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humanity & inclusion

Global Rehabilitation Alliance

Rehabilitation for the realisation of human rights and inclusive development



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Global Rehabilitation Alliance

The Global Rehabilitation Alliance (GRA) was founded in May 2018. Its mission is to advocate for the availability of quality, coordinated and affordable rehabilitation through system strengthening according to population needs.
The Alliance envisions a world where every person has access to timely, quality and user-centred rehabilitation services. It is a cohesive body of diverse stakeholders, currently with 19 member organisations, united to further the development of rehabilitation around the world.

Humanity & Inclusion

Humanity & Inclusion (HI) is an independent and impartial aid organisation working in situations of poverty and exclusion, conflict and disaster. HI works alongside persons with disabilities and vulnerable populations, taking action and bearing witness in order to respond to their essential needs, improve their living conditions and promote respect for their dignity and fundamental rights. On January 24th 2018, the global Handicap International network became Humanity & Inclusion. This network is composed of a Federation which implements our programmes in the field in around sixty countries and of eight national associations. These programmes or national associations are known as "Handicap International" or "Humanity & Inclusion", depending on the country.

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GRA members

American Speech-Language-Hearing Association (ASHA), Dementia Alliance International, CBM, Global Alliance for Musculoskeletal Health (GMusc), Humanity & Inclusion (HI), International Council of Nurses (ICN); International Committee of the Red Cross (ICRC), ICRC MoveAbility Foundation, International Society for Prosthetics and Orthotics (ISPO), International Society of Physical and Rehabilitation Medicine (ISPRM), International Spinal Cord Society (ISCoS), Light for the World, Liliane Foundation (LF), Motivation, World Confederation for Physical Therapy (WCPT), World Federation for NeuroRehabilitation (WFNR), World Federation for Occupational Therapy (WFOT), World Federation of Chiropractic (WFC).

Acronyms & Symbols

CBR	Community-Based Rehabilitation
CSO	Civil Society Organisation
DPO	Organisation of Persons with Disabilities and their families
DRRA	Disabled Rehabilitation and Research Association
GLAD	Global Action on Disability Network
GNI	Gross National Income
HI	Humanity & Inclusion (formerly Handicap International)
ICT	Information and Communication Technologies
ODA	Official Development Assistance
SGDs	Sustainable Development Goals
UNCRPD	UN Convention on the Rights of Persons with Disabilities
WHO	World Health Organization

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1. Introduction

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Unmet need for rehabilitation constitutes a failure to uphold the human right to health and wellbeing. Rehabilitation is not only beneficial for persons with disabilities but also people with a wide range of health conditions at various stages of their lives. Rehabilitation is person-centred and supports individuals in achieving their full potential by focusing on a person's abilities rather than limitations. This report illustrates how rehabilitation contributes to achievement of several of the Sustainable Development Goals (SDGs), improves global health, and promotes the realisation of human rights for all. The purpose of this report is to provide evidence to stakeholders upon which to build successful strategies to improve the availability of quality, coordinated, affordable, and user-centred rehabilitation. By situating disability and rehabilitation within global discourse and policy, it is intended to provide guidance on the implementation of effective rehabilitation-focused policy and practice, contributing to progress towards global development goals.

The report concludes with sets of specific recommendations for different stakeholders (states, donors and civil society, including disabled people's organisations), which have the potential to strengthen rehabilitation services and improve the health and wellbeing of millions around the world. Included in annex are case studies of government donors and their progress towards meeting the recommendations set out in this report. These case studies are intended to serve as examples for stakeholders for how some of the recommendations have already been included within national policies and activities, where gaps exist and identify areas for improvement.



2. Optimal functioning to fully participate in society

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Rehabilitation is one of the core health strategies, along with promotion, prevention, treatment, and palliative care. The World Health Organization (WHO) defines rehabilitation as 'a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain **optimal functioning in interaction with their environments'**.[1] By restoring, preventing or slowing deterioration in functioning (sensorial, physical, intellectual, mental, cognitive, or social),[2] **rehabilitation places the person at the centre and contributes to people reaching their full potential and participating in society**.[i] Its impact is therefore not only on the individuals, but also on their families, communities, and economies.

A great proportion of persons with disabilities have a direct interest in rehabilitation. Today, **15% of the world population lives with some form of disability**.[1] The prevalence of health conditions associated with severe disability has increased by 23% since 2005,[3] generating higher demand for rehabilitation services.

This is primarily due to demographic change, including an ageing population, increasing prevalence of non-communicable diseases (NCDs) and injuries.[4] Persons with disabilities often have more healthcare needs than persons without disabilities. While the general health needs of persons with disabilities are the same as everyone else and can often be met by primary healthcare services, they may also have additional specific health needs related to their impairment.[5] These include access to rehabilitation and assistive technologies or devices (such as wheelchairs, prosthesis, visual supports), as well as the support and empowerment offered by community-based rehabilitation (CBR).

Estimating the scope of rehabilitation need is challenging, as many disabilities are 'invisible' (e.g. autism, musculoskeletal pain, psychosocial disabilities, anxiety, depression), and are often not recognised, addressed and referred to adequate services.

Rehabilitation not only is beneficial for persons with certain disabilities but also for people with a wide range of health conditions, including acute or chronic diseases, injuries, traumas, as well as other circumstances such as pregnancy, ageing, stress, congenital anomaly, or genetic predisposition.[6] **Rehabilitation services are relevant along the continuum of care**, for the prevention of impairment and deterioration in the acute phase of care, as well as for optimization and maintenance of functioning in the post-acute and long-term phases of care.[6]

Recognising that disability is an 'evolving concept' resulting from the negative interactions between the health conditions of the individual and the attitudinal and environmental barriers,[7; preamble] rehabilitation operates at the level of impairments, activity limitations and participation restrictions.[ii]While the 2018 WHA Resolution on Improving access to Assistive Technologies and initiatives such as AT2030[8] and ATscale[9] emphasize access to assistive technologies (both WHO-promoted programmes for innovation in assistive technologies – see **WHO and rehabilitation** section), **rehabilitation encompasses a broad range of therapeutic measures**. These include provision of assistive technologies and devices, but also exercise, training, education, support and counselling, and adaptation of the environment to eliminate barriers. Information and communication technologies (ICTs) are increasingly integral parts of rehabilitation programmes and in the development of assistive technologies.

Depending on an individual's conditions, the provision of assistive technologies may be relevant and would need to be combined with other rehabilitation activities. **An integrated approach which considers rehabilitation services and assistive technologies as interrelated and mutually beneficial should be systematically adopted**. Rehabilitation services are offered by a range of different professionals: physical therapists, occupational therapists, prosthetists and orthotists, physiatrists (physical and rehabilitation medicine specialists), psychologists, speech and language therapists, social workers, chiropractors, nurses and other health professionals[2] including CBR workers. Rehabilitation services may be found in a variety of health care settings, from hospitals to communities.



3. The policy framework for rehabilitation

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Rehabilitation in global human rights and development frameworks

The **UN Convention on the Rights of Persons with Disabilities** (UNCRPD[7]) was adopted by the UN General Assembly in 2006 and to-date is ratified by 177 States. While the UNCRPD marks a shift from a medical to a rights-based approach to disability, this legally-binding instrument gives space to rehabilitation as a key element that enables persons with disabilities to attain and maintain maximum independence and full inclusion and participation in all aspects of life. There are several articles within the Convention that pertain specifically to rehabilitation.

- Article 26 of the UNCRPD is specifically dedicated to habilitation and rehabilitation and requires Member States to organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes.
- Article 20 demands taking effective measures to ensure personal mobility with the greatest possible independence, including by providing training in mobility skills and mobility aids, devices, and assistive technologies.
- Article 25 recognizes the right of persons with disabilities to the enjoyment of the highest attainable standard of health, without discrimination based on disability, and responding to individual needs. These articles in the UNCRPD provide a platform from which States can be held accountable for their obligations to implement and promote rehabilitation services.

Recognizing the interconnectedness of current global health trends with sustainable development, the **2030 Agenda**[(10)] adopted by UN Member States in 2015 aims to enhance

physical and mental health and wellbeing and to extend life expectancy for all through the promotion of universal health coverage and access to quality health care. Rehabilitation is considered part of **SDG target 3.8**:

"Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all." [10]

As rehabilitation is an element of essential packages of care, target 3.8 can only be fully achieved if rehabilitation is included as a core component.

Rehabilitation is aimed at improving people's ability to live, work and learn to their best potential. It is therefore also connected with and contributes to the realization of a broad range of SDGs (SDG1 on poverty reduction, SDG3 on health and wellbeing, SDG4 on education, SDG5 on gender equality, SDG8 on employment, and SDG11 on inclusive and resilient cities).

The World Health Organization shaping global commitments and policies on rehabilitation

> *"Persons with disabilities are often unable to access either mainstream services or the specialized programmes they need. Unless progress is made on this front, we will fail to achieve the Sustainable Development Goals and their ambitious vision to leave no one behind."*
>
> Etienne Krug, Director of Department for Management of Noncommunicable Diseases, Disability, Violence and Injury Prevention, WHO. [11]

The WHO has built political commitments around rehabilitation and assistive technologies, and has supported Member States to strengthen the provision of quality rehabilitation at all levels of the health system. WHO emphasises rehabilitation as a response to current health and social needs resulting from decrements in functioning. WHO is encouraging stakeholders to unify messages around rehabilitation under the concept of 'functioning'. WHO regards functioning as a key concept for political leaders in light of ageing populations, as well as the success in preventive strategies and advances in medicine leading to longer lives but with more disability. Functioning is WHO's third health indicator, after mortality and morbidity. [12]

One of the three objectives outlined in the WHO **Global Disability Action Plan 2014-2021** [13] is to strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and CBR. The WHO **Rehabilitation 2030 Call for Action**, [14] adopted in 2017, established joint commitments to raise the profile of rehabilitation. Based on this, WHO has developed several initiatives under the umbrella of "Rehabilitation 2030", [14] providing guidance to Member States and catalysing resources for rehabilitation. Among these, "Rehabilitation in health systems" [6] and the "Support Package for Rehabilitation" [15] provide support and guidance for Member States and others on how to strengthen and expand the availability of quality rehabilitation services.

In 2018, the World Health Assembly adopted the **Resolution on Improving Access to Assistive Technologies**[16] and launched the AT2030[8] and ATscale[9] initiatives, both creating partnerships for innovation, affordability and accessibility of assistive technologies. Led by the Global Disability Innovation Hub, AT2030 is a multi-stakeholder programme that supports ATscale and aims to transform the access to assistive technologies for over 3 million people through catalysing technologies and developing service delivery. Through these, as well as in commitments taken by states and organisations at the 2018 Global Disability Summit[iii], ATscale aims to reach 500 million people with life-changing assistive technology by 2030.

An additional important policy framework relating to rehabilitation, led by WHO, is the 2018 **Declaration on Primary Health Care** adopted in Astana.[17] Forty years after the Declaration of Alma-Ata was adopted (in 1978;[18]), this new declaration emphasizes the role of primary health and reaffirms rehabilitation as a pivotal component of its realisation.

Building on existing policy frameworks: rehabilitation for human rights and inclusive development

Between 110 million and 190 million adults have significant difficulties in functioning,[5] and 92% of global diseases relate to causes that require health professionals specialised in physical rehabilitation.[19] However, the WHO estimates that there are fewer than ten skilled rehabilitation professionals per million people in low- and middle-income countries.[3] This has led to more than 50% of persons with disabilities in many developing countries having unmet need for rehabilitation:[20] only 5-15% of people needing a wheelchair have access to one, and 200 million people needing visual devices do not have them.[21] Unmet need for rehabilitation can result in poorer health outcomes and impact on quality of life.

These unmet needs of rehabilitation represent a failure to fulfil the human right to health and wellbeing (Article 25, Universal Declaration of Human Rights[22]) and the right of persons with disabilities to the enjoyment of the highest attainable standard of health without discrimination based on disability (Article 25, UNCRPD[7]). As human rights are interdependent, indivisible and interrelated, the violation of the right to health may impact other human rights, such as the rights to education, work, independent living, participation in community life, and freedom of movement.

> *"If persons with disabilities do not have access to habilitation and rehabilitation services, many will not be able to fully realize their potential: attending school, maintaining a job or participating actively in the development of their communities."*
>
> Catalina Devandas-Aguilar, UN Special Rapporteur on the Rights of Persons with Disabilities.[iv]

The SDGs 'seek to realize the human rights of all'. Indeed, all 17 SDGs directly or indirectly reflect human rights standards. The enactment of human rights is closely connected to, and mutually reinforced by, the effective achievement of SDGs. By intervening mainly on health-related aspects, rehabilitation primarily contributes to the realization of the right to health and to SDG3 on health and well-being. However, **better health outcomes also help fulfil other individual rights, as well as enhance the impact of efforts to build inclusive, peaceful and prosperous societies**. An individual who can enjoy good standard of health is more able to fully participate economically, culturally, politically on equal basis with others, with the impact going beyond the individual and reaching the whole society.

The commitment to 'leave no one behind' is a recurring objective enshrined in the 2030 Agenda,[23] and requires all actors involved in the implementation of the SDGs to address the inequalities affecting vulnerable people, including persons with disabilities (who are disproportionately represented in low- and middle-income countries). Rehabilitation can benefit a large number of individuals, especially the most vulnerable and marginalised individuals and communities. For persons with severe health conditions and with disabilities,[24, 25, 26] it can provide them with concrete opportunities for empowerment, inclusion, and participation in development. Thus, **rehabilitation is a fundamental element to translate the "leave no-one behind" commitment into reality**.

Improving disability data collection

A recent systematic review of access to rehabilitation in low- and middle-income countries found limited data on the extent to which people needing rehabilitation have access, and on quality and type of service.[27] To accurately monitor unmet health needs and rehabilitation provision, as well as progress towards the SDGs and other development goals, these significant gaps in high quality data need to be addressed as a priority.[28]

Increasingly, donors and other stakeholders are requiring disability-disaggregated data to be collected as part of monitoring and evaluation activities. There are various approaches to disability data collection. One framework that is gaining increasing prominence is the Washington Group on Disability Statistics approach.[v] These question sets are designed to be internationally-comparable and frame disability in terms of difficulties in functional activities.

However, while these questions generate information about difficulties in functioning, this does not automatically translate into need for rehabilitation – e.g. not everyone with difficulty walking requires a prosthesis[27] – nor are they designed to be a diagnostic tool, meaning that clinical assessment may also be required in rehabilitative services.

Other disability data collection tools are available. These include WHODAS 2.0[vi] and the WHO Model Disability Survey. Choosing the appropriate methodology is dependent upon the data needed for monitoring access and provision. For example, the Washington Group questions and Model Disability Survey[vii] perform two very different functions. The former is designed to be incorporated into existing surveys as a quick way of collecting data that can be disaggregated by disability. The Model Disability Survey by contrast, is a stand-alone, in-depth survey for detailed information on persons with disabilities. These two surveys also require very different capacities for analysis.[29] [viii]



4. Rehabilitation is an essential component of inclusive health

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Given the impact that rehabilitation can have, it is **an essential service that should be available to everyone, particularly those persons with disabilities who need it**. However, given that global health outcomes are still largely measured by reduction of deaths, rather than improvements in health outcomes, or quality of life and wellbeing, rehabilitation services tend to be perceived as a 'luxury' and too demanding of financial and human resources.[21] Consequently, rehabilitation services are often under-resourced and undeveloped,[30] and an extensive need remains unmet. For some countries this unmet need can be as high as 50% of total need.[20] There is also evidence that the countries with the highest disease burden have the fewest rehabilitation professionals.[19]

Rehabilitation is rarely integrated into health system strengthening, policy and planning, and not prioritized especially by governments with limited health investment. **As a result, rehabilitation services are insufficiently supported**. The shortage of rehabilitation professionals is critical, particularly in low-income countries and rural areas.[31] For example, according to the WHO and based on its standards for prosthetics and orthotics, for every 1 million population, a country would need at least five prosthetics and orthotics professionals in order to meet the needs of all individuals. Data from the International Society for Prosthetics and Orthotics (ISPO) show that the number of registered prosthetist/orthotists, associates and technicians does not reach the minimum number of personnel even in high-income countries. In the African, South-East Asia and Western Pacific regions the number of professionals is one tenth of the number required.[3]
Only six rehabilitation-specialist physicians can be found in the whole sub-Saharan Africa.[31] However, few programmes in low- and middle-income countries exist for gaining qualifications in rehabilitation services.[27]

The provision of rehabilitation services, as an integrated component of inclusive health, should be guided by four principles, established by the WHO and widely recognised:

- availability (present in adequate quantity);
- accessibility (financially, geographically and physically accessible, without discrimination);
- acceptability (respectful of ethical standards, medical ethics, culturally appropriate and sensitive to gender and life-cycle requirements); and
- quality (scientifically and medically appropriate and of good quality).[32]

Health professionals and CBR workers play a key role in the effective delivery of inclusive health services.[33] CBR workers working at the intersection of health and social services can improve access to rehabilitation in rural areas.[34] For rehabilitation services to be effective and address current unmet need and future increasing demand, the current lack of professionals needs to be addressed as a priority. Increasing and strengthening human resources for rehabilitation should be a priority focus for inclusive health systems.

Rehabilitation, yet neglected in integrated health system approach

A health system comprises all the organisations, institutions, resources, and human resources for the promotion of health, including rehabilitation services and professionals.[35] In a comprehensive health system, rehabilitation is one of the key services at both the community- and hospital-level.[6] The integration of rehabilitation in health systems (across the continuum of care, at all stages of life, and for a range of health conditions) is expected to result in improved coordination with medical and other health services, accountability, quality assurance and sustainability.[6] In the medium- and long-term, this integrated approach will result in strengthened delivery of rehabilitation services, better workforce allocation, and adequate financing.

However, there is evidence that rehabilitation is not yet effectively integrated into many health systems globally.[6] Recognizing the value of rehabilitation and its impact on individuals, families, and communities, **the allocation of resources to rehabilitation services should be seen as an investment, rather than a cost**. By increasing human capacity, rehabilitation strengthens the work-force, enabling participation and economic productivity. Rehabilitation interventions tend to be cost-effective or showed cost-saving in a variety of disability conditions.[36] In addition, rehabilitation generates further economic benefits as it expedites hospital discharge and prevents readmission.[6]

Decentralisation of rehabilitation should also be a priority. Rehabilitation services in many countries tend to be concentrated in urban areas, not distributed according to need. A recent research project found that 94% of respondent speech and language therapists in sub-Saharan Africa were based in cities.[37] In contexts with limited resources, including in rural areas, CBR (see **box** below) aims to compensate for these gaps and reach people who otherwise would not access rehabilitation services. However, CBR should not exist in isolation, but should be complementary to specialist rehabilitation services operating through an integrated health system.[38]

Beyond the integration of rehabilitation into national health system policies, they need to be properly resourced to be fully implemented. In resource-poor settings with competing demands for limited budget, this is often not the case. For example, in five West African countries policies were often in place for free healthcare and access to rehabilitation services, but in practice there was often insufficient resources allocated for the policy to be effective.[39] To move towards an effective and fully integrated health system that includes rehabilitation, priority must be given to financing.

Community-Based Rehabilitation (CBR)

CBR consists of fostering collaboration between persons with disabilities, families, community members and health professionals to provide rehabilitation services in non-institutional settings (e.g. in remote areas), as well as fostering change within communities to support community participation for all. Thus, CBR aims to increase access to rehabilitation services, particularly in low-income countries or low-resource settings, by providing rehabilitation and training to individuals, as well as finding strategies for inclusion in their communities, making optimum use of local resources.[40]

Over time, CBR has evolved into a multisectoral development strategy which aims to address the broader needs of persons with disabilities, achieve equity and social inclusion to enhance quality of life.[41] It has five key components: health, education, livelihood, social inclusion and empowerment.

What is Community-Based Inclusive Development? Building on the recent evolution of the principles of CBR, Community-Based Inclusive Development is gaining increasing prominence. While CBR is linked to service provision (even if it encompasses also other areas), community-based inclusive development is a broader strategy that adopts the principles of CBR but integrates a wide range of disability-related policies and measures, in which rehabilitation is only one component.[34]



Country case: Bolivia

The Plurinational State of Bolivia ratified the UNCRPD in 2009. In the same year, the Political Constitution was adopted that protects and recognises the rights of persons with disabilities. Another key milestone in promoting the rights of persons with disabilities was the National Plan on Equality and Equal Opportunities (2006) which has 'psychosocial health and rehabilitation' as one of its focal points.

A system of financial mechanisms and insurance is in place, which aims to ensure that rehabilitative care does not lead to catastrophic health expenditure.[ix] Formal-sector workers are covered by insurance provided by their profession; the 'Caja Nacional de Seguro Social' provides health insurance for workers who are not covered by professional insurance; and the 'Seguro Integral de Salud' provides free coverage for children under 5, pregnant women, people over 60 and persons with disabilities who hold a 'disability card'.

The major obstacle is that only a small proportion of persons with disabilities possess a disability card. According to the Pan-American Health Organization, there are over one million persons with disabilities in Bolivia. However, data provided by the Register of Persons with Disabilities in 2014 showed that only 40,552 persons with disabilities held the disability card.[42] For those not in possession of a card, rehabilitation is not covered by insurance.

Efforts have been made to increase the outreach of rehabilitation services. Rehabilitation centres are now present in 22 out of 112 districts, and rehabilitation professionals perform regular visits to communities.[viii] Drawing on successful CBR projects, General Act No. 223 (2012) states that Bolivia will include a CBR strategy in its social, cultural, intercultural and economic policies. The adoption of the Community Intercultural Family Health policy has created a 'model' that places greater focus on rehabilitation with a view to reducing exclusion and inequalities

in communities. Since 2011, 39 rehabilitation centres have received resources through this policy.[43]

Civil society organisations have pointed out barriers in access to rehabilitation. Rehabilitation centres are concentrated in cities, with rural areas lacking in quality services; infrastructure is often not accessible;[42] there is a shortage of rehabilitation professionals or they are not adequately trained on all the medical and therapeutic disciplines.[44]

The policy aimed at integrating rehabilitation centres in hospitals, which has been initiated by the government, has the potential to pave the way for improved coordination with other health services, better workforce allocation, and more adequate decentralization. However, this needs full implementation to achieve greatest possible impact.

Country case: Rwanda

In recent years, Rwanda has increased political focus on disability and on the right to health for persons with disabilities. While challenges remain, specific activities have increased access to health and financial coverage, as well as participation in development for persons with disabilities.

Since the early 2000s, initiatives have been undertaken to provide a solid legal framework for disability. These include the 2003 National Policy on Disability, and laws relating to protection of persons with disabilities and disabled former war combatants. The ratification of the UNCRPD in 2008 further catalyzed political commitment, resulting in Law N° 54/2011 on the specific protection of children with disabilities, and the establishment of the National Council of Persons with Disabilities aimed at building capacity and ensuring the participation of persons with disabilities.[x]

Significant progress has been made towards ensuring health coverage. For persons with disabilities, the classification of the degree of disability determines the amount of medical care that is subsidized by the Government. For persons with the most severe disabilities, full health costs are subsidized. The Government will also cover the costs of prosthetics and orthotics for people whose degree of disability is between 70% and 100%. It should be noted, however, that while waiting for assessment, access to subsidized healthcare was effectively suspended.[45]

For other categories of disability, health costs should be covered by the 'Mutuelle de Santé'. This Government-subsidized community-based health insurance scheme, aims to relieve some of the financial burden of accessing healthcare. For the poorest households, enrolment fees are paid by the government. However, the introduction of higher premiums in 2010 has made it challenging for people with fewer financial resources, but who do not meet the criteria for governmental support, to pay the enrolment fees.[46]

The National Union of Disability Organizations in Rwanda points out that while 85% of persons with disabilities have some form of health insurance, the 'Mutuelle' does not cover all rehabilitation services (such as audiology and speech and language therapy) and many assistive devices are not readily available.[47] Another challenge is in the lack of accessible of health facilities. During the Committee on the Rights of Persons with Disabilities in 2019, the Rapporteur for Rwanda remarked on the poor application of the 2010 building codes and the continued infrastructure inaccessibility.

Rwanda is one of the few countries to have achieved the Abuja Declaration target of 15% of annual budgets allocated to the health sector.[48] Building on this strong basis, Rwanda can make further steps, counting on the growing fiscal space for the health sector (and rehabilitation sector), and on the systematic inclusion of disability in programs and strategies that target socioeconomic transition.



5. Mainstreaming rehabilitation and 'CRPD-compliant' SDGs

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The 2030 Agenda [10] was launched in New York in September 2015 and comprise 17 Goals to be achieved by 2030. Disability is mentioned explicitly 11 times in the Goals and referred to under the umbrella of 'vulnerable' 18 times. [49] Disability is also mainstreamed across the entire text through the principle of 'leave no-one behind'. **Rehabilitation plays a key role in both achieving global development objectives and implementing the UNCRPD**.

To realise the intended outcomes of the SDGs, disability and rehabilitation must be considered fundamental components of programmatic and policy measures focused on their progress. Outlined below are seven Goals which align with Articles in the UNCRPD, and where addressing barriers to rehabilitation is critical for their attainment. The potential impact of rehabilitation is also highlighted. Understanding the links and synergies between these instruments has the potential to support substantial progress towards the realisation of the Goals, using a disability-inclusion as a framework for action.

While seven SDGs are the focus of this section, strengthened rehabilitation services also promote the improvements in functioning of persons with disabilities, which can enable them to participate in progress towards many of the other Goals beyond those highlighted below.

SDG 1 - End poverty in all its forms everywhere

CRPD Art.28 - The right of persons with disabilities to an adequate standard of living for themselves and their families

Impact of rehabilitation

Accessible and affordable rehabilitation can enable persons with disabilities and their households to break the poverty cycle by improving rates of employment, increasing educational attainment and supporting participation.



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Disability and poverty operate in a cycle, with each reinforcing the other, especially in low- and middle-income countries.[50] Disability is significantly associated with higher multidimensional poverty and higher medical expenditures, and persons with disabilities have a 50% higher risk, compared to persons without disabilities, of facing catastrophic healthcare costs.[51]

There are often extra costs associated with disability, which can exacerbate poverty.[52] These costs can be related to general household expenses (such as transport or health expenditure) but may also be associated with rehabilitation and assistive devices[53] or where household members give up income-generating activities to provide care.[54]

In a household, not everyone lives at the same level of deprivation: women, children, persons with disabilities and elders are more likely to receive smaller portions of food or have less invested in their education and health.[55]

Financial conditions represent a major obstacle to access rehabilitation services, as health insurance protects only a minority of the population.[6] Rehabilitation can contribute to poverty alleviation by improving health outcomes and reducing the need for additional health services, as well as enabling people to engage in

income-generating activities. For rehabilitation to be effective in reducing poverty, services and assistive devices need to be affordable, accessible and of good quality. CBR workers need to have a good understanding of the causes and effects of poverty and how these can affect the person with disabilities themselves and their family.[56] Rehabilitation services should be incorporated into an integrated health system for this to have the most impact.

Accessible and affordable rehabilitation can increase educational attainment (SDG4), employment rates (SDG8), and participation in life, enabling persons with disabilities and their households to break the poverty cycle.

Project case study: Graduating from extreme poverty

Recognising the linkages between disability and poverty, Humanity & Inclusion (HI) in Bangladesh has been implementing a disability-inclusive poverty graduation model since 2011. The model, initially developed by BRAC to target households with basic unmet needs, aims to systematically include persons with disabilities as project holders and income earners. In addition to the standard 'graduation programme' activities (consumption support, asset transfer, building savings, skill building, social integration, coaching, etc.), HI included disability-specific support, ensuring that beneficiaries had access to rehabilitation, adapted tools and adjustments needed to increase their functional autonomy and employability.

HI's work on an inclusive poverty-graduation model embeds rehabilitation and personalised social support as central components to increase the ability of beneficiaries to be economically independent. Rehabilitation project staff reached out to households to assess their needs and understand whether these can be met at the household level or referred to specialised services.

The programme initially targeted 600 persons with disabilities in the Sitakunda Region via a DFID-funded programme. After the success of the pilot, HI scaled this initiative in partnership with DFID's Global Poverty Action Fund. With phase 2 (2015-2018), HI doubled the beneficiary target to 1,200 persons with disabilities and their households, and expanded the geographic scope to Kurigram Sardar. The approach was effective: 98% of extremely poor beneficiary households in Kurigram Sardar graduated from 'extremely poor' to 'poor' status (including women-headed households, which represented 38% of the total), lifting hundreds of persons with disabilities and their families out of extreme poverty, and ending their dependency on social safety nets.



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In addition to showing high rates of 'graduation,' these outcomes have been sustainable, with the vast majority of graduates in Sitakunda or Kurigram Sadar being set to continue to earn sufficient income to avoid falling back into extreme poverty, thus contributing to progress towards SDG1. The success of the inclusive-graduation model has translated into implementation by HI in other countries, including Chad, Mali, Burkina Faso, and South Sudan.

SDG 3 - Ensure healthy lives and promote wellbeing for all at all ages

CRPD Art.25 - Enjoyment of the highest attainable standard of health

Impact of rehabilitation

Rehabilitation has a direct impact on the health and wellbeing of individuals, improving their health outcomes. Rehabilitation can prevent the deterioration of existing health conditions or the development of new ones, subsequently reducing overall health needs.



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Persons with disabilities are more likely to experience poor health compared to persons without disabilities: among 43 countries, 42% of persons with disabilities compared with 6% of persons without disabilities perceive their health as poor.[20] A recent systematic review found evidence that utilisation of health services was higher for persons with disabilities compared with persons without disabilities for both tertiary and primary healthcare, and they had greater health expenditures.[57]

Women and men have different health needs, behaviours and different levels of access. As life expectancy increases, women spend more years in poor health than men, in most countries.[58]

Women are more likely than men to suffer from disabling conditions (e.g. most musculoskeletal disorders, iron-deficiency anaemia, and major depressive disorder), in addition to pregnancy-related conditions and maternal disorders.[58] Economic and information barriers, stigma and discrimination have an even greater impact on women and girls with disabilities as they face multiple discriminations.

Rehabilitation has direct impact on the health and wellbeing of individuals, improving their health outcomes.[59] Evidence shows that physical therapy services reduces length of stay, leads to improvements in self-care, activities of daily living, and health-related quality of life.[60] Rehabilitation

can prevent the deterioration of existing conditions or the development of new health conditions, subsequently reducing overall health care needs.

Rehabilitation can also improve the wellbeing of the families of persons with disabilities. For example, a study in Malawi with parents of children with intellectual disabilities [61] found over 40% of parents reported psychological distress, and that this was predicted by a range of factors including lack of knowledge of the disability, low confidence in managing the child with disabilities and having no psychological support. Here rehabilitation could produce a substantial and positive change on the health and wellbeing of both the child and the wider household.

Rehabilitation can apply to diverse health conditions [62, 63] and contribute to improving maternal health, child health, the health of persons living with HIV/AIDS and with NCDs, and alleviate suffering from injuries and trauma. Increasing awareness and education of rehabilitation for physicians and other health professionals, as well as integrating rehabilitation in training curricula and guidelines can help promote effective, integrated health services. [64] Rehabilitation should take an integrated approach to best promote health and wellbeing, considering a range of services as well as the provision of assistive devices.

Project case study: Support Tools Enabling Parents (STEP)

The STEP pilot was designed as a response to an observed increase in neurodevelopmental impairments such as cerebral palsy, and to improve the approach to rehabilitation. This one-year pilot was launched in May 2018 is implemented by the Liliane Foundation and co-funded by Dioraphte. STEP aims to change the approach to rehabilitation and improve the outcomes of existing services. Through these activities, the pilot aims to improve the quality of life and functioning of children with cerebral palsy and their caregivers. The pilot includes 158 children and their caregivers in Kenya, Tanzania, Uganda and Cameroon.

STEP contributes to healthy lives and wellbeing through improving the quality of the intervention process and improving the knowledge and skills of fieldworkers by providing training, support tools and coaching. Coaching caregivers is also a key component of the pilot.

While the project is ongoing, caregivers have already reported gaining confidence in caring for their child and have observed improvements in their child's health and wellbeing. Caregivers also reported increases in their own wellbeing, reporting improvements in their health, social activities, and economic activities among others. Fieldworkers report a renewed zeal for working with families and children with complex needs such as cerebral palsy.



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SDG 4 - Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

CRPD Art.24 - The right of persons with disabilities to education

Impact of rehabilitation

Rehabilitation addresses many of education's exclusion factors (e.g. inaccessible school facilities, lack of assistive technologies, poor health conditions, prejudice, and stigma), enabling children with disabilities to receive an education, which can have positive impacts across the life-course.

In most developing countries, out-of-school rates for children with disabilities are still extremely high: 9 out of 10 do not go to school.[65] Adults with disabilities are less likely to have received education than adults without disabilities. This is reflected in the lower literacy rate of persons with disabilities: 54% of persons with disabilities compared to 77% of persons without disabilities.[20] Limited education impacts throughout the life-course, including in accessing formal employment.

Exclusion from education is due to many reasons, including lack of accessible school facilities, lack of assistive technologies, poor health conditions, prejudice and stigma. It has long-term consequences, impacting social and economic development for persons with disabilities and exacerbating poverty. Rehabilitation addresses many of these factors. For example, the provision of a prosthetic leg or functional rehabilitation may enable a child to access school and participate in classes. Rehabilitation optimizes child development, with the largest gains registered when rehabilitation services are provided to children with traumatic injuries.[66]

Further efforts should be made to address the specific challenges faced by girls with disabilities in relation to education. To start, many families still do not consider education essential for their girls, as these are expected to take on domestic work; and as girls are less likely to be registered at birth, they eligible for school enrolment or examinations anyway.[67] When the girls are sent to school, the fear, and actual risk, of sexual violence is a major reason for dropping out.[67] Moreover, girls with disabilities have less access to assistive technology and rehabilitation and are less likely to receive additional educational support than boys.[68] As a result, 50.6% of males with disabilities have completed primary school, compared 41.7% of female with disabilities.[1]

The UNCRPD promotes inclusive education, whereby children are enrolled in mainstream classes to receive an education (Article 24[7]). This gives children with disabilities the opportunity to participate in education on an equal basis with other children, and rehabilitation has an opportunity to support children to engage successfully in these classes, supporting the child, parents and teachers.

Education can have positive impact throughout the life course. If children with disabilities are enabled to receive and education, it increases their chances of employment and inclusion in the community.[20] Rehabilitation can also play a role in enabling persons with disabilities to access vocational training and adult education, thereby increasing job prospects and reducing poverty.

Testimony: ‘They are inseparable'

Nirmala and Khendo were seven when the earthquake struck Nepal in April, 2015. In the district of Okhaldhunga, Nirmala, was trapped under a collapsed wall. At the same time, in Sindhupalchok, Khendo, was buried under the ruins of her house.

The two girls were sent to the Bir Trauma Center hospital in Kathmandu, and both had a leg amputated. The girls were there for almost three months and then moved to the National Disabled Fund, Humanity & Inclusion (HI)’s partner rehabilitation centre. With the support of HI, six months after the earthquake the children received prostheses and re-learned to walk. ‘They have made tremendous progress. They support each other. Their friendship is their strength’ says Sudan Rimal, a physiotherapist for HI.

Initially the girls attended the rehabilitation centre every month for rehabilitation sessions, for physiotherapy that helped them to stretch their muscles and become more flexible. Now they go less frequenlty, but regularly so that modifications can be made to their prostheses as they grow.

‘We adapt their prosthesis every six months, according to how much they grow. They become more aware of their bodies and the importance of rehabilitation exercises. They tell me when they are hurting, and where. […] They challenge each other to do the exercises, to progress. They are impressive’ explains Sudan Rimal.

Nirmala and Khendo now go to school and are in second grade. ‘Teachers have also been trained to teach rehabilitation exercises to children,’ says Sudan Rimal. They love English, badminton and playing hide and seek. And when we talk to them about the future, Nirmala replies, with shining eyes, that she dreams of becoming an actress. As for Khendo, she will be a teacher, ‘to help people become good person’.

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SDG 5 - Achieve gender equality and empower all women and girls

CRPD Art.6 - Full development, advancement and empowerment of women with disabilities

Impact of rehabilitation

Rehabilitation can have a significant impact on the empowerment and participation of women and girls. Women and girls, who are often the primary caregivers, also indirectly benefit from rehabilitation: improvements to the health of the person with disabilities means more time for caregivers to resume or start activities that they had been unable to do previously.



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The intersecting forms of discrimination experienced by persons with disabilities with other exclusionary factors, like gender, often result in multiple and intersectional discrimination and significant restrictions to their access to services. The furthest behind often endure multiple and intersecting deprivations, which perpetuate and entrench disadvantage. [(23)]

Like disability, gender cuts across many of the other SDGs. Compared with men without disabilities, women with disabilities are three times more likely to have unmet health needs (SDG3); three times more likely to be illiterate (SDG4); and twice less likely to be employed (SDG8[20]). Even compared with men with disabilities, women with disabilities are more likely to have unmet

healthcare needs,[20] including higher chances to be excluded from rehabilitation services.[69]

Rehabilitation, accessible to everyone without discrimination and on equal basis, can have a significant impact on the empowerment of women and girls and on their participation in life. Women and girls, who are often the primary caregivers of persons with disabilities or with other health conditions, can also indirectly benefit from rehabilitation: improving the health-outcomes of the person with disabilities can foster their autonomy, providing caregivers with additional time to resume or begin activities that they had to drop.

Testimony: Women leaders in disability and rehabilitation

Disabled Rehabilitation and Research Association (DRRA) first met Astomi Malo in 2002 when she was 12 years old and living in the Satkhira district Bangladesh. She had physical difficulties due to post-polio paralysis. The DRRA rehabilitation team enroled her in a CBR project and started rehabilitation. When Astomi was 20 she worked on a DRRA CBR project and started delivering CBR while also studying for a degree in the Arts.

Astomi was appointed as a Community Mobilizer in 2008 and was fully involved with Self Help Group mobilization, conducting training sessions, and advocating at local and national levels. This experience not only contributed to the success of the project, but also built her leadership skills.

In 2011 Astomi realized her dream of becoming a leader. With the support of DRRA, she formed a Disabled People's Organisation, Narikontha Unnayan Songstha (NUS), and now leads a team of 35. NUS works on health, education and empowerment for persons with disabilities through service delivery, school enrolment, and social safety net issues, as well as advocacy with local government.

Astomi's achievements as a women leader and mentor to persons with disabilities were first recognised in 2013 when she was awarded the Joyeete Award (a Bengali word which means victory of women). She went on to win the award for the second time in 2018. Astomi was also recognized as 'best woman entrepreneur 2018' of Shyamnagar Upozila, Satkhira by the Department of Youth Development.



© Testimony provided by DRRA, through the CBR Global Network; photo credit: DRRA.

SDG 8 - Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

CRPD Art.27 - The right of persons with disabilities to work, on an equal basis with others

Impact of rehabilitation

Rehabilitation enables access or return to the labour market, prevents illness, increases wellbeing, and reduces disability, thus playing an important role towards participation in the labour market, economic productivity, income, and poverty reduction.



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Persons with disabilities continue to have limited access to the labour market. The employment-to-population ratio of persons with disabilities aged 15 and older is almost half that of persons without disabilities and employed persons with disabilities tend to earn lower wages than their counterparts without disabilities.[20] In low- and middle-income countries, up to 80% of persons with disabilities of working age that are willing to work are unemployed.[70] The situation is even worse for women with disabilities, who experience intersecting forms of discrimination in the labour market. They have more difficulty finding paid employment in the formal or informal sectors than women without disabilities, leaving them with unpaid work as the only option.[20]

Rehabilitation enables access or return to the labour market, prevents illness, increases wellbeing, and reduces disability.[71] Rehabilitation can also reduce the number of days persons with disabilities need to take off work, increasing productivity, participation and income,[64] thus leading to sustainable poverty reduction. This is particularly true when women work, as they invest 90 percent of their income back into their families, compared to 35 percent for men.[72]

Vocational rehabilitation encompasses a broad set of interventions, including adjustments to the workplace related to the functional and psychological impact of impairments, work capacity evaluations, support for the self-management of conditions, and adjustments related to the medical and psychological impact of impairment. Services also include advice to support returning to work, placements and career counselling, and job development and analysis.[34]

Testimony: Rehabilitation for decent employment

Mohamed is 27 years old and lives in Alexandria, Egypt. He is the youngest child in his family and he has Down syndrome. His family has always been supportive, but they struggled to teach him self-care and to socially engage him as he had extreme anti-social behaviour. That was until he joined the vocational rehabilitation and employment program implemented by Caritas Egypt.

The program provided him and his family with counselling and support, trained him on independence, basic literacy and numeracy skills, appropriate job behaviour, communication and how to address colleagues, supervisors and clients at work.

Equipped with basic education and relevant job skills, Mohamed was able to access employment market on an equal basis as his peers (SDG8). He is now employed as an assistant pastry chef in a confectionery and pastry factory assisting the chef in preparing all sorts of sweets and pastries.

According to his parents, Mohamed is a new person: joyful, self-confident, sociable, and successful. Moreover, he joins the programme team in awareness-raising with prospective employers on employing persons with disabilities, showing the potential of persons with disabilities to work and contribute in the workplace.



© Testimony provided by Caritas, through the CBR Global Network; photo credit: Caritas.

SDG 10 - Reduce inequality within and among countries

CRPD Art.5 - Equality and non-discrimination

Impact of rehabilitation

Rehabilitation can reduce inequalities through the empowering persons with disabilities and help to ensure equal opportunities.
In many countries, particularly low and middle-income countries, CBR is crucial to enhance the quality of life for persons with disabilities and their families.



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Entrenched and rising inequalities impede global development and impact on national progress.[23] Persons with disabilities face persistent inequality in social, economic, and political spheres and are disadvantaged in all areas covered by the SDGs.[20] In some countries the gaps between persons with and without disabilities reach more than 20% in income poverty, and 50% points in experiencing good health, in literacy rates and in employment to population ratios.[20]

When addressing inequalities, it is important to recognize the impact of multiple discriminations on some groups of persons with disabilities. In particular, higher inequalities of outcomes are typically observed for women with disabilities, indigenous persons with disabilities and persons with intellectual and psychosocial disabilities.[20]

To reduce inequalities, particularly as countries develop, focus should be paid to decreasing the gap between persons with and without disabilities.

A household survey in Kenya, Sierra Leone, Uganda and Zambia found gaps in living standards between households that included a person with disabilities and those that did not in all countries apart from Sierra Leone (the least developed country in the project[73]). Rehabilitation can help to reduce inequalities between these households and improve living standards by supporting and empowering persons with disabilities to participate in the social, cultural, economic and political spheres.

In countries with limited resource-constraints, particularly low and middle-income countries, CBR is crucial to enhance the quality of life for persons with disabilities and their families.[74] In addition to increasing access to rehabilitation services, CBR adopts a multi-sectorial approach (encompassing health, education, livelihood, social, and empowerment) with a view to meet basic needs of persons with disabilities.[xi] It also helps to ensure their inclusion and participation in the community through reducing stigma and discrimination.[41]

This has the effect of reducing inequalities, both income-inequality, but also inequalities in inclusion and participation.

Project case study: Jumping Kids

Abdul Hamad Kipango, 11 years old, and Musa Hussein Msfari, 9 years old, two boys from Dar Es Salaam, Tanzania, both underwent a lower limb amputation after a road accident. They recently took part in 'Jumping Kids', a pilot prosthetic training programme in South Africa.

The programme aims increase the support available to children living with lower limb amputations without access to adequate prosthetics. Rehabilitation professionals attended a workshop where they received training on the latest prosthetics technology, methods and rehabilitation techniques. The workshop was followed by manufacturing and fitting of sports prosthetic devices. Among the participants in the programme were two ortho-prosthetists from Tanzania, where there is a substantial unmet need for access to assistive technology. The training was supported by MoveAbility, and hosted by Ottobock South Africa, Icexpress Prosthetics and Jumping Kids.

In partnership with the Tanzania Paralympic Committee, a sports training programme is also being developed with the JMK Youth Park in Dar Es Salaam. This programme will reduce inequalities in access to sport and allow the two boys and other children with disabilities, to play sports in and out of school with classmates and friends without disabilities. Musa hopes that it will also help him to achieve his dream of becoming one of the next Tanzanian Paralympic athletes!



© Case study and photo credit: MoveAbility.

SDG 11 - Make cities and human settlements inclusive, safe, resilient and sustainable

CRPD Art.11 - Ensure the protection and safety of persons with disabilities in situations of risk

Impact of rehabilitation

Rehabilitation is crucial to increase disaster preparedness by improving the individual's sensorial, physical, intellectual, mental, cognitive or social functioning. Rehabilitation is also crucial in disaster response: after disasters the disability rate increases due to trauma, injury or poor living conditions.

The proportion of the population living in urban area is increasing. It is estimated that by 2050, 66% of the world's people will reside in urban areas.[75] These have implications both for the need for accessible urban environments, as well as potentially precarious living arrangements increasing risk of the impacts of climate change and other disasters and emergencies.

To address accessible urban environments, a disability-inclusive New Urban Agenda[76] was adopted at Habitat III (2016). This Agenda aims to guide urban development with the principles of universal design to promote accessibility for all. Including rehabilitation in the design of environments is key to ensuring that they are fully accessible to persons with disabilities. A range of rehabilitation services and assistive technologies are also needed to enable persons with disabilities to interact effectively with the environment and infrastructure.

Disasters disproportionately affect persons with disabilities, as they face barriers to mobility, to information, and to access services.[77, 78] For example, in Japan, the fatality rate among persons with disabilities was twice that of the rest of the population.[79] A survey conducted by the UN found that only 20% of persons with disabilities reported being able to evacuate immediately in the event of a disaster.[80] A study conducted in Nepal found that, in the emergency or relief phase that followed the 2015 earthquakes, uneven patterns of relief distribution were exacerbated by intersectional forms of social exclusion related to gender, ethnicity, caste, class and geographic marginalization.[81] In addition to this, young women with disabilities were particularly vulnerable to sexual abuse and trafficking in camps for internally displaced persons and collective living situations.[81]

Disability issues must be included in disaster response planning, using a gender lens and involving persons with disabilities and their representative organisations.[82] This includes planning for emergency response and recovery rehabilitation, as for rehabilitation in risk reduction. Rehabilitation is crucial to increase disaster preparedness, by improving the individual's sensorial, physical, intellectual, mental, cognitive, or social functioning.

Rehabilitation is also crucial in disaster response, as the rate of disability increases during and after a disaster due to trauma, injuries, and poor living conditions. Both persons with disabilities and without disabilities are at risk of being injured during disasters:[83, 84] for every person killed in a disaster, another three are injured or left with a disability.[85]

Disasters may also lead to loss or damage to assistive devices,[85] increasing difficulties in

accessing emergency shelters or response and recovery programmes. Evidence from Vanuatu following Tropical Cyclone Pam found that persons with disabilities had more difficulty than persons without disabilities accessing mainstream disaster preparedness and response, but also that they reported disability-specific unmet needs, including loss of assistive devices and lack of rehabilitation services.[86] Rehabilitation should be included in emergency response to avoid long-term effects, at both individual and society levels. It is also important for DRR planning to be disability-inclusive and rehabilitation-focused.[87] Rehabilitation has a role in making human settlement more resilient and inclusive, including in situations of risk.

Project case study: Rehabilitation in disaster response and preparedness, Nepal

Since 2015, Humanity & Inclusion (HI) has been supporting the Nepal Ministry of Health to expand the coverage of rehabilitation services in five remote districts (Rasuwa, Nuwakot, Dhading, Sindupalchok, Dolakha) as part of the response to the long-term needs of people injured following the deadly earthquake that hit Nepal in April 2015.

Basic physiotherapy units were integrated in districts hospitals. Physiotherapists and social workers ensured needs identification, management of impairments, delivery of assistive devices, counselling and referrals to other services, either in the rehabilitation units or during outreach. As a result of the strengthened local health system, all communities in the five districts have benefitted from the new services, including older people, people with chronic diseases and persons with disabilities. From August 2015 to December 2017, a total of 9,725 people received rehabilitation services. Of these, 54% were women and girls and around 17% were earthquake survivors.

A pilot intervention was also implemented in Nuwakot district, which aimed to strengthen the local health sector emergency preparedness by supporting the District Hospital and three Primary Health Care centres to develop mass casualty management plans. Inclusiveness of local preparedness plans was improved through the establishment of a Vulnerability Focal Point to facilitate the identification of vulnerable individuals, ensure effectiveness of first response, and allow rehabilitation follow-up.



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6. Recommendations for changes in policies and practices by relevant stakeholders

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For States in low and middle income countries

- **Ensure that rehabilitation is integrated into health systems**, with a view to strengthening and expanding access to rehabilitation services for all. For effective integration of rehabilitation in health systems, adopt national health policies that align with WHO 'Recommendations on rehabilitation in health systems'[(6)] and consider the position of rehabilitation services across the continuum of care, at all stages of life, and for a range of different health conditions.
- Recognising rehabilitation as cross-cutting, **integrate rehabilitation across policy areas** and foster multi-stakeholders dialogue, synergies, and commitment (for example, across government branches with responsibility for education, social protection, employment and gender equality). Recognise and strengthen the role of education in raising public awareness about disability, stigma, isolation and discrimination, and unmet rehabilitation needs.
- Adopt and/or reform rehabilitation policies, laws and delivery systems in order to **meet the 'leave no one behind' obligation** of the 2030 Agenda and to **ensure compliance with the UNCRPD** (particularly with reference to Articles 19 on independent living, 25 on health, 26 on habilitation and rehabilitation, and 20 on personal mobility). To this effect, implement commitments taken via the WHA Resolution on Improving Access to Assistive Technologies,[(16)] and apply WHO standards and guidelines on rehabilitation.[(xii)]
- **Develop sustainable funding mechanisms to adequately finance rehabilitation services and CBR**. This requires dedicated financial resources to support and sustain quality rehabilitation services, including at the community-level. Rehabilitation should be part

of essential packages of care and covered by financial risk protection mechanisms (i.e. more robust and more inclusive health insurances), with the objective of achieving **universal health coverage**.

- **Increase and strengthen human resources for rehabilitation**, across all rehabilitation disciplines and with a view to respond, without discrimination or stigma, to the needs of the population. Besides addressing the workforce shortage by increasing the number of rehabilitation professionals, it is crucial to expand and improve training opportunities, recognition and retention of personnel (both health and CBR workers). Recognising the status of CBR workers and promoting their career and skills-development can ensure higher retention rates and maximise the impact of their work on individuals and communities.
- Considering the growing need for rehabilitation, **expand and decentralize service delivery**, especially in remote and rural areas. For this purpose, adopt a two-pronged approach that allows offering **essential rehabilitation services via Primary Health Care** as well as via adequately-supported **CBR programmes**. If possible, rehabilitation specialists should be accessible at the primary care level. In areas where this is not possible, and when resources allow, primary health workers could be trained to perform basic rehabilitation services.[88] Primary health care staff should be adequately trained to identify health conditions that require rehabilitation and refer patients to specialists. CBR and community-based workers should be recognised for their crucial role in improving the effectiveness of service delivery, especially in rural areas.
- **Expand and strengthen the collection of disaggregated data** (by age, disability, gender, income and geography) on the rehabilitation needs, access, cost-effectiveness, and impact, for better informed and adapted policies and actions. The Washington Group 'short set' of questions can be an important tool to understand the diversity of disability in communities in developing countries. Disability data can also be used to monitor progress towards the SDGs.
- **Ensure that persons with disabilities, patients, rehabilitation professionals, as well their representative organizations and other NGOs, are systematically consulted and actively participate** in the planning, monitoring and evaluation of policies and programmes. Decades of experience in CBR programming has shown that participatory planning is the only way to develop efficient rehabilitation services that are acceptable and accessible to all.
- **Promote and support initiatives that enhance research on rehabilitation and assistive technologies, and catalyse innovation and partnerships**. Focus should be placed on making rehabilitation and assistive technologies accessible to those most in need. For this purpose, States should join and support recently-launched initiatives such as AT2030 and ATscale, engage in multi-stakeholder partnerships, including with the private sector, and harness investments in research and testing.

For Donors

- **Include rehabilitation in the strategic planning and programming** of international cooperation aid for health and disability inclusion in priority, but also in all the sectors that rehabilitation can have a positive impacts on (e.g. education, employments, democratic governance, gender equality, etc.), both in development and emergency contexts, with a view to contributing to the implementation of the UNCRPD and the SDGs (directly to SDG3, and indirectly to a broader range of SDGs).
- **Dedicate an appropriate share of funding to rehabilitation**, taking into consideration the growing demand for rehabilitation services at all ages and in relation to many health conditions (for example, NCDs, maternal and child health, trauma and injuries).

- **Support research programmes and the data collection** regarding rehabilitation and rehabilitation services, and provide technical assistance in the use of methodologies such as the Washington Group on Disability Statistics questions. Robust disability-disaggregated evidence is needed on the cost-effectiveness of rehabilitation in low- and middle-income countries.
- **Focus on disability-inclusion and ensure the consultation and participation of persons with disabilities, patients, rehabilitation professionals and relevant NGOs** at all stages of the programme cycle (design, implementation, monitoring, and evaluation), including through their representative organizations.
- **Invest in innovative technological solutions**, including community-led and public-private solutions, to increase access to quality rehabilitation services and devices for the most in need.
- Recognising the need to complement regular rehabilitation services, **support CBR programmes** designed to enhance the quality of life for persons with disabilities through community initiatives encompassing rehabilitation, equalisation of opportunities, poverty reduction and social inclusion of persons with disabilities.

For Civil Society Organisations (CSOs), including Organisations of Persons with Disabilities and their families (DPOs), NGOs and Patients Organisations

- **Advocate to all relevant stakeholders for improved access to rehabilitation services**, including financial affordability, accessibility of rehabilitation-related information, accessibility of health infrastructure, language accessibility, culturally-sensitive approaches, and quality and timeliness of care.
- **Enable participation of persons with disabilities, patients and rehabilitation professionals** in the planning, implementation, monitoring and evaluation of policies and programmes on rehabilitation, by facilitating their direct involvement and representing their voices.
- **Contribute to the effective and independent monitoring** of rehabilitation facilities and programmes, to assess their availability, accessibility, acceptability and quality, and prevent discrimination, exploitation, violence, and abuse of persons with disabilities[32] and patients.
- **Advance research and the production of evidence** on the barriers to and the cost/benefits of rehabilitation, and the effects that it can have on the inclusion of marginalised groups. Integrate research and evidence in policy work across different disciplines.
- **Promote and implement CBR programmes** in line with WHO Guidelines.[41] Apply a multi-sectoral, cross-disability, rights-based approach that supports communities to access the full range of mainstream and disability-specific services and opportunities (in health, education, livelihood and social welfare). Place the empowerment of persons with disabilities and their families at the centre, as the foundation to accessing benefits across all these domains.[89]



Annexes 7.

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Annex 1: National donor progress against recommendations

Introduction

This annex analyses, in a non-exhaustive way, the extent to which and how specific institutional donors have integrated rehabilitation in their strategic programming and funding actions. These six short case studies of national donors (differing in size, geographical scope, and overarching aid priorities) portray their progress against the recommendations listed in the Report.

The blue check-sign indicates that the recommendation has been met satisfactorily, or to a large extent. The yellow cross indicates that the recommendation has been only partially met and further progress can be made. The case-studies in this annex were developed based on desk-reviews and consultation of publicly available documents and sources.

Australia
Department of Foreign Affairs and Trade (DFAT)

Include rehabilitation in their strategic planning and programming

Australia was the first donor country to have a strategy on disability-inclusion ('Development for All, towards a disability-inclusive Australian aid program 2009-2014'). A second, more ambitious, strategy was adopted in 2015 and includes rehabilitation ('Development for All 2015-2020, Strategy for strengthening disability-inclusive development in Australia's aid program'). This strategy aims to improve the quality of life of persons with disabilities in developing countries. DFAT has adopted a 'twin track' approach to disability inclusion, supporting disability-specific

aid investments as well as including persons with disabilities across all sectors.

Rehabilitation has been integrated in humanitarian assistance, promoting rehabilitation services to persons with disabilities in emergency contexts (including for people injured by landmines). Targeted efforts listed in the Strategy also include providing disability-specific support and services, such as assistive technologies/ devices and community-based rehabilitation to meet the basic needs and improve the quality of life of persons with disabilities and their families.

Dedicate an appropriate share of funding to rehabilitation

Australia has been a keen promoter of international cooperation (both in development and humanitarian contexts) for the realisation of the objectives of the UNCRPD. Official Development Assistance (ODA) provided by Australia for disability-inclusion amounted to AU$110.1 million in 2017-2018.[90]

Of the projects funded by DFAT and implemented by NGOs in 2018-2019, 19 address rehabilitation, for a total budget of approximately AU$4.8 million.[91]

A partnership between DFAT and the World Health Organization in the Western Pacific region has had a clear focus on rehabilitation services in the region through a fund of AU$6.16 million (2011-2018).

Support research programmes to collect data and produce evidence

The partnership between DFAT and the World Health Organization in the Western Pacific region included rehabilitation data and research as a core pillar in its framework using the WHO Model Disability Survey.

Focus on disability-inclusion, and ensure the consultation and participation of persons with disabilities, patients, professionals and CSOs

DFAT is co-chair and member of the Global Action on Disability (GLAD) Network.[92] The first Development for All strategy (2009-2014) resulted from advocacy by civil society organisations following the ratification of the UNCRPD.

Support community-based rehabilitation programmes

8 of the projects funded by DFAT 2018-2019 are on community-based rehabilitation and development. The DFAT/WHO partnership in the Western Pacific region strengthened community-based rehabilitation guidelines and provided related technical assistance, built the capacity of national health ministries to deliver appropriate rehabilitation services, and developed disability-related guidelines and information.

Belgium

Include rehabilitation in their strategic planning and programming

Belgium ratified the UNCRPD in 2009. Despite this, Belgium does not have specific planning that includes rehabilitation. Its cooperation is led by the 'Law on Development Cooperation', 19 March 2013 (updated 16 June 2016[93]), which defines strategies, objectives, actors of cooperation and relevant States. Priority thematic areas are human rights (including rights of the child), decent and sustainable work and the strengthening of society. In terms of cooperation actions, Belgium focuses on healthcare, education and training, agriculture and food security, and basic infrastructure, in 14 partner countries in Africa and the Middle East.[94]

Rehabilitation interventions and services in developing contexts are supported mainly as part of framework agreements with NGOs; rehabilitation in emergencies is supported through funding to specific projects. In 2018, Belgium dedicated €1.77 million to medical services in international cooperation, which included rehabilitation activities, implemented by HI among others.[95]

Dedicate an appropriate share of funding to rehabilitation

In 2017, Belgium dedicated 7.4% of its aid to Health.[96] Belgium's interventions in Health are framed terms of increasing the quality and accessibility of the basic health services with the aim of ending health-related inequalities. It is not clear the exact proportion of ODA that is specifically dedicated to rehabilitation.

Belgium is one of the main government partners in the ICRC Humanitarian Impact Bond (HIB).[97] The HIB is an innovative funding mechanism mobilizing private capital to support ICRC's work in the rehabilitation sector. That aim is to capture social investors who will dedicate money in advance to the ICRC's activities. After 5 years of the HIB, outcome funders including Belgium will pay back, in full or partially, the investors. The financial partners have initially pledged €23 million to this rehabilitation funding scheme, including €8.7 million provided by Belgium.[98]

Invest in innovative technological solutions

A project funded by Belgium and implemented by Humanity & Inclusion has pursued research for the application of 3D technology in the field of functional rehabilitation. The objective is to acquire reliable and scientifically-recognised indications on this innovative mode of production, still largely unknown. At the same time, the project allows to establish and test telemedicine, as a resource for rehabilitation in West-Africa.

Focus on disability-inclusion, and ensure the consultation and participation of persons with disabilities, patients, professionals and CSOs

While Belgium has not joined the GLAD Network, it has been responsive to the disability community and open to dialogue with NGOs operating in the disability sector. There is less evidence of them consulting directly with persons with disabilities, professionals and CSOs, however.

Support community-based rehabilitation programmes

While there is little evidence that Belgium directly supports CBR, such programmes may be implemented by partners, particularly as Belgium has an ongoing five-year framework agreement with HI (2017-2021), of which approximately €5,6 million are dedicated to rehabilitation activities (almost 60% of the total grant).

Germany
Bundesministerium Für Wirtschaftliche Zusammenarbeit (BMZ)

Include rehabilitation in their strategic planning and programming

BMZ does not have specific policies that mainstream rehabilitation. The 'Development Policy in the Health Sector' aims to contribute to provision of healthcare that is 'accessible to everyone, encompassing prevention, treatment and rehabilitation'.

In 2013, BMZ published the 'Action Plan for the Inclusion of Persons with Disabilities' (2013-2015), which builds on the commitment to inclusive development cooperation that was made following the ratification of the UNCRPD. The 'Action Plan' incorporates the 'twin-track' approach to disability, but while rehabilitation is mentioned in the document only briefly.

German external aid uses the 'WHO Health System Framework' as guidance for the inclusion of disability in health planning and programming, recognising the need for a comprehensive approach to disability-inclusion in the health sector across several areas (service delivery, financing, information, technologies, governance, human resources, people).

BMZ promotes the scaling up of community-based rehabilitation, referral pathways for rehabilitation, and insurance schemes also covering rehabilitation (for example through the inclusion of physiotherapy in basic healthcare packages),[99] but it is not clear if this is a requirement of all grants.

Dedicate an appropriate share of funding to rehabilitation

In 2015, Germany allocated 3.1% of its aid to the 'health and population' sector.[100] Through its G7 and G20 presidencies (2015 and 2017 respectively), Germany has placed great emphasis on global health, holding the first-ever G20 meeting of health ministers.

According to the data published by BMZ,[101] there are 9 projects currently under implementation relating to rehabilitation, for a total commitment of more than €42 million.[102]

Focus on disability-inclusion, and ensure the consultation and participation of persons with disabilities, patients, professionals and CSOs

Germany ratified the UNCRPD in 2009 and BMZ is a member of the GLAD Network steering committee.

BMZ is currently conducting a global project ('Anchoring the inclusion of persons with disabilities in international cooperation') to develop a new cross-sectoral strategy for the inclusion of persons with disabilities in development cooperation. This project is undertaken with the strong contribution and participation of DPOs worldwide. Through consultations with CSOs, it was also agreed that the current 'Action Plan' (which expired in 2015), should continue to serve as guiding document until a replacement action plan agreed.

Support community-based rehabilitation programmes

Strong focus is placed on community-based rehabilitation and on the health needs of displaced persons in ongoing BMZ-funded rehabilitation projects.

Luxembourg
Ministry of Foreign Affairs (MOFA)

Include rehabilitation in their strategic planning and programming

MOFA does not have dedicated disability or rehabilitation frameworks. The 'Health Strategy'[103] (2014) includes rehabilitation as a component of health in humanitarian action, implemented by multilateral partners and humanitarian NGOs, and encompassing functional rehabilitation for victims of conflicts, access to physical rehabilitation services and assistive technologies for persons with disabilities, as well as respiratory physiotherapy for malnourished children.

Luxembourg has 7 partner focus countries where it concentrates bilateral cooperation accross the continents.

7 out of the 54 projects currently implemented by the Luxembourg agency for development cooperation (LuxDev) are on the field of health, with a total budget of €59.2 million.[104] With the primary aim to strengthen health systems in low-income countries, these projects do not directly invest in and support rehabilitation services. MOFA does not require health and disability grants or agreements to include rehabilitation.

Dedicate an appropriate share of funding to rehabilitation

Luxembourg's commitment to global health is also reflected in the strong support, as a funder and promoter, of the Universal Health Coverage Partnership, which aims to foster policy dialogue on strategic planning and health systems governance, developing health financing strategies and supporting their implementation, and enabling effective development cooperation in countries towards universal health coverage.

Via framework agreements, MOFA has supported NGOs in implementing programmes focused on the most marginalised and excluded populations. For the period 2019-2023, seven framework agreements were signed for a total amount of €36.6 million.[105] Through the current five-year agreement with HI (2018-2022), €5.5 million are

dedicated to rehabilitation activities (representing 37% of the operations budget and 31% of the total budget).

Support research programmes to collect data and produce evidence

Luxembourg is open to integrate funding for research in broader programming. For example, in the current framework agreement, MOFA granted €250,000 to Handicap International (HI) Luxembourg for research.

Focus on disability-inclusion, and ensure the consultation and participation of persons with disabilities, patients, professionals and CSOs

Luxembourg has not joined the GLAD Network. However, it has proven to be responsive to concerns of the disability community and open to dialogue and support to NGOs operating in the disability sector. The strong reference to rehabilitation in the humanitarian aid section of the Health Strategy is the result of dialogue and constructive interactions between the government and humanitarian organisations, including HI. There is less evidence of consultation with persons with disabilities or their representative organisations.

Invest in innovative technological solutions

Luxembourg funds projects aimed at providing assistive technologies. It has also supported the development of Emergency.lu, an innovative mobile telecommunication platform for humanitarian aid agencies. This platform was developed after the Haiti earthquake, and is a public-private partnership that aims to support coordination of humanitarian organisations after disasters.

Support community-based rehabilitation programmes

In previous framework agreements, Luxembourg supported CBR-focussed projects (e.g. Cuba and Egypt). Although no specific programme was introduced in the current framework agreement, CBR-type activities are integrated as a component, and Luxembourg still promotes a community-based approach.

UK
Department for International Development (DFID)

Include rehabilitation in their strategic planning and programming

The United Kingdom is the second-largest government donor to global health, after the USA, dedicating 13% of the total ODA to this sector.[106] DFID does not have specific policies that mainstream rehabilitation. In December 2018, DFID published its 'Strategy for Disability Inclusive Development 2018-23'. The Strategy defines standards on disability inclusion which all DFID departments will have to meet (including the systematic participation of persons with disabilities and use of disability disaggregated data), and four priority focus areas (inclusive education, social protection, economic empowerment, and humanitarian action). Neither rehabilitation sector nor access to health are included in the priority areas; however, DFID envisions placing greater emphasis for mental health and psychosocial support. The Strategy includes a humanitarian deliverable to 'Include an accredited spinal injury cell in the UK Emergency Medical Team'. This will further strengthen the provision of assistance to persons with disabilities post disaster and in follow-up treatment.

The Select Committee on International Development inquiry is also expected to make recommendations regarding DFID cooperation with other departments, particularly around health systems strengthening. The report is due out in July 2019.

The disability sector is the entry point for UK funding on rehabilitation, although with an angle that is limited to assistive technologies. Access to appropriate assistive technologies is also considered ‘cross-cutting’ and a central

component to disability inclusion and will be systematically addressed across all DFID work. In connection with assistive technologies, the Strategy recognises that equal access to quality healthcare is of critical importance, in order to address both disability-related health needs and wider health needs. DFID provides support to national governments to move towards Universal Health Coverage, ensuring that persons with disabilities are heard and included in measures for health systems strengthening.

Dedicate an appropriate share of funding to rehabilitation

The UK commits 0.7% of GNI to Official Development Assistance (ODA). Based on the data provided online by DFID, there are 11 ongoing projects on rehabilitation (in Syria, Jordan, Iraq, Nigeria, Uganda, DRC, India and Seychelles). Mental health and psychosocial support are focus areas. The total budget for these projects is approximately £60 million.[107]

Support research programmes to collect data and produce evidence

DFID requires disability-disaggregated data to be collected in funded programmes, and promotes the use of the Washington Group on Disability Statistics questions.

Focus on disability-inclusion, and ensure the consultation and participation of persons with disabilities, patients, professionals and CSOs

The UK ratified the UNCRPD in 2009 and DFID is co-chair of the GLAD Network. In July 2018, the UK co-led the organisation of the first Global Disability Summit, together with the International Disability Alliance and the Government of Kenya.[108] Regular and routine consultation with persons with disabilities and their representative organisations is one of the key standards of the Disability Strategy.

Invest in innovative technological solutions

The Global Disability Summit, co-organised by the UK, created momentum around inclusive development, with emphasis on access to assistive technologies. The 'AT 2030: Life Changing Assistive Technology for All' programme was announced at the Global Disability Summit. AT 2030 is being delivered by a global partnership (including WHO, the Clinton Health Access Initiative, UNICEF, universities and DPOs) and is structured around six projects: a Global Disability Innovation (GDI) Hub, market-shaping activities, system innovation and policy standards, investment measurement, community participation, and ATScale (supporting the development of a global partnership on assistive technologies). £10 million was granted by DFID to the GDI Hub to lay the foundations for the programme, which aims to reach over 3 million people, finding evidence of what works, testing new approaches, and opening market access to assistive technologies in priority countries.

USA
United States Agency for International Development (USAID)

Include rehabilitation in their strategic planning and programming

USAID does not have a specific framework addressing rehabilitation; its activities are framed by strategies and policies which aim to advance disability-inclusive development. USAID has an old, but still in force, disability policy (1997), which governs both employment at USAID as well as inclusion in all USAID programmes. The fact that USA has signed but not ratified the UNCRPD represents a serious matter of concern.

USAID invests in rehabilitation by supporting and providing comprehensive training of candidates, with or without disabilities, including health

professionals, community health workers and graduates. In this regard, USAID has developed partnerships with training institutes to overcome the lack of trained professionals in rehabilitation in low income and middle-income countries.[109]

USAID invests in rehabilitation by supporting the development and/or strengthening of rehabilitation services throughout humanitarian and emergency settings to reach underserved population in remote areas (in compliance with the Sendai Framework).

✓ Dedicate an appropriate share of funding to rehabilitation

USAID is a major actor of international cooperation. It is by far the largest institutional donor in global health, investing $9.9 billion on health Official Development Assistance (ODA) in 2016.[110] The majority of funds for health are for HIV/AIDS programmes, and less than 25% of health programmes mention disability-inclusion (by contrast, around half of education projects reference inclusion).[111] 2016-2017 USAID invested $14 million into 16 rehabilitation projects.[112] Funds dedicated to rehabilitation are invested through specific sources (the Leahy War Victims Fund and the Victims of Torture Fund[113]), rather than being mainstreamed in general fund streams.

In addition to these funding streams, USAID is also providing additional rehabilitation-focused support to long-term initiatives aiming to enable the implementation of four WHO tools (STARS, GRASP, FRAME and ACTOR[114]). This indirectly shows commitment to the approach promoted by the WHO towards universal health coverage, even though USAID does not have a related strategy.

✓ Support research programmes to collect data and produce evidence

USAID has developed a Global Health Research and Development Strategy (2017-2022)[115] which articulates a cross-cutting approach to achieve its objectives in terms of health and development. Through this strategy, USAID commits to prioritising health-related research and development as a means to achieve its objectives and improving the impact of health programmes globally.

✗ Focus on disability-inclusion, and ensure the consultation and participation of persons with disabilities, patients, professionals and CSOs

USAID guidelines encourage the empowerment and participation of persons with disabilities through DPOs or other representative organisations.[116] It recommends that such organisations should be strengthened to be able to advocate, create and run their own development programs as well as access direct funding. USAID also funds initiatives that support persons with disabilities and self-advocacy.[117] USAID is member of the GLAD Network steering committee. There is less evidence of USAID consulting directly with persons with disabilities, professionals and CSOs, however.

✓ Invest in innovative technological solutions

In 2018, at the Global Disability Summit, USAID together with other partners committed to joining the Global Partnership on Assistive Technologies and became one of the initial partners of ATScale.

✓ Support community-based rehabilitation programmes

USAID's funded programmes provide, non-exhaustively, fitting of assistive devices, physiotherapy and community-based rehabilitation.[118] USAID's investments also integrate advocacy and awareness raising initiatives. Some projects include the provision of information on rehabilitation services and on the availability of prosthetic and orthotic devices.[119]

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