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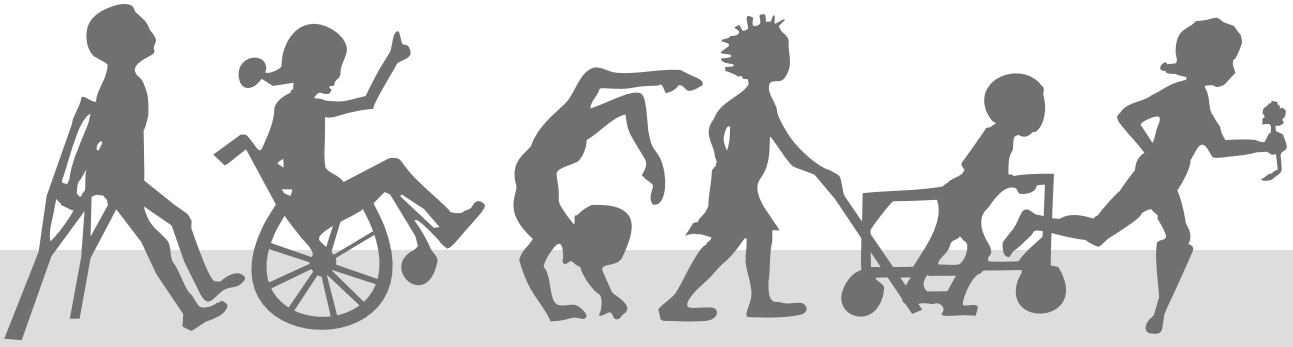

CBR, Health and Rehabilitation

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Like all persons, persons with disabilities also have different health care needs, from childhood till old age. Some of them also have specific health care and rehabilitation needs linked to their impairments. Only a small percentage of persons with disabilities in the developing world has access to health care and rehabilitation services. This article looks at the barriers faced by persons with disabilities in accessing health care and rehabilitation services and the development of health care related activities in the CBR.

Introduction

The Alma Ata declaration in 1978 defined health "as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity" (unpaged). Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD 2006) asks the States to "recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination of disability". Articles 20 (accessibility) and 26 (habilitation and rehabilitation) outline the measures States Parties should undertake to ensure that people with disabilities are able to access health and rehabilitation services that are gender-sensitive.

The right to health is not only about access to health services; it is also about access to the underlying determinants of health, such as safe drinking water, adequate sanitation and housing. The right to health includes the right to be free from non-consensual medical treatment. The health-related entitlements include the right to a system of health protection, the right to prevention, treatment and control of diseases, access to essential medicines and participation in health-related decision-making (WHO/UNESCO/ILO/IDDC 2010, Health Module:1).

More than one billion people in the world live with some form of disability, of whom nearly 200 million people experience considerable difficulties in functioning. Studies from different parts of the world have revealed large gaps in health care needs of persons with disabilities (WHO/World Bank 2011:xi).

Health Care and Rehabilitation Needs of Persons with Disabilities

General health care needs: The general health care needs of persons with disabilities - as of all persons - vary during different phases of their lives, from vaccinations in childhood, to support for reproductive health care services as young adults, and to care and treatment for health conditions linked to old age.

Certain disabilities can be associated with specific health conditions. For example, children born with Down syndrome can also have heart problems and dislocated hips (Werner 1987:279). For such persons, needs for support from general health care services may be greater.

Specific health care needs of persons with disabilities: Not all persons with disabilities require specific health care and rehabilitation services. For example, persons who are deaf or blind may not require any specific support.

However, some disabling conditions require specific health care, rehabilitation and assistive devices. These needs may be occasional, periodic or ongoing and life-long. For example, persons with arthritis, diabetes or convulsions require life-long treatment for these conditions. On the other hand, a person with a disabling infectious disease such as leprosy or Buruli ulcer needs antibiotic treatment for a certain period to cure the infection.

Rehabilitation services for persons with disabilities: Rehabilitation is defined as "a set of measures that assist individuals who experience, or are likely to experience disability, to achieve and maintain optimal functioning in interactions with their environments" (WHO/World Bank 2011:96). Rehabilitation is a multisectoral concept and includes different activities such as barrier removal initiatives at societal level. Rehabilitation, as a part of health care, targets improvements in individual functioning. This article limits itself to those rehabilitation aspects that are part of health care services.

Rehabilitation services in the health care systems can involve different departments depending upon the specific disabling conditions. For example, a child with cleft lip or a person with reduced vision due to a cataract often need surgical interventions.

The kind of support required from the rehabilitation services may change with time. For example, persons who had a stroke may need hospital level specialised health care support in

the acute phase. After the person has stabilised with full or partial recovery, home or day-care centre based support may be adequate.

Many persons with disabilities also need to take daily care of their bodies to avoid worsening of impairments. Thus persons with paraplegia due to spinal cord injury or persons with nerve paralysis due to leprosy need to take regular and life-long care of their joints and limbs. An active role of persons and their families is needed for daily self-care.

Assistive devices: Assistive devices are used to increase, maintain or improve the functional capabilities of individual with disabilities. Different groups of persons with disabilities can benefit from different kinds of assistive devices. Some common assistive devices include crutches, wheel chairs and tricycles for persons with mobility difficulties; prostheses (such as artificial limbs for persons with amputations) and orthoses (equipment to correct or support specific body parts, such as shoes with braces); hearing aids; and, white canes, magnifiers and audio books.

CBR and Health Care Services

Health is one of the five key domains of Community Based Rehabilitation (CBR). The role of CBR programmes vis-à-vis health is "to work closely with 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" (WHO/ UNESCO/ILO/IDDC 2010, Health module:3).

Role of CBR in Promoting Access to Health Care and Rehabilitation Services

CBR Guidelines include a module on the health component of CBR. In addition, the supplementary module of CBR guidelines includes information about three specific health conditions - mental illness, HIV/AIDS and leprosy (WHO/ UNESCO/ILO/IDDC 2010).

The five-by-five CBR matrix in the Guidelines divides the role of CBR in health care for persons with disabilities in five areas:

1 Health promotion activities aim to increase the control of persons over their health and its determinants. Promoting healthy food habits and doing regular physical activities are examples of such activities. CBR works to ensure that all health promotion activities at community level are inclusive of persons with disabilities.
2 Activities for prevention of health conditions include screening tests and vaccinations. These activities are also part of primary prevention (avoidance) of disabilities. For example, vaccination campaigns against polio have resulted in prevention of disabilities due to polio in large parts of the world. CBR works to ensure that all the prevention activities at community level are inclusive of persons with disabilities.
3 Medical care activities are for early identification and treatment of health conditions, and their resulting impairments, with the aim of curing or limiting their impact on individuals. For example, early diagnosis and treatment of leprosy and Buruli ulcer is important for preventing disabilities due to these conditions.
4 Rehabilitation activities serve to limit the impact of disabilities, to prevent their worsening and to avoid development of new impairments. CBR programmes can play an important role in the maintenance phase of rehabilitation activities. For example, making simple parallel bars in a village can be useful for a person recovering from a stroke who needs to learn to walk again.
5 Assistive devices require support for user education, environmental adaptations, repair and replacement when worn out or broken. CBR programmes can help in making simple assistive devices. More often, they help in providing information and facilitating access to assistive devices produced in specific workshops and centres. CBR can also play a role in user training and repair of assistive devices.

Implementation of Health Care Activities in CBR

Providing information and skills is a key role of CBR programmes. Persons with disabilities may not be aware of different services available and how these can be accessed. Lack of information can be even more significant among persons living in rural and isolated areas, and in persons from poor families.

Mainstreaming means ensuring that all existing health care and rehabilitation services are accessible to persons with disabilities. CBR programmes can play an important role in promot-

ing mainstreaming. For example, specialised assistive technology workshops based in large cities, often have difficulties in reaching and collecting information about the needs for assistive devices from rural areas and small towns. CBR programmes can facilitate access to these services.

A research on the impact of CBR showed that in the areas covered by a CBR programme the percentage of persons with disabilities having access to assistive devices was almost twice the percentage in an area not covered by the CBR programme (Biggeri et al. 2012).

However, sometimes there are no existing services and mainstreaming is not possible. Thus, a twin-track approach may be needed. This means, where mainstream activities are not available CBR programmes can provide or promote the organisation of specific activities for persons with disabilities. Networking with existing governmental and non-governmental stakeholders is a crucial part of the twin-track approach to ensure sustainability of services.

Promoting self-care skills: CBR programmes facilitate skills in self-care and autonomy in activities of daily living. A person may require continued support and assistance in using new skills and knowledge at home and in the community after initial rehabilitation at a specialised centre (WHO/UNESCO/ILO/IDDC 2010, Health Module:49).

The WHO CBR manual (WHO 1989) provides information for promoting self-care at home and in the community. This can be achieved during home visits, when CBR personnel can provide information and skills to persons with disabilities and their family members. Self-care can also be promoted through peer support activities in the self-help groups. Finally, it can be promoted through collaborations with rehabilitation centres, where persons with disabilities and their family members can visit to learn the different self-care skills.

Challenging barriers and facilitating access to referral services: Maintaining close links with specialised rehabilitation services for the referral of persons in case of specific needs is another role played by CBR programmes. Facilitating access to assistive devices produced at specialised centres is part of these activities. The role of the CBR is to work with people with disabilities and their families to determine their needs for assistive devices, facilitate access to assistive devices and ensure maintenance, repair and replacement when necessary (WHO/UNESCO/ILO/IDDC 2010, Health module:67).

In collaboration with DPOs, CBR programmes also work for creating awareness among health professionals and policy makers about dismantling of the different barriers faced by persons with disabilities in accessing the health care and rehabilitation services.

CBR programmes can also provide information to persons with disabilities about the advantages and disadvantages of different health care and rehabilitation interventions so that persons take informed decisions about their own lives.

Links Between Health Care Services and CBR

Community level activities of CBR need support from the referral services. Personnel skilled in rehabilitation technology who can train and support community workers, and provide referral support, is necessary.

Often specialised health service personnel have no or limited understanding of CBR programmes and activities. Thus, involving personnel from the referral services to take part in training activities and meetings organised by CBR programmes and visiting the CBR activities can be useful for promoting awareness and creating links with the health care institutions.

The community alone cannot meet all the needs of people with disabilities. In their various roles, physicians, nurses, health assistants, midwives, and other Primary Health Care (PHC) workers provide preventive, promotive, curative and rehabilitative care (WHO 1994:12).

Thus within the health services, CBR programmes should work in close collaboration with PHC services to ensure that all health care and rehabilitation services are also accessible to persons with disabilities. If no CBR programmes exist in some areas, personnel working in PHC services can promote a CBR approach by involving persons with disabilities and their families in activities such as self-care.

Health Care Services, CBR and Disabled Peoples' Organisations

Historically, the concepts and understanding about disability were closely linked to the health care services. The coming together of persons with disabilities to form their own organisations (DPOs) over the past decades, challenged those concepts and understandings. This process has also influenced the relationships between CBR and DPOs.

Classification of disabilities in the health care: A medical model of disability that located the disability in the individuals and proposed rehabilitation as an effort to the *normalisation* of the

person was developed in the industrial era. The international classification of impairments, disabilities and handicaps (ICIDH) adopted by WHO in 1980 was based on medical model of disability and proposed the following definitions:

Disease ⟶ Impairment ⟶ Disability ⟶ Handicap

In the ICIDH, impairment was defined as "any loss or abnormality of psychological, physiological, or anatomical structure or function", disability was defined as "any restriction or lack of ability to perform an activity in the manner or within the range considered normal for human beings" while handicap was defined as "a disadvantage for a given individual that limits or prevents the fulfilment of a role that is normal for that individual" (WHO 1980:13-14).

During the 1970s and 1980s, DPOs proposed a social model of disability that focused on physical, attitudinal, cultural and socio-economic barriers created by societies. *United Nations Standard Rules on the Equalisation of Opportunities for Persons with Disabilities* (1994) took note of the social model and proposed a human rights based approach for looking at disability issues.

The social model of disability influenced the modification of the concept of disability as defined in the ICIDH. A new classification system called *International Classification of Functioning and Disability* (ICF) was developed by WHO in 2001 in consultation with DPOs. It adopted the human rights approach and looked at the impact of a health condition on body functions, structures, activities and participation. ICF focuses on two kinds of factors - environmental and personal factors (WHO 2001b).

CBR and DPOs: The initial ideas of CBR came from the World Health Assembly in 1976, which adopted a resolution encouraging the application of effective and appropriate technologies to prevent disabilities while integrating disability prevention and rehabilitation into the health programme at all levels including primary health care (WPRO 1991).

The first version of the WHO Manual, *Training in the Community for people with disabilities*, was published in 1979. Its main focus was on the activities of daily living and simple exercises that could be done at home by the families and local preparation of simple technical appliances (WHO 1989).

In 1987, another CBR manual was produced, *Disabled Village Children, a guide for community health workers, rehabilitation workers and families*. Its aim was to help "village rehabilitation workers and parents understand the basic principles behind different rehabilitation activities, exercises or aids" (Werner 1987:A5), so that they could adapt these to the local contexts.

In 1994, the first Joint Position Paper on CBR by three specialised organisations of the United Nations (ILO, UNESCO and WHO) presented the idea of multi-sectoral collaboration, where different aspects of life including health, education and livelihood were considered as equally important.

Thus initially, many of the ideas about CBR were closely linked with health care and rehabilitation services. Many DPOs considered CBR as dominated by the medical model. For example, in an international consultation in 2003, Disabled Peoples' International (DPI) raised the issue of domination of a medical viewpoint in CBR:

> "Some of our regions report that CBR is still medically oriented, not considering the human rights, social and economic needs of individual disabled persons. In other instances, regions report that even when their input is requested, their opinions are not equally weighted to that of professionals. Worst, there were instances when disabled peoples' ideas were totally disregarded. Their input therefore is meaningless" (DPI 2003:2).

However, in the recent past, collaborations between CBR programmes and DPOs have become much more productive. In 2009, in an international workshop on the United Nations Convention on Rights of Persons with Disabilities (CRPD) concluded in its recommendations that CBR offers an important opportunity for implementation of CRPD in the field (Deepak 2009).

During the past decade, a large number of persons with disabilities and DPOs from different countries took an active role in the preparation and field-testing of CBR Guidelines (WHO/UNESCO/ILO/IDDC 2010). Regional and global CBR networks have been set up in which persons with disabilities and DPOs are playing key roles. At the same time, in many countries, DPOs themselves are running CBR programmes.

Neglected Health Care Issues in CBR

There are some issues related to the health care needs of persons with disabilities that are often neglected in CBR.

Such neglected areas can be in relation to specific kinds of disabilities associated with social stigma such as leprosy related disabilities and psychosocial disabilities. For this reason, one module of the CBR Guidelines (supplementary module) contains detailed information about three specific groups of persons - persons affected with leprosy, persons with mental illness and persons with HIV/AIDS (WHO/UNESCO/ILO/IDDC 2010).

Some other areas linked to health care that require more attention from CBR programmes are the taboo areas such as issues related to sexuality, reproductive rights, violence, abuse and sexual abuse. Working at community level in close collaboration with the families, CBR programmes can play a significant role in looking at and raising awareness about some of these issues.

For example, during an international workshop on *Going beyond Taboo areas in CBR*, participants agreed on the key roles played by CBR workers in prevention of violence and abuse towards persons with disabilities: "CBR workers visit homes of persons with disabilities and this helps to reduce violence and abuse in the family. CBR workers talk to families and they understand that there is no need to be ashamed of their child's disability" (Deepak 2013b:18).

Challenges for Health Care and Rehabilitation Activities in CBR

There are different challenges for an effective role of CBR programmes in health care, rehabilitation and assistive devices related activities. Disability is closely linked to poverty. Poverty also means limited resources for obtaining health services and high risk of personal illness (WHO 1998:136). Sometimes, the referral services may even be free but for families of persons with disabilities living in isolated and rural areas, barriers exist due to the lack of accessible transport or high cost of the transport or due to the loss of income resulting from a prolonged stay near the referral services.

Lack of skills among specific CBR workers: In some countries, CBR programmes work with community volunteers who receive limited training. In other countries, CBR personnel is composed of full time CBR workers, but often they need to work with a very large number of persons with disabilities. At the same time, they may have a high turnover and they receive limited training.

A research involving CBR workers from seven countries showed that 96% of the CBR workers were involved in health related activities, and most of them were working with different groups of persons with disabilities. 83% of the workers identified *home based care* of persons with disabilities as their most important learning need. 30% of them identified assistive devices as the area in which they lacked skills and an additional 11% felt that they needed training about the use of medications linked with certain disabilities such as persons with convulsions and mental illness (Deepak/Kumar et al. 2011:85-97).

Lack of services in rural areas and small cities: Health care services, including rehabilitation services, are organised at different levels - national, intermediate (such as provincial or district level) and peripheral levels (primary health care services). In most countries, all specialised health care services and rehabilitation services are available only at national level and in some big cities. A few specialised services may also be available at district level.

Thus, if persons with disabilities living in rural areas and small cities need any specialised health care and rehabilitation services, they must go to a big city or the national capital. Sometimes, specialised health care and rehabilitation support may be needed for prolonged periods of time, for example among some persons with severe disabilities. Lack of accessible transport, loss of income, high cost of the services and leaving the families for long periods, are some of the barriers blocking access to health care services for persons living in rural and isolated areas.

Many of the specialised centres are run by non-governmental organisations (NGOs) or private service providers. Often, these services are fragmented and nor the relevant ministry or the different organisations are able to overview the different responsibilities and activities. For example, a survey in 29 countries of Africa (WHO 2004) showed that a large number of NGOs were involved in running rehabilitation institutions and care services, however specific information about their activities was not available.

Physical and attitudinal barriers: Physical barriers, lack of understanding about the needs of persons with disabilities, a narrow focus on the disability rather than a holistic vision of the persons and all their needs and sometimes, negative attitudes of health professionals are significant barriers.

For example, hospitals may not have staff who knows sign language to communicate with persons with hearing impairments. They may not understand the specific needs of persons with vision impairment and thus, the health education materials may not be accessible to

them. Sometimes, orthopaedic laboratories that provide some assistive devices are placed on higher floors and there are no lifts, so that persons with mobility difficulties need to be carried over the stairs, to access these services.

Among the persons with disabilities, women with disabilities often find it harder to get the health care they need. Some common barriers that they face include: lower beds or good quality catheters are often not available; the hours the health centre is open may not be convenient; and, there may be few women doctors even though many women feel embarrassed to go to a male doctor (Maxwell/Belser/ David 2007:35).

In a workshop on sexuality and reproductive health issues for persons with disabilities (Deepak 2013a) a CBR worker explained: "If a woman with a disability gets pregnant, the health workers ask her - 'How did you become pregnant?' They cannot believe that a woman with disability can have sex or that a man would have sex with such a woman. Their attitude puts off women with disabilities. So when women with disabilities are pregnant they don't want to go to hospital for check-ups".

Organisation of health services for acute care: Health care systems were developed a couple of centuries ago, when certain acute infectious diseases were the leading cause of illness and death. The health care systems were designed to address pressing concerns. For example, testing, diagnosing, relieving symptoms, and expecting cure are hallmarks of contemporary health care. Moreover, these functions fit the needs of patients experiencing acute and episodic health problems. However, a notable disparity occurs when applying the acute care template to patients who have chronic problems (WHO 2002:29).

The *acute care* model of health services locates expertise in the health professionals, while the persons needing health care are seen as passive receivers. On the other hand, chronic conditions are usually life-long requiring continuous and regular care and life style changes. This means that persons with chronic conditions need to develop skills for self-care and take an active role in their own care. Impairments are also chronic conditions that require life-style changes. Thus health care and rehabilitation services responding to specific needs of persons with disabilities need to have active engagement with their clients to provide knowledge and skills for self-care.

The focus of the health and rehabilitation services, which are presently organised around *acute care* and based solely on the expertise of professionals, needs to shift to a *chronic care* model of services, with greater role of persons with disabilities and their families in their self-care.

Difficulties of multi-sectoral collaboration: CBR programmes recognise the need for multi-sectoral collaboration, because the goal of CBR is to contribute towards the empowerment of persons with disabilities, facilitating an independent life style in which they participate in all aspects of community life. Multi-sectoral collaboration is therefore imperative if such a goal is to be achieved, as no sector alone can achieve such a broad objective. However, multi-sectoral collaboration is beset with different challenges including the lack of political commitment, rigid ministerial demarcations, poor communication and vertical management processes (O'Toole 1996:11-16).

Thus, if a CBR programme is not under the health ministry but is under another ministry or if it is managed by a NGO, then collaboration with health care services may face difficulties. Sometimes, even when a CBR programme is under a ministry of health, it may still face difficulties in accessing referral services as CBR programmes are usually under community health services and do not have direct links with services dealing with institutions and hospitals.

Other challenges: In many developing countries, national coverage of primary health services is often patchy and incomplete. Health centres, even if they exist, lack trained staff, medicines and medical supplies. Globalisation and linked changes such as increased privatisation of services have created additional challenges.

For example, in China, the government share of health expenditure fell by over half between 1980 and 1998, almost trebling the portion paid by families. This led to the growth of private delivery systems for those who could afford them, and increased cost-recovery schemes for services that were still under some form of public health insurance. In India, Government expenditure on health care accounted for just 18% of health care spending, with the rest financed by users - making it one of the world's most privatised health care systems (GHW 2005:19-20).

WHO Guide on referral health services (WHO 1994:ii-iii) underlined "the inadequacy of current services to meet the needs" of persons with disabilities - "In developing countries, even most basic services and equipment are lacking".

In 1999, the Disability and Rehabilitation team of the World Health Organisation (WHO/

DAR) conducted a survey to collect information on rule 2 (medical care), rule 3 (rehabilitation), rule 4 (support services) and rule 19 (personnel training) of the *U.N. Standard Rules on Equalisation of Opportunities for Persons with Disabilities* (1994) from Ministries of Health (MoH) and Non-Governmental Organisations (NGOs) including organisations of disabled people. All together, 104 ministries and 115 NGOs responded to this survey (WHO 2001a).

This WHO/DAR survey provided information about availability and access to different health care and rehabilitation services, including information about assistive devices and training of health care personnel. The reports of this survey identified different areas where health and rehabilitation services were inadequate and where persons with disabilities faced different barriers to access. For example, the survey showed that in almost 50% of the countries, less than 20% of population had access to rehabilitation services (WHO 2001a, Part 1, summary:21).

Promoting Greater Access to Health Care and Rehabilitation Services

Considering the continuing difficulties faced by persons with disabilities to receive health care, in May 2013, the World Health Assembly approved a resolution

> "... people with disabilities have the same need for general health care as non-disabled people, yet have been shown to receive poorer treatment from health-care systems than non-disabled people; Also recognising the extensive unmet needs for habilitation and rehabilitation services, which are vital to enable many people with a broad range of disabilities to participate in education, the labour market, and civic life, and further that measures to promote the health of people with disabilities and their inclusion in society through general and specialised health services are as important as measures to prevent people developing health conditions associated with disability" (WHO 2013:5).

This resolution invited member countries to:

- work to ensure that all mainstream health services are inclusive of persons with disabilities, an action that will necessitate, inter alia, adequate financing, comprehensive insurance coverage, accessible health-care facilities, services and information, and training of health-care professionals to respect the human rights of persons with disabilities and to communicate with them effectively;
- promote habilitation and rehabilitation across the life-course and for a wide range of health conditions through: early intervention; integrated and decentralised rehabilitation services, including mental health services; improved provision of wheelchairs, hearing aids, low vision devices and other assistive technologies; and training to ensure a sufficient supply of rehabilitation professionals to enable people with disabilities to achieve their potential and have the same opportunities to participate fully in society;
- promote and strengthen community-based rehabilitation programmes as a multi-sectoral strategy that empowers all persons with disabilities to access, benefit from, and participate fully in education, employment, health and social services.

Future Trends in CBR and Health

The ratification of the CRPD in a large number of countries along with the preparation of national disability action plans for implementing the CRPD, have strengthened the CBR programmes in a number of countries. This tendency is likely to continue with the expansion of CBR activities through national programmes.

CBR programmes are about working together with persons with disabilities and their families at the community level. The gradual expansion of communication and information technologies over larger areas of the developing world can offer newer ways of implementing CBR. For example, the role of CBR programmes in providing information and promoting awareness can be reinforced through mobile telephony. Similarly, online training opportunities can provide more cost effective ways of reaching persons with disabilities, families, DPOs and CBR workers.

The majority of CBR programmes have been developed in rural areas, though there are some examples of successful urban CBR programmes. Growing urbanisation across the world may require a fine-tuning of new approaches to implement CBR programmes in urban areas.

Linking CBR programmes with the post 2015 development agenda so that international efforts like the Millennium Development Goals, the Mental Health Gap programme and the campaign around non-communicable disease are inclusive of persons with disabilities is another key area that is going to influence implementation of CBR programmes in future.

Conclusions

Health care including rehabilitation care and assistive devices are key components of CBR programmes. People with disabilities need health services for general health care needs like the rest of the population, including different needs in different phases of life. While not all people with disabilities have health problems related to their impairments, many will also require specific health care services, on a regular or occasional basis and for limited or lifelong periods.

CBR programmes promote health care activities in terms of health promotion, prevention, medical care, rehabilitation and assistive devices. The health care related activities of CBR include information and skill provision, mainstreaming, provision of some specific services, promotion of self-care and autonomy in activities of daily living, facilitation and advocacy.

Persons with disabilities face many barriers in accessing health care services. CBR programmes, in partnership with primary health care services and in collaboration with referral services can do a lot to overcome some of these barriers.

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Zusammenfassung: *Wie alle Menschen haben auch Menschen mit Behinderung verschiedene Bedarfe in der Gesundheitsversorgung, von der Kindheit bis ins hohe Alter. Manche von ihnen haben auch spezifische Bedarfe im Bereich Gesundheit und Rehabilitation, verbunden mit ihren Beeinträchtigungen. Nur ein kleiner Prozentsatz von Menschen mit Behinderung in Entwicklungsländern hat Zugang zur Gesundheitsversorgung und zu Rehabilitationsangeboten. Dieser Beitrag richtet den Blick auf die Barrieren, denen sich Menschen mit Behinderungen beim Zugang zu Gesundheitsversorgung und Rehabilitationsangeboten gegenüber sehen und beschäftigt sich mit der Entwicklung von medizinischen und damit verbundenen Aktivitäten in der CBR.*

Résumé: *Comme toute personne, les personnes handicapées ont différents besoins de soins de santé, de l'enfance au grand âge. Certaines ont aussi des besoins spécifiques liés à leur handicap. Seul un nombre restreint de personnes handicapées dans les pays en développement a un accès aux soins de santé et aux services de réadaptation. Cet article observe les barrières rencontrées par les personnes handicapées pour l'accès aux soins et les services de réadaptation ainsi que le développement des soins de santé dans le cadre des activités de RBC.*

Resumen: *Como todas las personas, las personas con discapacidad también tienen diferentes necesidades de atención de la salud, desde la infancia hasta la vejez. Algunos de ellos tienen además, dependiendo de su deficiencia, necesidades de atención o de de rehabilitación específicas. Sólo un pequeño porcentaje de personas con discapacidad en el mundo en desarrollo tiene acceso a servicios de salud y rehabilitación. Este artículo analiza las barreras que enfrentan las personas con discapacidad en el acceso a la asistencia de salud y los servicios de rehabilitación. Además se enfoca el desarrollo de las actividades de atención a la salud que son relacionadas con la RBC.*

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