A man has his eyes examined by a refractionist at the CDD/CBMG medical centre based in a clinic run by the Bangladesh Red Crescent Society (BDRCS) in a refugee camp in Cox's Bazar. He will be referred for surgery
Photo credit: CBM/Hayduk

Integrating rehabilitation and medical care for people with disabilities

Bangladesh Red Crescent Society, CBM Global and the Center for Disability and Development

CASE STUDY

ifrc.org

Patients wait to be seen by the physiotherapist at the the CDD/CBMG medical centre based out of the Bangladesh Red Crescent Society (BDRCS) in a refugee camp in Cox's Bazar. *Photo credit: CBM/ Hayduk*

Contents

Summary 3

Who was supported and how? 3

The Pilot Model 4

What were the Learnings from Practice? 5

Next phase: Moving Forward After the Pilot 7

Summary

Since August 2017, almost a million people from Rakhine state, Myanmar have fled violence in Myanmar sought refuge across the border into Cox's Bazar, Bangladesh. In Myanmar, services for people with disabilities were extremely limited, with most never having received rehabilitation or psychosocial support in their lifetime. Medical services were restricted to traditional healers and village doctors, and many experienced discrimination and ignorance from service providers about their specific requirements.

Video: Rehabilitation in Mass Displacement (with sign language – click to watch on Youtube)

In December 2017, CBM Global and the Centre for Disability in Development (CDD) established a comprehensive health and rehabilitation program based on rapid assessment results conducted with Arbeiter Samariter Bund (ASB). The program focused on providing accessible primary health care and rehabilitation services under one roof, complemented by a Home-based Rehabilitation (HBR) team for those unable to reach the health center.

An Age and Disability Working Group (ADWG) was established under the leadership of CBMG, CDD, Humanity & Inclusion, and HelpAge International to promote inclusion of persons with disabilities in humanitarian response and ensure coordination among rehabilitation service providers. Despite four years of humanitarian services, significant gaps in rehabilitation services remained.

Key assessments revealed critical service gaps:

- The Age and Disability Inclusion Needs Assessment identified poor quality healthcare services and inadequate treatment for disability-related conditions
- The rapid Assistive Technology Assessment (rATA) found that only 1% of people with disabilities had their assistive technology needs met, while 51% had unmet needs

To address these gaps with limited resources, CBMG and CDD, supported by the New Zealand Aid Programme, piloted an innovative "Outreach Rehabilitation Team" model in partnership with the Bangladesh Red Crescent Society (BDRCS), with support from IFRC.

Who was supported and how?

- Individuals requiring rehabilitation services in underserved camp areas
- People with disabilities who previously had no or limited access to rehabilitation services

Pilot Model

Outreach Rehabilitation Service Team

Rehabilitation Officer
Therapy Assistant
Community Mobiliser

Services Provided

Physiotherapy
Occupational Therapy
Speech and Language
Caregiver Training
Assistive Devices
Community Awareness
Referrals

Integration with BDRCS

Therapeutic services provided to BDCRS beneficiaries on a rotation basis

Training for BDRCS Staff

Disability identification
Rehabilitation and inclusion

An initial partnership was established between Centre for Disability in Development (CDD) and CBM- Global (CBMG), with the Bangladesh Red Crescent Society whereby rehabilitation services were provided at BDRCS' field hospital.

The CDD team was integrated into the BDRCS field hospital health care team, and provided services under a separate shade on the grounds of the field hospital. The team was present in the hospital two days per week. Due to the fact that clients were coming from different areas of the camp, rehabilitation services were only conducted in the field hospital and not at patient's homes. Referrals to the rehabilitation team were made through both the BDRCS registration desk and from the BDRCS doctors. If the registration desk officer found a client experiencing pain or paralysis, they would refer directly to the CBMG-CDD team. Likewise, if any of the doctors during their client exam found a client in need of rehabilitation, they referred to CBMG-CDD. Referrals were made using either a referral form or verbally.

CBMG-CDD therapists also initiated referrals to medical services for clients who were receiving rehabilitation services and who needed other primary healthcare services. A one-day training was provided to BDRCS field hospital staff at the start of the partnership. This training covered both an introduction to disability inclusion and rehabilitation focusing on the importance of rehabilitation services in primary health care and how to identify clients in need of refer to rehabilitation.

What were the Learnings from Practice?

Learning #1: A Rehabilitation Team Working in Partnership with Primary Health Care Providers Provides More Comprehensive Healthcare

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.

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. 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. By having CBMG and CDD's therapists present at the BDRCS field hospital allowed for clients to have their health care and rehabilitation needs met in one location. This helped prevent people from "slipping through the cracks" and being discharged following hospitalization without necessary rehabilitation.

> *"Having both medical and rehabilitative care at the same time allows the patient to recover faster". Dr. Shaila Akter, Medical Officer, BDRCS.*

Initially the CBMG-CDD was receiving a very limited number of referrals from the registration desk and doctors. However, after the BDRCS team saw the effectiveness of rehabilitation of client's functional outcomes and positive outcomes of referring clients to the rehabilitation team, the team saw a three-fold increase in referrals.

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. Having the rehabilitation team on site helped improve interdisciplinary communication as the referring practitioner could discuss directly with the therapy team.

One of the critical factors in determining whether CBMG and CDD would respond to a referral through the ADWG was the referring agency. In order to promote continuity of care and follow up with clients even when the CBMG CDD team was not present, CBMG and CDD only accepted referrals from health actors.

> *"My condition has improved a lot through receiving timely medical treatment, as well as the use of the assistive medical devices, both of which, I believe, have improved my physical condition" Mr. Samso, CBMG and CDD's project participant.*

Learning #2: In Underserviced Areas, Outreach Teams Provide Access to Rehabilitation which would Otherwise be Inaccessible

The needs and demand for rehabilitation services amongst both displaced people from Myanmar and the Bangladeshi host community is significantly higher than the availability of services. One of the criteria for the outreach rehabilitation team to provide services was that no other rehabilitation actor was present in that operating area. The service mapping completed by the ADWG was one tool used by CBMG and CDD in deciding if they would respond to a request for rehabilitation services in a given area.

The CBMG-CDD team had found that in their regular coverage areas, where services were provided through fixed health centres and homebased rehabilitation teams, they were able to provide more comprehensive services to clients. However, in a context whereby the need for rehabilitation services significantly outweighs the resources available, there is a need to triage and ensure that the people with the most pressing needs and urgent cases are able to have their rehabilitation needs met.

The outreach service model allowed for people in need of rehabilitation services in camps which were unreached by rehabilitation service providers to access such services. By providing training to healthcare workers at the BDRCS field hospital, follow ups could be provided by the BDRCS team thereby freeing up time for the CBMG-CDD rehabilitation team to see more clients.

Part of CBMG-CDD's homebased rehabilitation model is to provide information raising on available rehabilitation services. By providing services at BDRCS's field hospital, the BDRCS team also made patients aware of the rehabilitation services provided by CBMG-CDD, thus providing information on available rehabilitation services that people may not otherwise have had. Relying on the established infrastructure of an existing health actor allowed CBMG CDD to move into new areas of the camp in a cost-effective manner to provide integrated services.

Learning #3: Systematic Change Takes Time and Buy In at Multiple Levels

Over the course of the engagement between BDRCS and CBMG-CDD, improvements were made to make services more disability inclusive. In addition to services being provided at the field hospital, community workers were also providing more services in client's homes in the community. With the technical support from the CBMG-CDD team, BDRCS also made some modifications to make their pathways throughout the hospital more accessible.

While the CBMG-CDD team had been present at the BDRCS field hospital for over a year, the rehabilitation service provision was solely overseen and provided by the CBMG-CDD team. Follow up on rehabilitation services remained within the remit of the CBMG-CDD team, and was only available the two days the team was at the hospital. An initial training around the importance of rehabilitation service provision and referrals was provided to the registration officers and doctors, however, a more systematic training curriculum with buy in from the staff would have been needed in order for more skills transfer to happen for BDRCS' medical team and health officers to be able to provide some basic rehabilitation services and follow ups. Capacity building of other health staff

can help to improve continuity of care, especially when rehabilitation professionals may be rotating and not in the clinic on a daily basis.

Creating systematic change to integrate rehabilitation into the primary health provision of an organization requires commitment across all levels of the organization. Funding for the CBMG-CDD rehabilitation team was secured entirely by CBMG-CDD, with these services being dependent on CBMG-CDD being able to secure funding for the positions. While both organizations were agreeable to pursuing joint funding opportunities which could fund the rehabilitation work within the BDRCS field hospital, these opportunities did not materialize during the engagement together. Funding needs to be considered and secured for all key roles and services, including rehabilitation service provision.

While the CBMG-CDD team provided services at the BDRCS field hospital they were not integrated into the hospital management structure and were seen as a service provided by an external agency. While having the therapists present on site helped to meet a critical gap in rehabilitation service provision at the field hospital, a more ideal model would see rehabilitation services integrated within the primary health care structure of the hospital which could promote smoother referral systems and longevity.

Next phase: moving forward after the pilot

Services at the BDRCS field hospital will be decreasing in coming years as fewer clients come to the facility. There are now other health facilities within the refugee camps providing the same services which are easier for people to access. At the same, requests for rehabilitation services including assistive device provision are continuously being brought to the Age and Disability Working Group.

During the pilot phase, CBMG-CDD also responded to some ad-hoc requests from other agencies to provide rehabilitation services including the provision of assistive devices for their beneficiaries. The next phase will respond to providing services at the location of other organizations in the form of “mobile services”, whereby the therapy team will travel to the referring organizations site for three to five days. During this period, clients will be assessed and fitted for assistive devices. Client and caregiver training will be incorporated within the camps.

Learnings from the pilot phase have been incorporated into the design of the next phase and will continue to be collected. Similar to the services provided under the pilot phase, this model should allow CBMG-CDD to reach people who would otherwise not have access to rehabilitation services. A stronger capacity-building component will be built into the next phase, with an emphasis on job coaching and mentoring for the staff of the referring agencies on the use of the assistive devices and how to support the client in using them. As the model is entirely dependent on referrals being managed by the referring organization, training on when to refer back to CBMG CDD for reassessment or further support will be provided and uptake monitored.