
ORIGINAL RESEARCH

Anticipated Barriers to Implementation of Community-Based Rehabilitation in Ribeirão Preto, Brazil

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ABSTRACT

Purpose: Disability is a global health and a global development concern. To address both issues, a community-based rehabilitation (CBR) approach is increasingly recommended to meet a spectrum of needs, especially for people with disabilities. It is first necessary to understand the perceptions of local, frontline providers, in order to design effective measures for implementing CBR programmes. This paper aimed to understand the conceptions of Primary Healthcare Providers (PHPs) - serving a sub-urban, socially-vulnerable territory in Brazil - about: 1) disability, 2) rehabilitation, and 3) the possible local implementation of a CBR strategy, including any anticipated barriers.

Method: Cross-sectional, exploratory qualitative research was based on focus groups conducted between 2013 and 2016. It involved a total of 78 PHPs serving the western region of the Ribeirão Preto municipality in São Paulo, Brazil. Data analysis was based on Habermas' critical hermeneutics approach.

Results: PHPs understood disability mostly within the biomedical paradigm. Similarly, the predominant conception of rehabilitation was focussed on enabling individuals' capacity, more than their environment. For local CBR implementation, the barriers that were anticipated were: 1) difficulties in managing and running action across sectors, and 2) the broader socio-political environment that hardly empowers civil society and is affected by power differentials.

Conclusion and Implications: While local PHPs identified important CBR implementation barriers which are contextual in nature, the predominant

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conceptions of disability and rehabilitation (i.e., biomedical, impairments-based) also act as a barrier. Contextual and cognitive barriers must both be addressed when envisioning a local CBR implementation.

Key words: *People with disabilities; rehabilitation; CBR; primary healthcare*

INTRODUCTION

The number of people with a permanent disability is estimated as 1 billion or 15% of the world's population (World Health Organisation and World Bank, 2011). Furthermore, prevalence has been increasing over time. For example, using data from the Global Burden of Disease Study, the World Health Organisation (WHO) reported a 23% increase in the global prevalence of health conditions associated with severe disability from 2005 to 2015 (World Health Organisation, 2017), while most of the disability "burden" is carried by middle- and low-income countries (World Health Organisation and World Bank, 2011).

In contrast with this epidemiological trend, most health systems are insufficiently equipped to respond to the needs of people with disabilities (Chatterji et al, 2015; Prince et al, 2015). In many lower-income territories, physical rehabilitation services are in short supply (Bunning et al, 2014; Wylie et al, 2016; Agho & John, 2017; Jesus et al, 2017; Krug & Cieza, 2017). Besides, in those areas, people with disabilities typically experience more financial, transportation or attitudinal barriers to access needed healthcare than people without disabilities (Mlenzana et al, 2013; Abdi et al, 2015; Neille & Penn, 2015; van Hees et al, 2015; Ganle et al, 2016; Munthali et al, 2017; Visagie et al, 2017; Vergunst et al, 2017), even though people with disabilities usually have higher health needs, higher risks of chronic and secondary health conditions, higher cost of living, and finally, lower earnings and lower employment rates (Mitra et al, 2009; Rimmer et al, 2011; World Health Organisation and World Bank, 2011; Gudlavalleti et al, 2014; Mitra et al, 2017).

Apart from health issues and determinants, people with disabilities often struggle to perform everyday activities or desired social roles due to a restricting environment (e.g., social stigma, non-inclusive legislation, inaccessible services), which prevents them from participating in society on an equal basis with others (World Health Organisation, 2001; Skempes et al, 2015). Concretely, people with disabilities often experience restrained access to education, employment, livelihood, to empowered civil society participation, as well as to a myriad of public or private services or goods, especially those not universally designed

or not designed to accommodate the special needs of people with disabilities (MacLachlan, 2009; World Health Organisation, 2010; Visagie et al, 2017).

In that context, the United Nations Convention on the Rights of Persons with Disabilities, launched in 2006, has brought the issue of the human rights of people with disabilities into international law (Durham et al, 2014; Skempes et al, 2015). Even global development policies such as the Sustainable Development Goals, are now disability-inclusive (United Nations, online) in contrast with the earlier Millennium Development Goals.

In short, beyond a global public health issue, disability is increasingly a global development concern - with equity, human rights and social justice issues.

Consideration of community-based initiatives is required to address all these issues and to meet the health, rehabilitation and societal needs of people with disabilities, especially in lower income, socially-vulnerable territories (Bunning et al, 2014; Gilmore et al, 2017).

Community-Based Rehabilitation (CBR) is a multisectoral approach working to equalise opportunities and include people with disability in all aspects of community life. It is globally recommended as a strategy for community-based inclusive development – i.e., one that empowers and actively engages people with disabilities and their families, and addresses health, education, livelihood, and empowerment issues towards ensuring an effective inclusion in society (World Health Organisation, 2010).

As of 2010, the WHO reported that CBR was implemented in over 90 countries (World Health Organisation, 2010). Besides, a recent scoping review also found that a large pool of literature on CBR was published from 2003 to 2012, with a focus on 26 countries; however, those studies were published only in the English language and, perhaps for that reason, only 1 came from the Americas (Cleaver & Nixon, 2014).

On effectiveness, a systematic review found that CBR for people with disabilities in low- and middle-income countries may be effective in improving health-based outcomes; however, the heterogeneity of the interventions and the scarcity of good-quality evidence mean that findings should be interpreted with caution, while non-health outcomes remain understudied (Patel et al, 2013; Lemmi et al, 2015).

The evaluation of CBR approaches comes with challenges. A literature review published by Lukersmith et al (2013) found a dearth of common, standardised

procedures or tools for monitoring and evaluating CBR programmes. Fortunately, there have been systematic advances since then (Grandisson et al, 2014; Grandisson et al, 2016a; Grandisson et al, 2017), which complement the WHO-launched CBR guidelines (World Health Organisation, 2010) and the recent standardised CBR outcome indicators (Mason et al, 2017). In sum, there are now important tools enabling the proper implementation and evaluations of CBR approaches.

Nonetheless, implementation barriers and functioning challenges remain all too often. That includes a "disconnect" between acute and community-based rehabilitation (Khan et al, 2015) and overall lack of coordination between all stakeholders and sectors involved (McVeigh et al, 2016). Furthermore, lack of stakeholders' awareness and understanding of CBR remains among the most significant implementation barriers (Dennis et al, 2016). Once again, that international CBR knowledge comes mostly from the Asia-Pacific region and from Africa (Cleaver & Nixon, 2014; Dennis et al, 2016), while socio-cultural variables, including those typical of Latin America (Andrade et al, 2015), may play an important role.

In Brazil, a large middle-income American country in which social, territorial and health inequalities are common (Szwarcwald et al, 2011; Andrade et al, 2015), laws and policies exist for meeting the whole spectrum of needs of (the most vulnerable) people with disabilities (Almeida & Campos, 2002; Leão, 2011). Since 1988, the Federal Constitution enacts the need to meet and protect the human rights of people with disabilities, including the need to offer them healthcare and social protection under the public service provision (e.g., the national health system). Finally, legislation also calls for the needed articulation among entities at the primary, secondary and tertiary healthcare levels, as well as across societal sectors (Health Ministry, Brazil, 2010; Rocha et al, 2011).

However in Brazil, as in many other countries, people with disabilities - especially those living in lower-income, socially-vulnerable territories of the country - experience a myriad of disparities in the access to health and education as well as in moving around or performing active social participation roles (Othero & Aires, 2012; Souza, 2012; Aoki & Oliver, 2013; Fiorati & Elui, 2015).

In this context, Brazilian primary healthcare providers (PHPs) have mandates for the promotion of health, prevention of diseases and early identification of people with disabilities in need of care within their territories, as well for the provision

of rehabilitation services within the context of intersectoral collaboration, for an integrated care to people with disabilities, including at the community level (Junior et al, 2012). However, those mandates which align with CBR principles have not been fully operationalised into multisectoral CBR practices all across the Brazilian context (Oliver & Carvalho, 2007; Aoki & Oliver, 2013).

To understand the root causes of this sub-optimal implementation of CBR approaches in socially-vulnerable Brazilian contexts, and hence to inform further implementation measures, it is important to first understand the actual conceptions of disability, rehabilitation and of the CBR approach among Brazilian PHPs (Othero & Dalmaso, 2009). That includes any readiness to engage with the CBR approach as well as the anticipation of any factors that may affect its functioning and effective implementation into practice.

Objective

As such, with the focus on a socially vulnerable, sub-urban Brazilian territory, this study aims to understand how local, frontline PHPs perceive: 1) disability, 2) rehabilitation, and 3) CBR; including whether PHPs perceive CBR as a viable model to be implemented in their territory, and which factors they anticipate could affect such implementation.

METHOD

Study Design

This cross-sectional qualitative exploratory study, using focus groups of PHPs, was conducted between 2013 and 2016. The study was approved by the Ethics Committee of the School Health Centre of the Ribeirão Preto Medical School, University of São Paulo.

Setting

The focus groups were conducted in 6 sub-urban primary healthcare units, specifically in 6 sub-units of Family Health Centres (FHCs) serving the socially-economic deprived west region of the Ribeirão Preto municipality. Shanty towns or squatter areas (“favelas” in the Brazilian terminology) exist in plenty there, and a significant number of the inhabitants, including people with disabilities, have lower income, experience social iniquities and are in a more socially vulnerable

position when compared with inhabitants of other regions of the Ribeirão Preto municipality.

The studied Family Health Centres (FHC1, FHC2, FHC3, FHC4, FHC5 and FHC6) are all located in that sub-urban territory but centrally coordinated by the Ribeirão Preto Medical School, being part of a broader health system that also contains hospitals, a rehabilitation centre and other rehabilitation units.

In these 6 centres, in addition to the activities performed by permanent staff, there are clinical training or supervised practices for undergraduate programmes (Medicine, Occupational Therapy, Physiotherapy, Speech Therapy and Nutrition) and graduate programmes of the Ribeirão Preto Medical School (Residency Programme in Community and Family Medicine and the Multi-Professional Residency in Integrated Health Care), as well as other programmes of the University of São Paulo at Ribeirão Preto, such as those of Pharmacy, Nursing, Dentistry and Psychology.

Participants

The participants were healthcare workers from the FHC (i.e. permanent staff), as well as university-affiliated clinical professors, undergraduate students, and medical or multi-professional residents studying or providing service in those centres at that time.

A total of 78 individuals (i.e., all participating in the different activities of the included FHCs) were part of the study: 17 from FHC 1; 9 from FHC 2; 14 from FHC 3; 15 from FHC 4; 12 from FHC 5, and 11 from FHC 6. The total number of participants is stratified by profession as follows: 7 physicians, 2 Family Health Centre coordinators, 5 nurses, 9 auxiliary nurses, and 30 community health agents. In addition to the permanent staff, there were 9 medical residents, 12 multi-professional residents, 1 undergraduate student, 1 clinical professor of dentistry and 2 dentistry residents.

Informed consent was obtained from all participants.

Procedure

Six focus groups, one for each unit included in the study, were conducted by the main investigator (RCF) with help from a graduate Occupational Therapy student (KPJ) who is also one of the authors. The focus group meetings were between 60 - 90 minutes in duration. All focus groups started with a brief contextualisation

of the research, followed by the outline of the procedures as well as the questions to be debated: 1) What is disability? 2) What is rehabilitation? 3) Whether a CBR programme would be valid and feasible in their own territory, and which factors could affect its functioning and implementation?

Data Analysis

The group sessions were audio-recorded, and all content transcribed verbatim in Portuguese. The raw data was de-identified and only supplied with the professional identification of who said what and when, as these were important elements for the analysis. That de-identified raw data is available from the first author upon request.

Data was analysed according to Jürgen Habermas' (1988) theoretical framework of Critical Hermeneutics, based on his Theory of Communicative Action and the concepts of mutual understanding, and finally using the respective methodological guidelines.

This approach was deemed ideal for the study as it promotes elements for the interpretation and understanding of the expressed group conceptions for a given phenomenon. For this study, the main phenomenon (i.e., CBR) is essentially intersectoral, interdisciplinary and requires cooperation; therefore, the data analysis was based on a collaborative context of inter-subjectivity, as the researcher conversed with the study participants to understand their 'collective' messages through a method which has an interpretative-reconstructive nature (McIntosh, 1994).

Following this interpretative-reconstructive approach, data analysis was interactive, shared with members of the research team (RCF, RYD, KPJ, AFP), while the coordinator (RCF) made a final review, in interaction with the senior author (TJ). The process consisted of the following stages:

1. Sorting data by reading and re-reading the information contained in the transcripts of the discussions, towards identifying themes that emerged in each focus group and relating them to the other groups. The objective was to identify a thematic body that either converged or diverged among the different focus groups and their participants.
2. Developing thematic axes that emerged from the discussion, which outlined the symbolic shared universe - what Habermas calls propositional truth (Habermas, 1988).

3. Establishing relationships between statements and contextual elements, such as cultural, political, economic, historical and social contexts.
4. Analysing the reports according to intention of validity and veracity, supported by the subjective authenticity of the statements in accordance with their positions of reciprocity or putative coercion in the argumentative process. The presence of hierarchical relationships among the members was therefore considered.
5. Interpreting reports based on the study's objective and the tenets of the analytical approach, which was intended to re-constructively unravel the reasons that led the participants to deliver such reports in a particular time, space and context.

Participants' quotations have been reported, without identifying the exact participants or services. Only the professions are disclosed to point at hierarchical issues or those related to power differentials, as this is relevant for the methodology. Table 1 unravels the acronyms/codes used in the results to identify each profession. Finally, quotations and their themes are reported in supportive Tables, while leaving the text focussed on the interpretative-reconstructive nature of the method and its findings.

Table 1: Acronyms / Codes by which each Professional Category is reported

Professional Category	Acronym / Code
Physician	P
Nurse	N
Community Health Agent	CHA
Medical Resident	MR
Multi-Professional in Health Resident	MHR
Occupational Therapy Student	OTS
Physiotherapy Student	PHYSIO
Psychology Student	PSYS
Speech Therapy Student	STS
Dentistry Student	DS
Nutrition Student	NTS
Nursing Student	NSS
Dentistry Teaching Staff	DTS

RESULTS

The results are organised according to the focus group questions, and presented in light of the theoretical analytical framework.

1. “What is disability?”

In most focus groups, the first reports were made by the physician, then by the nurses, followed by the community health agents and, in some groups, by medical residents. The students had limited participation in the discussions.

Regarding the content of the reports, the initial responses reflected, in general, organic conceptions of disability, such as reflecting an injury or morphoanatomical issue. Initial responses also were focussed on deficits of functional capacity and the individual who has a dysfunction, with standards of ‘normal’ capacity as the backdrop.

Only when the moderator asked a question to encourage discussion - *“Do you think disability can be socially or culturally determined?”* - did the participants provide reports that nonetheless were dynamically balanced between the merely organic view of disability and one that incorporated social determinants and consequences of disability. Even in this new context some participants, usually with a biomedical background, reiterated a purely organic conception of disability - debating, disagreeing and counter-arguing on any social perspective of disability proposed by some of the other participants. Excerpts of the reports and conceptions are presented in Table 2.

Table 2: Conception of Disability expressed by the Reports

Conception of Disability	Reports
Reports that reveal an organic conception of disability	<i>“It is a limitation of a given capacity, be it mental, physical or sensorial, which leads to some functional impairment for a person.” (P1)</i>
Conceptions that balance between organic and social conceptions	<i>“Society is organised for... for daily activities considering a standard of normality, the functionality of individuals. When someone, as we say, falls, that is... presents a greater difficulty in a given aspect, they... They can’t adapt to what society expects them to be able to do in their day-to-day routine. So, it is also a difficulty of society; we are not prepared to embrace all types of people, we are not prepared to accept these differences people</i>

	<i>have. Society is adapted to a standard, the normal human being, who can do everything that is expected from us, but if a person fails to meet these expectations, they are excluded from society.” (CHA1)</i>
Reports that discuss a social perspective of disability, reiterating the organic conception	<i>“In fact, it was not the society that established this standard; all children are born with four limbs, so if a child is born with one limb less, you know, physically, she has, she has a different anatomy, just as being born without an eye, being born with the heart over there and not over here, so, as such, it is a morbidity, the same as a hypertensive or diabetic person, it’s... and within what society... physically there are some adaptations; she doesn’t have the conditions or is not prepared or it is not common, people would die before using a wheelchair, like, you know?” (P3)</i>

2. “What is rehabilitation?”

The professionals outlined two main conceptions. Initially, and more strongly, professionals, mostly driven by medical doctors’ viewpoints, presented a conception of rehabilitation as a process in which an individual with disability regains capacity and (re-)acquires skills, as a process focussed on the ability of the individuals, not so much on their environment. Only later, and not so strongly, did other participants present a conception of rehabilitation, not only focussed on individuals (within an idealisation of normality) but also considering the social dimension of disability as well as the modification of the environment and of social relationships as possible interventions. Examples of these conceptions and respective reports are presented in Table 3.

Table 3: Examples of Conceptions concerning the Rehabilitation of a Person with Disability

Conception concerning Rehabilitation	Reports
Functional conception of rehabilitation – centred on the individual capacities and normality standards	<i>“...we want to recover an ability. I think that’s it... And in the context of disability, I think that it is an attempt to re-establish lost efficiency, unachieved efficiency.” (MR1)</i>
The few conceptions recognising the need to change the environment	<i>“In fact, I think that’s the problem with rehabilitation, because we focus, not only us, but society as a whole, on the individual, you don’t have a capacity, so you have to adapt to everything, because the world is like this...” (MHR1)</i>

	<p><i>"It's no use taking a disabled person, someone with a physical disability, a paraplegic, for example, there is no way I can transform that paraplegic into an able person, making him autonomous or independent, if I don't build ramps, if I don't create the means, elevators, accessibility for that person. But nobody does this, not the government, not society and not even health services. Do you think a wheelchair user can get in and move around, even here?." (N4)</i></p>
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3. CBR: "What are the potential benefits and difficulties you may find for implementing CBR in your territory?"

Most of the participants were receptive to the need for and viability of implementing a CBR programme in their territories. Even though they were not against the general idea (examples are presented in Table 4), participants often raised important contextual difficulties (examples are presented in Table 5).

Table 4: Examples of Conceptions regarding the Potential Benefits and Difficulties in the Implementation of a CBR Programme

Conception on the Implementation of a CBR Programme	Statements
<p>Positive conceptions concerning the implementation of a Community-Based Rehabilitation programme</p>	<p><i>"I think it's super important... I think that we have to believe in this type of thing. I think the question of viability has to pass through credibility and willpower too. I think that it is viable, I think that we have to try and encourage it, but I think that it is a long-term process, for many reasons, especially because of many of the things that were said here." (N4)</i></p> <p><i>"Let's suppose, if I had a programme of this kind for the six FHCs, if they rotated, among the six, I think it would be very interesting, because then we would have support in the visits, would have to tell, right? Attend closer, because for some people have difficulty doing, let's assume, physical therapy at the specialised rehabilitation centre, for them is</i></p>

	<i>very complicated because they don't have adequate transportation, even access difficulty. If it had something closer to their house it would be very interesting."</i> (CHA6)
Conceptions showing difficulties concerning the implementation of a Community-Based Rehabilitation programme	<p><i>"I was thinking about this, about these three partners that are directly involved, but they need to approximate... Because today, we can achieve some things, but the difficulty in dialoguing, it has to be everyone really together, everyone with the same objective, with the same purpose... So, I think that there is work to be done, but there should be the moment to discuss and to make it viable."</i> (N5)</p> <p><i>"I think that there is a lack of central planning, there has to be a municipal policy establishing what the services are supposed to do, sharing everything, meeting periodically and regularly to develop that policy, that programme, together."</i> (P6)</p>

Table 5: Examples of Challenges for the implementation of Community-based Rehabilitation programmes pointed out by Participants

Challenges pointed out by Participants	Statements
Coordinating action across sectors	<p><i>"Is more than a lack of communication, lacking a culture to work in intersectorality. People generally remain in their own squares and cannot share actions and strategies. They send the problem to the other sector and forget that problem exists, as if becoming a problem of the other, it is no longer their problems."</i> (P1)</p> <p><i>"I think people need to be trained to work in an intersectoral way, because they think that intersectorality is to work forwarding problems to others, picking up the phone and passing the case to the other."</i> (N3)</p>
The Brazilian political context	<i>"Do you believe that governments are concerned about improving the lives of the population? Do you believe that they are concerned about a person with a disability? If</i>

	<p><i>that person votes, she/he will win a wheelchair at the time of the election. If she/he does not vote, she/he will neither be seen nor listened.”</i> (N5)</p> <p><i>“Politicians are worried about re-election and will not invest in programmes that require the hiring of several professionals from different areas of activity and they are only interested in assistance and punctual actions that give them credit to the media.”</i> (P1)</p>
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Within a more interpretive-reconstructive stance conferred by the analytical method, the anticipated barriers reported by the participants can be categorised and interpreted as related to: 1) the challenges of coordinating action across sectors, and 2) the Brazilian political context.

Indeed, one of the reported concerns was the inherent difficulty of managing an intersectoral programme with the characteristics of a CBR programme, such as difficulties in terms of interaction and coordination of objectives, plans and actions. Participants pointed out the anticipated difficulties in the articulation of all agents involved, and finally the lack of managerial vision for creating intersectoral forums and running decentralised agencies or units accountable for the local and regional management of cross-sectoral CBR action. These considerations would thus emerge as important challenges to the effective implementation and functioning of a CBR programme.

Another pointed concern was the Brazilian macro-political context. According to the participants, policy-makers are mainly focussed on their own interests and on actions that have the potential to promote their image in an electoral cycle, rather than in promoting the public interest. This macro-political context is seen as broadly reflected in the way social policies are (not) made and (not) implemented in the country. It was commonly understood that the broader socio-political environment barely empowers the civil society, little addresses its concerns and is rather affected by power differentials. Professionals often spoke about the underlying motivations for the policy-making process that typically were, according to them, more often related to lobbies and particular interests of those in positions of power, and less so on the common good and on the needs of the most vulnerable, including people with disabilities.

Overall, it was a common understanding that well-intended but broadly-defined policies for serving the needs of people with disabilities often remain only as good intentions, which somehow get lost when it comes to being translated into practice. That issue seemed prevalent in the participants' reasoning about the minimal penetration of full CBR approaches in the Brazilian context – and it therefore remains as an anticipated challenge.

DISCUSSION

The biomedical and impairments-based model of disability and rehabilitation were predominant among participants' viewpoints. That might reflect the culture of their training as well as it seems aligned with the predominant biomedical model of providing care to people with disabilities in Brazil (Bampi et al, 2010). This biomedical ideology in the Brazilian health system apparently overcomes an interdisciplinary, holistic and intersectoral one (Conill, 2008; Müller & Artman, 2012; Andrade et al, 2015). However, that scenario does not seem exclusive to the Brazilian context. For example, Community Health Workers in an established Mongolian CBR programme found difficulties in shifting from a medical approach to disability and rehabilitation (Como & Batdulan, 2012). So, it seems that either in anticipation of or for an established CBR programme, the biomedical view of disability and rehabilitation can be problematic for optimal CBR functioning and/or its effective implementation.

The predominance of the biomedical and impairments-based reasoning in this study can also reflect the predominance of the viewpoints of medical doctors observed in the focus groups, which seemed to reflect a professional hierarchy determining the focus, scope and paradigm of the services provided, and thus the 'collective' perspectives taken. While medical doctors typically spoke first, followed by the nurses, the perspectives of other professionals either did not emerge or were not totally free of coercion. It is likely that the implicit use of power positions had inhibited the opportunity for reciprocal dialogue and arguments (e.g., from the frontline community health workers), which is far removed from the ideal dialogue and a truly collective perspective-building idealised by Habermas (1988).

Similarly, a recent review of ethical issues around CBR programmes found that key topic areas are: partnerships among stakeholders, respect for culture and local experience, empowerment, accountability, and fairness in programme design. Authors also claim that all those involved in CBR projects should pay close

attention to the development of partnerships that, despite asymmetries among stakeholders, are respectful and effective (Clarke et al, 2016). This can currently be hard to achieve in the studied scenario, given the observed imbalances of power in the perspectives. With a strong biomedical view of disability and rehabilitation, it is not easy for primary healthcare services to be prolifically extended to actively incorporate CBR principles in its full spectrum.

PHPs explicitly anticipated difficulties in coordinating action across sectors in their territory. The difficulty in cross-sectoral coordination seems to resonate with the CBR literature around the globe (McVeigh et al, 2016). In the case of Brazil and the broader Latin America, studies have also pointed to similar challenges in developing, managing and running programmes across sectors, which might relate with the way strong silos are nationally, regionally and locally established and maintained; obviously, that complicates the share and delegation of roles and accountability for those closer to the frontline (Conill, 2008; Müller & Artman, 2012; García-Ramírez & Vélez-Álvarez, 2013). Again, it seems there is sometimes a political discomfort (e.g., a need to retain power positions) and/or organisational difficulties in decentralising operations and deliberative capacity to intersectoral forums. These latter have, nonetheless, potential benefits for implementing a cross-sectoral programme (Conill, 2008; Müller & Artman, 2012; García-Ramírez & Vélez-Álvarez, 2013; Andrade et al, 2015).

Policy options to delegate decision and management capacity to decentralised stakeholders exist, and particularly for the scope of CBR (McVeigh et al, 2016). These options can emerge from the civil society itself and can actively include people with disabilities, while empowering them in doing so. For instance, engaged stakeholders might actively contribute towards the planning and management of the CBR services across sectors, and even towards planning and doing research for its support. Most notably, in a low-income country, a Community Action Research on Disability, nurturing participation and collaboration between all stakeholders, has been established to drive research agendas that likely are translated into practice – as the ultimate knowledge-users and beneficiaries are involved in the agenda-setting process (Hartley et al, 2017). That type of collective involvement and leadership can reverse the power differentials pointed out by the participants, but that involvement was far from achieved in the context of the current study. Nonetheless, this solution may well apply and help overcome most anticipated challenges.

CONCLUSION and IMPLICATIONS

PHPs in an economically and socially deprived sub-urban region of Ribeirão-Preto, Brazil, anticipated important CBR implementation and functioning barriers which could be addressed. Options may include the decentralisation and re-balance of the management and decision-making power, creation of decentralised entities to manage action across sectors and, finally, the empowerment of the civil society and of people with disabilities in doing so. However, it is important that PHPs' predominant conceptions (i.e., biomedical, impairments-based) of disability, rehabilitation and CBR are addressed, even before the actual implementation of a CBR programme. Otherwise, a narrow view of disability and rehabilitation can be reflected into a narrow contribution of PHPs for a multisectoral CBR programme.

Limitations

The study was focussed on a specific context and territory, so the results cannot be generalised for others, even though many issues resemble aspects addressed by related literature in Brazil (for programmes across sectors) and challenges in implementing CBR programmes in other parts of the globe. Another major limitation is that the challenges for the implementation and functioning of a CBR programme are merely anticipated, and are not the result of a lived experience. Nonetheless, local professionals might be knowledgeable about the very local factors that may be expected to influence the implementation of a multisectoral programme in their own territory. Different professional categories of PHPs were purposively brought together at the same focus group discussions to identify: 1) 'collective' perspectives of those in the same service unit, and 2) how 'dominant' professional-group perspectives affected those 'collective' thoughts. These are useful findings for the context of this study as they reveal that future implementation endeavours need to address current dominant-group perspectives first, if they want to succeed. On the other hand, that pragmatic option impeded the more active and free participation of lower-level providers, whose 'real' perspectives might not be reflected in the study's results. Finally, the study considered the perspectives of PHPs but not those of other stakeholders such as people with disabilities, their families or their representatives. That could be an important avenue for further research.

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