assessments of ongoing MDGs will be followed with great anticipation by the global disability community.12

People with disabilities can no longer be placed at the bottom of a long list of significant social concerns with the assumption that their needs can be addressed after other development problems are solved. The new Convention on the Rights of Persons with Disabilities has reframed the health and wellbeing of individuals with disabilities as a human right, a point that must now be taken note of within the MDGs and the related MDG targets and indicators.9 Moreover, unless we address the needs of the world’s estimated 650 million people with disabilities, none of the MDGs will be successfully met. Inclusion of people with disabilities in any and all development efforts is therefore an act of enlightened self-interest on the part of all who work on global, national, and community development projects and health efforts.

*Nora Ellen Groce, Jean-François Trani
Leonard Cheshire Centre for Disability and Inclusive Development, University College London, London WC1H 0BT, UK
Nora.groce@ucl.ac.uk
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Disability, conflict, and emergencies

The UN Convention on the Rights of Persons with Disabilities (UNCRPD) outlines the obligation of States to protect and ensure the safety of people with disabilities in situations of risk, including armed conflict. In practice, disability is rarely considered in humanitarian programmes, even when a growing body of evidence shows that people with disabilities in such situations are at particular risk.1–3

Although some guidelines and manuals support the specific inclusion of people with disabilities in emergencies,4 most programmes focus on disability as a crosscutting issue, or on protecting people with disabilities as a vulnerable group, rather than on the specifics of inclusion and overcoming barriers. There is little evidence that these guidelines are used to any effect with people with disabilities, in part because of a lack of standards and indicators to monitor inclusion; but also because of the lack of awareness and training at field level. Local disabled people’s organisations are rarely included in planning and coordination meetings, particularly in crises. Thus the opportunity is missed to improve coordination and inclusion of people with disabilities in humanitarian aid.

Many staff working in humanitarian agencies share common misperceptions about individuals with disabilities: that they either require expensive specialist care or their needs will be covered by general aid distributions; that they are unable to participate in most education, work, or community activities. In situations such as earthquakes or flooding, there is too often the perception that people with disabilities will simply not survive. Many current delivery structures for humanitarian aid perpetuate these assumptions. Many programmes allocate separate funding to victim assistance programmes5 whereby only those injured or impaired by conflict are given priority funding, medical care, or assistive devices, while those disabled before the conflict are overlooked.
Moreover, the needs of patients with pre-existing or conflict-induced severe mental disabilities have only recently received much attention. Despite 181 postconflict surveys of prevalence rates of post-traumatic stress disorder (PTSD) and depression, little is known about rates of mental disability. Mental disorders and mental disability are only partly overlapping concepts, and surveys of mental disorders have rarely provided much useful information on mental disability. Indeed, it is not known what percentage of patients with PTSD or depression have associated mental disability that is so severe that they have difficulties protecting themselves or caring for their children.

Yet, among patients with mental disorders—whether PTSD, depression, a psychotic disorder, or dementia—a subset with severe mental impairments warrant highest priority in humanitarian action because they are at social risk of abuse or early death in crises.

More and more evidence shows that a combination of mainstreaming disability and specifically targeting groups (twin-tracking) within humanitarian work is most likely to lead to greater inclusion and long-term benefits for the whole community. Rights-based approaches and targeted aid leading to more inclusive programming are more likely to get done immediately after an acute emergency, when many agencies, donors, and the mass media are in the field. However, as the media glare dies down and attention moves elsewhere, so too can the attention to human rights, equity, and justice, unless strong national and international partners have taken these points on board. Thus the particular challenges that have arisen from conflict have also offered some unexpected opportunities, including raising the profile of disabled people's organisations in some countries, leading them to become stronger and more active as a result of war (eg, in Sierra Leone).

Monitoring and evaluation are of concern. Few indicators have been developed to analyse the extent to which people with disabilities have genuinely been included into programmes and whether such programmes lead to sustained improvements in quality of life. The rare studies that have been done in post-conflict countries have mostly focused on individuals with specific types of impairments to assist donors and government ministries to plan services for specific problems. Such studies, although valuable, have concentrated on disability as a medical or welfare issue, rather than a social or human rights one. Nevertheless, when information has been available, it has been used to significantly affect policies, especially those preventing disability—eg, the Ottawa Mine Ban Treaty (1997) or the Convention on Cluster Munitions (2008).

Although it is too early to assess the effect of the UNCRPD, the Convention has drawn much greater attention to disability within the UN system, especially at the level of implementing agencies, and several UN and non-governmental organisation initiatives have started to consolidate a disability focus within the humanitarian sector. For example, in 2004, disability was included as a specific crosscutting issue in the Sphere Handbook, a key text for humanitarian practitioners. Better training for both humanitarian staff and disabled people's organisations in conflict and disaster-affected countries will further increase awareness and understanding, as well as capacity to address disability. Such efforts, although promising, will not be fully effective until and unless disability is seen as a key issue by all who work in the humanitarian sector.

*Maria Kett, Mark van Ommeren
Leonard Cheshire Centre for Disability and Inclusive Development, University College London, London WC1H 0BT, UK (MK); and Department of Mental Health and Substance Abuse, WHO, Geneva, Switzerland (MvO)
m.kett@ucl.ac.uk
Community-based rehabilitation: opportunity and challenge

Community-based rehabilitation (CBR) is the main way in which disabled people in most of the world have any chance of accessing rehabilitation services. CBR was first promoted by WHO in the mid-1970s to address the shortage of rehabilitation assistance by providing services in the community with use of local resources. The strategy drew on the principles of primary health care, accepted international rehabilitation practices of the time, and also existing local practices.

Over the decades, development of CBR has been influenced by concerns of disabled people at the community level and by disabled people’s organisations. These concerns have contributed importantly to the evolution of the CBR concept and resulted in increased recognition of discrimination and exclusion, and the need to address social and political aspects of disability. As a result, the medically orientated individualised model, on which CBR was originally based, has expanded and now includes socially orientated rights-based approaches. This process of change caused confusion over the definition of CBR but in 2004 it was clarified as “a strategy within general community development for rehabilitation, equalization of opportunities, and social inclusion of all people with disabilities...implemented through the combined efforts of people with disabilities themselves, their families and communities, and the appropriate health, education, vocational, and social services”. The objectives of CBR are not only to maximise physical and mental ability but also to support access to regular services and opportunities and assist people with disabilities to actively contribute to their own communities as well as encouraging communities to promote and respect their human rights. Its community orientation aligns with the UN Convention on the Rights of Persons with Disabilities and its breadth of scope is consistent with the conceptual base of the International Classification of Functioning, Disability, and Health.

Although no comprehensive database of CBR implementation is available, global CBR networks are emerging in Africa, Asia, and South America. From their activities we now know, for example, that there are 280 registered CBR programmes in 25 African countries, about half are run by non-governmental organisations, including disabled people’s organisations, and half by governments which involve ministries of social services, health, and disability.

Because CBR cannot be described as a discrete intervention, and the expected outcomes are not standardised, its effectiveness is hard to establish. A summary of published research in the past decade noted that CBR-type programmes have been described as effective or highly effective. Outcomes reported included: increased independence, enhanced mobility, and greater communication skills for people with disabilities. CBR activities were linked to positive social outcomes, enhanced social inclusion, and greater adjustment of people with disabilities. The summary noted that livelihood interventions integrated into...