Review Article

Community-Based Rehabilitation in Bangladesh, Health Components Need to Be Integrated with Primary Health Care

Md. Shahidur Rahman[1]

Received: March 12, 2017 Accepted: December 21, 2017
doi: http://dx.doi.org/10.3329/jemc.v8i1.35435

Abstract

Community-based rehabilitation (CBR) is defined as a strategy within general community development for the rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities. The role of CBR is to work closely with the health sector to ensure that the needs of people with disabilities and their family members are addressed in the areas of health promotion, prevention, medical care, rehabilitation and assistive devices. CBR also needs to work with individuals and their families to facilitate their access to health services and to work with other sectors to ensure that all aspects of health are addressed. Health components of CBR as per WHO guidelines are grossly neglected in Bangladesh. Some government and non-government organizations are working independently, but health components are inadequately addressed. We observed that primary health care, if integrated with medical rehabilitation of disabled, will better address the need and help bring disabled into mainstream of development. Health care providers at grass root level need to be trained in CBR activities which can be arranged centrally with health ministry, social welfare ministry and rehabilitation specialists. In this review we have tried to reveal the health components of CBR in global and Bangladesh context and importance of integrating health components of CBR with primary health care.

Key words*: Community-based rehabilitation; Health components; Primary health care*

J Enam Med Col 2018; 8(1): 41−45

Background

More than one billion people currently experience disability, which equates to approximately 15% of the world's population. Among them 110 to 190 million adults experience significant difficulties in functioning. The number of people who experience disability will continue to increase due to ageing populations, and a global increase in chronic health conditions.[1] Community-based rehabilitation (CBR) was first initiated by the World Health Organization (WHO) following the International Conference on Primary Health Care in 1978 and the resulting Declaration of Alma-Ata.[2]

In 2003, an international consultation to review community-based rehabilitation held in Helsinki made a number of key recommendations.[3] Subsequently, CBR was repositioned, in a joint International Labor Organization (ILO)/United Nations Educational, Scientific and Cultural Organization (UNESCO)/ WHO position paper, as a strategy within general community development for the rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities.[4] Bangladesh is a low resource country in South Asia, but achieved significant progress in primary health care in comparison to other low resource countries in Asia. Health components of CBR as per WHO guidelines are grossly neglected in Bangladesh. Some government and non-government organizations are working independently, but health components are inadequately addressed.

Health-care provision

Health care within each country is provided through the health system, which comprises of all those organizations, institutions, resources and people whose primary purpose is to promote, restore and

1. Professor, Department of Physical Medicine and Rehabilitation, Bangabandhu Sheikh Mujib Medical University, Shahbag, Dhaka

Correspondence *Md. ShahidurRahman, Email: shahidurpmrbd@gmail.com*

maintain health. While ultimate responsibility for the health system lies with the government, most health care is provided by a combination of public, private, traditional and informal sectors.[5] The 2008 World Health Report emphasizes the essential role of primary health care in achieving health for every person.[6] Primary health care is an essential heath care made universally accessible to individuals and families at a cost they can afford. It is the first level of contact with the national health system for individuals, families and communities and brings health care as close as possible to where people live and work.[7]

Barriers to health-care services for people with disabilities

The poor health that people with disabilities may experience is not necessarily a direct result of having a disability. Instead it can be linked to difficulties in accessing services and programs.[8] It is estimated that only a small percentage of people with disabilities in low-income countries have access to rehabilitation and appropriate basic services.[9] Some people with disabilities may be more vulnerable to discrimination and exclusion than others. They may suffer double or multiple disadvantages, for example due to the type of disability they have, their age, gender and/or social status[10] and so find it more difficult to access health-care services. CBR programs should particularly include following groups of people: women, children and older people with disabilities; people with multiple impairments, e.g., those who are both deaf and blind, or who have intellectual impairments, disabilities and HIV/AIDS, mental health problems, leprosy, or albinism.

CBR and the health sector

CBR programs can facilitate access to health care for people with disabilities by working with primary health care in the local community, providing the much needed link between people with disabilities and the health-care system. In many countries, e.g., Argentina, Indonesia, Mongolia and Vietnam, CBR programs are directly linked with the health care system – they are managed by the ministry of health and implemented through their primary health care structures. In other countries, CBR programs are managed by nongovernmental organizations or other government ministries, e.g., social welfare, and in these situations close contact must be maintained with primary health care to ensure that people with disabilities can access health care and appropriate rehabilitation services as early as possible. The Standard Rules on the Equalization of Opportunities for Persons with Disabilities state that rehabilitation measures include those which provide and/or restore functions, or compensate for the loss or absence of a function or a functional limitation.[11] Rehabilitation may range from more basic interventions such as those provided by community rehabilitation workers and family members to more specialized interventions, such as those provided by therapists.

Primary health care, community-based strategies

In Bangladesh continued development of innovative, community-based strategies of health service delivery, and adaptation of new technologies are needed to address neglected and emerging health challenges, such as increasing access to skilled birth attendance, improvement of coverage of antenatal care and of nutritional status, the effects of climate change, and chronic disease.[12] Health components of CBR activities have not been emphasized in this context as per WHO guidelines.

The government and NGOs have consistently trained and deployed community health workers effectively and adaptively throughout the country.[13-16] Large investments in these workers were apparent well before the 1978 Alma-Ata conference on primary health care, which garnered international attention and interest in the role of community health workers.[13] Bangladesh was one of the first countries to develop national-scale cader of community health workers, beginning with its smallpox and malaria workers in the 1960s, followed by the deployment of oral rehydration workers by Bangladesh Rural Advancement Committee (BRAC) in the 1970s, and the mobilization of thousands of government family welfare assistants to visit homes, counsel couples, and distribute contraceptives.[13]

Community-based participation

Arifeen et al[12] outline the mobilization of community-based participation that have many advantages, not only for fostering of social cooperation but also for extending the reach of the health initiatives and their impact. The innovations in health service delivery from which Bangladeshis have benefitted have been possible partly because of these participatory features in the process of social change.[17] Consistent focus

on the development of community-based approaches and use of community health workers arose mainly to address the major shortage of human resources in the health sector that has existed in Bangladesh for decades. We refer to community health workers as all community-based workers delivering some form of health service to their communities although some types might not fit WHO's definition of community health workers exactly.[13] Despite good approach by community health workers to standardize the primary health care like immunizations, family planning and reducing maternal and infant mortality, medical rehabilitation of disabled important health components of CBR have not been included in their service agenda.

Primary health care at rural outset

Health care infrastructure at government level consists of 436 hospitals at upazilla level with 18290 beds, 31 hospitals at union level and 12356 community outpatient clinics are now operating. It was expected that community clinics would ensure provision of quality health care for the mass population of rural Bangladesh, particularly the poor, vulnerable and the underprivileged and would contribute to the achievement of the Millennium Development Goal (MDGs) within 2015.[18] Despite availability of infrastructure and supplies at government level, medical rehabilitation of disabled is not specifically included in health care services in these centers. Health care providers are not aware of or trained in delivering medical rehabilitation services to the disabled. The objectives of community clinic concepts may not be fulfilled if we do not bring the medical rehabilitation of disabled into the primary health care system at the community level.

Community-based services

These include providing services focused on rehabilitation to people living in low-income countries through the use of local community resources. Rehabilitation at specialized centers may not be necessary or practical for many people, particularly those living in rural areas and many rehabilitation activities can be initiated in the community. The WHO manual on training in the community for people with disabilities is a guide to rehabilitation activities that can be carried out in the community using local resources.[19] Community-based services may also be required following rehabilitation at specialized centers. A person may require continued support and assistance in using new skills and knowledge at home and in the community after he/she returns. CBR programs can provide support by visiting people at home and encouraging them to continue rehabilitation activities as necessary. In Bangladesh the CBR approach has been increasingly accepted and in recent years medical and occupational rehabilitation services have been included in CBR. NGOs and governmental agencies have been increasingly implementing CBR programs and projects across the country. Center for Rehabilitation of Paralyzed (CRP) operates CBR program in 49 thanas with the assistance of the Bangladesh Social Service Department.[20,21] But their activities are rarely visible at rural outset. They are following their own strategies rather than WHO guidelines on CBR.

Successful rehabilitation depends on strong partnerships between people with disabilities, rehabilitation professionals and community-based workers. Before making a rehabilitation plan and starting activities, it is important for CBR personnel to carry out a basic assessment with an individual and his/her family members to identify needs and priorities. Assessment is an important skill, so CBR personnel should receive prior training and supervision to ensure competency in this area. As there is scarcity of CBR personnel, community-based health workers in the community should be trained in CBR activities. CBR programs can facilitate home and/or community-based therapy services and provide assistance to people with a wide range of impairments, enabling them to maintain and maximize their function within their home and community.

CBR personnel can provide training for people with disabilities and their families about the different ways to carry out activities; education for families on how to best assist people with disabilities in functional activities to maximize their independence; training in the use of assistive devices, e.g., walking/mobility devices to make activities easier; education and instruction on specific techniques used to address impairments, e.g., muscle weakness, poor balance and muscle tightness, which impact a person's ability to carry out activities.

Conclusion

Government and NGOs' efforts and community approaches have enabled Bangladesh to exceed target of most of the health indexes in South Asia. Medical rehabilitation of disabled at low resource and at rural outset has not been incorporated in primary health care deliveries. We need to address underprivileged poor disabled at rural outset to bring them to mainstream of development by treating their medical disability, improving quality of life and quality adjusted life years. Some organizations are working independently on different components of CBR, but health components are inadequately addressed. Community-based approach to different components of primary health care should be integrated with CBR's structured medical care which includes optimizing functions by medical treatment, therapy, assistive devices etc. These concepts will be more financially viable than establishing separate CBR services. Health care providers at grass root level need to be trained in CBR activities which can be arranged centrally with health ministry, social welfare ministry and rehabilitation specialists.

References

1. WHO global disability action plan 2014–2021: better health for all people with disability, 67th World Health Assembly. Provisional agenda item 13.3 A67/16, 4 April 2014.
2. Convention on the rights of persons with disabilities. New York, United Nations, 2006. Avaialble at: http://www.un.org/disabilities/. Accessed March 2010.
3. Blackman R. Project cycle management. Teddington, Tearfund 2003. Available at: http://tilz.tearfund.org/.Publications/ROOTS/Project+cycle+management.htm. Accessed May 2010.
4. Australian Agency for International Development. Aus Guideline: 3.3: The logical framework approach. Canberra, Commonwealth of Australia, 2005. Available at: http://www.ausaid.gov.au/ausguide/pdf/ausguideline3.3.pdf. Accessed May 2010.
5. Health systems. Geneva, World Health Organization, 2010. Available at: www.who.int/topics/health_systems/en/. Accessed May 2010.
6. World health report 2008: primary health care – now more than ever. Geneva, World Health Organization, 2008. Available at: www.who.int/whr/2008/whr08_en.pdf. Accessed May 2010.
7. Declaration of Alma Ata: International Conference on Primary Health Care, Alma Ata, USSR, 6–12September 1978. Geneva, World Health Organization, 1978. Available at: www.who.int/publications/almaata_declaration_en.pdf. Accessed May 2010.
8. Rimmer JH, Rowland JL. Health promotion for people with disabilities: implications for empowering the person and promoting disability-friendly environments. Journal of Lifestyle Medicine 2008; 2(5): 409–420.
9. Disability, poverty and development. London, Department for International Development, 2000. Available at: www.dfid.gov.uk/Documents/publications/disabilitypovertydevelopment.pdf. Accessed May 2010.
10. International norms and standards related to disability, Section V – rights of special groups with disabilities. NewYork, United Nations, 2003–2004. Available at: www.un.org/esa/socdev/enable/discom500.htm. Accessed May 2010.
11. The standard rules for the equalization of opportunities of persons with disabilities. New York, United Nations, 1993. Available at: www.un.org/esa/socdev/enable/dissre00.htm. Accessed May 2010.
12. Arifeen SE, ChristouA, Reichenbach L, Osman FA, Azad K, Shamsul K et al. Community-based approaches and partnerships: innovations in health-service delivery in Bangladesh. The Lancet, Early Online Publication, 21 November 2013.
13. Perry HB. Health for all in Bangladesh: lessons in primary health care for the twenty-first century. Dhaka: University Press Limited, 2000.
14. Ahmed SM, Hossain MA, Rajachowdhury AM, Bhuiya AU. The health workforce crisis in Bangladesh: shortage, inappropriate skill-mix and inequitable distribution. Hum Resour Health 2011; 9: 3.
15. Standing H, Chowdhury AMR. Producing effective knowledge agents in a pluralistic environment: what future for community health workers? Soc Sci Med 2008; 66: 2096–2107.
16. Chowdhury AMR, Chowdhury S, Islam MN, Islam A, Vaughan JP. Control of tuberculosis by community health workers in Bangladesh. Lancet 1997; 350: 169–172.
17. Amartya Sen. What's happening in Bangladesh? The Lancet, Early Online Publication, 21 November 2013.
18. Health Bulletin 2013, Primary health care, Ch-4, 28-39. MOHFW. Available at: www.dghs.gov.bd. Accessed May 2010.

19. Training in the community for people with disabilities. Geneva, World Health Organization, 1989. Available at: www.who.int/disabilities/publications/cbr/training/en/index.html. Accessed May 2010.

20. Country profile of disability, Peoples Republic of Bangladesh, March 2002; 27–29.

21. VHSS (Voluntary Health Services Society), NFOWD (National Forum of Organizations Working with Disabilities). Dhaka Forum Report: Community Based Rehabilitation, Workshop and the Seminar, February 1992. Dhaka: VHSS. 1993.