DISABILITY PREVENTION AND REHABILITATION (DPR) & LIFE STYLE RELATED DISEASES (LSRD) PROGRAM

Introduction

After Bhutan became signatory to ESCAP Commission on Disability in 1993 there has been increased concern for disability prevention, rehabilitation and providing equal opportunities for the disabled. The Community Based Rehabilitation (CBR) Programme was initiated in 1997 as a pilot project in Khaling, Trashigang by using the primary Health Care infrastructure. WHO initially and DANIDA in 1999 provided technical and financial support. The pilot program was extended to Mewang, Thimphu in 2000 then to other districts during the 9th FYP. A review was done at the end of 8th FYP and 9th FYP formulation was based on the review findings.

There is no doubt that the CBR Programme is highly relevant in the country, considering that there has not been a plan earlier to address the needs of persons with disabilities who constitute about 3.4% of the population. Since a majority of persons with disability live in remote rural areas, the CBR approach is relevant and appropriate to address their needs.

A very promising start has been made to implement the CBR Programme in the country till now, within a very short span of time. However, The effectiveness of the Programme can be greatly enhanced by increasing the coverage of interventions, increased awareness at all levels, greater emphasis on capacity building and strengthening of referral and technical support systems.

Disability is not well defined condition in Bhutan and there are many terminology and conceptual difference. According to a survey from the pilot programme, the disability prevalence is 3.5%. The National Population and Housing Census stated 3.4% of the total population people with disabilities. From the experiences, CBR needs multi-sectoral approach. The CBR Programme will seek to address the needs of all identified disabled persons in the community.

VISION

"All Persons with Disabilities are able to attain the fullest potentials, become self reliant within their limitations and be active contributors in nation building to the extent possible".

POLICY AND PROGRAMME OBJECTIVES

In order to enhance the quality of life of people with disabilities and achieve their full integration, the accessibility of the health care delivery system for people with disabilities will be improved, a decentralization process of rehabilitation services within the health care delivery system developed, and disability prevention and rehabilitation programmes strengthened within the 10th Five Year Plan period.

1. To introduce community-oriented disability prevention and rehabilitation services as an integral part of the comprehensive primary health care delivery

system in all remaining Dzongkhags based on the WHO Manual 'Training in the Community for People with Disabilities".

2. To undertake human resource development in rehabilitation professional and in the knowledge of community rehabilitation at all levels.
3. To develop/establish a National Rehabilitation Resource Centre for the country.
4. To diminish the overall impact of disability by:
    - Reducing the occurrence of disability through prevention, health promotion and increased awareness.
    - Reducing the consequences of existing disability through early detection, early intervention and rehabilitation.
5. To facilitate and co-ordinate the involvement of other sectors in disability prevention and rehabilitation programmes in making use of the multi-sectoral coordinated approach.

STRATEGIES

The overall guiding strategy for support to programmes for/with people with disabilities is the ***community-based model*** with the main features being the grass-root participation in development

Disability prevention and rehabilitation programmes will be ***integrated*** from the very concept, in the planning, service delivery, and evaluation in the health care delivery system. It will ***mobilize*** traditional family units and social structures, supportive traditional practices to create a ***sustainable network*** to improve the quality of life of people with disabilities.

Complementary programmes and strategies will be developed and implemented to meet the goals. ***People with disabilities', families' views*** will be taken into account in addressing their needs. Systems will be put in place to ensure ***quality of services*** to meet the needs of people with disabilities and their families. ***Cost-effectiveness*** will be promoted through efficient and effective use of resources available to increase access for people with disabilities. ***Monitoring, assessment and evaluation*** will be incorporated in the Programme from the start but occurring at several levels.

Within the above framework, the major strategies envisaged are listed below:

1. Capacity building for different levels of personnel to achieve the Programme objectives Identification and needs assessment of people with disabilities in the 20 Dzongkhags;
2. Prevention of disabilities;
3. Medical rehabilitation for those in need;
4. Creation of awareness at different levels/sectors;
5. Development and strengthening of referral and technical support services;
6. Development of family and community support groups;
7. Strengthening of multi-sectoral linkages and collaboration;
8. Referrals for education for those identified as need of such services.

The major achievements of the CBR Programme to date are summarised below.

- Identification of children with speech and hearing disabilities has been initiated in all schools.
- BHU staffs were trained on CBR through in-service training courses.
- Provision of Assistive Devices – hearing aids, crutches, wheel chairs, walkers etc.
- Up gradation of Artificial Limb Workshop at Gidakom for producing prosthesis/orthosis.
- Physiotherapy units established in 4 hospitals.
- Early intervention clinic for children with special needs initiated at Paediatric Unit, JDW NRH.
- Establishment of Audio logy Unit at JDW NRH.
- Formation of National Co-ordination Committee on Disability (NCCD) concerns
- Close working relationship established with the Education Department.
- Incorporation of Disability Information Collection into HMIS initiated.

The integration into the health infrastructure has worked reasonably efficiently till now. The major strength from a community based programme perspective has been the motivation of the staff at the BHU level and of the village health workers, to add on rehabilitation responsibilities to their existing duties. However, the efficiency of the Programme can be greatly enhanced with more efforts on capacity building, strengthening the referral and technical support systems and collaboration amongst the different sectors to achieve the goals of the CBR Programme.

Chronic non-communicable diseases are an emerging challenge all over the world; a challenge more so for the resource limited countries. The increasing burden of non-communicable diseases (NCD), particularly in developing countries, threatens to overwhelm the already resource stretched health services. It is known through several researches that the risk factors underlying major non-communicable diseases like the heart diseases, stroke, diabetes, cancer and respiratory conditions are more or less common and limited.

Bhutan suffers from a double burden of disease as is true for other countries in the Region. The mountainous terrain of the country, communication difficulties and predominantly sustenance agriculture as the basis of living for most of the population, ensures the able bodied population to be physically active and fit. However, NCDs such as cardiovascular diseases, cancers, chronic pulmonary diseases and diabetes mellitus are on the rise. There has been a changing trend in the life style of the urban population. Obesity as well as sedentary habits is not so uncommon.

There are no precise studies conducted to find the prevalence of NCDs in the country. However, it is been noted that NCDs are on an increase:

- Common NCDs are ***Type II Diabetes, Hypertension,*** and ***Stroke***. A study conducted by the Epidemiology and Research unit of the Ministry of Health found that ***48%*** of persons visiting the JDWNR Hospital have ***hypertension.***
- ***Alcohol*** is available anywhere. It is used in most occasions including religious, and its use bears no social stigma. According to a study conducted by the Information Education Communication for Health ***(IECH), 58 %*** of people in the ***Eastern dzongkhag*** and ***34 %*** in the west drank alcohol. It was further observed that ***42 %*** of female respondents drank alcohol.
- ***Smoking*** is prohibited in the teaching of Lord Buddha that most people do not indulge in it .It has been a very positive step in the curtailment of exposure to one of the important NCD risk factors that ***Bhutan has banned sale of tobacco*** and ***related products in the entire kingdom*** and it is strictly implemented . All these, result in minimizing exposure to tobacco smoke.

Therefore, the basis of NCD prevention is the identification of the major common risk factors and their prevention and control. From a primary prevention perspective, surveillance of the major risk factors, known to predict disease is an appropriate starting point. Primary prevention based on comprehensive population based programme is the most cost-effective approach to contain this emerging epidemic.