

Integrated Health and Rehabilitation Services in Mass Displacement

A model for inclusive healthcare from
the Rohingya response in Bangladesh



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Front cover caption: Yeasin, a five year old Rohingya boy, practices walking with his physiotherapist. Home based rehabilitation services improve accessibility of services and provide for holistic treatment of clients within their home environment.

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Foreword

In August 2017, deadly violence and persecution by Myanmar's army on the Rohingya community sent hundreds of thousands fleeing across the border into Bangladesh. According to the UN almost 900,000 refugees are housed in Cox's Bazaar Refugee Camp, the largest in the world. Four years on, the humanitarian response in Bangladesh remains focused on meeting the massive humanitarian needs and on mitigating the impact of the seasonal monsoon rains.

During mass displacements, persons with disabilities in particular are disproportionately affected due to physical, environmental and attitudinal barriers or other obstacles. They go through many hurdles in accessing assistance and protection and may face a heightened level of disability during displacement, because of changes in their environment or lack of appropriate care and services.

Building on years of a genuine, productive and successful partnership in disability inclusion programming in Bangladesh, CBM and CDD came together at the onset of the crisis to support and complement the efforts of the humanitarian community in addressing the needs and rights of the affected populations, including the host communities. Focus was through both mainstreaming services, and specific targeted interventions for persons with disabilities in line with the IASC Guidelines on Inclusion of persons with disabilities in Humanitarian Action. The experience CBM brought providing rehabilitation services in response to major crisis around the world, combined with the local knowledge and expertise of CDD in country, set the groundwork for a comprehensive service design appropriate for the local context.

A major focus of the CBM and CDD joint response over the past four years has been on delivering an inclusive and multidisciplinary model for Health Care and Rehabilitation service provision. This model, which includes psychosocial support and distribution of assistive devices, has allowed persons with and without disabilities to access a comprehensive package of services in the same location resulting in very positive results to the mental, physical and social well-being of the populations.

Along the way, there have been many challenges, but also numerous moments for internal and external consultation, reflection and analysis, in order to adapt and improve the model as we moved forward. We are now delighted to share with you the results and learnings from this unique joint collaboration hoping that it can contribute to showcase what we honestly believe is a good and possibly unique example of inclusive Health Care and Rehabilitation in a large refugee setting.



Christian Modino Hok
Humanitarian Director
CBM Global Disability Inclusion



A.H.M. Noman Khan
Executive Director
Centre for Disability in Development

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Staff from CBM-CDD team in front of the health and rehabilitation center in Camp 18.

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Aerial view of Camp 18 and the CBM-CDD health and rehabilitation center (two adjacent green structures) and inclusive Child Friendly Space (adjacent grey structure).

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List of Acronyms

ADLs	Activities of Daily Living
CDD	Centre for Disability in Development
HBR	Homebased Rehabilitation
IADLs	Instrumental Activities of Daily Living
OT	Occupational Therapist
OPD	Organization of Persons with Disabilities
P&O	Prosthetics and Orthotics
PT	Physiotherapist/Physical Therapist
WaSH	Water, Sanitation and Hygiene
WHO	World Health Organization

Introduction

Since 25th August 2017, extreme violence in Rakhine state, Myanmar has driven over 859,000 refugees across the border into Cox's Bazar in Bangladesh.¹ Prior to their departure from Myanmar, people with disabilities received limited services with most never having received any sort of rehabilitation or psychosocial support in their lifetime and medical services being limited to traditional healers and village doctors. Many often experienced discrimination, stereotyping, or ignorance of service providers about their specific requirements.

A rapid assessment conducted by Centre for Disability in Development (CDD) and Arbeiter Samariter Bund (ASB) in November and December 2017 found that persons with disabilities did not have equal access to humanitarian aid.^a Overall, the assessment showed that women, men, girls and boys with disabilities living in the Rohingya camps face considerable discrimination and barriers including stigma and negative attitudes as well as a general deficit of access to services, humanitarian programs and facilities, including gaps in accessible health and rehabilitation services. This considerably limits their participation and inclusion in the humanitarian response particularly for women and girls with disabilities living in the camp who face additional barriers due to cultural and religious aspects. The inaccessible nature of the camp further restricts the participation of persons with disabilities and their ability to access services.²

In December 2017, based on the results of the rapid assessment, CBM and CDD established a comprehensive health and rehabilitation program focussed on providing accessible primary health care and rehabilitation services under one roof, with a Homebased Rehabilitation (HBR) team to reach persons who were unable to come to the health and rehabilitation center.

Key learnings from this program demonstrate that medical care and rehabilitation should not be seen as separate components, but rather as a model of multidisciplinary service where medical care and rehabilitation (including provision of assistive devices and home adaptation) along with psychosocial support are delivered together, providing for more comprehensive client care. CBM and CDD's inclusive approach of providing these comprehensive health care services for both persons with and without disabilities has allowed persons with disabilities to access both services at the same location, and has increased interaction between persons with and without disabilities.

An external evaluation conducted by CBM in November 2019 revealed that the unique model of health and rehabilitation service provision under one roof provided more holistic services and greater access for persons both with and without disabilities. Feedback from both clients and other key informants indicates that health outcomes were improved through having comprehensive health and rehabilitation services in

a. The assessment consisted of secondary data review, survey, semi-structured interviews with 27 older persons and persons with disabilities and key informant interviews.

one location. Data was collected through interviews and focus group discussions with CBM and CDD staff and the clients who have received services. The most significant changes created by the good practice were analysed, including how the changes occur and could be replicated or sustained. This evidence is used to provide practical and constructive recommendations to provide integrated and inclusive health services in situations of mass displacement.

This document is intended to provide a replicable example to be used by humanitarian health actors to implement integrated health and rehabilitation services which are inclusive and accessible for all persons. Some of the key challenges which were experienced by the teams, along with the solutions which were put in place to address, are also documented.



Health and Rehabilitation Services in Situations of Mass Displacement

Situations of conflict and mass displacement present complex challenges for health and rehabilitation service provision. The unpredictable nature of conflicts, security and other constraints that can impact access to an affected population, and the often protracted nature of conflict, make health service planning very challenging. At the same time surges in trauma cases and exacerbation of chronic medical conditions occur, increasing the need for health and rehabilitation services. In situations of mass displacement, health and rehabilitation services and associated referral systems frequently have to be established from scratch.

Misperceptions about the capacities and requirements of persons with disabilities often cause medical staff to assume that persons with disabilities only need disability-related services.³ People with disabilities are routinely excluded from the planning and delivery of health services, and as such, accessible health information and services which meet their needs are frequently overlooked.⁴ When health facilities and programs are established quickly in order to meet the surge in needs and gaps in services which occur during mass displacement, accessibility in the design of infrastructure and programming is frequently overlooked, creating barriers for persons with disabilities in accessing essential health services.³

The stress and trauma experienced during situations of conflict and long-term displacement cause distress and, in some people, leads to mental health conditions such as depression, anxiety, post-traumatic stress disorder and even psychosis. Pre-existing mental health conditions and psychosocial disabilities can also be exacerbated. Persons with disabilities may be at increased risk of developing such conditions as a result of amplified barriers and ongoing systemic exclusion.⁵

The strengthening of emergency medical preparedness and response has led to a situation where the humanitarian community is getting better at saving lives, however, effective rehabilitation still lags behind and often remains an afterthought.⁶ According to the World Health Organization (WHO, 2018, p5), "The health needs of people with long-term and chronic health conditions are unlikely to be effectively addressed without rehabilitation, leaving them at risk of being left behind unless rehabilitation is made accessible at the primary care level. For this reason, access to essential rehabilitation interventions at the primary care level is a key component of universal health coverage."⁷ While it has been recognized that rehabilitation professionals should be integrated into emergency medical teams to ensure that rehabilitation needs are identified and addressed as early as possible⁸, rehabilitation has not been consistently integrated into health programming.⁹ Denial of early rehabilitation for



persons with traumatic injuries and persons with disabilities can lead to increased co-morbidities, poorer prognosis and longer-term dependence on the health care system.⁶ Surgical care without ongoing rehabilitation can result in failure to restore functional capacities of the client.¹⁰

Rehabilitation not only has a significant impact on a person's functioning, but can also prevent the occurrence or deterioration of health conditions, thereby reducing the burden on other health services. In addition to its benefit for persons with disabilities, rehabilitation is also beneficial for people with various health conditions across the lifespan.¹¹ Lack of early rehabilitation puts a person at risk of developing further complications and negatively affects longer term prognosis, with health needs of persons with chronic health conditions unlikely to be effectively addressed without rehabilitation.⁶ In addition, primary and preventative health care is more cost efficient than curative health care.¹² By helping to prevent comorbidities and improving overall health of the recipient, rehabilitation helps to reduce overall health service delivery costs.

Access to assistive devices is a critical component of rehabilitation, as it facilitates the user's ability to move, see and communicate, helps reduce risk of secondary complications and supports a user to overcome environmental barriers to better engage in community life.¹³ Injuries and loss of existing assistive devices during conflict and ensuing displacement can cause increased demand for such products, as people are forced to leave behind their devices when fleeing or acquire a new need for assistive devices.

Organizations of Persons with Disabilities (OPDs) have expressed genuine concern regarding the need for rehabilitation in humanitarian crisis, including situations of mass displacement.¹⁴ Denial of rehabilitation services, including the provision of assistive devices, can significantly impact the ability of persons with disabilities and older persons to complete their activities of daily living (ADLs) and access humanitarian assistance in a dignified manner. While health and rehabilitation services can improve or maintain the health condition and functional skills of persons with disabilities, access to all other humanitarian services is essential for the health and well-being of persons with disabilities. Provision of rehabilitation including assistive devices can be an essential prerequisite for persons with functional limitations to access humanitarian services.

Service Model

The CBM-CDD health and rehabilitation disability inclusive services within the Cox's Bazar Refugee Camps include general health services (medical consultations, nursing, and medicine distributions), eye health services (refraction and spectacles provision), audiometry (including provision of hearing aids), rehabilitation therapy (physiotherapy, occupational therapy and speech and language therapy) and mental health and psychosocial support (MHPSS). These are provided within one rehabilitation and health center in Camp 18 (about 20 minutes walk from the nearest road) and also through homebased rehabilitation teams.^b

In order to reach those unable to come to the rehabilitation and health center site due to the topography of the camp and other barriers, homebased rehabilitation (HBR) teams, comprising of physiotherapists, occupational therapists and therapy assistants, provide home therapy services. The HBR team specifically targets persons with moderate to severe physical disabilities who are unable to reach the center to ensure that they are able to access therapy services.

The health and rehabilitation center has limited capacity to do in-depth diagnostics and treat more severe illnesses. While surgery is an important component of comprehensive rehabilitation for some clients, the center lacks the capacity to provide surgical services. As such, referral systems have been established with field hospitals and primary healthcare centers for diagnostic tests, laboratory work, surgery, higher level consultation (e.g. neurological or orthopaedic consultations) and complex treatment needs. Simultaneously, referral pathways exist for medical centers to refer clients to CBM-CDD for post-surgical rehabilitation follow up, provided by the HBR team after a client returns home.



Rashida, an 11 year old Rohingya girl who experienced a fracture of the left leg at the age of six in Myanmar which went untreated, participates in her first physiotherapy assessment at the CBM-CDD health and rehabilitation center in Camp 18.

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b. The focus of this document is on the model of the integrated health center in the Rohingya camps, but it should be noted that the model is replicated outside the camp in the host communities (in unions of Ukhia sub-district) as a mobile clinic. The mobile clinic sets up in one community for up to six months and then following consultations with local health authorities moves to another community.

In order to meet the need of clients who require prosthetics and orthotics, dedicated camps are held, where measurements for devices are taken by a specialist team from CDD's workshop in Dhaka. The devices are then produced in Dhaka, and a follow up camp is organized for fitting of the devices and training the clients on their use.

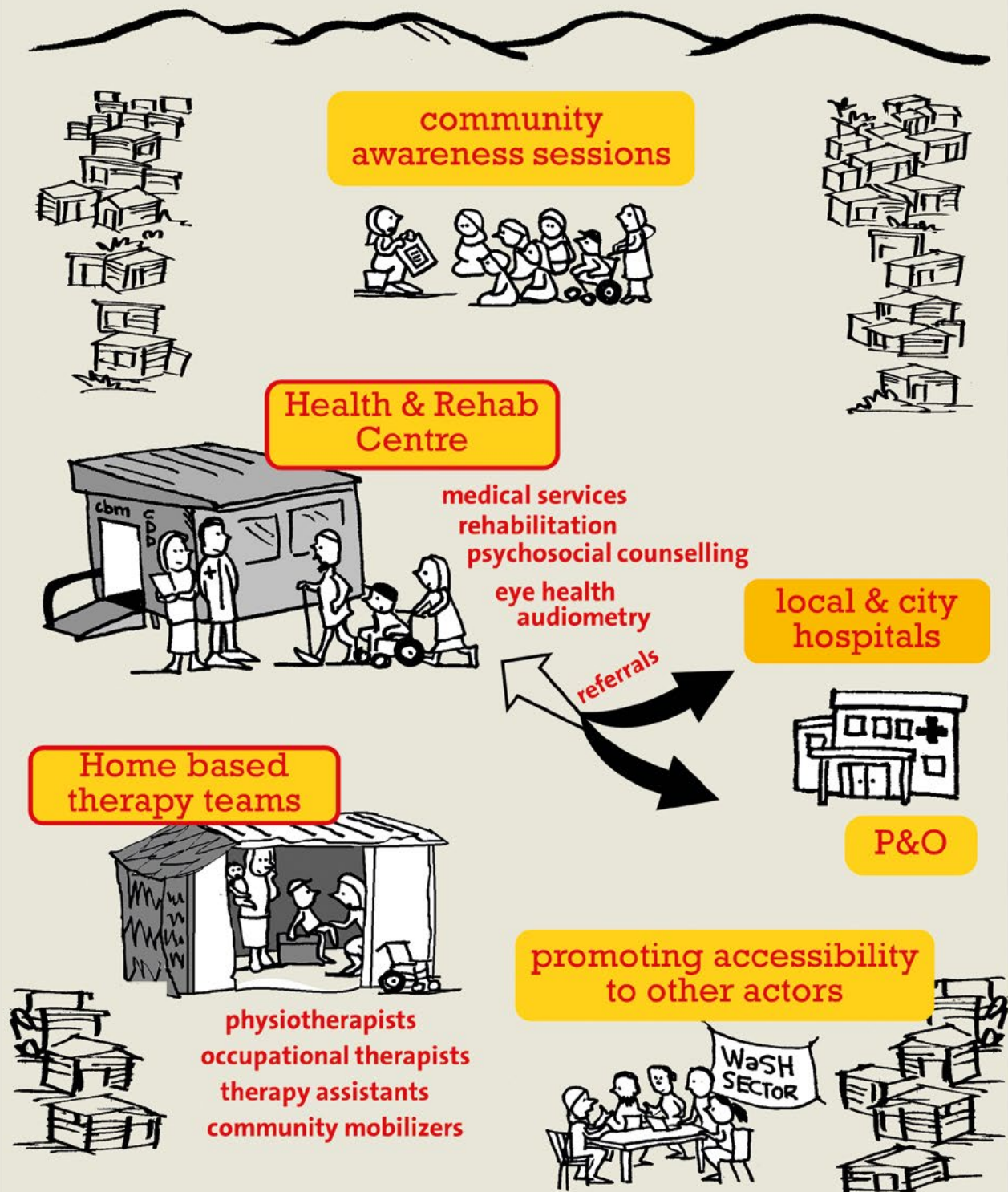
According to interviews conducted with both clients and field staff, the multidisciplinary team approach has been effective in improving health outcomes of not just persons with disabilities, but all clients including older persons and persons with chronic health conditions. The multidisciplinary health model serves to provide more comprehensive and coordinated provision of health care; having all service providers at the same location naturally promotes interdisciplinary care planning and collaboration among professionals for the benefit of the client. Providing access to a team of health and rehabilitation professionals under one roof promotes a client-centered model, whereby a client only has to go to one location to have their primary health and rehabilitation care needs met.

Homebased rehabilitation services allow for holistic assessment and treatment of a client within their own environment. In a displacement setting where clients are required to travel outside their immediate shelter to complete even some of their basic ADLs such as toileting and bathing, as well as access critical humanitarian aid, an understanding of the home environment and barriers are critical for a therapist to design a relevant rehabilitation program and prescribe assistive devices which are appropriate for the terrain. Home and community accessibility modifications, such as the installation of handrails between a person's shelter and Water, Sanitation and Hygiene (WaSH) facilities, are conducted by the HBR team to help reduce environmental barriers to accessing services.

While rehabilitation and access to assistive devices are important prerequisites for persons with disabilities and older persons to access humanitarian services, these services in turn need to be made accessible in order for all persons to be able to go about their ADLs in a humanitarian setting and access critical aid. The HBR teams are well placed to develop a strong understanding of the barriers which prevent their clients from accessing humanitarian services. When lack of access to services for a specific client are identified, the HBR team directly contact the staff of the other service providers to raise the concerns and provide support on developing solutions to improve accessibility. The close collaboration between the HBR team and other humanitarian service providers has resulted in improvement in access for clients to health services, WaSH facilities, food distributions and protections services.

This document provides an in-depth overview of the service model serving as a guide for other humanitarian actors on implementing inclusive health and rehabilitation services. Three main components which make the model successful: 1. accessibility of services, 2. the multidisciplinary team approach and 3. provision of homebased rehabilitation are described in more detail, including examples of good practice and lessons learned from the model.

Health and Rehabilitation Service Model



The inclusive health and rehabilitation service model provides holistic client centred care under one roof. Home based rehabilitation teams provide therapy services in the client's home, ensuring accessibility and that no one is left behind.





Julekha, a Rohingya girl, practices gait training with her new prosthetic limb on the folding parallel bars adjacent to the health and rehabilitation center in Camp 18.

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Accessibility of Services

WHO (2020, p39) defines physical accessibility of health care as “the availability of good health services within reasonable reach of those who need them and of the opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them”. Accessibility considerations in the design of health programming, including the provision of measures to address barriers to reaching the facility, is essential to ensure that all people can avail the services of the facility in a comfortable and dignified manner.

Physical accessibility is one of the major barriers persons with disabilities face and which often exclude them from even basic services. In rapid onset crisis, when services need to be established quickly and under difficult circumstances, accessibility is often overlooked. The highly population-dense Rohingya camps are located in a hilly area with many steep and narrow paths or crude stairs, which are difficult to navigate.

According to the REACH Age and Disability Inclusion Needs Assessment, conducted in the Rohingya camps and published in May 2021, 64% of persons with disabilities face barriers to accessing health services (compared to 39% of persons without disabilities), with the most notable barriers faced being the distance and lack of transport to access health facilities. Older persons also experience barriers to accessing health facilities, with 64% of female older persons and 49% of male older persons reporting barriers to accessing health facilities.¹⁵

Furthermore, there are barriers to participation and to accessing health services for people with psychosocial disabilities and those with increased mental health needs including, but not limited to, the following:⁵

- Misconceptions, stereotypes, prejudices and stigmatizing beliefs among some health workers, policymakers and health professionals (i.e. erroneous ideas about persons with disabilities being dangerous or being unable to make decisions or to contribute to the emergency response, especially in reference to persons with psychosocial, cognitive and intellectual disabilities)
- Limited resources, capacity and knowledge of staff on adapting infrastructure and service delivery to the requirements of persons with disabilities
- Persons with disabilities being constrained (i.e. forced institutionalization, forced treatment, and physical and chemical restraint), which violates human rights and strongly prevents any form of participation in society and in humanitarian response
- Limited opportunities for persons with disabilities, particularly with psychosocial, cognitive and intellectual disabilities, to participate in and influence the response, decision-making, planning/programming, monitoring and evaluation and research.

In this chapter, the approach CBM-CDD took to promoting accessibility of services (from the design of the facility, to addressing information barriers and barriers to reaching the facility) is described, along with some of the key challenges and learning from practice. Gender intersectionality and the challenges and solutions taken by the team to improve access to health and rehabilitation services in their context are described in more detail.

Accessible Design of the Health and Rehabilitation Center

Accessibility was taken into the design of the health and rehabilitation center, with ramps, wide toilet doors, toilet chairs and railings installed. Colour contrast was used within the center, and signage/use of symbols was provided for each service provider. Several consultations with the community were conducted on how they wanted the service to operate. After the construction, one of CDD's OTs initially conducted an accessibility audit of the facilities as a check before use. An accessibility audit helps to identify physical barriers and strategies for improvement, and in cases where accessibility has not been considered during the design phase is the first step to improving physical accessibility.^c

Such design considerations help ensure that all persons can access the services with dignity and as independently as possible. Physical accessibility considerations allow for persons with reduced mobility or vision and those using assistive devices to safely navigate within a space. Signage and use of symbols help to orient a client and find the services needed. Use of symbols is especially important for helping clients who cannot read to locate services. Use of colour contrast can provide warnings or cues for persons with low vision, and help with perception of images.



Pictorial signage is one method to improve accessibility of a facility.

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c. For an example of an accessibility audit for a health center, see the WHO (2020) Disability Inclusive Health Services Toolkit pp 47-49: <https://iris.wpro.who.int/bitstream/handle/10665.1/14639/9789290618928-eng.pdf>



Folding parallel bars are a solution for small spaces. When not in use, the bars fold up against the wall so as to not block the walkway. © Liton Paul, CDD

The physical terrain of the camp and the small area in which CBM and CDD were allocated for construction restricted the size of the health and rehabilitation facilities. The team thus were required to implement creative solutions to meet accessibility standards, such as having parallel bars which could be folded against the side of the building when not in use. Client consultation was done before installing any accessibility features in the clinic.



COMMUNITY CONSULTATION IS IMPORTANT

Checklist: low-cost strategies and reasonable accommodations to improve physical accessibility of health facilities



Community consultation, that includes people with disability, on the design of the facility.



Clear signage in local language with pictures.



Accessibility audit of the facility that involves people with disability.



Chairs or benches in shaded areas where people can wait, and in treatment rooms.



Transport system to allow clients to reach the facility.



Accessible latrine and handwashing station on site with wide door, adequate space inside, raised toilet seat and grab bars.



Orient clients to the facility and where to go for services.



Consider separate queues and waiting areas for men and women, including priority lines.



Ramps and pathways into and between buildings.



Wide hallways and treatment rooms clear of obstructions and clutter.



Home based services for those unable to reach the facility.



Accessibility Considerations during Design Phase versus Retroactive Accessibility Modifications

Costs to ensure accessibility are estimated at 0.5 to 1% of total budget for construction if accessibility is taken into account in the design phase.¹⁶ If accessibility modifications are made retroactively to existing structures this cost can be significantly higher. Budgeting for accessibility in the design phase is important for both keeping costs low, but also ensuring that persons with disabilities have access to the necessary services immediately once construction is completed.

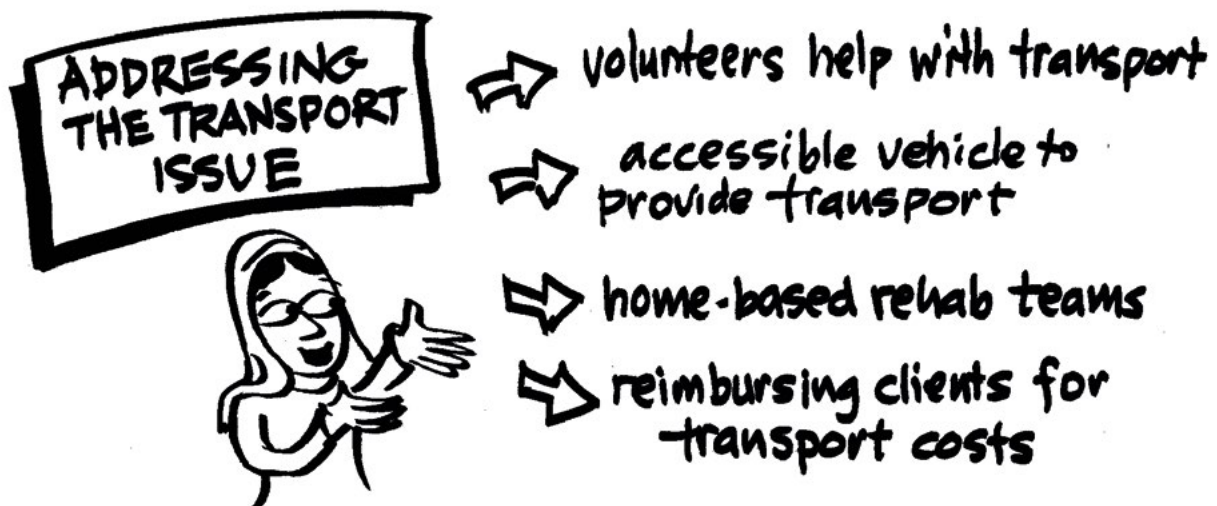
For the most part, accessibility was taken into account during the design phase of the health and rehabilitation center and integrated into the initial construction plans. As such, the costs and staff time associated with making the facility accessible in the initial construction were negligible. The one item which added more cost was an accessible pathway that was constructed between the two structures on the site, which cost approximately 100 EUR.

Reconstruction was necessary to ensure that the latrine which had been hurriedly built met accessibility standards. The costs to reconstruct the latrine were approximately 400 EUR, not including associated costs of staff time to develop creative solutions to improve accessibility retroactively.



Reaching the Facility

When considering accessibility, it is important to not only consider the physical accessibility of the facility itself, but also how persons with disabilities will reach the facility. In this context, the distance to the facility from parts of the camp, lack of public transportation inside the camp and the hilly terrain, create barriers for people to reach the clinic. Cost of transportation can be an important barrier for people in accessing health and other services, and thereby including funding for this within the service package can be important to ensure that persons with disabilities can access needed medical and rehabilitation services.



Reasonable Accommodation

In cases where full accessibility of services cannot be guaranteed, it is important to provide reasonable accommodation^d to address barriers and ensure that persons with disabilities are able to access services on an equal basis as others. While the topography of the camp cannot be changed, CDD put measures in place to allow clients to reach the facility. Other reasonable accommodations which were provided by CDD include a priority line for persons with disabilities and older persons and arranging meetings (i.e. community consultations) close to the shelter/home of the clients with disabilities.

While visuals/use of symbols were used to show the different services which were available, CDD found that some clients were still having difficulty finding the service location after referral. Volunteers were thus utilized to orient clients to the facility and if needed accompany clients to get to their appointment location. By orienting clients to the correct service rooms and accompanying clients who may have had difficulty navigating within the complex to reach their treatment room, clients were able to access services in a timely and comfortable manner.

d. Reasonable accommodation means necessary and appropriate modifications and adjustments, not imposing a disproportionate or undue burden, where needed in a particular case to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms

“I had a stroke about nine months ago. As a result, the left side of my body became numb. At first, I couldn’t do anything on my own. After a few days of treatment, I am now somewhat healthy. I have to take regular medication for my treatment which I have to go far from home to get, but there is a steep staircase...which is often not accessible for me alone. Moreover, old people like me have to stand in the health service point for a long time. When I came to CDD for therapy and eye treatment, I saw that I could come here alone with the help of a stick and take treatment. There are many benefits to using the toilet and ramp in this place. I never have to worry about having a toilet chair. I can’t read the text, but I can easily understand any information by thinking that the signboard is marked. I don’t really have any worries about treatment here.”

Aman, 78 year old Rohingya male

Addressing Information Barriers

While environmental barriers may prevent persons with disabilities from being able to access health services, information and communication barriers may prevent potential clients from even knowing that services exist. In order to provide information to the community on available services, when the health and rehabilitation center was initially established the team actively identified persons with disabilities and informed them about available services. The following methods were used to spread information on available services:

- As part of the program preparatory work while the health and rehabilitation center was under construction, 15 staff conducted a survey in the camp over a three-day period. As part of this survey, if persons in need of health and rehabilitation services were identified, they were provided information on the available services.
- A consultation was held with local community leaders to explain the services which were going to be provided so they could inform community members about them.
- Information on services was provided through loudspeaker announcements.
- Nearby health centers were informed about the services so that they could start referring clients.
- As part of the first phase of the program, CBM and CDD provided blankets to 4,000 households. During the distribution of blankets, CDD staff described available health and rehabilitation services to families.

In addition to the methods which CDD actively employed to spread information on available services, knowledge about the health and rehabilitation center spread by word of mouth. Clients came from up to 40km away (some from the host communities surrounding the camp) to receive services from CDD after hearing about the services from their relatives. Involving persons with disabilities in a snowballing mechanism helped greatly with the identification processes.

This process to spread awareness of services was done by existing staff, and in many cases was conducted as part of their daily tasks. As such, very little additional resources were required for awareness raising, but it had an important impact on reducing the information barriers and making people aware about the services.

In the Rohingya camps there were no OPDs established. However, in contexts where OPDs do exist, they often have information on persons with disabilities in the community who may benefit from rehabilitation services and can help to provide information to these people on the available services.

Gender Intersectionality

When the center initially began operating, staff noticed significant differences in health care seeking behaviour between men and women with a disproportionately high proportion of men and boys attending the center. As with most patriarchal cultures, men make most of the household decisions including when women in the household receive medical treatment. One of the barriers which can prevent women and girls from accessing health care is the cost of treatment; spending money for women's health may not be a priority issue within the family with men tending to ignore milder sickness from women to avoid spending money on treatment. Sickness in men on the other hand is taken more seriously as the attitude is often that "men need to be fit to earn". As such women tend not to report milder illness which if left untreated can become more severe and cause other more serious health problems.

Another barrier preventing women from accessing health care is fear regarding the gender of the medical professionals. Rohingya men are typically against having their wives, mothers or daughters seen by a male doctor or other professional, and many Rohingya women and girls feel uncomfortable receiving health care or rehabilitation services from male practitioners. In addition, even if the medical practitioner is female, men and sometimes older women in the family will want to see that the practitioner is covered up due to fear that a female doctor or other professional who is not viewed as modest enough will have a negative influence on their female family member.



To address these barriers, CDD made a conscious effort in their recruitment to have a balanced number of male and female staff on the team so that female clients could receive services comfortably. Separate seating areas for men and women at the registration desk were established for privacy. Assurances were given by the HBR team whenever referring women and girls to come to the health post that they would be seen by a female doctor or nurse. Informing families that services were offered free of charge helped to convince men to allow female family members to attend the center. When referring a female client to other health service providers, trusted CDD staff members would sometimes accompany them to help alleviate any apprehension or fear. Women and girls tend to be the primary caregiver for a person in the home who is ill or in need of rehabilitation services, and would tend to bring a family member for treatment if needed. On the other hand, if there is a woman with disability in the home with a male caregiver, he is less likely to seek medical treatment or rehabilitation for her. Providing HBR services allowed the CDD team to reach out to people, especially women and girls, who may not have previously accessed health services.

Homebased rehabilitation delivers a positive impact on both the person receiving the services and the wellbeing of their family. Rehabilitation can empower women and girls, who are often primary caregivers, as improved health of their dependant family member may result in more time for caregivers to engage in livelihood or other meaningful activities.¹¹ Through HBR services, many caregivers have reported a positive impact on their well-being and lower levels of stress, as the family member improved their functional abilities and the caregiver received training, for example, on proper posture for transfers to help prevent caregiver injury. Modifications to the shelter and provision of assistive devices also help improve client independence with ADLs and decrease reliance on a caregiver.

ENSURING WOMENS' ACCESS TO HEALTH CARE OFTEN STARTS WITH MEN



This experience highlights the importance of conducting a gender and barrier analysis as soon as possible in the program cycle to identify challenges for women and girls in accessing health care and rehabilitation services and the measures which can be put in place to ensure equitable access to services.

Inclusion and Accessibility as Everyone's Business

One of the important learnings from the program is the importance of inclusion and accessibility being viewed as everyone's business. This should not be a specialty area left to a few "experts" but central in all systems and processes. Orientation and training for staff on accessibility, with the depth and level of content tailored to the position and role of the staff, is one way to ensure that all staff are at least sensitized on inclusion. Service providers and other frontline staff who interact with clients would benefit from having an understanding of disability etiquette and how to communicate with persons with disabilities. Staff involved in the design and construction of infrastructure would benefit from understanding of accessible design and knowing where to access technical specifications on accessibility. Managerial level staff would benefit from having a general understanding of inclusion throughout the program cycle in order to design and manage inclusive programs.



Multidisciplinary Team Approach

WHO states that a multidisciplinary workforce in health systems ensures that the range of rehabilitation needs within a population can be met. Multidisciplinary rehabilitation interventions have been shown to be effective in the management of many chronic, complex or severe conditions that may significantly impact multiple domains of functioning (vision, communication, mobility and cognition). As different rehabilitation disciplines require specific skills, a multidisciplinary workforce can significantly improve quality of care and improve health outcomes.¹⁷



Depending on the group and setting, persons with disability may experience greater vulnerability to secondary conditions, co-morbid conditions, age-related conditions, engaging in health risk behaviours and higher rates of premature death.¹⁸ People with disabilities are particularly vulnerable to certain deficiencies in health care services. Too often, health needs for persons with disabilities are thought of just in terms of access to rehabilitation and assistive devices, however, persons with disabilities have the same need to access all health services as everyone else. People with disability are more than twice as likely to report finding health care provider skills inadequate to meet their needs, four times more likely to report being treated badly and nearly three times more likely to report being denied care.¹⁸ As such, if general health services are not accessible, or if the different services are not well coordinated and require travel from one location to another, persons with disabilities may not be able to avail the full spectrum of health services even if they do exist. However, provided

accessibility is considered in the design of services, a multidisciplinary health model allows a client to access all primary care services within one team. A care plan can be jointly developed among the health care team and referrals can be closely coordinated and followed up on. In addition, the integration of rehabilitation into primary health care can optimize outcomes of other health interventions, and prevent or manage complications associated with other health conditions.⁷

The rapid assessment conducted by CDD and ASB showed that persons with disabilities faced significant barriers in accessing health and rehabilitation services. In order to address this gap, and ensure that the needs of persons with disabilities for both health and rehabilitation services could be met, CBM and CDD took a multidisciplinary approach to the design of health facilities providing both health and rehabilitation services together. The CBM-CDD multidisciplinary team consists of registration desk officers, doctors, nurses, paramedics, physiotherapists, occupational therapists, therapy assistants, orthopaedic technicians, refractionists, audiometric technicians, psychologists/psychosocial counsellors and community mobilizers. These services are provided under one roof, whereby team members jointly develop a comprehensive health and rehabilitation plan for their clients. Internal cross-referral between health and rehabilitation professionals is one of the strengths of the multidisciplinary team model and helps prevent persons with disabilities from falling through the gaps in accessing all necessary health services.

In this chapter, the approach CBM-CDD took in providing multidisciplinary services, starting from the registration process and including the value of interdisciplinary collaboration is described, along with some of the key challenges and learnings from practice.

“When a client is identified as having limitations in different components of functioning, the multidisciplinary team tries to provide support in all different components. For that case, rehab professionals internally refer the client to other teammates so that all the needed service is ensured. Sometimes team members discuss in a group regarding the beneficiary’s situation to decide the combined rehab goal. When there is need of additional services for the beneficiaries, the team engage a community mobilizer and refer the client to other organizations through referral. Thus, this multidisciplinary approach ensures the maximum output for the client.”

Liton Paul, CDD Rehabilitation Manager

Registration Process

Immediately upon arrival at the health and rehabilitation center, clients are registered with the registration desk officer who completes an intake form to identify service(s) needed along with asking the questions from the Washington Group Short Set on Functioning (WG-SS)¹⁹. The registration desk officer then refers the client to the appropriate health or rehabilitation service(s) based on their presented need(s). Although people tend primarily to come to the center when they are ill, during the registration process, in addition to being referred for a medical examination, they may also be referred internally to further psychosocial assessments and counselling support, eye and ear tests, and/or rehabilitation where needed. Similarly, if a client comes to the center for rehabilitation and other health care needs are detected, they will be referred to an appropriate service provider.

CDD provided a series of training to the registration desk officers on administering the forms, triaging clients and then identifying which service(s) to refer the client to. The registration desk officer is supervised by a nurse or medical officer, who is available should the officer have any uncertainties during the registration process. While ideally every client would initially be referred to the doctor for initial assessment and referral, limited resources combined with high demand for services led to CDD adopting this approach, which is also common throughout Bangladesh. Where any medical issues or red flags are identified by a treating therapist, they refer the client to the doctor before continuing their intervention.





Registration desk with separate queues for men and women, including a priority queue for persons with disabilities. © Matthieu Lunard, CBM

Use of Washington Group Short Set Questions:

The purpose of the Washington Group Short Set Questions (WG-SS) is to identify prevalence of disability; not as a diagnostic, assessment or referral tool. The use of the WG-SS by the registration desk officers was initially intended as a measure to collect disability data of clients utilizing the services, however, it also started to be used by the registration desk officers as a tool to refer clients to services.

While use of the Washington Group Questions (by the registration desk officers) is a valuable tool for collecting data on prevalence of disability^e, other measures should be taken to determine health and rehabilitation service needs and initiate appropriate internal referrals. Ideally, every client is first assessed by the medical officer, and using a combination of clinical judgement and assessment tools is referred to appropriate service providers. This ensures that every client is assigned to a medical officer who maintains clinical oversight of the client's treatment program. In a situation where the needs for services outweigh the human resource capacity and it is not possible for every client to receive an initial assessment by a medical officer, it may be necessary to train the registration desk officers to complete a simple referral tool which asks specific questions related to need for services with each client. The client is then referred to the relevant service provider based on their most pressing needs. This service provider then maintains clinical oversight of the client's treatment and initiates referrals to other members of the multidisciplinary team as required.

e. When used for identifying prevalence of disability, the Washington Group Short Set on Functioning – Enhanced (WG-SS Enhanced) is needed to capture prevalence on persons with psychosocial disabilities. <https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-%e2%80%93-enhanced-wg-ss-enhanced/>

Interdisciplinary Collaboration and Referral Systems

Effective communication between professionals in a multidisciplinary team is crucial to ensure quality of care, but high caseloads and time constraints can cause challenges for team members to discuss every case with other health professionals on the client's team. Whenever possible, for any internal referral the referring practitioner accompanies the client to the appointment with the new service provider to discuss the client's case and reason for referral. However, due to the high workload of the doctors, unless the client's case is very complex he or she is usually accompanied by the nurse or paramedic.

Ideally, common case files should exist for each client, which are accessible to all professionals on the client's team, but if this is not the case teams will rely heavily on verbal communication. One strategy CDD takes to strengthen multidisciplinary collaboration is organizing formal case presentations on a weekly basis for critical and exceptional cases. As an additional benefit this also helps to promote cross learning among the team. Another strategy CDD has put in place is monthly coordination meetings where, among other topics, the different service providers discuss pertinent clinical issues.

Referral systems need to be well coordinated so as not to overload receiving services and/or duplicate efforts in resource-poor areas. As with most services providers, rarely can one provider cover everything that is needed. Therefore, a good referral pathway and system is essential. As the health and rehabilitation center has limited capacities to do in-depth diagnostics, and treat more severe illnesses, they refer to local hospitals for laboratory work, surgery and complex treatment needs.

For external referrals, having an agreed protocol and referral pathway can help to ensure a smooth referral process. This should include a feedback loop to provide clinical information and expectations for the referral to the receiving organization, and for the referring organization to follow up if their client has accessed the services and to what extent further diagnosis or treatment were successful.



Iddris, a Rohingya man, receives a medical consultation at the health and rehabilitation center.

© CDD

Increasing Professional Competence and Responsibility to Address Shortages in Professional Staff

Shortages of available qualified health professionals including therapists and counsellors, along with budgetary constraints may necessitate a shift in thinking regarding the traditional roles of nurses, therapists, assistants and volunteers. Increased training and capacity building of assistants and volunteers under the supervision of a qualified therapist can allow them to take on increased clinical responsibilities, while interdisciplinary knowledge sharing can allow professionals to develop skills outside of their traditional realm of practice. Both of these may contribute to a decrease in the number of health and rehabilitation professionals one client may need to see.

In our model, therapy assistants are supervised by qualified PTs and OTs, and implement treatment programs under their supervision. For each client, assessment results, treatment protocols, contraindications and precautions are explained by the therapist to the assistant. CDD provided on the job training and coaching to therapy assistants who then, under the instruction of the therapist, provide treatment sessions independently approximately 80% of the time.

Community mobilizers in turn are trained to do door to door screening. This training is a continuous process and includes basic knowledge on disability and data collection. Once the door to door screening in an area has been completed, the HBR team leader reviews the forms and decides which clients to refer to the HBR team for





Md. Nur, a 65 year old Rohingya man has his vision assessed by a refractometer.

© Alberto Tonon, CBM

clinical assessment and a decision whether therapy services are required. In this way the therapist is still responsible for the assessment but a large volume of screening is managed by the community mobilizers. In addition, community mobilizers also organize outreach camps and awareness sessions, assist in implementing the feedback and reporting mechanisms at community level, and may assist the clients on initial visits when referred to other services in other organizations.

While the role of community mobilizers was originally strictly dedicated to non-clinical tasks, through training and capacity building, community mobilizers can be trained to take on more clinical tasks under the supervision of a qualified therapist. In this way, the initial client assessment and design of a treatment program is developed by a qualified therapist, but administered by a community mobilizer. This allows a therapist to oversee a larger caseload, providing a solution which can be employed when there is a lack of trained professionals in a country or budgetary constraints do not allow hiring the required number of therapists or therapy assistants.

While most medical staff and therapists operated within their traditional realm of practice, broadening the clinical skills of these professionals allowed them to take on clinical responsibilities that would typically be addressed by another member of the multidisciplinary team. For instance, providing some basic training to health care workers allowed them to offer some simple rehabilitation strategies before referring to a dedicated rehabilitation professional. In such cases it is important that “red lines” are established, placing clear limits on a professional’s scope of expanded practice based on their education, experience and personal level of comfort and that acknowledging that mentorship is available for each professional. For example, while CDD’s therapists build the capacity of the therapy assistants, certain clinical tasks such as initial assessments and prescription of assistive devices remain with the

therapist. While the therapist develops the initial therapy plan, which is then carried out by the therapy assistant, the assistant may discuss with the therapist any proposed changes to the plan as the client's condition changes. Another example includes CDD's OTs being trained to do initial screening to determine if a client should be referred to PT for manual therapy, but not conducting such therapeutic interventions themselves. Broadening of clinical skills among medical and therapeutic staff means that it can be possible to decrease the number of professionals each client sees thus allowing limited human resources to reach a higher number of clients.

“The rehab team attends weekly in-service sessions where different professionals share different techniques, disease related info, or other knowledge-based materials on different service approaches. This helps different professionals in their capacity building. Regarding an important activity of the rehab team which is home adaptation, Occupational Therapists helped the Physiotherapist to improve their understanding on the standards, check list and activities of home adaptation. Moreover, our therapy assistants were trained by different rehab professionals (Physiotherapy, Occupational Therapy, Speech & Language Therapy) to perform follow-up sessions properly without the help of other professionals”

Md. Kawser Rezwan, CDD Rehabilitation Coordinator

Staff Capacity for Inclusive Health Delivery

Positions in remote locations, or with short term contracts, often attract health and rehabilitation staff who are fresh graduates with limited field experience. Without proper on the job training and capacity building this can result in client treatment being basic, and following standard schoolbook exercises and approaches, which may not be suitable for the context. Because of lack of experience and exposure, without opportunities for mentorship and professional growth, treatment protocols run the risk of lacking creativity, variety and innovation. Clinical mentorship and progressive experience are necessary for a junior therapist to develop their clinical skills and deliver creative and tailored interventions based on the client's goals beyond textbook solutions. To address this CDD has implemented various on the job solutions to build capacity of their team.



Homebased Rehabilitation

When the health and rehabilitation center was initially established, initial consultations revealed that it was very challenging for caregivers to bring the client to the center for multiple appointments and that not all persons were able to reach the center. To address this feedback, CDD quickly started providing mobile homebased rehabilitation services. Homebased Rehabilitation (HBR) is a form of outreach service which takes place in the client's home rather than in a therapy center/static point/clinic.

This program's HBR service is a multidisciplinary, goal-based rehabilitation program delivered in a client's home for a minimum of one visit but may extend to multiple visits over several weeks.^f Dedicated rehabilitation teams consisting of Physiotherapists, Occupational Therapists, Therapy Assistants and Psychosocial Counsellors visit adults and children with disabilities at home, register and assess clients, take measurements for assistive devices, provide therapy, and train family members to help with basic exercises.

While the exact composition of the teams has varied over time as the service has evolved, in general each HBR core team is composed of an OT, PT, psychosocial counsellor, therapy assistants and community mobilizers. A speech language therapist, audiometric technician and refractionist is shared between the teams. The teams provide services five days a week, travelling between client's homes on foot. Each therapist usually sees five clients per day (three to four for assessment and one to two for therapeutic sessions) with each therapy assistant conducting five therapy sessions per day. As the team travels on foot between homes, this is lower than the caseload of the therapists in the center, which is usually around eight to nine clients per day.

Provision of homebased rehabilitation ensures that children and adults with disabilities who are unable to access the health and rehabilitation center are able to receive therapy services in their home environment. This has been especially significant for clients with moderate to severe disabilities who either did not come to the health and rehabilitation center, or only came for registration, and who otherwise would not have had the opportunity to receive rehabilitation.

Upon referral, the therapist assesses the client and develops a treatment plan. Assessment tools are adapted for the context and service delivery system.^g Under the supervision of the therapist, therapy assistants are responsible for treatment of the client according to the treatment plan developed. The therapist continues to monitor the progress of the client, reassesses the client as required, and updates the treatment plan according to client improvement. Gains in functional improvement and participation in ADLs and instrumental activities of daily living (IADLs), including

f. The number of weeks depend on the severity, rehabilitation needs, prognosis and willingness of clients.

g. Standardized assessment tools used by CDD include the Functional Independence Measure (FIM), Manual Muscle Testing (MMT) and the Modified Ashworth scale. CDD is also using tools developed by the Centre for the Rehabilitation of the Paralyzed (CRP) which have been modified to suit the context.

participation in education and livelihood activities have been documented in clients who have received HBR services.

Clients are discharged from HBR services once rehabilitation goals have been achieved, the client has plateaued, the client or their family are not willing to participate in therapy or the client relocates outside of the coverage area. A discharge plan is developed which includes home exercises and linking with other relevant service providers.^h



Hosnima, an eight year old Rohingya girl with suspected spinal cord injury, with her father Tojim near their shelter. Homebased rehabilitation allows the therapist to assess the client within their environment.

© Daniel Hayduk, CBM.

h. Discharge mechanisms may look very different in community settings where more services are provided by national authorities/actors and have a longer term focus. Considerations on how clients will access necessary services, including how they will cover funding to avail such services and how they will reach facilities where services are provided need to be considered.

Client Identification

Clients may be referred for HBR services through the health and rehabilitation center, another health actor or through community outreach. When an internal referral is made, the HBR team is verbally informed about the referral. A referral pathway from external health actors has been established which allows them to directly refer a client to the HBR teams for follow up.

While some clients may be directly referred to the HBR team, community mobilizers work to raise awareness of the services throughout the camp. In each new area of the camp, the community mobilizers first reach out to local community leaders and shopkeepers to help identify people in need of rehabilitation services. Local leaders who are well connected to their communities are a valuable source of local knowledge of the people living in their community and those who could benefit from the services being offered. In contexts where OPDs do exist, these can be excellent resources for identifying people in need of HBR services.

The community mobilizers also conduct community awareness raising sessions on disability prevention and available rehabilitation services and go door to door to identify clients who may benefit from HBR services. Additionally, persons with disabilities and their families have started to help CDD identify other families with persons with disabilities in need of HBR; this has come from generating greater awareness in the community on what services the HBR team are providing.

Having a community outreach strategy is especially important in a context where people may have had no previous access to rehabilitation services or may not be aware of the benefit of such services, and therefore may not seek out these services even if they exist and are accessible.

“When HBR team came to my house I denied taking rehabilitation service. When I with my family attended the community awareness session conducted by HBR team, it helped to open my eyes to the disability and therapy service protocol of CDD. Finally, I get registration and get Occupational Therapy, Physiotherapy and it improves my mobility and ADLs. I joined OIKKO SHG in September and came to know different topics like Disability orientation, Person with Disability Rights, Advocacy and Leadership training from CDD, social safety net programs, and services from govt. Now I coordinate with community people, local NGOs, INGOs, govt offices, other organizations near my community where I talk about the problems and barriers of persons with disabilities and asked for their services and support for the betterment of persons with disabilities and linked with them to CDD team. Sometimes I took lead in getting a “Disability-Identity Card” from the social welfare office for other persons with disabilities in my community.”

Md. Rofiq 45 year old Rohingya male

Holistic Service Provision within a Client's Home Environment

HBR services allow for holistic assessment and treatment of a client and empowers the client and their family to set rehabilitation goals within the context of their own home and community environment. It encourages the client to take greater initiative in verbalizing their needs and requirements and take more ownership of their rehabilitation goals. Provision of services in the home allows for the therapist to better understand the environmental factors involved, such as the physical setup of the home, surrounding environment, the social and cultural factors within the home and community, including any support systems which are in place. Assessment can be made regarding the interaction of these factors with the client's personal factors, such as physical, cognitive and affective strengths and limitations, and factors that may affect their occupational performance and participation in self-care, productivity and leisure activities. In addition, the client often feels more comfortable and relaxed within their home environment, allowing the relationship between therapist and client to develop more naturally and often resulting in better rehabilitation outcomes for the client.



Understanding the client's environment allows a therapist to adequately design a rehabilitation program and prescribe assistive devices which are appropriate for the specific environment while at the same time addressing environmental barriers which, where possible, can be reduced or eliminated.



Yeasin's PT conducting initial assessment. Following the assessment, Yeasin's father was provided with training to carry out exercises at home.

© Alberto Tonon, CBM

Caregiver Training

Caregiver training is an integral part of HBR services. With consent of the client, caregivers are closely engaged in the therapy sessions. When a therapist is conducting a session, he or she will request the caregiver to conduct hands on exercises. The therapist will check that exercises are being performed by the caregiver correctly and revise the exercises with the client and the caregiver as progress is made. In this way, the caregivers gradually learn about home exercise protocols. The therapist will also train the caregiver on how to safely transfer and assist a client with mobility limitations, in order to prevent injury to both the client and the caregiver.

Home and Community Accessibility Modifications

Home and community accessibility modifications are completed by the HBR team to facilitate participation in ADLs and IADLs. This can be especially important in environments where communal facilities for participation in ADLs exist, such as shared WaSH facilities in a refugee camp. In such cases, the therapist will need to assess with the client access to such facilities and prescribe creative solutions including any home and environmental adaptations. This may involve liaison with other humanitarian actors to improve accessibility of the services provided.



The HBR team conducted an accessibility assessment with their client, Laila. Following the assessment, stairs with handrails were constructed by Laila's home to provide more accessible access to her home. © Abu Fattah, CDD

Assistive Device Provision

Access to assistive devices is a critical component of rehabilitation, with considerable health, social and economic benefits for the recipient. Assistive devices facilitate the user's ability to move, see, communicate and access health and humanitarian services, participate in the community and engage in education and economic opportunities. Assistive devices can also reduce risk of secondary complications (i.e. pressure sores). Assistive devices thus play a significant role in contributing to improved physical and mental health.¹³

It is important to train clients and staff in the effective safe use and maintenance of assistive devices. Rehabilitation providers can ensure that the devices which people receive are suitable for them and their environment and are adapted as the needs of the user evolve.²⁰

In our program qualified therapists assess clients for appropriate assistive devices taking into account both personal factors and the environment in which the client lives. Once a client has been assessed for an assistive device, and it has been ordered, they are then fitted for the device, trained on how to use it, and followed up to make sure that the device remains in good working order.

Provision of assistive devices should never be seen as a "distribution". Employing professionals with appropriate training and skills to prescribe assistive devices is important as improperly prescribed assistive devices which do not meet the needs of the client or are not appropriate for their environment may end up unused or cause injury.

In order to keep the time between assessment and provision of assistive device as short as possible, CDD keeps a stockpile of common assistive devices which can be easily adjusted to the client. This includes items such as cervical collars and lumbar corsetsⁱ, walking sticks, crutches, hearing aids and toilet chairs. These assistive devices are able to be provided within 10 to 15 days after the time of assessment.

For clients requiring prosthetics and orthotics (P&O), referrals are made to the P&O technicians based out of CDD's workshop in Dhaka. The need for P&O is initially assessed by the client's therapist, who then initiates a referral. CDD organizes regular P&O "camps" in the Rohingya camps whereby P&O technicians travel from Dhaka to measure and cast clients. The devices are then made in Dhaka and during a follow up camp the technical fit of the device for the client occurs. Where the P&O is for the lower limb the technician and the client's therapist together provide gait training, helping to identify if any further adjustments are required. A therapist can also submit a request to have a client's device adjusted at a later date if the client's condition changes or if there is damage to the device. While this solution has helped to meet an important gap in P&O services for the Rohingya people, bringing such services closer to the camp (versus being centralized in the capital) would allow for the devices to be made, fitted and adjusted on site, providing more timely provision of proper fitting devices.

i. Cervical collars and lumbar corsets are typically provided for spondylitis and disc prolapse.

A thorough understanding of the client's environment is important to allow a therapist to prescribe assistive devices which are appropriate while at the same time addressing any environmental barriers which can be reduced or eliminated. For example, if assessing a child who cannot walk, without a proper understanding of a child's environment a therapist may prescribe a wheelchair. However, a proper assessment of the environment may reveal physical barriers such as steep slopes, uneven ground or stairs within either the client's home or surrounding environment. This would need to be addressed in order for a child to use a wheelchair and access important services, such as WaSH facilities and to attend school. Assessment may reveal that a wheelchair is not appropriate for the environmental context and the therapist will need to work with the child, their family and service providers to find an appropriate solution.



CDD Orthotist casting client for Ankle Foot Orthosis (AFO) during Prosthetics and Orthotics Camp.

© Alberto Tonon, CBM

Reducing Time Between Medical Intervention and Rehabilitation

As the time between medical intervention and provision of rehabilitation increases, conditions become more chronic and prognosis generally deteriorates. Lack of early rehabilitation puts a person at risk of developing further complications and negatively affects longer term prognosis, with the health needs of persons with chronic conditions unlikely to be effectively addressed without rehabilitation.⁶

CBM and CDD have established referral systems with other health actors in the camp, including field hospitals. When referral systems with primary and secondary health care actors are well established, the HBR team can begin to see the client shortly after discharge home. Prognosis in this situation is usually better, and a more intensive rehabilitation program is prescribed.

Frequent relocation of clients in camp contexts result in additional challenges for therapists to locate clients and follow up on referrals. In cases where clients are relocated by camp authorities, new location data is available to CDD. If the client relocates to an area outside of the CBM-CDD working area, CDD refers them to another service provider where available. However, when a client or their family relocate themselves, unless CDD is notified in advance it is very difficult for the HBR team to find the client again.

When there has been a significant delay in referral to rehabilitation services, the client may present with secondary complications. In some cases, with strong clinical management the client can make rapid progress, however, in other cases therapists are required to set a less ambitious treatment goal, and intensity of therapy sessions will be reduced as progress is often achieved at a much slower pace. For these clients there is usually a stronger focus on maintenance and prevention of complications, with therapists providing exercises for the client or their family and provision of assistive devices. For sub-acute cases, treatment plans usually focus on positioning and the prevention of pressure sores. Treatment then progresses to bed mobility, active range of motion, balance and coordination training, and gait training while simultaneously working on functional skill development.

Home-Made Therapeutic Solutions

In resource scarce or remote environments, it may not always be possible to provide each client with store bought therapeutic tools to use during their rehabilitation sessions. The therapists in the HBR team design low cost, home-made solutions which allow a client to complete their exercises at home. These solutions are tailor made to each client, and generally use materials which already exist in the client's home or materials which can be locally sourced at low cost. For example, a water bottle filled with sand can be used as a weight for muscle strengthening, with more sand added to increase the weight as the client's strength improves. Creative thinking to provide such homebased solutions allows a therapist to eliminate the barriers to access created by expensive prefabricated therapeutic tools which may not be affordable to most clients.



Bottle and cap being used to practice fine motor skills.

© Bashar Ul Islam, CDD



Pulley system installed in client's shelter to practice shoulder range of motion.

© Kabir Hosen, CDD

Addressing Attitudinal Barriers

During the HBR sessions, the team often observed that the community perception of persons with disabilities was quite negative and there was limited awareness about disability from either the family members or the wider community. They also found that many of their clients and families had low morale coupled with low confidence that therapy could improve their functional abilities and could be considered a health intervention.

Accordingly, community awareness sessions on disability prevention and disability etiquette have been added to the HBR programming. This includes myth busting information on the causes of disability, rights and needs of persons with disabilities to access services and participate in community life and a focus on the capacities of persons with disabilities. Since providing these sessions, CDD has noticed a slow shift in the attitude of community members regarding the perception of persons with disabilities, along with increased confidence of persons with disabilities and their families in their functional abilities and desire to participate in community life. Shifting negative attitudes and stereotypes around disability is essential for helping to break down the attitudinal barriers which may inhibit persons with disabilities from accessing services and taking part in their community, including accessing health and rehabilitation services.

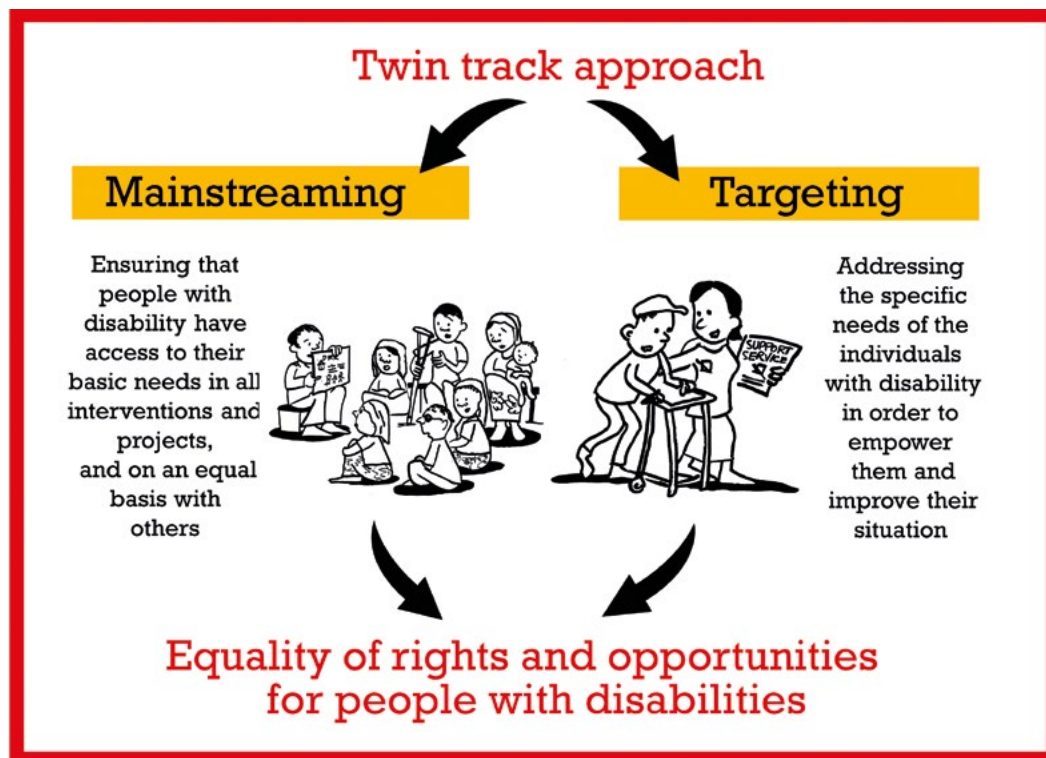
Challenges and Restrictions for Homebased Rehabilitation Teams

HBR teams are often required to cover a large amount of ground in a day, as clients can be scattered over a large area. Time for travel needs to be allocated into the targets which are set for rehabilitation. This is especially relevant when teams are required to travel on foot as is often the case in camp settings where roadways are often limited. Targets for clients seen per day for homebased rehabilitation teams will therefore be lower than for staff who are center based. CDD set a target of four to five client sessions per day for each therapist and five sessions per day for therapy assistants, with staff often walking up to around two hours per day between client's homes.

HBR teams can face increased risk as they work directly in client's homes and travelling between client's homes throughout the day. These risks include both security threats due to potential clashes between different groups in the camp and also environmental hazards such as heat and excessive rain creating landslides and pathway blockades. To mitigate this, CDD developed a specific security plan, which included provisions such as staff always travelling in pairs and community mobilizers from the host community, who speak the local language, accompanying staff at all times.

Promoting Disability Inclusion

While rehabilitation and access to assistive devices are important prerequisites for persons with disabilities and older persons to access humanitarian services, these services in turn need to be made accessible in order for all persons to be able to go about their ADLs in a humanitarian setting and access critical aid.

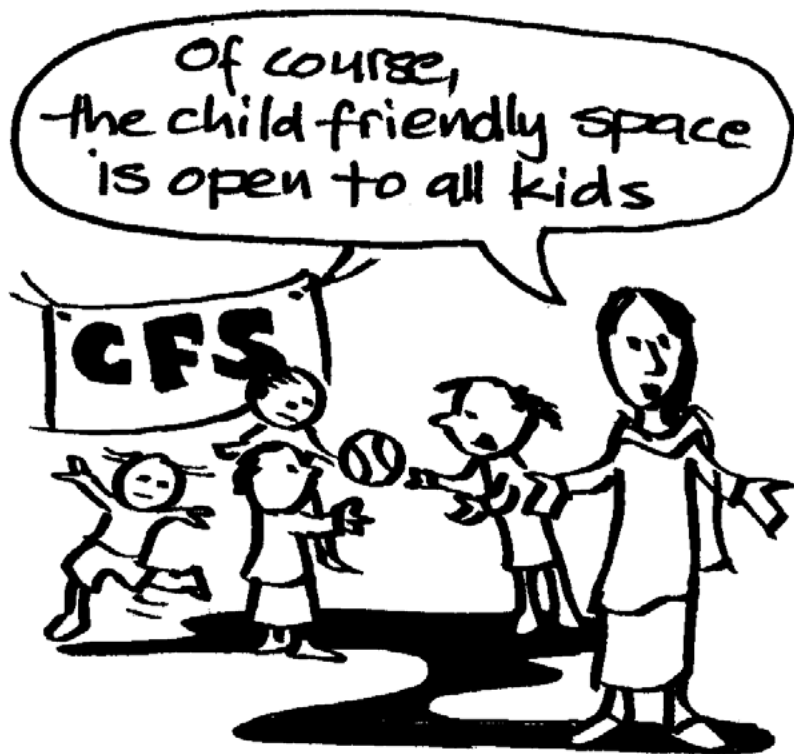


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Health and rehabilitation providers collect data on the prevalence of disability and may develop a good understanding of the barriers which prevent their clients from accessing humanitarian services. Rehabilitation service providers are well placed to support their clients in accessing humanitarian services and participating in community functions.⁹ In our program when lack of access to services for a specific client are identified, the HBR team directly contact the field staff of the other service providers to raise the concerns and provide support on developing solutions to improve access. This has resulted in improvement in access for clients to health services, WaSH facilities, food distributions and protection services. Simultaneously, information on barriers to access were raised at the cluster level, and lessons learned/ solutions developed shared in this forum.

We participated in a focus group discussion where we discussed about resolving existing problems of the community. We experience about how they (persons with disabilities) avail different service points and barrier they faced to go and return from those service points. We developed an action plan to make the service points and facilities appropriate for persons with disabilities.

Md. Rashadul Alam, Protection Assistant, IOM (discussing an on site intensive training received from CBM-CDD on disability inclusion)



REHABILITATION & ASSISTIVE DEVICES ARE PREREQUISITES TO ACCESSING SERVICES

Conclusion

CBM and CDD hope that this documentation of the health and rehabilitation model in Cox's Bazar, Bangladesh, will provide a useful example of an approach to multi-disciplinary health services under one roof, including homebased rehabilitation, in a context of mass displacement. While components and principles of this model may also be applicable to other situations, analysis of existing gaps and service provision would be especially important when applying the model to situations where some health and rehabilitation services already exist.

Key learning which can be taken from this programme includes:

Accessibility of Services: While health and rehabilitation services are critical for persons with disabilities for activities of daily living and to enable access to humanitarian aid, it is important that these services are made accessible. It is ideal that accessibility is considered from the design phase, and that persons with disabilities are involved in the planning of health services. Accessibility goes beyond physical accessibility of built structures, and should also consider how people will reach and navigate around the health and rehabilitation center and how they receive information on available services. It is important that intersectionality, including gender, be considered when analysing accessibility of service design.



Jahangir, a 33 year old Rohingya man with provisional diagnosis of Transverse Myelitis practices gait training using parallel bars installed in his shelter with his OT. The bars allow Jahangir to move independently around the shelter.

© Prosenjit Baidya, CDD



Rashida uses one of the water points in the camp while her father Nurul holds her crutches. The homebased rehabilitation team assess their client's access to humanitarian services and liaise with humanitarian actors to improve accessibility of services.

© Jabed Patwary, CBM

Multidisciplinary Team Approach: In order for the multidisciplinary health care model to function effectively, it is important to establish strong internal referral processes and procedures to promote interdisciplinary collaboration. Capacity building of staff is essential especially when the team is comprised of mainly junior staff. As resources are often constrained or availability of qualified staff may be limited, capacity building is also essential to upskill the team in order for team members to take on responsibilities beyond their traditional realm of practice. In these cases, it is imperative that clear "red lines" are established, placing clear limits on a professional's scope of expanded practice.

Homebased Rehabilitation: HBR services are an important component in accessible health care delivery as they allow access to rehabilitation services for people who may not be able to access a fixed center. HBR services also allow a therapist to assess a client within their home environment and prescribe a treatment plan and assistive devices which are appropriate for the environment. Home and community modifications are an important part of HBR services for promoting accessibility within the home and to essential services. Rehabilitation services (HBR or at a center) should be provided as soon as is practically possible, as with increasing time lag between an injury or medical procedure and beginning rehabilitation the prognosis of a client decreases.

As an overarching principle, it is important that inclusion is seen as everyone's business and training and budget for inclusion should be integrated within program planning. Health and rehabilitation providers become familiar with the barriers preventing their clients from accessing humanitarian services. They are thus well positioned to liaise with other service providers to make services more accessible and contribute to persons with disabilities living lives where participation in the home and community is possible.

Key Concepts and Definitions

Accessibility means ensuring that people with disabilities are able to have access to the physical environment around them, to transportation, to information such as reading material/audio messaging and to communication technology and systems on an equal basis with others. Accessibility requires forward thinking by those responsible for delivery of private and public services to ensure that people with disabilities can access services without barriers.

Activities of Daily Living (ADLs) are basic actions which involve caring for one's body and include activities such as eating, dressing, bathing, toileting and basic mobility. **Instrumental ADLs (IADLs)** require more complex planning and thinking, and include activities such as cooking, cleaning, transportation and managing finances.

Assistive Devices include a range of products, from wheelchairs, walkers, braces, special chairs, and crutches, to hearing aids, electronic reading devices, and braille displays. There are many groups who can benefit from assistive devices, including people with chronic health conditions, people with physical or sensory impairments, temporary injuries and diseases or older people.¹³

Disability is an evolving concept and that results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.²²

Holistic and Comprehensive Services refer to an approach to health care service provision which looks at the entire picture of the client's health within the environment which they are living and provides services tailored to the clients' needs and personal goals.

Inclusive Services/Approach to Health Care refers to an approach where all persons, including persons with disabilities, are able to meaningfully participate in design and implementation of health care services which are appropriate for their needs.

Intersectionality is an analytic framework that demonstrates how forms of oppression (such as racism, sexism, ableism) overlap, defining unique social groups. An intersectional approach assumes that harms and violations associated with disability, race and ethnicity, gender, or other identities cannot be understood sufficiently by studying them separately. To see clearly how they affect access to resources or create risks for persons with disabilities, it is necessary to see how disability, age, gender and other factors interrelate and to evaluate their overall effect.³

Mental Health and Psychosocial Support (MHPSS) is a composite term used to describe any type of support that people receive to protect or promote their mental health and psychosocial well-being. One major component of MHPSS is treatment and prevention of mental health conditions.²³

Multidisciplinary Care is when professionals from a range of disciplines work together to deliver comprehensive care to address as many of a client's needs as possible. This can be delivered by a range of professionals functioning as a team under one organizational umbrella or by professionals from a range of organizations.²⁴

Organizations of Persons with Disabilities (OPDs) should be rooted in and committed to the UN CRPD and should fully respect the principles and rights that it affirms. OPDs must be led, directed and governed by persons with disabilities. A clear majority of their memberships should be persons who have disabilities.

Reasonable Accommodation means necessary and appropriate modifications and adjustments, not imposing a disproportionate or undue burden, where needed in a particular case to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.²⁵

Rehabilitation is a set of measures which assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments.²⁶ Rehabilitation takes a holistic view of a person within their environment, with a focus on improving a person's functional abilities according to their individual goals. Rehabilitation services are provided by professionals including Occupational Therapists, Physical Therapists, Speech and Language Therapists, Orthotic and Prosthetic Technicians and other allied health care professionals who focus on assessment, treatment, education, counselling, environmental adaptations and provision of assistive devices. Access to rehabilitation can improve functioning and independence for those with health conditions that result in short or long term limitations in functioning, and that may be associated with injuries, illnesses, non-communicable diseases, ageing, surgery, developmental delays and disabilities.⁴



Hedayet, a Rohingya boy with clubfoot, walks using the handrail outside of his shelter. As part of his therapy program, Hedayet's therapist worked closely with the shelter sector to have the ground outside of Hedayet's shelter levelled and handrail installed. This has allowed for Hedayet to safely and independently walk around his shelter. © Prosenjit Baidya, CDD

References

1. Joint Government of Bangladesh - UNHCR Population factsheet as of 30 August 2021
<https://data2.unhcr.org/en/documents/details/88713>
2. Arbeiter-Samariter-Bund, Centre for Disability in Development Bangladesh & Aktion Deutschland Heft. (2017). Rohingya refugee crisis in Bangladesh age and disability inclusion rapid assessment report. <https://reliefweb.int/sites/reliefweb.int/files/resources/ASBCDD%20Rohingya%20Refugee%20Crisis%20-%20Age%20and%20Disability%20Inclusion%20Rapid%20Assessment%20Report.pdf>
3. Inter-Agency Standing Committee. (2019). Guidelines Inclusion of Persons with Disabilities in Humanitarian Action. <https://interagencystandingcommittee.org/iasc-task-team-inclusion-persons-disabilities-humanitarian-action/documents/iasc-guidelines>
4. Disability-inclusive health services toolkit: a resource for health facilities in the Western Pacific Region. Manila, Philippines. World Health Organization Regional Office for the Western Pacific. (2020). Licence: CC BY-NC-SA 3.IGO.
<https://iris.wpro.who.int/bitstream/handle/10665.1/14639/9789290618928-eng.pdf>
5. Information note on disability and inclusion in MHPSS – IASC MHPSS Reference Group (2021) (Draft).
6. Lathia et al. (2020). Early Rehabilitation in Conflicts and Disasters. (1st ed.).
<https://hi.org/en/early-rehabilitation-in-conflicts-and-disasters>
7. World Health Organization. (2018). Access to rehabilitation in primary health care: an ongoing challenge. <https://apps.who.int/iris/bitstream/handle/10665/325522/WHO-HIS-SDS-2018.40-eng.pdf?ua=1>
8. Guidance note on disability and emergency risk management for health. (2013).
<https://www.who.int/publications/i/item/guidance-note-on-disability-and-emergency-risk-management-for-health>
9. Emergency medical teams: minimum technical standards and recommendations for rehabilitation. Geneva: World Health Organization. (2016). Licence: CC BY-NC-SA 3.0 IGO.
<https://www.who.int/publications/i/item/emergency-medical-teams>
10. Sphere Association. The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response, fourth edition, Geneva, Switzerland. (2018).
www.spherestandards.org/handbook
11. Humanity and Inclusion & Global Disability Alliance. (2019). Rehabilitation for the realisation of human rights and inclusive development https://handicap-international.de/sn_uploads/document/Study2019_Rapport_rehab_human_rights_v4_Web.pdf
12. World Health Organization. (2018). Technical Series. On Primary Healthcare. Building the economic case for primary health care: a scoping review.
<https://apps.who.int/iris/rest/bitstreams/1241121/retrieve>

13. ATscale. (2020). The case for investing in assistive technology. The dramatic economic, health, and social benefits of assisting a billion people to live fulfilling and dignified lives <https://atscale2030.org/investment-case>
14. Palmer et al. (2019) Inclusion of persons with disabilities in humanitarian action <https://interagencystandingcommittee.org/system/files/2019-12/Case%20studies%2C%20Inclusion%20of%20persons%20with%20disabilities%20in%20humanitarian%20action%2C%202019.pdf>
15. REACH, Protection Sector Cox's Bazar, Age and Disability Working Group. (2021). Bangladesh - Age and Disability Inclusion Needs Assessment – Rohingya Refugee Response – April 2021. https://www.impact-repository.org/document/reach/17afa088/REACH_BGD_Report_Age-and-Disability-Inclusion-Needs-Assessment_May-2021.pdf
16. Age and Disability Consortium. (2018) Humanitarian inclusion standards for older people and people with disabilities. https://reliefweb.int/sites/reliefweb.int/files/resources/Humanitarian_inclusion_standards_for_older_people_and_people_with_disabi....pdf
17. World Health Organization. (2017). Rehabilitation in health systems. World Health Organization. <https://apps.who.int/iris/bitstream/handle/10665/254506/9789241549974-eng.pdf?sequence=8>
18. World Health Organization. <https://www.who.int/en/news-room/fact-sheets/detail/disability-and-health>
19. WG Short Set on Function (WG-SS). (n.d.) <https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/>
20. World Health Organization. https://www.who.int/disabilities/brochure_EN_2.pdf?ua=1
21. DFID. (2000). As cited in CBM Humanitarian Hands-On Tool. <https://hhot.cbm.org/en/card/twin-track-approach>
22. United Nations. (n.d) Convention on the Rights of Persons with Disabilities: Preamble. <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>
23. Inter-Agency Standing Committee (IASC). (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC. https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
24. NSW Government (n.d.) <https://www.health.nsw.gov.au/healthone/Pages/multidisciplinary-team-care.aspx>
25. United Nations. (n.d) Convention on the Rights of Persons with Disabilities: Convention on the rights of persons with disabilities. Article 2. Definitions. <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-2-definitions.html>
26. World Health Organization. (2011). World report on disability. <https://www.who.int/teams/noncommunicable-diseases/disability-and-rehabilitation/world-report-on-disability>



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For more information, please contact:

emergencyunit@cbm-global.org

info@cdd.org.bd



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