & orthotists, physical therapists and

occupational therapists, when they exist): raise awareness of the value of working together and of each other’s work at the initial training.

- Develop a community-based approach to structuring identification/referral/follow-up mechanisms: “In resource-poor contexts [rehabilitation] may involve non-specialist workers – for example, community-based rehabilitation workers [or social workers] in addition to family, friends, and community groups”<sup>87</sup>.
- Develop strategies that incentivise professionals to work in the community: some measures concerning health professionals are applied, based on WHO recommendations<sup>88</sup>, in particular. Recommendations regarding rehabilitation professionals still need to be formalised based on the WHO recommendations and on an analysis of Handicap International’s best practices at the various community-based physical and functional rehabilitation projects.
- Promote the spread of mid-level, rather than specialist-level, “core target” occupations: an approach where many, more rapidly-trained, workers provide greater coverage under the supervision of a few specialists (see [2.3.3: Clarification](#))<sup>89</sup>.
- Regarding these mid-level workers, develop supervised dual system training models, which enable rehabilitation services to open or improve quality as soon as the training process starts. This mechanism also fosters workforce retention, insofar as it applies to the people recruited by the rehabilitation service being created or expanded.

- Consider promoting a “skill mix”: “mid-level workers, therapists and technicians can be trained as multipurpose rehabilitation workers with basic training in a range of disciplines (occupational therapy, physical therapy, speech therapy, for example), or as profession-specific assistants that provide rehabilitation services under supervision. (...) In the absence of rehabilitation specialists, health staff with appropriate training can help meet service shortages or supplement services”<sup>90</sup>.  
That recommendation – from the Global Health Workforce Alliance<sup>91</sup> under the auspices of the WHO – to broadly expand physical and functional rehabilitation skills among health professionals is in contradiction to existing professional standards. Depending on the situation analysis, it can be implemented in emergency contexts where sustainability is not an objective, but in other situations should be considered only under certain conditions:
  - If the training being considered **targets** the standards, so that skills can be upgraded to meet them when the situation permits (continuing education).
  - If the personnel trained have their skill recognised locally and are integrated into the system (national rehabilitation or health plan).
- If, when this is decided upon, the initially-designed training is replaced by training that meets the standards as soon as the situation permits. In this case, the practitioners trained initially should be able to upgrade their skills to meet these standards or, if necessary, the updated occupation description should not exclude them as long as they continue to practice.



### Pilot project in Haiti

Given the human resource shortage in Haiti, Handicap International chose to experiment with the **rehabilitation technician** job classification, which combines physical therapy and occupational therapy skills. That mid-level training, which was aimed at combining two rehabilitation sector occupations, made it possible to:

- meet the need for rehabilitation care requiring a broader skill set than that of either occupation alone, without having to increase the number of practitioners;
- create a professional identity in rehabilitation without compromising a potential path, via continuing education, to one or the other of the two occupations once the situation permitted.

The framework and training methods for that occupation could be the same as those for the proposed mid-level physical therapy (see **2.3.3**: Clarification).

## 2.3.5

### In summary

#### Priority occupations

The Unit considers it a priority to promote occupations that enable it to meet the needs of the greatest number of people (impact). It lists these as “core target” occupations, support occupations and targeted impact occupations.

The priority “core target” occupations include not just physical therapists, occupational therapists and Prosthetic & Orthotic fitting occupations, but also trainers, who are essential to creating rehabilitation practitioners, replacing them and maintaining and improving their skill level.

Promotion of any other rehabilitation occupation must be justified by a situation analysis that validates its pertinence, and the so-called priority occupations and quality training courses for them must already exist.

The support occupations facilitate the work of the “core target” occupations and improve the quality and impact of their provision (pertinence and continuity of care, etc.); the targeted impact occupations work with a limited number of impairments and disabilities.

#### Professional standards and contextual reality

There are reference standards for the competencies of some physical and functional rehabilitation professions. Whenever it is a question of promoting the emergence of an occupation or strengthening its own competencies, Handicap International supports compliance with existing reference documents, validated by ad hoc professional associations.

When there is no standard or the standard does not fit the contextual reality of developing countries, Handicap International should assert its own position and collect best practices from existing projects so they can be used to influence, via the networks, the development of appropriate reference documents.

For that reason, Handicap International is lobbying for the recognition and promotion of mid-level physical therapy in countries where the level of training required by the WCPT is inaccessible. Similarly, occupations that Handicap International considers priority can be supported in order to develop competencies at the specialist, mid- and support levels.

### Human resource shortages

In human resource shortage contexts, promoting physical and functional rehabilitation requires three things:

- knowledge and recognition of physical and functional rehabilitation by the population and health care practitioners;
- professionals with appropriate skills in physical and functional rehabilitation;
- realistic, appropriate physical and functional rehabilitation actions or provision.

### Suggested actions

- Develop actions to raise the population's awareness and train health professionals regarding disability-related issues and the stakes and importance of physical and functional rehabilitation.

- Develop a community-based approach to structuring the identification/referral/follow-up cycle. Strengthen that cycle at the service provision level via a systemic approach in which health professionals – physical and functional rehabilitation professionals included – must work together. Also develop strategies that incentivise practitioners to work in the community.
- Promote the spread of mid-level, rather than specialist-level, “core target” occupations: an approach where many, more rapidly-trained practitioners provide greater coverage. Develop a supervised dual system of training.
- Encourage multidisciplinary teamwork among physical and functional rehabilitation practitioners to make up for the frequent lack of doctors assumed to be needed to prescribe physical and functional rehabilitation – or even, under some conditions, promote the sharing of physical and functional rehabilitation skills with health professionals.
- Monitor the progress of the pilot project in Haiti, which is experimenting with the rehabilitation technician occupation (occupation that combines both physical therapy and occupational therapy skills), so that it can be duplicated once its impact has been assessed.

## 2.4 Physical and functional rehabilitation-related themes

The Rehabilitation Services Unit promotes and supports the development of projects on a large number of themes - most of which could be the subject of their own reference document.

By presenting the physical and functional rehabilitation-specific issues, principles and recommendations and to ensure the technical consistency of what is written, this document:

- sets out a framework within which each thematic paper can be written;
- serves as a guide for all physical and functional rehabilitation-related documents produced by the Technical Resources Division.

Each thematic paper will help fuel, guide or supplement the discussion in terms of recommendations when physical and functional rehabilitation projects are being developed.

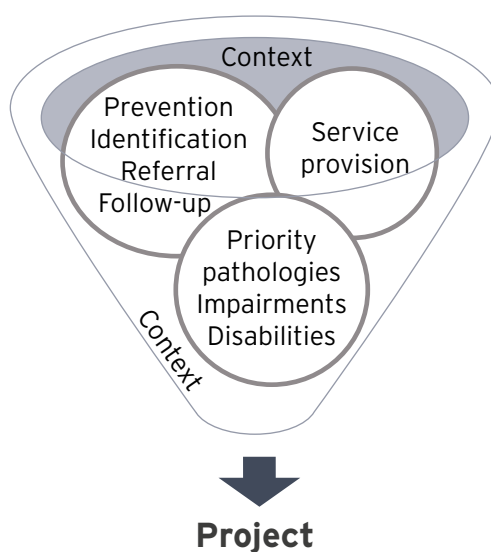
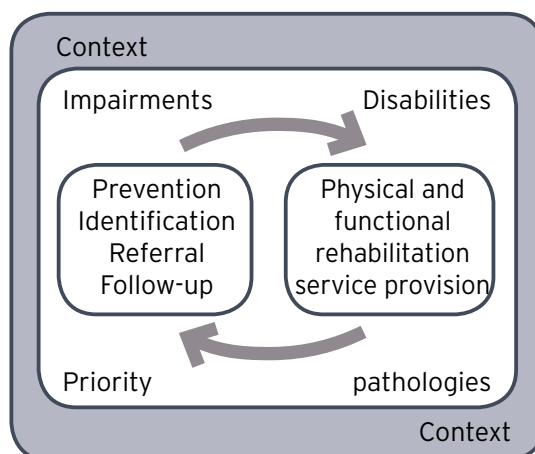
The purpose of this section is thus to offer an organised approach to creating a non-exhaustive, evolving list of Unit-specific themes that could be the subject of their own paper.

The provision of rehabilitation is the Unit's core concern; rehabilitation focuses on a condition causing impairments and disabilities in a given context, and depends on preventive actions and those related to the identification-to-follow-up cycle.

We will look at four parameters (see figure) that must be considered when designing a physical and functional rehabilitation project, taking the WHO recommendations for overcoming the obstacles to rehabilitation into account as well.

### Intervention modalities for physical and functional rehabilitation users

#### Four parameters to consider when developing a project



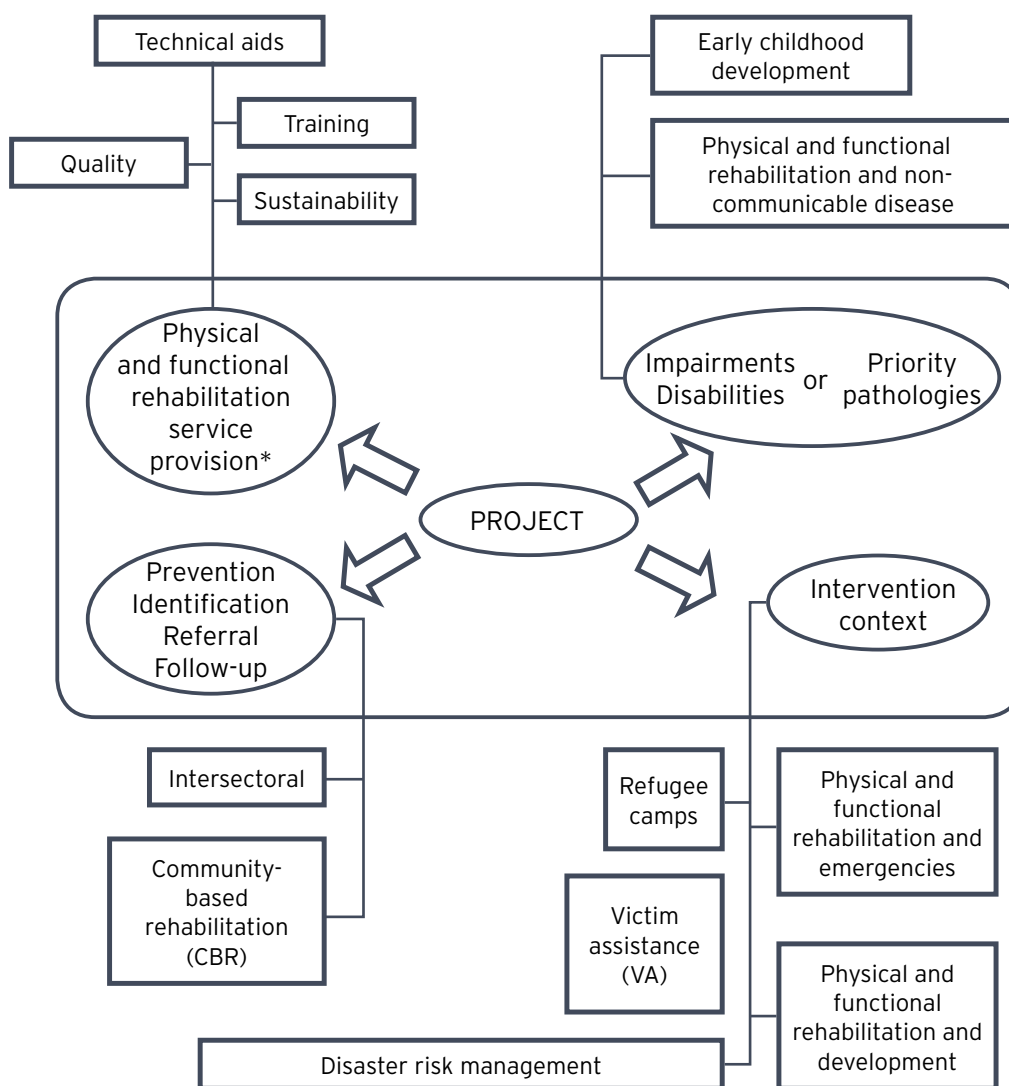
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## Physical and functional rehabilitation-related themes

For each of these parameters there is a corresponding set of themes, within which

existing or future Unit documents can be listed.

### Project themes by parameter



\* Development context

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That list by theme - presented in table form and updated by the Unit - should serve as a planning tool for writing documents that

do not yet exist, according to the priorities defined in the multi-year strategy for physical and functional rehabilitation.

### Framework for the table listing the documents produced or to be produced by the Unit

Main theme	Number of documents	Status	Handicap International publication (internal or external)
Provision of physical and functional rehabilitation services			
Sustainability	4	Published: 8 In development: 8 In discussion: 2	Internal: 15 External: 3
Quality	5		
Training	3		
Technical aids	6		
Prevention Identification Referral Follow-up in physical and functional rehabilitation			
Intersectoral	4	Published: 2 In development: 3 In discussion: 2	Internal: 6 External: 1
Community-Based Rehabilitation	3		
Priority Impairments, Disabilities and Pathologies			
Physical and functional rehabilitation and non-communicable diseases	2	Published: 2 In development: 3 In discussion: 1	Internal
Early childhood development	4		
Intervention context for physical and functional rehabilitation			
Development	1	Present document	Internal
Emergency	5	Published: 1 In development: 2 In discussion: 2	
Refugee camps	1	In discussion	
Victim assistance	1	In development	
Disaster risk management	1	In discussion	

This table, detailed and updated regularly, can be found at Skillweb:  
<http://www.hiproweb.org/en/home/areas-of-competence-and-sectors-of-activity/rehabilitation.html>

## 2.5 Perspectives 2011-2015

Over the course of its history, Handicap International has established its legitimacy and reputation with respect to physical and functional rehabilitation actions.

The implementation of the 2011-2015 federal strategy<sup>92</sup> has given the Rehabilitation Services Unit new impetus. One of the five priority objectives for this period is access to rehabilitation services for people with disabilities in reconstruction or development situations. Consistent with the broad outline set out by the federal strategy, the Unit's main focus for the next three years will be to continue or expand its involvement in the following areas:

### Influencing policies and practices

We structure our research efforts (scientific themes and collaborations) to promote appropriate practices and lobby institutions and funding bodies to take responsibility for providing the resources essential to creating sustainable systems and sectors. "The duration of a Handicap International intervention in a given country plays a key role in the definition of mid- to long-term action strategies. A strategy that targets the reform of the services system cannot be developed when Handicap International is only present over the short-term.

The sustainable introduction of new types of services on a large scale, the support for national policies in the services sector, the initial training and follow-up of professional, etc., altogether require Handicap International's stable presence in a country over a well-defined period of more than 5 years.

In a reconstruction or development situation, an intervention at local and national level requires a minimum presence of around 4 to 5 years to bring about lasting change.

On the other hand, if Handicap International only expects to have a short-term presence (1 to 3 years), the programme could support only targeted services and apply measures to multiply further their positive results. In this case, it is particularly important to form alliances or partnerships with actors who are expected to remain in the country, territory or region for longer periods, in order to transfer the "multiplier" roles and the necessary skills by providing these actors with intensive support"<sup>93</sup>.

### Quality and sustainability of rehabilitation services

- We are finalising the testing phase and implementation of the "rehabilitation services management system" from Handicap International's South Asia programmes for distribution to other programmes, in order to promote a complete, continuous quality management process for the physical and functional rehabilitation system and services in our projects.
- The results of the rehabilitation services sustainability study<sup>94</sup> are being put to use, in the form of lessons learned, to design a national-level sectoral approach, analysis and planning methodology.

## Rehabilitation professions

We are bolstering our support tools for improving the quality and relevance of initial training, continuing education and refresher courses for physical and functional rehabilitation professionals.

## Post-trauma care and rehabilitation

In collaboration with the Emergency Response Division, we are creating tools to facilitate implementation of a quality assurance process in accordance with recommended protocols and techniques (emergency orthopaedic fitting).

## Future plans

### ➤ **Financial access to rehabilitation services**

We will propose action research and field actions on financial access to physical and functional rehabilitation services for the disadvantaged.

### ➤ **Orthopaedic and reconstructive surgery**

We will conduct a review of our experiences in order to use the lessons learned to create a framework for our actions and mobilise international networks of specialists.

Lastly, our internal efforts can feed and be enriched by our work with the WHO to produce the 2014 Guidelines on Health-Related Rehabilitation, which will provide a reference frame for the next ten years. This new WHO reference document, which applies specifically to our scope of activities, will provide critical support when arguing for the integration of physical and functional rehabilitation into health care.



Togo, 2001

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## Acronyms

<b>AIDS</b>	Acquired Immunodeficiency Syndrome	<b>WCPT</b>	World Confederation for Physical Therapy
<b>CBR</b>	Community-Based Rehabilitation	<b>WFOT</b>	World Federation of Occupational Therapists
<b>CRPD</b>	Convention on the Rights of Persons with Disabilities	<b>WHO</b>	World Health Organization
<b>DCP</b>	Disability Creation Process		
<b>DPO</b>	Disabled People Organisation		
<b>FATO</b>	African Federation of Orthopaedic Technicians (Fédération Africaine des Techniciens Orthoprothésistes)		
<b>HIV</b>	Human Immunodeficiency Virus		
<b>ICF</b>	International Classification of Functioning, Disability and Health		
<b>IDDC</b>	International Disability and Development Consortium		
<b>IO</b>	International Organisation		
<b>ISCO</b>	International Standard Classification of Occupations		
<b>ISPO</b>	International Society for Prosthetics and Orthotics		
<b>MCH</b>	Mother and Child Health		
<b>MDG</b>	Millennium Development Goals		
<b>NGO</b>	Non-governmental organization		
<b>P&amp;O</b>	Prosthetist and Orthotist		
<b>UN</b>	United Nations		
<b>VA</b>	Victim Assistance		



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Page 12: © Brice Blondel / Handicap International (Nepal, 2012: Amarjit Rana, 4 years old, suffers from cerebral palsy. Received special chair, walker, and visits from community worker. Here with Prema (community worker), his mother and grandfather).

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**Printing**

NEVELLAND  
GRAPHICS c.v.b.a. - s.o  
Industriepark-drongen 21  
9031 Gent  
Belgique

Imprint in December 2013  
Registration of copyright: December 2013



the 1990s, the number of people in the UK who are employed in the public sector has increased by 1.5 million, from 2.5 million in 1980 to 4 million in 1999. The public sector has also become an important employer of people with disabilities, with 1.5 million people with disabilities employed in the public sector in 1999, compared with 1.2 million in 1980.

There are a number of reasons why the public sector has become an important employer of people with disabilities. One reason is that the public sector has a long history of employing people with disabilities. In the 19th century, the public sector employed people with disabilities in a number of different roles, including as clerks, typists, and stenographers. In the 20th century, the public sector continued to employ people with disabilities, but in a more limited capacity. It was not until the 1970s that the public sector began to employ people with disabilities in a more significant way.

One of the main reasons why the public sector has become an important employer of people with disabilities is that it has a large and growing workforce. The public sector is one of the largest employers in the UK, with over 4 million people employed in 1999. This means that the public sector has a large pool of potential employees, including people with disabilities. The public sector also has a long history of employing people with disabilities, which has helped to create a culture of inclusivity and diversity.

Another reason why the public sector has become an important employer of people with disabilities is that it has a strong commitment to equality and diversity. The public sector is a public body, and it has a duty to ensure that it is accessible to all people, including people with disabilities. This means that the public sector must take steps to ensure that people with disabilities can access its services and employment opportunities. The public sector also has a strong commitment to equality and diversity, which has helped to create a culture of inclusivity and diversity.

There are a number of other reasons why the public sector has become an important employer of people with disabilities. One reason is that the public sector has a long history of employing people with disabilities. In the 19th century, the public sector employed people with disabilities in a number of different roles, including as clerks, typists, and stenographers. In the 20th century, the public sector continued to employ people with disabilities, but in a more limited capacity. It was not until the 1970s that the public sector began to employ people with disabilities in a more significant way.

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## **Physical and functional rehabilitation**

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This document presents the physical and functional rehabilitation-specific challenges, principles and recommendations for Handicap International. Above all, it sets out the overall framework within which the theoretical underpinnings of the Rehabilitation Services Unit are applied; the primary objective is to ensure consistency between the association's mandate and the implementation, in its programmes, of projects falling within the unit's scope of activities.

The secondary objective is to formalise the selection and/or identification of external guidelines for adaptation for internal use.

This document has two main parts.

The first part presents the theoretical underpinning of the Rehabilitation Services Unit - the principles, models, approaches and contexts necessary to designing a physical and functional rehabilitation project strategy.

The second part offers a more operational framework within which the different theoretical elements are laid out. The objective is to guide the selection of - and aid decision-making on - the physical and functional rehabilitation activities to be undertaken.

Lastly, the document presents the different subject areas within the unit's scope that are - or could be - covered by a reference document.

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