

## BRIEF REPORTS

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# Improving Disability and Rehabilitation Systems in Low and Middle-income Countries: Some Lessons from Health Systems Strengthening

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### ABSTRACT

***Aim:** This report seeks to draw attention to, summarise, and make inferences from the “Good Health at Low Cost” studies for the area of disability and rehabilitation service delivery.*

***Methods:** Key findings from this series of important studies are identified. Based on reflection, potential implications for CBR and inclusive development systems in low and middle income countries are identified.*

***Conclusions:** These studies underscore the importance of organisational, political and systems thinking to improve service systems in low and middle income countries. They reinforce the importance of sustained and visionary political action and lobbying. They show that substantial improvements can be made to service systems despite limited resources.*

***Implications:** The advancement of CBR and disability-inclusive development is dependent on effective systems in low and middle income countries. Participatory research to inform such system strengthening is vital.*

## INTRODUCTION

A few years ago a major report (Balabanova et al, 2011) was released based on extensive research and case studies of healthcare systems in low and middle-income countries (LMIC). This work outlined key features of successful healthcare systems in these countries. More recently, key publications linked with this work have been published in *The Lancet* (Balabanova et al, 2013) and the *New England Journal of Medicine* (Mills, 2014). These publications are connected with the Good Health at Low Cost (GHLC) initiative (<http://ghlc.lshtm.ac.uk/>) funded by the Rockefeller Foundation. The current commentary seeks to consider possible

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implications of these findings for community-based rehabilitation (CBR) and disability service systems. It draws principles identified in these case studies and seeks to make connection with the disability sector in LMIC.

While it is not wise to make direct parallel associations between health systems and disability and rehabilitation service systems, it may be beneficial to consider some of what has been learned in this major study. It could foster debate and reflection regarding the hallmarks of successful disability and rehabilitation service delivery systems in LMIC, and hopefully will stimulate much needed research on this topic.

## **GOOD GOVERNANCE AND POLITICAL COMMITMENT**

The GHLC researchers, who conducted multifaceted in-depth case studies of successful health systems in LMIC, found that good governance was a key success factor. Governance relates to the regulation and management of a system, which can include both governments and non-government organisations (NGOs). For disability and rehabilitation systems in LMIC, good governance may be reflected in services which are managed to be responsive to people with disabilities and their families, which are based on research and evidence, and which are monitored appropriately. Good governance in disability and rehabilitation systems would also be reflected in a vision for improvement and a commitment to equity and transparency.

Key elements of good governance include effective leadership and long-term vision, which are vital for strong services. Based on the example of the GHLC research, if improvement in disability and rehabilitation systems are to be seen, inspirational leaders and committed political workers will be needed. Visionary leadership within a country is vital. It was found that successful leaders seized windows of opportunity that emerged, taking advantage of political, legal, funding or policy opportunities that aligned with their broader vision.

From the GHLC case studies, clear priorities and realistic policy goals were also important. The authors described instances where clear and coherent policies and priorities helped guide system reform, improved outcomes, and also attracted the support of others. Their observation of the importance of responsiveness to diverse population needs is of key relevance to the disability sector. Inclusive development is based on the premise that people with disabilities benefit when mainstream agencies are responsive. Similarly, this characteristic is also a

reminder that good disability and rehabilitation systems should actively include rural, isolated and marginalised people and families. Ensuring their access to services and opportunities, and engaging with such communities are hallmarks of successful systems.

An important finding of the GHLC research was that good health systems showed ongoing reform. Likewise, effective disability and rehabilitation systems will maintain ongoing growth and improvement, regardless of changes in government, or trends among donors or the development sector. This will depend not only on visionary leadership as noted above, but also on a careful sequencing of reforms, where small steps are planned, deliberate and ongoing, and lead to greater change over time.

Finally, the GHLC researchers found that strong systems showed greater accountability and safeguards over scarce resources. In disability and rehabilitation services, high levels of accountability would boost trust and affect how people with disabilities and their families perceive and access them. Such accountability includes measures to make financing flows more efficient and transparent, thereby tackling corruption and the misuse of resources.

## **EFFECTIVE BUREAUCRACIES AND INSTITUTIONS**

The second over-arching attribute of successful healthcare systems in LMIC was bureaucracies and institutions which functioned well (at the ministry level, district or sub-district level, and including donor agencies or NGOs). The researchers found that particularly where resources were scarce, strong regulatory and managerial capacity were important. In the disability sector, this would be reflected in appropriate laws for adequate service provision, inclusion, employment, and anti-discrimination, and would include bureaucracy with the capacity to manage and meaningfully implement such laws. A part of this implementation is that managing bureaucracies need appropriate information and evidence to monitor outcomes and progress. For disability services, this would likely depend on well-conducted pilot studies, and eventually, appropriate indicators and meaningful evaluations.

In the disability and rehabilitation sector, in which departments and NGOs are always far smaller than health departments and health-related NGOs, there may be substantial scope to bring about some of the factors described in the GHLC study. First, for potential changes and reforms to be sustained, stability of

bureaucracy at the relevant level of government is required. This stability over time maintains the vision and values that guide system improvement. Next, ensuring that relevant disability related departments and bodies have sufficient autonomy and flexibility to manage effectively is another important success factor. Third, disability-related departments or sections and even NGOs (being smaller than health-related institutions) may be in a better position to engage with many stakeholders, including non-state actors and local communities. Indeed, in the disability and rehabilitation area, such engagement could foreseeably be one of its key strengths.

A further lesson from the GHLC study is the importance of governments and donors working together to formulate and implement policy. In the disability service sector, NGOs have taken, and can continue to take, a lead role in establishing such links and partnerships. Likewise, in the disability sector there is considerable experience in using the media as a catalyst for change, disseminating information, increasing awareness and tackling deeply-rooted beliefs and attitudes.

## **INNOVATION**

All of the case studies in the GHLC research showed a degree of innovation which was crucial to their success. First, they used novel health workforce strategies to address need. While the CBR tradition itself can be seen as an innovative workforce strategy, there may be scope for further task shifting, role expansion and skills enhancement to ensure the needs of people with disabilities are met. Second, they reflected new approaches to system financing and financial protection. This is a reminder that outcomes for people with disabilities will be directly affected by the share of government expenditure attributed to people with disabilities. It is vital to explore innovative options to ease the financial burden on vulnerable households. Finally, case studies of successful healthcare systems showed innovation and pragmatism in service delivery. Being practical and seizing opportunities to deliver services in new ways, using different strategies and focussing on grassroots' priorities are lessons relevant to disability services.

## **RESILIENCE IN THE SYSTEM**

Finally, successful health systems studied by the GHLC team showed a degree of resilience. They had benefited from system strengthening in the past and exhibited the capacity not to be diverted when obstacles arose. They were

relatively streamlined systems and were prepared for both internal crises as well as for physical or environmental disasters.

Interestingly, the GHLC study also showed that non-health system factors played an important role in health outcomes. Drawing parallels with the disability and rehabilitation sector in LMIC, it can be assumed that “external” factors including country infrastructure (such as roads and electricity), empowerment (especially of women) and national education, will also have considerable direct and indirect impact on the capacity of the system, and on the lives of people with disability.

## **KEY ISSUES FOR DISABILITY AND REHABILITATION SYSTEMS**

What does this mean for the disability and rehabilitation services sector in low and middle-income countries? Fundamentally the analyses of case studies included in the GHLC initiative indicated that substantial improvements to services can be made and coverage increased, despite limited resources. This was a core finding, which is also very encouraging for those hoping to see improvement in the disability service system within which they work.

Importantly, the emphasis in the GHLC findings on political and organisational issues, on the role of key individuals, and on the value of persistence and creative lobbying, are worth noting. In CBR and inclusive development circles it is possible to fall into the trap of thinking that operationalising the CBR Matrix, following the CBR Guidelines or implementing international conventions such as the UNCRPD, will lead to the establishment of successful disability service systems. The findings of the GHLC studies are a reminder that focusing on strategic, political, organisational and social influences may be even more important. Fostering openness to dialogue and collaboration – building consensus on the importance of disability services and aligning common interests - will be core to establishing successful systems.

It is understood that in each country there will be constraints and opportunities imposed by history and the current realities of that context. Similarly, this research is a reminder that understanding the social, economic, and political context in which disability services are embedded will help to realise success or failure. Indeed the breadth of these findings suggest that attempts should be made to influence a range of sectors, not just the sectors of health or welfare. Further, successful systems are not necessarily initiated from the top down.

Social movements, the mobilisation of communities, political and social actions all have the potential to improve systems.

While sustained financial investment in disability service systems will be essential for progress, this research indicates that committed politicians, effective managers, motivated workers, effective institutions, and involved communities can take many constructive steps, even in difficult financial circumstances.

In order to support more effective systems, CBR and disability activists should in particular:

- Seek to build capacity with skilled individuals who have the ability and vision to inspire, and who are supported by strong organisations. This might be at local, regional or country levels.
- Carefully identify potential catalysts for change. It is crucial to seize windows of opportunity to promote key reforms and build broad political support.
- Ensure that policies are responsive to the needs and social values of people with disabilities. They should be adapted to the circumstances of the country in question.
- Once change occurs, activists should support continuity. Real change requires stability so that reforms can be seen through to completion. Sustainable change also depends on organisations learning lessons over time; they need an institutional memory that helps them focus regardless of changing priorities.

## CONCLUSION

In conclusion, recognising the value of the GHLC project, future research on disability and rehabilitation services in LMIC would benefit by a similar initiative. Such research should take a longer term and systems approach, comparing countries which face similar circumstances in order to understand success (and failure) factors more adequately. The CBR world benefited substantially from the multi-country case studies in the early 90s conducted by Peter Coleridge (1993). To successfully plan service systems for the coming decades, a participatory research programme using systems case studies should be established. Comparative case study research across multiple stakeholders in many countries could assist to set benchmarks, inform policies, improve the quality and coverage of services, and create opportunities for learning across contexts.

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