

*directing council*



# PAN AMERICAN HEALTH ORGANIZATION

XXX Meeting

*regional committee*

# WORLD HEALTH ORGANIZATION



XXXVI Meeting

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## HEALTH OF DISABLED PERSONS

In its XXVIII Meeting (1981) the Directing Council of the Pan American Health Organization discussed the International Year of Disabled Persons and approved Resolution XLIII recommending that the subject be reexamined at the XXX Meeting of the Directing Council in 1984 with a view to evaluating the progress made.

The present document is in three parts: the first in a summarized background, the second reviews activities from 1981 to 1984, particularly in the field of community-based rehabilitation, and other technological advances for extending the coverage of programs; and the third part presents suggestions for future activities in prevention, the design of a care system, research, technical cooperation, and intra- and extrasectoral manpower training, with the involvement of the disabled persons themselves in these activities.

Annex I presents a scheme for a care system in levels of increasing complexity. Annex II is the report of the Discussion Group on Services for Disabled Persons, which met at PAHO Headquarters from 17 to 19 May 1983. Document CD28/29, presented to the XXVIII Meeting of the Directing Council (1981), is attached as Annex III.

1. Introduction

In its XXVIII Meeting (1981), the Directing Council of the Pan American Health Organization discussed the International Year of Disabled Persons on the basis of a report (Document CD28/29) presented by the Director (Annex III).

The Directing Council was also mindful of the resolutions adopted by the World Health Assembly in 1979 and 1981, which recommended that the Member States increase their efforts to ensure the success of that Year and develop permanent programs on behalf of disabled persons; requested the Director-General of the World Health Organization (WHO) to collaborate with programs of disability prevention and rehabilitation within the primary health care context, and to enhance cooperation with other United Nations agencies, and intergovernmental and nongovernmental organizations.

In that Meeting the Directing Council approved Resolution XLIII urging Member Governments to continue to increase those efforts and to establish permanent programs for disabled persons as an integral part of the health services, and requested the Director to continue to cooperate with Member Governments for these purposes.

It also urged Governments to promote the provision of primary rehabilitation services at the community level, and recommended that the subject be reexamined at the XXX Meeting of the Directing Council (1984), with a view to evaluating the progress made.

2. Conceptual basis and frame of reference

The Plan of Action for the Implementation of Regional Strategies for attainment of the goal of health for all by the year 2000, approved by all the Member Governments of the Pan American Health Organization, stresses the need to ensure satisfaction of the health needs of the entire population, and especially of the groups bypassed by development. Priority activities are the protection and promotion of the health of these groups, one of which is disabled persons.

In 1983 the United Nations General Assembly adopted the World Program of Action for disabled persons. Intended for all nations, this program must perforce be adjusted to the existing situation in each country in keeping with its resources and its capacity to formulate and implement the measures identified in the Program.

It is calculated that by the year 2000 the Americas will have a population of 600 million inhabitants, 64% of which will be living in urban surroundings.

The demographic profile of the Region is characterized by intense growth, rapid urbanization, a sharp downtrend of fertility, and a rising life expectancy at birth.

As mortality declines, the life expectancy at birth will rise and is expected to range between 65 and 70 years.

A majority--58%--of this population will be between 15 and 64 years old. The elderly population will double from 14 to 28 million persons.

In the age group of those over 45 years old, the group in which it is reasonable to expect higher probabilities of the occurrence of disabling diseases, the population will grow by about 46 million persons during the same period.

Assuming that disabled persons constitute 7% of the total population, we must expect that in the year 2000 the Region will have 42 million disabled persons, of which 26.8 million will be living in cities.

About 30 million of these people will require rehabilitation services; 16.8 million may meet their needs with community-based rehabilitation, 8.4 million will do so with services at the intermediate level, and 4 million will require services at the highest level of complexity.

If we continue with the care arrangements of the present, we believe that in the year 2000 these rehabilitation services will be available to only 400,000 to 800,000 persons.

A transformation is visibly taking place in the environment and in the habits, customs and life-styles of these populations and, in consequence, in the nature and magnitude of the risk factors, which find expression in injuries.

The evolution of traditional into industrialized societies is increasing the prevalence of chronic and degenerative diseases and the sequelae of accidents. As mortality diminishes, residual functional impairments, disabilities, go into uptrend.

From the sociological standpoint, as communities evolve the disadvantaged position of those groups and their right to be a part of and enjoy the same opportunities as the rest of the population become more evident.

The institutions that have traditionally concerned themselves with these groups have been philanthropic and have operated mostly outside the health sector.

Fortunately, countries, and especially the people concerned, are becoming aware of the magnitude and significance of this problem, largely in consequence of measures taken in the framework of the International Year of Disabled Persons, and today under the Decade of Disabled Persons.

3. Activities from 1981 to 1984

In Document CD28/29, presented in 1981, disabled persons were estimated at between 7 and 10% of the total population. Subsequent research in some countries of the Region--Argentina, Mexico, Peru and Uruguay--suggests that these figures are not far from accurate.

These studies correspond to preliminary estimates obtained in surveys of homes or to cases found in the implementation of community-based rehabilitation (CBR). None of these studies covered urban, suburban and rural populations concurrently, nor did they take account of the population of disabled persons who are institutionalized.

These preliminary studies also show that one third of the 7-10% of disabled persons can solve their problems without specialized care. These are the people who carry pathologies that are minimal or moderate in their functional effects and social impact. Forty percent of the people in this group can solve their problems through community-based rehabilitation; 20% need further professional help, and 10% require institutional rehabilitation.

Document CD28/29 said that the following aspects in particular have to be strengthened:

- a) Development of policies and programs;
- b) Development of technologies;
- c) Promotion of community participation;
- d) Development of human resources and research.

The Plan of Action for the Implementation of Regional Strategies for the attainment of Health for All by the Year 2000 stresses the need for intersectoral coordination. In particular, it calls for coordination with social security, education and labor agencies, and for cooperation with the private sector, the community, and nongovernmental organizations for the purpose of activating and promoting the occupational, care and recreational opportunities inherent in the integral care of disabled persons.

Examination of the activities carried out during this period shows that, despite the progress made, the effort must continue unabated so that not only will the problem be understood by the people who are in direct contact with disabled persons, but also to ensure that those persons all have access to the care they need.

In most of the countries in the Region, no policy for disabled persons has been adopted. Many of them have programs but, unfortunately, they are not always integrated into those of the health sector. In the health ministries of not more than six countries has a technical unit been identified as responsible for rehabilitation programs, and a minority of the countries have enacted specific laws for the comprehensive

care of the disabled, particularly in connection with measures in the health, education and labor areas, and with physical adjustments to remove architectural barriers that hinder the participation of the disabled in community activities.

One positive trend during this time has been the improvement of cooperation between health and education programs and between programs initially undertaken for specific pathologies, such as blindness, and social and vocational programs. Activities in this direction have taken place in Argentina, Barbados, Brazil, Chile, Costa Rica, Mexico, Nicaragua, Panama, Paraguay, Peru and Saint Lucia. The Regional Seminar on the Situation of the Disabled Child and Youth in Latin America, held in Panama in 1982, stressed the importance of intra- and intersectoral coordination.

In 1983 PAHO convened a discussion group to make recommendations on the Organization's future policy in rehabilitation matters (Annex II).

Important advances have been made in the application of simple technologies in community action and the fields of orthotics and prosthetics. Community-based rehabilitation (CBR) has been shown to result in improved utilization of institutional resources by those who really need care at higher levels of complexity.

Since 1981 PAHO has collaborated in the application of community-based rehabilitation technology and in the use of the manual for it. The program covers persons with general rehabilitative, social, education and domestic problems, and also covers functional problems of motion, vision, hearing and speech.

In 1981 Argentina, Brazil, Jamaica, Mexico, Peru and Saint Lucia began programs on a limited scale with PAHO's collaboration. These countries are working essentially in rural communities, and in the last year the programs have been extended to include populations in the fringes of large cities as well. These trial runs seem to show that techniques directed at specific pathologies have validity in most situations, but that those for social rehabilitation have to be adjusted to the situation and needs of the particular community.

In February 1982 PAHO was able to present a community-based rehabilitation program to the Fourth Congress of the International Rehabilitation Medical Association (IRMA), held in Puerto Rico. In August of that year WHO held an interregional meeting in Colombo, Sri Lanka, in which the latest experiences in the application of community-based rehabilitation were reported.

Since 1981 there has been a change in the provision of orthoses and prostheses in the Region. Production techniques have been simplified, which has reduced costs, made services more widely available, and resulted in better utilization of the resources on hand in the countries.

PAHO has collaborated for these purposes in the conduct of 18 country courses in Argentina, Chile, Colombia, Ecuador, Mexico, Peru and Uruguay on the manufacture of orthoses and prostheses by this simplified technology and using thermoplastic materials available in the countries themselves.

The following 192 persons were trained in the 18 courses:

Orthotists and prosthetists	66
Physicians	49
Auxiliaries	43
Physical therapists	27
Residents in physiatrics	4
Occupational therapists	2
Industrial engineer	1

These eminently practical courses provided 112 orthoses and 43 prostheses to persons with motor disabilities.

In addition to the personnel trained in the manufacture of orthoses and prostheses, about 250 community workers were trained in the administering of community-based rehabilitation. The number of these agents will go up considerably when the countries of the Region with large populations start to apply this technology or step up its application. It must be born in mind, however, that the responsibility of this personnel to disabled persons is shared with other programs in the primary health care framework.

In recent years PAHO has succeeded in identifying a network of country resources especially in Argentina, Chile, Colombia, Ecuador, Panama, Peru and Uruguay, which has permitted the conduct in those countries of regional training courses in different areas of rehabilitation in a context of technical cooperation among developing countries.

Between 1981 and 1984, PAHO granted 51 fellowships for the training of professionals. Nineteen of these fellowships (37%) were awarded to physicians and 32 (63%) to other members of the rehabilitation team.

Of the total fellowships, 45% were for training in countries of South America, 17% for countries in the Caribbean, 33% to countries in Middle America, and 4% to North America.

Forty-seven per cent of the fellowship recipients were trained in different aspects of general rehabilitation, and the others in specific pathologies and techniques.

FELLOWSHIPS GRANTED FROM 1981 TO 1984  
IN THE DIFFERENT SPECIALTIES

<u>Specialty</u>	<u>Number</u>
General rehabilitation	24
Occupational therapy	3
Physical therapy	7
Surgery	1
Leprosy rehabilitation	1
Orthoses and prostheses	8
Rehabilitation of the blind	2
Rehabilitation of the deaf	5

GEOGRAPHICAL DISTRIBUTION

	<u>Number</u>	<u>Percentage</u>
North America	2	4
Middle America	17	33
Caribbean	9	17
South America	23	45

The Regional Technical Meeting held at the Headquarters of the Economic Commission for Latin America (ECLA) in 1980 to draw up a program of action for the International Year of Disabled Persons stressed the need to strengthen coordination among international and nongovernmental organizations to make the most of the resources for technical cooperation in country programs.

PAHO has cooperated with the United Nations Children's Fund (UNICEF) and with Rehabilitation International in the preparation of a manual for the community-based prevention and rehabilitation of disabilities in children. It also maintains permanent relations with the International Labor Organization (ILO) for the coordination of related activities and with other institutions such as the World Rehabilitation Fund (WRF), Partners Appropriate Technology for the Handicapped (PATH), and Disabled Persons International (DPI). An interagency coordination meeting will be held at PAHO Headquarters in December 1984.

4. Suggestions for Future Activities

Primary Care has been defined and accepted as the principal strategy for the attainment of Health for All by the Year 2000. There is universal agreement on the need to arrive at a system of levels of increasing complexity and to devise machinery for referral.

The main purpose of the rehabilitation program of the Pan American Health Organization is:

To promote and improve knowledge and the understanding of the problem of disabilities and handicaps, their prevention, and the treatment of the largest possible number of disabled persons.

To accomplish this purpose, specific strategies will have to be introduced that are consistent with the objectives of Health for All.

#### 4.1 Strategies

##### 4.1.1 Introduction of rehabilitation into general health services

We regard rehabilitation as a multidisciplinary and intersectoral process the portal of entry to which is Health, and which must be integrated into medical care as a therapeutic component.

The comprehensiveness of Health transcends the confines of the disease-no disease phenomenon. Today we prefer to view injury as the manifestation of an interaction among medical, environmental, cultural and social factors.

This injury may eventuate in a functional impairment, a disability or a handicap.

Owing to the variety of risk factors and the characteristics described above, prevention and rehabilitation measures have to be incorporated into general health services at all levels of complexity throughout the life of the individual.

##### 4.1.2 The care system in the context of Primary Health Care

Annex I presents an outline for a care system of increasing complexity in keeping with the Primary Health Care Strategy. Its implementation will make it easier to extend the coverage of care to disabled persons, particularly with the introduction of the community-based rehabilitation technology.

The technology presented by PAHO/WHO in the manual for the training of disabled persons in the community must continue to be applied in the countries as long as possible. This technology must be fitted to the needs of the different countries and contain suitable cultural guidelines to enable it to be extended to human groups living in great poverty, particularly in the fringes of major cities and in settlements of displaced persons.

Community-based rehabilitation measures will only be successful when they have the backing of the community and the local and central health, education and social action authorities, and when they become part of a comprehensive care system, and must therefore be put into practice only when these requirements have been met.

When the countries acquire experience in this technology, adapted to their actual situations, community-based rehabilitation may be extended to any area that satisfies these criteria through training courses conducted for health agents already in place in the community.

#### 4.1.3 Coordination with other programs and sectors

Prevention work must be done in both the medical and the social area, for an injury may derive from medical (chronic, communicable and inherited diseases) or social (malnutrition, accidents, lack of environmental control, etc.) factors. Hence, these activities must be coordinated with measures for the prevention of accidents, the prevention of chronic diseases, and the treatment of those diseases so as to reduce or prevent the emergence of impairments; measures against environmental and occupational risk factors; the reduction of factors of risk to mental health; strengthening the family and support to the community; adequate coverage of immunization programs; standards for proper child rearing, and prevention of the social stress that accompanies old age.

#### 4.1.4 Research

Owing to the scarcity of information on regional and country prevalences of the different disabilities, the pattern of disabling pathologies, and their relations to risk factors, it is important to conduct epidemiological studies at the national and regional level, and PAHO will promote collaborative intercountry projects for this purpose..

The technology used in rehabilitation is not, on the whole, suited to conditions in the great majority of the countries in our Region.

We must investigate appropriate technologies which, like community-based rehabilitation and the manufacture of equipment using simplified technology, confer personal independence on the largest possible number of persons and emancipate countries from technological dependence.

#### 4.1.5 Technical cooperation

Rehabilitation, and with it a better quality of life, must be promoted in coordination with other agencies of the United Nations system, and with nongovernmental organizations.

The implementation of all these measures will require increased international technical cooperation with the countries. The flow of additional resources must be minutely programmed and coordinated because of the multisectoral character of rehabilitation, so as to assure a maximum impact and avoid costly duplications. PAHO will continue to serve in a catalytic and coordinative function in this area.

#### 4.1.6 Manpower training

The countries must take stock of the human resources available in them for rehabilitation work. The conception of rehabilitation as part of the health system and a component of general services and the three levels of care, marks a departure from the earlier approach of specialization at any cost.

Hence medical information and training must be provided at the undergraduate and graduate levels and in training for health agents and health workers, including the technology of community-based rehabilitation so as to be able to extend the coverage of these services under the Primary Care Strategy.

Outside the health sector, more knowledge and better training must be given to professionals in the areas of education and social services and to those responsible for the development of communities and their infrastructures in order to remove architectural and structural barriers.

The types of personnel, their professional and technical profiles and the pedagogical models to be adopted for their education and training, must be revised. Encouragement must be given to training disabled persons themselves so that they will be able to contribute support to rehabilitation programs, and become agents for change in the understanding of their problems and their own integration into society.

## CONCLUSIONS

The countries in the Region as a whole have a long history of rehabilitation work in health programs. However, there is still a wide range of variation in the conduct of comprehensive programs.

In the last decade a profound change began in the conception of the disability problem and rehabilitation technologies. The new approaches are in line with the primary care strategy and particularly with community participation and training.

Some of the most important changes being seen in programs are a broadening of the spectrum of pathologies covered, the introduction of rehabilitation measures into general health services in the context of primary health care, intra- and intersectoral coordination and participation of disabled persons themselves and of their communities in the search for and application of measures that contribute to a better quality of life.

The Member Governments must take measures and apply techniques that bring a better quality of life closer for disabled persons. This will surely require a sustained effort during which the number of disabled persons will continue to increase. Unless this effort is made, the consequences of disabilities will be superadded to the many other obstacles that limit the emergence of countries from underdevelopment. It is hence imperative that the development plans and programs of the countries in the Region include immediate measures for the prevention of disabilities and the rehabilitation and social integration of disabled persons.

## Annexes

COMPONENTES OF THE CARE SYSTEM

Level	Function	Performed by
1. Home	<ul style="list-style-type: none"> <li>- Recognition of signs of disability</li> <li>- Giving information to the health agent</li> <li>- Application of simplified technology</li> <li>- Advising local supervisor</li> </ul>	<ul style="list-style-type: none"> <li>- The family</li> <li>- Health agent</li> <li>- Health worker or equivalent</li> </ul>
2. Community	<ul style="list-style-type: none"> <li>- Supervising the health agent--Counselling</li> <li>- Referral to local medical supervision</li> </ul>	<ul style="list-style-type: none"> <li>- Local supervisor</li> </ul>
3. First-level health post	<ul style="list-style-type: none"> <li>- Identification of unresolved cases</li> <li>- Use of diagnostic methods nonexistent in other categories</li> </ul>	<ul style="list-style-type: none"> <li>- Nursing auxiliary</li> <li>- Nurse</li> <li>- Itinerant physician</li> <li>- Physician with minimum of training in rehabilitation</li> </ul>
4. Provincial or state hospital	<ul style="list-style-type: none"> <li>- Administration of treatment</li> <li>- Personnel training in community-based rehabilitation</li> </ul>	<ul style="list-style-type: none"> <li>- Nurse</li> <li>- Informed physician with related specialty</li> <li>- Physical therapist</li> </ul>
5. Regional hospital of highest complexity Specialized rehabilitation units	<ul style="list-style-type: none"> <li>- Diagnosis of degree and type of disability</li> <li>- Comprehensive rehabilitative treatment</li> <li>- Personnel training for the whole system</li> </ul>	<ul style="list-style-type: none"> <li>- Rehabilitation team</li> <li>- Medical specialists</li> </ul>



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IN REPLY REFER TO:

DISCUSSION GROUP ON SERVICES FOR THE DISABLED

Washington, D.C. 17-19 May 1983

## DISCUSSION GROUP ON SERVICES FOR THE DISABLED

Washington, D.C. 17-19 May 1983

### INTRODUCTION

By 1983, PAHO had completed twenty-five years of activities in the field of Disability Prevention and Rehabilitation. In view of the many changes that have taken place during this period it was considered that this was an appropriate time to review the work done in the past and suggest guide-lines for the future.

A Discussion Group was therefore convened for this purpose, consisting of PAHO staff members and outside experts (Appendix I). They met for three days in Washington, D.C. and discussed the subject in accordance with the attached Agenda (Appendix II).

Past activities were briefly reviewed (Appendix III) and the comment made that although the Organization had obviously widened its philosophical approach to this matter through the years, this change was not yet evident in the countries' rehabilitation programs.

The Group considered that the policy for rehabilitation activities as given in the "Plan of Action for Health for All by the Year 2000" was acceptable (Agenda Item 2) and took note that the 28th Directing Council had made Recommendations that Member Governments should establish permanent

programs for their disabled populations (Appendix IV). However, in view of the size of the problem (Appendix V) and the need for early action, the Group felt it important that the Organization should actively assist Governments to implement realistic programs to improve the way of life of disabled persons. Such programs should give particular emphasis to the health aspects of the problem but have also a keen awareness of the social and educational factors.

To achieve this the Group suggested to the Organization the following short, medium and long term activities.

#### SUGGESTIONS CONCERNING ACTIVITIES TO IMPLEMENT FUTURE POLICY

##### I. RESEARCH

- 1.1 Test the viability of the Manual for training the disabled in the community, in those countries in the Region which are developing primary health care programs and which, where possible, can be chosen to demonstrate the different characteristics of the Region. It is indispensable that the countries chosen already have established intermediate and superior levels of medical rehabilitation.
- 1.2 Collect basic information concerning the types of disability and the problems which they are causing, specifying the handicap as given in the above mentioned Manual.

- 1.3 With the information obtained, note the prevalence of disability with regard to movement, hearing, vision, mental retardation, learning problems and problems of unemployment.
- 1.4 Design the research procedures so that they can be applied to give comparable results in different areas or regions.
- 1.5 Design and set up registers and classifications of disabilities which can be incorporated into countries' existing information systems.
- 1.6 Increase research work on a) disability in early infancy, with emphasis on the new-born at high risk and b) those who are 60 or over.
- 1.7 Study existing programs for the handicapped which increase self-respect and assist integration into their communities.
- 1.8 Research the present situation in the countries of the Region concerning architectural barriers.

## II. TRAINING

- 2.1 Study the type of and training for the most suitable personnel required to implement the intermediate level of medical rehabilitation.
- 2.2 Include activities in prevention, identification and rehabilitation of disabled persons into those functions carried out by community health workers.

- 2.3 Prepare manuals, audiovisual material and other teaching material required to develop these activities. The material should be inexpensive and be suitable for use at the various levels of care.

### III. STANDARDIZATION

- 3.1 Organize a Steering Committee to prepare position papers for discussion at a Conference for the authorities and specialists responsible for rehabilitation programs.
- 3.2 The objectives of the Conference will be:
- The official presentation in the Region of the Americas of the Policy for the provision of services for the disabled using community resources.
  - The presentation of the statistical information obtained by the research carried out in selected countries as mentioned earlier.
  - To draw up a Plan of Action for the Region appropriate for the needs and available resources.

### IV. INFORMATION

- 4.1 Arrange interchange of experiences and information between the countries of the Region.
- 4.2 Distribute the information obtained from the field tests and also the Plan of Action proposed by the Conference mentioned in 3.1.

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DISCUSSION GROUP ON SERVICES FOR THE DISABLED

Washington, D.C. 17-19 May 1983

PROVISIONAL AGENDA

1. Review of PAHO's past activities in the field of Rehabilitation.
2. Suggestions for future policy for "Services for the Disabled".
3. Suggestions concerning activities to implement future policy:
  - a) Long term (1984-2000)
  - b) Medium term (1984-1989)
  - c) Short term (1984-1985)

Time Activity	Short Term (1984-1985)	Medium Term (1986-1989)	Long Term (1990---2000)
I. Research  a) Manual b) Epidemiology c) Classification and register d) Architectural barriers	Field testing and analysis Prevalence and function  Present situation	Continuation Evaluation Epidemiological evaluation  Accumulating experience	-----> -----> ----->
II. Training  - Doctors  - Paramedical personnel	Orientation to new concepts  Development of teaching material	Training in application of new concepts  ----->	
III. Standardization	-Position papers  -Steering Committee	Conference 1985 or 1986  Plan of Action	Promotion of Policy and Plan of Action
IV. Information		Preparation, publication and distribution of Conference Findings and Plan of Action  Interchange of Information	Distribution of Conference Findings and Plan of Action

DISCUSSION GROUP ON SERVICES FOR THE DISABLED

WASHINGTON D.C. 17-19 MAY 1983

Agenda Item N°1 Review of PAHO's past activities in the field of rehabilitation

Twenty-five years ago when PAHO first started to work in the field of rehabilitation, the approach which was based originally on the needs of the war wounded, was largely that of physical restoration for a part of the body damaged by injury or disease. The rehabilitation practitioner specialized mainly in orthopedic and neurological problems and therapy mostly concerned with reeducation or replacement of the damaged part such as that provided by physical and occupational therapy or prosthetics.

Today the concept has widened greatly, both in the physical nature of the disabilities covered and by including services not only for the physical problems but for the social, educational and economic consequences of disability. This expansion is well indicated by the fact that in 1982 PAHO changed the name of these activities from "Medical Rehabilitation" to "Services for the Disabled."

Services for the Disabled now include not only locomotor problems but also the problems of sight, speech and hearing and include the responsibility for training disabled persons in self-care, social and domestic activities, education or job training and mental problems. Also "Services for the Disabled" are no longer confined to those which are given in hospitals and rehabilitation centers but are being expanded to include those which can also be given in disabled persons own homes or communities.

A review of the principal activities of PAHO over this period shows this gradual change of perspective. The early years show a concentration on the setting up of rehabilitation departments or institutes, frequently within a hospital or other medical facility and the training of the rehabilitation professionals required to work in these areas.

At first these professionals were mainly those needed to provide services for locomotor problems (doctors of physical medicine, physical and occupational therapists and prosthetist/orthotists.) By the seventies training was being included for therapists for speech, hearing and visual problems and by the mid-seventies the concept of auxiliary or assistant therapists had been accepted and was being included.

By the late seventies it was being realized that although the institutional approach was producing good results, the coverage provided by those institutions was very inadequate and it was also realized that it would be economically impossible to provide this type of coverage on a world basis.

At the request of member states, therefore, investigation was carried out as to the possibility of providing at least some services for disabled people in their own homes and communities. By 1982 this approach had been shown to be technically valid and some countries in the region are, with PAHO's co-operation starting tentative programs for providing services for the disabled at the community level.

PAHO REHABILITATION ACTIVITIES

MAIN EVENTS 1958 - 1982

- 1958 Institute started in Sao Paulo, Brazil (Medical Officer, Physio., OT, Prost.)
- 1963 Institute started in Santiago, Chile (Regional post created)
- 1965 PT school started in Caracas, Venezuela
- 1966 OT and Prosthetics schools started in Caracas, Venezuela
- PT schools started in Buenos Aires, Argentina
- 1967 Prosthetics school started in Buenos Aires
- 1969 PT teacher course given in Mexico (Regional)
- Study Group on Doctors
- 1971 Study Group on P/T, O/T, Social workers and Administrators
- Regional Adviser moved to Washington (October)
- 1972 PT school started in Jamaica
- Study Group on Blind
- 1973 Official programs in eight countries
- 1977 Assistant Therapists trained in Guyana
- First field tests of community assistance for disabled in Venezuela
- 1978 Regional Adviser transferred to Mexico for full field tests
- of community rehab. (1979/1981)
- 1981 PAHO/UNICEF program in Nicaragua
- Regional Adviser transferred to Washington
- 1982 Pilot projects planned in Colombia, Chile, Perú and Argentina in
- community rehab.

# STUDY GROUPS

PAHO Training of Rehabilitation. Doctors.	1969	Chile
P.T., O.T., Social Workers	1971	Mexico
Prosthetics and Orthotics	1972	Washington
Speech	1973	Washington
Blind	1975	Washington

# SCHOOLS

BRAZIL:	Schools of Physical Therapy Occupational Therapy Prosthetics	1958/1961	Sao Paulo
CHILE:	Schools of Occupational Therapy Prosthetics	1963/1966	Santiago
ARGENTINA:	Schools of Physical Therapy Prosthetics	1967/1969 1967/1977	Buenos Aires
VENEZUELA:	Schools of Physical Therapy Occupational Therapy		Caracas Caracas
COLOMBIA:	School of Prosthetics		Bucaramanga
JAMAICA:	School of Physical Therapy	1972/1975	Kingston
MEXICO:	School of Prosthetics	1972/1982	Mexico City

# MAJOR TRAINING COURSES (not schools)

1969	Teacher Training course for Instructors at L/A Physical Therapy Schools.	Mexico City
1977	Training course for Physical Therapy Assistants.	Georgetown, Guyana
1979/81	Training of Community Health Workers in rehabilitation.	Toluca, Mexico

WHA34.38 on the function of the physician and other health workers in the maintenance and promotion of peace as the prime factor in the attainment of health for all, and to request the Director to act to ensure that their intent and purpose are conveyed to Member Governments.

*(Approved at the fifteenth plenary session,  
1 October 1981)*

## Resolution XLIII

### International Year of Disabled Persons

*The Directing Council,*

Having examined the report presented by the Director on the International Year of Disabled Persons (Document CD28/29);

Considering Resolution 31/123 of the United Nations General Assembly proclaiming the year 1981 as "International Year of Disabled Persons;" and

Recalling Resolutions WHA31.39 and WHA34.30<sup>34</sup> of the World Health Assembly recommending that Member States increase their efforts to ensure the success of the Year and develop permanent programs for the disabled as part of the goal of health for all by the year 2000, and requesting the Director-General of WHO to collaborate in programs of disability prevention and rehabilitation within the primary health care context and to enhance cooperation with United Nations agencies, intergovernmental organizations, and nongovernmental organizations in the implementation of such programs,

*Resolves:*

1. To thank the Director for the information provided on the International Year of Disabled Persons.

2. To urge Member Governments to continue to increase their efforts to ensure the success of the International Year of Disabled Persons and, on the basis of those efforts, to establish permanent programs for disabled persons as an integral part of the health services.

3. To urge Member Governments to promote the provision of primary rehabilitation services at the community level.

4. To request the Director to continue to cooperate with Member Governments in assessing the problems produced by disability and adopting policies for their solution.

5. To recommend that the subject be re-examined at the XXX Meeting of the Directing Council of PAHO, XXXVI Meeting of the Regional Committee of WHO for the Americas, to be held in 1984, with a view to evaluating the progress made.

*(Approved at the fifteenth plenary session,  
1 October 1981)*

IN WITNESS WHEREOF, the President of the Directing Council and the Secretary ex officio, Director of the Pan American Sanitary Bureau, sign the present Final Report in the English and Spanish languages, the two texts being equally authentic.

DONE in Washington, D. C., United States of America, on this first day of October, nineteen hundred and eighty-one. The Secretary shall deposit the original texts in the archives of the Pan American Sanitary Bureau and shall send copies thereof to the Governments of the Organization.

*(In the absence of the President)*

Lyall M. Black  
Vice President of the Directing Council  
Representative of Canada

Héctor R. Acuña  
Secretary ex officio of the Directing Council  
Director of the  
Pan American Sanitary Bureau

(Appendix IV)

Disability in Latin America and the Caribbean - Some Considerations  
of the Number of Disabled Persons in the Region

No statistics are available concerning the number of disabled persons in this Region. However the following estimates may be made:

By 1990 the TOTAL POPULATION will not be less than 300,000,000

Several recent field trials have suggested that the  
DISABLED POPULATION is not less than 5%, i.e.: 15,000,000

Of these, field trials suggest that:

30% require no services	(4,500,000)
40% require community level services	6,000,000
20% require services at the secondary level	3,000,000
10% require services at the institutional level	1,500,000

A community health worker can supervise about 60 disabled a year (10 active cases, one new case a week and one discharge a week).

(The numbers served by secondary level facilities and institutes are too variable to generalize).

*directing council*



# PAN AMERICAN HEALTH ORGANIZATION

XXVIII Meeting

*regional committee*

CD30/14 (Eng.)

ANNEX III

# WORLD HEALTH ORGANIZATION



XXXIII Meeting

Washington, D.C.  
September-October 1981

Provisional Agenda Item 35

CD28/29 (Eng.)

29 July 1981

ORIGINAL: ENGLISH

## INTERNATIONAL YEAR OF DISABLED PERSONS, 1981

This document is an attempt to draw attention to the problem of disability with particular reference to the situation in the Region of the Americas in the year 1981, the "International Year of Disabled Persons."

The document also refers to PAHO's contribution to the solution of the problem through measures to prevent disability from occurring and by extending programs to provide wider coverage. Methods are suggested for the strengthening of programs for disabled persons, with particular emphasis on primary rehabilitation care at the community level.

## INTRODUCTION

1. The year 1981 was proclaimed by Resolution 31/123 of the United Nations General Assembly of 1976 as the "International Year of Disabled Persons (IYDP)," with the theme "Full Participation." At its 34th Session in 1979 the General Assembly expanded this theme to "Full Participation and Equality" (Resolution 31/154).

2. In 1979 the Thirty-first World Health Assembly requested the Director General to contribute as extensively as possible, within the approved budget of WHO, to the success of the Year (Resolution WHA31.39). The Thirty-fourth World Health Assembly, in May 1981, recommended continued efforts for the success of the Year, and the establishment of permanent programs for the disabled as part of health for all by the year 2000. It also requested the development of disability programs within the primary health care context and enhanced cooperation with UN agencies and intergovernmental and nongovernmental organizations in planning and implementing the above programs.

3. The purpose of IYDP is to call the attention of health and welfare authorities to disability as a health and social "problem," to increase general understanding of disability by all people, and to increase services for the disabled, particularly for those who, for economic or geographic reasons, do not have access to existing facilities.

#### DISABILITY AND THE DISABLED\*

The changes in functions and social roles that accompany a disease, accident, congenital condition, or other pathological process have been described as Impairment/Disability/Handicap, where Impairment is any loss or abnormality of psychological, physiological or anatomical structure or function; Disability is any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being; and Handicap is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal, depending on age, sex, and social and cultural factors, for that individual.

Examples of the use of the above terms are given in Annex I.

It has been estimated that from 7 to 10 per cent of the world's population have some type of physical or mental disability and that about 1.5 per cent of the population is, at any given moment, in need of assistance. This means that a country of 10,000,000 inhabitants can expect to have a disabled population of from 700,000 to 1,000,000, of whom 15,000 are in active need of some type of rehabilitation service.

The principal causes of disability and approximate numbers on a world basis are given in Annex II.

#### PREVENTION OF DISABILITY

First-level prevention is applied after the accident or disease has occurred which might lead to impairment and attempts to prevent that impairment from taking place; second-level prevention is an attempt to prevent the impairment from becoming a disability; and third-level prevention includes those actions designed to prevent the disability from becoming a handicap.

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\*Adapted from "Training the Disabled in the Community," WHO DPR/80.1

## EVOLUTION IN THE DEVELOPMENT OF SERVICES FOR THE DISABLED

During the past decade the emphasis in finding solutions for the problem of disability has shifted from the provision of traditional rehabilitation services in an institutional setting towards programs for the prevention of disability and the provision of primary rehabilitation services at the community level.

Rehabilitation services were originally provided in Europe and the United States of America to people who had suffered severe war injuries, and such cases were of necessity cared for in hospital surroundings. From this developed the concept of the rehabilitation center which became more and more sophisticated in its technology, both with regard to equipment and human resources. From the years 1950 to 1980, most countries in Latin America developed one or more centers along these lines, with PAHO frequently cooperating in the preparation of appropriate personnel. The medical rehabilitation centers were usually equipped to serve paraplegics, hemiplegics, amputees, and neuro-muscular problems, whereas special centers were provided for children with cerebral palsy or speech and hearing problems, and special education centers developed for the mentally retarded.

About ten years ago, concern began to be felt that although these centers were serving well for a limited number of people, they were costly to construct and maintain, and their capacity was limited to those who lived close to them and who could either meet the costs themselves or have them met by some government or insurance agency. It was estimated that possibly some 2 per cent of disabled persons were actually able to use the world's existing facilities and, hence, to continue developing these approaches only along institutional lines would be an economic impossibility for most countries.

It was considered that at least some of the services required could be carried out in simpler surroundings and by less highly trained personnel, and it was decided, therefore, to investigate up to what point it would be feasible to provide basic services at home.

In 1979, a manual was prepared by WHO, Geneva, entitled "Training the Disabled in the Community," and a Spanish version was prepared for Latin America. It consists of 20 individual handbooks written in very simple Spanish, with illustrations designed to be easily understood by the users. The booklets cover general rehabilitation problems such as social, domestic, and educational difficulties; specific problems such as those of movement, sight, hearing, and speech; and there are three further guides for those in the community who are principally involved--the local authorities, schoolteachers, and community health workers.

The application of these techniques by community health workers in peoples' homes has added a new element in the field of disability prevention and rehabilitation, and opens the way for a much greater coverage for the world's disabled population.

#### THE SITUATION CONCERNING SERVICES TO THE DISABLED IN THE REGION, 1981

The situation in this Region at the moment is that most rehabilitation of disabled people is being carried out in institutions. Highly developed countries such as the United States of America and, to a lesser extent, Canada, by virtue of having many specialized centers and hospital departments have a greater coverage than most countries in Latin America. However, even in these two countries coverage is far from complete.

In Latin America, where there are far fewer rehabilitation facilities, coverage of disabled persons is very poor, and available only to those who live close to one of the few existing centers or departments, and even then financial restrictions may prevent their use.

Rehabilitation centers do, of course, have a useful part to play in assisting disabled persons, but their usefulness could be far more widely felt if they were used not only as service centers but as training centers for community health workers in rehabilitation activities, as supervisors of work being carried out at the community level, and as referral institutions for disabilities too severe to respond to assistance at the community level.

For the past 20 years PAHO has been involved in the preparation of personnel for the provision of rehabilitation services. Training courses and fellowships have been given for doctors, physical and occupational therapists, speech therapists and prosthetists/orthotics. During the 1960's and early 1970's, a series of study groups were held concerning the appropriate training required for each of these disciplines, with the aim of enabling relatively uniform training to be provided for such personnel throughout the Region. In 1981 work along these lines is continuing in Argentina, Chile, Mexico, Peru, and Venezuela.

During 1981 PAHO has also been collaborating with government and non-government agencies in implementing rehabilitation programs, and has been represented at both national and international meetings concerned with IYDP.

Training schools for doctors and therapists in rehabilitation work have been set up in most countries in the Region, which has become largely self-sufficient in this area. For those countries still requiring outside assistance, the use of short-term consultants can usually fill

the need. However, the fact that most countries are providing training for conventional rehabilitation personnel unfortunately does not solve the problem of disability in the Region. As pointed out earlier, the sheer number of disabled persons requiring assistance means that, if all the services required are to be provided by specialized staff, they will be needed in such large numbers that the cost of maintaining them will be totally unrealistic. Other complimentary methods must be found.

#### PROPOSALS FOR FUTURE PROGRAM DEVELOPMENT

The International Year of Disabled Persons has increased the awareness of many people of the magnitude of the problem of disability throughout the world. It is a propitious moment therefore for re-emphasizing the need for the prevention of disability and rehabilitation of the disabled to be included in all public health programs and for the reorientation of some of the ways in which this may be achieved.

The document, "Health for All: Plan of Action for the Implementation of Regional Strategies," refers to four main areas of action for the disabled:

- a) Development of policies and programs;
- b) Development of technologies;
- c) Promotion of community participation;
- d) Development of human resources and research.

#### A. Policies and Programs

To create a policy leading to programs which will provide national coverage requires that the matter be considered from several points of view. First some kind of estimate should be made of the number of people needing rehabilitation assistance. A rough guide is the 1.5 per cent quoted above, but surveys should also be made at least in selected areas. A further estimate should then be made of how many of these are moderate disabilities which can be assisted at the community level, and how many need institutional help. A survey in Mexico suggests that 41 per cent can be helped at the community level, rising to 59 per cent if therapists or other specialized personnel are available, and that 12 per cent cannot be assisted without institutional help, but these figures will vary in accordance with the availability and sophistication of existing facilities. This gives a guide as to how much community activity will be needed and the minimum of institutional care which should be provided.

Consideration has to be given to effective multisectoral cooperation, particularly with regard to health education and labor.

Provision of services has to be made for the following categories of disabled persons:

1. Mild disabilities which can be improved at the community level.
2. Moderate to severe disabilities which need:
  - a) evaluation and early care at an institution providing surgery and physical therapy; or
  - b) evaluation and early care at an institution providing appropriate rehabilitation services (physical therapy, speech and hearing therapy, therapy for visual problems or therapy for mental problems);
  - c) provision for education in the case of disabled children; and
  - d) provision for job-training in the case of disabled adults.
3. Very severe disabilities which are not susceptible to rehabilitation and require custodial care.

The provision of appropriate services for all the disabled population, including programs for the prevention of disability, can, in most countries, only be accepted as a long-term goal. The people that can be assisted at the community level (group 1) the greater, of course, will be the coverage. An analysis of disabled persons in group 2 and of the existing specialized services in the country will indicate whether more specialized institutions or hospitals are needed. Further assessments could be made as to whether existing facilities are being used to provide the fullest possible coverage.

Institutional facilities staffed by specialized personnel should only be provided to cover the real needs of the country. Wherever possible, the problems of the disabled should be solved at the community level.

#### B. Technologies

The conventional technologies must continue to be taught so that they are available when required. Every country must have its cadre of well-trained rehabilitation personnel. However, more and more it will become part of the jobs of these specialized persons to train and supervise community health workers so that as much as possible of the proposed assistance can be given at home, using the technology mentioned previously in this paper. In fact it is to be hoped that techniques for helping the disabled at the community level will include the training of all community

health workers, and it would be of great value if, at least, the concept of helping disabled persons in relatively simple ways were to become part of the training of all health personnel, especially doctors.

C. Community Participation

In addition to having suitable technology to be applied at the community level, it is equally important that the community as a whole be oriented in its attitudes toward the disabled. Disabled persons should be encouraged to move around in the community as much as possible, and to take part in community activities both socially and politically.

Community leaders should be closely involved in the organization of these services, and schoolteachers should be asked to cooperate in both identifying disabled schoolchildren and accepting them wherever possible in the regular classes.

The community should also be encouraged to assist disabled persons to find employment, however simple such employment may be. The more involved the community can become, the less disability will prove to be a handicap.

D. Human Resources and Research

Support should be given, therefore, to training programs at all levels. Where still required, training should be provided for medical rehabilitation doctors and rehabilitation therapists, (physical and occupational therapists, speech therapists, prosthetists/orthotists and vocational workers). However, at the same time, provision must be made for community work, preferably giving training in simplified rehabilitation to existing community health workers.

Further research is needed both to improve this basic technology and to find ways for its implementation on a large scale. The technology has been shown to work when there are permanent appropriate local staff to apply it. It appears that more and more countries are training community health workers for various aspects of health care, and it would seem that this would be the key to extended coverage for the disabled on a wide basis. When it becomes possible to ensure that all community health workers are also capable of giving basic rehabilitation services, then health authorities will be in a better position to give disability the attention it requires.

## CONCLUSIONS

The International Year of Disabled Persons is of value in calling the world's attention to the problem of disability, but it will only be of lasting value if use is made of this awareness to create policies which will continue long beyond the Year itself.

Conventional rehabilitation services should be strengthened in those countries which have not yet sufficiently developed them, and training provided for appropriate personnel to provide such services; however, all countries should consider complimenting these services with additional programs to provide primary rehabilitation services at the community level.

## Annexes

EXAMPLES OF IMPAIRMENT/DISABILITY/HANDICAP

Example 1: A 16-year-old boy is involved in a traffic accident and one leg had to be amputated above the knee.

Impairment: Loss of leg.

Disability: Decreased ability to walk.

Handicaps: Decreased ability to work, to enjoy normal social activities (sports, dancing) and to have social relationships.

Example 2: A 50-year-old male, who has had hypertension for several years, suffers a stroke resulting in a right-side hemiparalysis and dysphasia.

Impairment: Hypertension.  
Disturbance of brain function.

Disabilities: Decreased ability to talk.  
Decreased ability to walk and use right hand.  
Fatigue through low physical endurance.

Handicaps: Inability to work, partial inability to look after himself, and reduced ability to interact with surroundings.

Example 3: A 3-year-old girl is left with severe scars on her face and her entire left arm after burns.

Impairments: Burn scars.  
Abnormal appearance.

Disabilities: Decreased mobility of arm.  
Decreased interest in and contact with surroundings.

Handicaps: Decreased capacity to take part in household work, disturbed social relationships (rejected by family and community members), and marriage prospects greatly decreased.

Example 4: An adult married female, with two children, with a two-year history of "schizophrenia."

Impairments: Auditory hallucinations.  
Lack of volition (i.e., normal drive and interest).  
Disturbance of thought processes.

Disabilities: Inability to maintain drive and interest in daily tasks.  
Poor attention and grasp of information.  
Lack of contact with reality.

Handicaps: Failure to care for children, perform housework, maintain personal hygiene and appearance, and relate to family members and friends.

Example 5: A 50-year-old married man with daily intake of 300 ml absolute alcohol in the form of distilled spirits owing to an inability to abstain from alcohol, withdrawal symptoms each morning (tremor, anxiety, and butterflies in stomach, which are suppressed by further alcohol intake), and episodes of amnesia.

Impairments: Inability to abstain from alcohol intake (note: may also have disturbance of brain function, impaired sensation in hands and feet, liver damage, etc.)

Disabilities: Lack of judgement and motor skills.  
Drive and motivation disturbed by need to obtain alcohol.

Handicaps: Marked decreased in working efficiency (increased errors, decreased output, absenteeism) leading to inability to work, inability to maintain economic necessities of life, and disturbed social relationships.

Example 6: A 15-year-old mentally retarded boy with no education.

Impairment: Abnormally low intelligence.

Disabilities: Slowness in acquisition of skills and knowledge.  
Inability to read, write, or make simple calculations.

Handicaps: Unable to work, and disturbed social relationships.

Example 7: A 40-year-old woman with leprosy for several years.

Impairments: Loss of tissue from hands and feet.  
Loss of sensory function in several areas.  
Ulceration of skin.  
Rash.

Disability: Decreased mobility and motor skills.

Handicaps: Unable to perform household and family duties  
and to have normal social relationships.

THE CAUSES OF DISABILITY AND APPROXIMATE NUMBER OF  
DISABLED PEOPLE IN THE WORLD

Medical cause	Estimated disabled people (world population 4,000 million)	
	Million	%
Congenital disturbances:		
Mental retardation <sup>1/</sup>	40	7.7
Somatic hereditary defects	40	7.7
Non-genetic disorders	20	3.9
Communicable diseases:		
Poliomyelitis	1.5	0.3
Trachoma	10	1.9
Leprosy	3.5	0.7
Onchocerciasis	1	0.2
Other communicable diseases	40	7.7
Noncommunicable somatic diseases	100	19.3
Functional psychiatric disturbance	40	7.7
Chronic alcoholism and drug abuse	40	7.7
Trauma/injury:		
Traffic accidents	30	5.8
Occupational accidents	15	2.9
Home accidents	30	5.8
Other	3	0.6
Malnutrition	100	19.3
Other	2	0.4
<hr/>		
	Total	<u>516</u>
Correction for possible double accounting (-25%)	- 129	<u>100.0</u>
	Total	<u>387</u>

<sup>1/</sup> Not all of these are congenital cases

## PREVENTION OF DISABILITY<sup>1/</sup>

Measures to diminish disability and handicap area of great importance, and should be given priority whenever possible.

As defined by WHO<sup>2/</sup>, prevention may be seen operating at three different levels:

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MALNUTRITION  
DISEASE  
ACCIDENTS  
CONGENITAL CONDITIONS  
OTHER CAUSES

---

### FIRST LEVEL PREVENTION

---

IMPAIRMENT

### SECOND LEVEL PREVENTION

---

DISABILITY

### THIRD LEVEL PREVENTION

---

HANDICAP

- a) First level prevention includes all action taken to reduce the occurrence of impairment.
- b) Second level prevention includes all action taken to reduce the transition of impairment into disability.
- c) Third level prevention includes all action taken to reduce the transition of disability into handicap.

Some details regarding these three levels follow.

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<sup>1/</sup> As given in "Training the Disabled in the Community," WHO DPR/80.1  
<sup>2/</sup> A29/INF.DOC/1, World Health Organization, Geneva, 1976.

a) First Level Prevention

Examples of what can be done to prevent or limit occurrence of impairment.

SUMMARY OF THE MOST IMPORTANT MEASURES TO PREVENT DISABILITY

PROBLEMS	EXAMPLES OF MEASURES
Nutrition	Improved agriculture to increase and diversify output, to improve distribution of foodstuffs, provision of fertilizers and training of rural population in appropriate agricultural techniques, irrigation, etc., public education to improve composition of meals and cooking habits, better control of gastrointestinal infections, supplementary feeding, e.g. vitamins and iodine.
Communicable diseases	Provision of proper water and sewage systems, public education to improve hygiene and avoid transmission of disease, vaccination.
Road accidents	Public education for drivers and pedestrians, better supervision of children at accident-prone age, technically improved roads and safer vehicles, legislation and improvement of traffic regulations.
Home accidents	Community education, better supervision of children, improvement of housing and home installations (e.g., cooking stoves and use of dangerous fuel), legislation and enforcement of rules to prevent accidents.
Occupational accidents and diseases	Education of workers, improved tools and machinery (including agriculture), monitoring of accidents and environmental hazards, use of safety devices (e.g., when climbing houses and trees), legislation to protect against hazardous agents, safety committees.
Genetic disorders	Counselling to discourage consanguineous marriages, child spacing to reduce natality in high risk families. Contraception, pregnancy termination, sterilization, if culturally acceptable.

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PROBLEMS	EXAMPLES OF MEASURES
Perinatal diseases (e.g. cerebral palsy and brain damage)	Improved perinatal care.
Child neglect and abuse	Community education, improved level of schooling, legislation and law enforcement.
Alcohol and drug abuse	Legislation and law enforcement to reduce supply, public education to understand consequences of abuse.
Impairment caused by medicines	Better control of drug import and manufacture, legis- lation to forbid potentially hazardous drugs.

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It may be estimated that measures such as those mentioned may reduce the incidence of disability/handicap by about one-third. As most of the preventive action suggested will have an impact on disability in infants and children, this means that life-long disability/handicap, and excessive mortality in infants and children, may be substantially reduced.

b) Second Level Prevention

When an impairment has already appeared, it is necessary to try to prevent any long-term disability from occurring and to do so requires measures specifically in three areas.

1. Ability to identify those impairments that might lead to disability e.g., to recognize a person with mental retardation, to make a simple test of visual and hearing acuity, to diagnose leprosy, tuberculosis, a fracture, epilepsy, psychosis, etc.
2. Proper care of impairments in the acute stage to avoid subsequent disability, e.g. skills to administer first aid, to splint a fracture and to advise on suitable exercise during its treatment, to sterilize or avoid infection of wounds and burns, to effectively treat persons with acute otitis, trachoma and other eye infections, to manage a patient with an epileptic fit, or one with acute symptoms of psychosis, etc.

3. Proper care of impairments in a chronic stage; drug, surgical and other treatment of patients with epilepsy, leprosy, tuberculosis, psychosis, high blood pressure, diabetes, chronic arthritis, bronchial asthma, chronic skin lesions, cataracts, etc.

The above involves mainly improvements in the delivery of primary and secondary health care. If fully effective, the occurrence of disability/handicap may be reduced by about 20-30 per cent. When planning the development of health services, most attention is presently paid to acute diseases, and less to measures that are effective in prevention of disability.

Thus, it is important that the planning for health care is revised with the aim to ensuring the provision of the care mentioned.

c) Third Level Prevention

Once a long-term disability has developed, one should try to institute measures aimed at the prevention of handicap.

The incidence of disability/handicap can be reduced by at least 50 per cent, possibly even more, if appropriate, effective primary and secondary level prevention is implemented in developing countries.

The preventive effects would be most obvious among infants, children and young people, thus avoiding long-lasting disabilities.

INTERNATIONAL AGREEMENTS AND POLICIES RELEVANT TO THE DISABLED

1. Excerpts from the Universal Declaration of Human Rights  
Adopted and proclaimed by the U.N. General Assembly, Resolution  
217 A (III) of 10 December 1948

Preamble

Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human families is the foundation of freedom, justice and peace in the world,

Whereas the peoples of the United Nations have in the Charter reaffirmed their faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women and have determined to promote social progress and better standards of life in larger freedom,

Whereas Member States have pledged themselves to achieve, in cooperation with the United Nations, the promotion of the universal respect for and observance of human rights and fundamental freedoms,

Whereas a common understanding of these rights and the freedoms is of the greatest importance for the full realization of this pledge,

Now, therefore,

The General Assembly

Proclaims this Universal Declaration of Human Rights as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction.

Article 1

All human beings are borne free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

Article 2

Everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.

Article 22

Everyone, as a member of society has the right to social security and is entitled to realization, through national effort and international cooperation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality.

Article 23

1. Everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment.

2. Everyone, without any discrimination, has the right to equal pay for equal work.

3. Everyone who works has the right to just and favorable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.

4. Everyone has the right to form and to join trade unions for the protection of his interests.

Article 24

Everyone has the right to rest and leisure, including reasonable limitations of working hours and periodic holidays with pay.

Article 25

1. Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.

#### Article 26

1. Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit.

2. Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among all nations, racial and religious groups, and shall further the activities of the United Nations for the maintenance of peace.

3. Parents have a prior right to choose the kind of education that shall be given to their children.

#### Article 27

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

2. Everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author.

#### Article 28

Everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized.

#### Article 29

1. Everyone has duties to the community in which alone the free and full development of his personality is possible.

2. In the exercise of his rights and freedoms, everyone shall be subject only to such limitations as are determined by law solely for the purpose of securing due recognition and respect for the rights and freedoms of others and of meeting the just requirements of morality, public order and the general welfare in a democratic society.

3. These rights and freedoms may in no case be exercised contrary to the purposes and principles of the United Nations.

2. Declaration on the Rights of Disabled Persons  
Adopted by the U.N. General Assembly, Resolution 3447 (XXX),  
9 December 1975

The General Assembly,

Mindful of the pledge made by Member States, under the Charter of the United Nations, to take joint and separate action in cooperation with the Organizations to promote higher standards of living, full employment and conditions of economic and social progress and development,

Reaffirming its faith in human rights and fundamental freedoms and in the principles of peace, of the dignity and worth of the human person and of social justice proclaimed in the Charter,

Recalling the principles of the Universal Declaration of Human Rights, the International Covenants on Human Rights, the Declaration of the Rights of the Child and the Declaration on the Rights of Mentally Retarded Persons, as well as the standards already set for social progress in the constitutions, conventions, recommendations and resolutions of the International Labour Organization, the United Nations Educational, Scientific and Cultural Organization, the World Health Organization, the United Nations Children's Fund and other organizations concerned,

Recalling also Economic and Social Council resolution 1921 (LVIII) of 6 May 1975 on prevention of disability and rehabilitation of disabled persons,

Emphasizing that the Declaration of Social Progress and Development has proclaimed the necessity of protecting the rights and assuring the welfare and rehabilitation of the physically and mentally disadvantaged,

Bearing in mind the necessity of preventing physical and mental disabilities and of assisting disabled persons to develop their abilities in the most varied fields of activities and of promoting their integration as far as possible in normal life,

Aware that certain countries, at their present stage of development, can devote only limited efforts to this end,

Proclaims this Declaration on the rights of Disabled Persons and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights:

1. The term "disabled person" means any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of a deficiency, either congenital or not in his or her physical or mental capabilities.

2. Disabled persons shall enjoy all the rights set forth in this Declaration. These rights shall be granted to all disabled persons without any exception whatsoever and without distinction or discrimination on the basis of race, color, sex, language, religion, political or other opinions, national or social origin, state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family.

3. Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.

4. Disabled persons have the same civil and political rights as other human beings; paragraph 7 of the Declaration of the Rights of Mentally Retarded Persons applies to any possible limitation or suppression of those rights for mentally disabled persons.

5. Disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible.

6. Disabled persons have the right to medical, psychological and functional treatment, including prosthetic and orthetic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counselling, placement services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the process of their social integration or reintegration.

7. Disabled persons have the right to economic and social security and to a decent level of living. They have the right, according to their capabilities, to secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions.

8. Disabled persons are entitled to have their special needs taken into consideration at all stages of economic and social planning.

9. Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative or recreational activities. No disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than that required by his or her condition or by the improvement which he or she may derive therefrom. If the stay of a disabled person in a specialized establishment is indispensable, the environment and living conditions therein shall be as close as possible to those of the normal life of a person of his or her age.

10. Disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature.

11. Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensable for the protection of their persons and property. If judicial proceedings are instituted against them, the legal procedure applied shall take their physical and mental condition fully into account.

12. Organizations of disabled persons may be usefully consulted in all matters regarding the rights of disabled persons.

13. Disabled persons, their families and communities shall be fully informed, by all appropriate means, of the rights contained in this Declaration.