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Promotion and protection of all human rights, civil political, economic, social and cultural rights, including the right to development

Habilitation and rehabilitation under article 26 of the Convention on the Rights of Persons with Disabilities

Report of the Office of the United Nations High Commissioner for Human Rights*

Summary

The present report, submitted pursuant to Human Rights Council resolution 37/22, provides an overview of the obligation to provide habilitation and rehabilitation under article 26 of the Convention on the Rights of Persons with Disabilities. It contains guidance on a human rights-based approach to habilitation and rehabilitation for persons with disabilities and recommendations to assist States in implementing their obligations under international human rights law.

* Agreement was reached to publish the present report after the standard publication date owing to circumstances beyond the submitter's control.

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I. Introduction

1. In its resolution 37/22, the Human Rights Council requested the Office of the United Nations High Commissioner for Human Rights to prepare its next annual thematic study on the rights of persons with disabilities on article 26 of the Convention on the Rights of Persons with Disabilities, to be submitted prior to its fortieth session.

2. Article 26 of the Convention provides that States parties must take habilitation and rehabilitation measures to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. States parties have an obligation to organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services (art. 26 (1)). States parties are further obliged to promote the availability, knowledge and use of assistive devices and technologies (hereafter "assistive products") as they relate to habilitation and rehabilitation (art. 26 (3)).

3. In this report, habilitation and rehabilitation are approached from the perspective of the human rights of persons with disabilities, including with respect to the removal of attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others (Convention, preamble, para. (e)). To understand the appropriate scope and role of habilitation and rehabilitation vis-à-vis other enabling measures, they are viewed in the context of a broad array of strategies adopted in the Convention to ensure and promote the full autonomy, independence and inclusion of persons with disabilities, including accessibility and reasonable accommodation, awareness-raising, inclusive education, access to justice, supported decision-making, and in-home, residential and other community support services. The report also covers the need to distinguish between action related to rehabilitation and wider community development strategies for the inclusion of persons with disabilities.

4. For the purposes of this report, habilitation and rehabilitation are understood to be a set of interventions designed to optimize the functioning of individuals with impairments in interaction with their environment. The aim of habilitation is to assist individuals who acquire impairments congenitally or in early childhood to learn how to better function with them. The aim of rehabilitation, in the strict sense, is to assist those who experience a loss in function as a result of acquiring an impairment to relearn how to perform daily activities to regain maximal function. By providing or restoring functions, or compensating for the loss or absence of a function or a functional limitation, habilitation and rehabilitation ultimately equip persons with disabilities to achieve a higher level of independence. While rehabilitation is of particular relevance to persons with disabilities, not all persons with disabilities need habilitation and rehabilitation. In this report, the term "rehabilitation" is used to designate both habilitation and rehabilitation, unless the discussion is specific to habilitation.

5. For the preparation of the present report, a note verbale requesting input was sent to all Member States, and written contributions were received from 17 States. Submissions were also received from civil society organizations. In addition, the Office of the United Nations High Commissioner for Human Rights held an in-person consultation on 5 and 6 November 2018 in Geneva to discuss substantive aspects of the report. The contributions received and a summary of the meeting will be made available on the website of the Office of the United Nations High Commissioner for Human Rights.[1]

[1] www.ohchr.org/EN/Issues/Disability/Pages/StudiesReportsPapers.aspx.

II. Understanding habilitation and rehabilitation

A. International legal framework for habilitation and rehabilitation

6. Access to rehabilitation has long been understood to be an intrinsic element of the right to health. Although rehabilitation is not expressly mentioned in article 12 of the International Covenant on Economic, Social and Cultural Rights, the Committee on Economic, Social and Cultural Rights explained in its general comment No. 5 (1994) on persons with disabilities (para. 34) that the right to physical and mental health also implies the right to have access to, and to benefit from, medical and social services, and that persons with disabilities should be provided with rehabilitation services that would enable them to reach and sustain their optimum level of independence and functioning. In its later general comment No. 14 (2000) on the right to the highest attainable standard of health (para. 17), the Committee further affirmed that the provision of equal and timely access to basic rehabilitative health services fell under article 12 (2) (d) of the Covenant on the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

7. Rehabilitation has also been recognized as part of redress for victims of serious human rights violations. In particular, under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, victims of torture are guaranteed an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible (art. 14 (1)). The right of victims to rehabilitation has been recognized in the contexts of sexual violence (A/70/222, para. 25), human trafficking (A/HRC/7/8) and slavery (A/HRC/24/43, paras. 62–66).

8. The Convention on the Rights of the Child became the first United Nations human rights treaty to include an explicit obligation to provide rehabilitation services to persons with disabilities. Under article 23, States parties must ensure that children with disabilities have effective access to and receive education, training, health-care services, rehabilitation services, preparation for employment and recreation opportunities. Under that article, rehabilitation is treated as being separate from health care. It has long been understood that rehabilitation of persons with disabilities is not confined to the medical realm.[2]

9. Under the Convention on the Rights of Persons with Disabilities, a cross-sectoral approach to rehabilitation is recognized and reinforced. During the drafting of the Convention, the initial proposal to address rehabilitation alongside health in one provision was quickly rejected. There was a shared understanding within the Ad Hoc Committee on a Comprehensive and Integral International Convention on the Protection and Promotion of the Rights and Dignity of Persons with Disabilities that rehabilitation had social, educational, vocational and other non-health components. In the end, it was agreed that a separate article specifically dedicated to rehabilitation was the most appropriate solution.

10. While elements of rehabilitation are present in other articles under the Convention, article 26 increases its visibility as an important strategy for ensuring the inclusion and participation of persons with disabilities to attain, maintain and maximize their independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. The result is the creation of a unifying framework for the provision of coordinated and comprehensive rehabilitation services that are voluntary, individualized and community-based. The services and programmes should begin at the earliest stages possible and be based on a multidisciplinary assessment while supporting participation and inclusion. Article 26 also requires that States parties promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation while promoting the availability, knowledge and use of assistive devices and technologies.

[2] World Health Organization (WHO), “WHO Expert Committee on Medical Rehabilitation: second report” (Geneva, 1969), p. 6. See also the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, rule 3.

11. Article 25 expressly guarantees health-related rehabilitation as an element of the right to health, requiring that States parties take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. Article 16 obliges States parties to promote the rehabilitation of persons with disabilities who become victims of exploitation, violence and abuse. Article 27 lists the promotion of vocational and professional rehabilitation as one of States parties' positive obligations related to the right of persons with disabilities to work. In the context of the right to education, reference is made in article 24 (3) to measures to enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community, which could be considered habilitation and rehabilitation. Article 20 requires States parties to facilitate access to personal mobility aids, devices and assistive technologies, whereas the provision of a broader spectrum of assistive technology and devices is one of the general obligations under article 4.

B. Forms of rehabilitation interventions

12. Rehabilitation involves a wide range of functional interventions, both medical and non-medical. For example, some people may need rehabilitation to learn or relearn skills such as coordinating leg movement to walk, learn new ways of performing tasks such as bathing and dressing, or learn how to communicate when their use of language has been affected. Rehabilitation is not only for persons with physical impairments. For instance, torture, sexual exploitation and trafficking survivors may be in need of psychosocial rehabilitation in the form of counselling, peer support and other measures.

13. Rehabilitation is an evolving concept and is interrelated with the enabling or restrictive conditions of the environment. Rehabilitation processes include measures with respect to the immediate environment of the person concerned, such as the provision of communication aids, accessible features in the person's home environment (for example, installing a toilet handrail) or job accommodations (for example, having accessible software).

14. It may not always be evident to distinguish where rehabilitation ends and other forms of support begin. Differentiating them contributes to better policy programming and implementation. For example, a person may require in-home rehabilitation, including access to assistive devices and personal assistance to contribute to that process. At the same time, these services and goods may contribute to the person's participation in society beyond the rehabilitation process and should also be available after the rehabilitation ends.[3]

1. Health-related rehabilitation interventions

15. Health-related rehabilitation has been defined as a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment.[4] Rehabilitative interventions can be distinguished from other medical interventions insofar as rehabilitation is not aimed at curing or treating the underlying causes of a health condition or managing a disease process.

16. The World Health Organization (WHO) recommends that health-related rehabilitation services should be available in both community and hospital settings.[5] Evidence shows that rehabilitation outcomes are often better in home-based or community settings, and that rehabilitation provided at home is generally the preferred and more highly valued option for users.[6] The presence of rehabilitation services in hospitals often means that interventions can start at the earliest stage possible, thus accelerating recovery and

[3] See *H.M. v. Sweden* (CRPD/C/7/D/3/2011), paras. 8.8 and 8.9, on the breach between the provision of rehabilitation under article 26 and support under article 19 of the Convention.

[4] WHO, *Rehabilitation in Health Systems* (Geneva, 2017), p. 35.

[5] Ibid., pp. 17–18.

[6] Ibid, p. 17.

optimizing outcomes.[7] Evidence has also shown that hospitals should include specialized rehabilitation units for persons with complex rehabilitation requirements.[8] The need to provide some rehabilitation in hospitals must not be conflated with the concentration of rehabilitation services for persons with disabilities within institutional settings. The latter practice is incompatible with the Convention because institutionalization, also when based on the need for rehabilitation services, is in contradiction of articles 26 and 19 (A/73/161, para. 58).[9]

17. According to the Special Rapporteur on the rights of persons with disabilities, access to essential habilitation and rehabilitation and access to essential assistive devices should be considered as core obligations that are not subject to progressive realization (A/73/161, para. 18). The obligation to ensure access to health-related rehabilitation for persons with disabilities on a non-discriminatory basis is a core obligation of immediate effect.[10]

2. Non-health rehabilitation interventions

18. In addition to health, under article 26 access is guaranteed to rehabilitation in areas such as employment, education and social services, which may not be health-related. Some non-health-related interventions can be done in rehabilitation centres, but they can also be provided in other settings. For example, mobility orientation can be provided both in rehabilitation centres and in schools. Rehabilitation in employment can be done in a work training centre or in the context of the job itself. As rehabilitation is a cross-sectoral and environment-dependent process, it should be tailored to the person concerned and kept flexible as to where the best expected outcome could be achieved.

19. Vocational rehabilitation is not defined in the Convention. In the past, vocational rehabilitation was often understood to be a broad set of measures relating to the employment of persons with disabilities.[11] In the Convention, a narrower view is taken of the role and place of vocational rehabilitation in the implementation of the right of persons with disabilities to work, and it is bundled with job retention and return-to-work programmes (art. 27 (1) (k)), to support those who acquire an impairment when already in the labour market for their inclusion on an equal basis with others. Vocational rehabilitation includes techniques such as the provision of advice in support of returning to work, support for self-management of health conditions, adjustments related to the medical and psychological impact of an impairment, psychosocial interventions, functional and work capacity evaluations, and career counselling, job analysis, job development and placement services.

20. It should be recognized that not all the services that persons with disabilities require to have better chances of being included in their communities have to do with rehabilitation. For example, to enter the labour market, they will benefit from inclusive education (including equal access to general tertiary education, vocational training, adult education and lifelong training, as per article 24 (5)) and from inclusive vocational guidance and placement programmes, reasonable accommodation and other support envisaged in article 27 (1), which should not be read as rehabilitation services.

21. In the context of education, rehabilitation measures may come under measures that enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community, such as Braille, alternative script, augmentative and alternative modes, means and formats of communication and orientation and mobility skills (art. 24 (3)). In Ireland, for instance, the Department of Education and Skills provides a range of support measures to enable

[7] Ibid, p. 18.

[8] Ibid, p. 21.

[9] See also Committee on the Rights of Persons with Disabilities, general comment No. 5 (2017) on living independently and being included in the community, paras. 21 and 30.

[10] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 43 (a).

[11] International Labour Organization, Vocational Rehabilitation (Disabled) Recommendation, 1955 (No. 99); see also Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983 (No. 159).

participation in mainstream education from primary level through to higher and further education, including resource teachers, in-school speech and language therapies, occupational therapies and assistive technology.

22. National practices show that some rehabilitation services can be integrated into the social protection system. For example, in Germany, distinctions are drawn between medical rehabilitation assistance, occupational integration assistance and social integration assistance. The latter includes the provision of non-medical and non-vocational aids, assistance in developing the practical knowledge and skills necessary for maximum participation in community life, and assistance in obtaining, adapting, furnishing and maintaining a home that accommodates specific requirements.

3. Rehabilitation as a component of community-based inclusive development

23. As stated above, it should be recognized that not all policies and services enabling the inclusion of persons with disabilities in the community amount to rehabilitation. The term "rehabilitation" has come to be used broadly to designate policies aimed at the inclusion of persons with disabilities or disability-related policies in general. This is linked to the context in which habilitation and rehabilitation emerged, whereby action and policies related to persons with disabilities were primarily focused on "fixing" a person's impairment as a precondition for their participation in society. Using the term "rehabilitation" in this broad manner is a throwback to the medical model of disability: the application of the term in this manner is thus outdated and incompatible with the Convention, and risks perpetuating stereotypes relating to persons with disabilities.

24. In recent years, umbrella concepts such as disability-inclusive policies (A/71/314) and community-based inclusive development have been used to frame a broad range of disability-related policies and measures, of which rehabilitation in the sense of article 26 of the Convention is only one of its many elements. For example, community-based rehabilitation evolved from a strategy that focused on increasing access to rehabilitation services in the community for persons with disabilities in resource-constrained settings to a multisectoral strategy within general community development to achieve equity and social inclusion. While community-based rehabilitation is much broader than rehabilitation within the meaning of the Convention, the strategy continues to be identified with rehabilitation services. Community-based inclusive development builds on community-based rehabilitation, adopting the latter's principles as the key tool for its implementation.[12] Further research and methodological frameworks from the perspective of the rights of persons with disabilities are required to better evaluate the outcomes of community-based rehabilitation and community-based inclusive development.[13]

III. Unpacking the obligation to provide habilitation and rehabilitation

A. Elements of rehabilitation

1. An individualized approach to rehabilitation

25. Article 26 (1) of the Convention stipulates that rehabilitation services and programmes must be based on the multidisciplinary assessment of individual needs and strengths. Rehabilitation interventions should be based on individual rehabilitation plans

[12] See www.cbm.org/Community-Based-Inclusive-Development-250825.php.

[13] See, inter alia, Valentina Iemmi and others, *Community-based Rehabilitation for People with Disabilities in Low- and Middle-income Countries: A Systematic Review*, Campbell Systematic Reviews, 2015:15 (Oslo, Campbell Collaboration, 2015); Marie Grandisson, Michèle Hébert and Rachel Thibeault, "A systematic review on how to conduct evaluations in community-based rehabilitation", *Disability and Rehabilitation*, vol. 36, No. 4 (2014), pp. 265–275; and Sally Hartley and others, "Community-based rehabilitation: opportunity and challenge", *Lancet*, vol. 374, No. 9,704 (28 November 2009), pp. 1,803–1,804.

that are person-centred, goal-oriented and fit to achieve their purpose. Access to rehabilitation must be based on the actual needs of an individual and official recognition or certification as a person with a disability must never be a precondition for accessing rehabilitation services.

26. Rehabilitation interventions are typically geared towards full or partial recovery, and therefore tend to be of a limited duration. It is a good practice for individual rehabilitation plans to have a defined time frame. For some persons with disabilities, however, rehabilitation is required on a long-term or continuous basis in order to maintain a certain level of functionality. In such cases, it remains advisable to review the rehabilitation plan regularly to adjust the established goals at each stage in a series of cycles. The emphasis on time frames must not lead to interruptions in or the discontinuation of required rehabilitation support.

2. Early intervention

27. Article 26 (1), in recognition of the importance of early intervention, stipulates that habilitation and rehabilitation services and programmes begin at the earliest possible stage. While early interventions are crucial for all people, it is particularly important for children with disabilities who have acquired impairments congenitally or in early childhood. Early intervention, including through the use of assistive products, allows the identification of risks of developmental delays, reduces developmental gaps and improves the child's chances of benefiting from their education, and also reduces further support requirements and provides focused habilitation interventions (A/71/314, para. 44).

28. States should establish mechanisms for early identification and individualized assessment of developmental and learning support requirements and provide child- and family-centred comprehensive habilitation and support aimed at helping the child reach their full potential. In accordance with respect for the evolving capacities of children with disabilities and to provide support to enable and strengthen their independent decision-making, children with disabilities should be empowered to participate in their habilitation and rehabilitation from the earliest age.[14] Early intervention mechanisms must not reinforce the medical model of disability that leads to segregation and exclusion from education and other mainstream services.

3. Assistive products

29. Under article 26 (3) of the Convention, States parties are required to promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation. Access to assistive products is further guaranteed as part of the general obligations of States parties in article 4 (1) (h) and (g), in the context of personal mobility in article 20 (facilitating access to quality mobility aids, devices and assistive technologies, including by making them available at affordable cost), and as part of the right to social protection under article 28 (ensuring access to appropriate and affordable services, devices and other assistance for disability-related needs).

30. WHO has defined assistive devices as any external product, including devices, equipment, instruments and software, specially produced or generally available, the primary purpose of which is to maintain or improve an individual's functioning and independence and thereby promote well-being and contribute to preventing secondary health conditions.[15] Assistive products allow individuals to perform an activity that they would otherwise be unable to do, or increase the ease and safety with which these activities are performed (A/71/314, para. 44). Wheelchairs, walkers, prosthetics, hearing aids, alarm devices, spectacles, voice recognition software, communication boards and speech synthesizers are all examples of assistive products.

[14] Committee on the Rights of the Child, general comment No. 12 (2009) on the right of the child to be heard, para. 21.

[15] WHO, *Rehabilitation in Health Systems*, p. 35.

31. Although comprehensive data on unmet needs for assistive devices do not exist, there is evidence that many people with disabilities across the world, even in high-income countries, do not have access to basic assistive products.[16] To ensure the affordability of assistive products, States should include assistive devices in the coverage of national health insurance and/or social protection schemes, and consider other cost-reducing measures such as waiving import duties and taxes on assistive products manufactured abroad, supporting local producers through grants, loans and tax credits, or improving procurement-managed expenditure (A/71/314, para. 47).

32. Assistive products must suit the environment and the user. The availability of follow-up care and affordable local maintenance is important for ensuring safe and efficient use (ibid., para. 46). Trained personnel are essential for the proper prescription, fitting, user training, follow-up and maintenance of assistive products.[17]

4. Peer support

33. In article 26 (1), reference is made to peer support as one of the potential elements of the provision of rehabilitation services. Peer support can be defined as the social, emotional or practical support that people with lived experience of disability are able to give to one another. States must recognize the voluntary nature of the activity and fully respect the freedom of association and expression of peer support groups, while taking positive measures to support and promote peer-led rehabilitation services.[18] Peer support in the form of self-help groups has proven an effective strategy for providing certain forms of rehabilitation in low-income countries as part of community-based inclusive development.[19]

34. The benefits of peer support are widely recognized. Experience shows that peer support can be successfully integrated in comprehensive rehabilitation programmes in a number of ways. It can be an independent means of providing certain types of interventions, support or help with certain elements of rehabilitation provision, such as awareness-raising. Peers can also work alongside professionals, including in health settings, assisting in the communication between the client and the rehabilitation personnel and helping overcome barriers such as learned helplessness, anxiety and mistrust.[20]

B. Ensuring a human rights-based approach to rehabilitation

1. Free and informed consent

35. All rehabilitation services and programmes must be voluntary and based on free and informed consent.[21] This requires that the individuals be provided with adequate information about the suggested intervention(s) in a manner that is accessible and understandable to them and they are enabled to exercise free choice in the matter. Information provided by rehabilitation personnel must include a full and impartial explanation of the reason for the suggested intervention, its expected outcomes including potential benefits and risks, the methods to be used (including the likely duration and frequency of sessions), the consequences of not undergoing the intervention, and the available alternative interventions. Consent is not a once-and-for-all activity, but it should be regularly reviewed to ensure the individual's wish to continue, particularly when circumstances change. A person has the right to withdraw from receiving the service at any time, as well as to re-engage the process.

[16] WHO, "Priority assistive products list", May 2016, p. 3.

[17] WHO, "Priority assistive products list", p. 3. See also WHO, *Rehabilitation in Health Systems*, p. 26.

[18] For instance, by providing public funding to organizations of persons with disabilities, including child- and youth-led organizations, or by providing training.

[19] WHO, *Community-based Rehabilitation: CBR Guidelines – Empowerment Component* (Geneva, 2010), pp. 37–47.

[20] WHO, *Community-based Rehabilitation: CBR Guidelines – Health Component* (Geneva, 2010), p. 55.

[21] Committee on the Rights of Persons with Disabilities, general comment No. 5, para. 90.

36. All adults with disabilities, including those with intellectual or psychosocial disabilities, must enjoy full autonomy in decisions about rehabilitation interventions. The practice of restricting or removing the legal capacity of a person because of their impairment and transferring the decision-making powers to a third party (such as a legal guardian) is contrary to article 12 of the Convention, also in rehabilitation.[22] Some persons with disabilities may wish to seek support, including peer support, for decision-making regarding their rehabilitation (A/HRC/37/56, para. 27). Support arrangements can enhance communication between the individual and rehabilitation personnel – which is key to the principle of free and informed consent – at all stages of the rehabilitation process. It can also assist the individual to evaluate available rehabilitative options (ibid., para. 41).

37. Children with disabilities, regardless of their age, must be enabled to fully participate in decisions relating to their habilitation and rehabilitation (Convention on the Rights of Persons with Disabilities, art. 7 (3); and Convention on the Rights of the Child, art. 12).[23] They should be provided with information about proposed interventions in a manner and format that are understandable and accessible to them. The child's opinions, preferences, wishes and concerns must be given due weight in accordance with their age, maturity and evolving capacities, during the development of the habilitation or rehabilitation plan and throughout the rehabilitation process. Rehabilitation service providers should create a secure, respectful and inclusive environment to enable the child's participation,[24] and to ensure respect for the right to preserve his or her identity (Convention on the Rights of Persons with Disabilities, art. 3 (h)). Children with disabilities who are victims of violence or abuse should be free to access counselling and rehabilitation envisaged in article 16 of the Convention on the Rights of Persons with Disabilities without the consent of their parents or legal guardians.[25]

38. Rehabilitation cannot be regarded as consent-based if a person must accept the intervention to avoid institutionalization. Similarly, undergoing rehabilitation should not be a precondition for accessing social benefits and other forms of essential social protection (A/70/297, para. 68).

2. Non-discrimination

39. States must ensure that persons with disabilities can access all rehabilitation services, both public and private, on an equal basis with others, regardless of their impairment, sex, age, ethnicity, sexual orientation, gender identity, or other grounds. Multiple and intersecting grounds of discrimination should be identified and addressed to prevent these individuals from falling between policy gaps. Any discrimination in accessing rehabilitation services must be prohibited in law and eliminated from legislation, policies and practice.[26] Inherently discriminatory practices that affect how persons with disabilities receive rehabilitation, such as institutionalization, substitute decision-making and segregated education, must be abolished, but until this has been achieved their application must be immediately discontinued in the rehabilitation context.

40. Reasonable accommodation is also an intrinsic part of the non-discrimination principle and is therefore a duty of immediate effect (A/73/161, para. 58). Reasonable accommodation may involve modifications and adjustments to the delivery of rehabilitation services to meet the specific requirements of an individual. It may also involve accommodation within settings unconnected to the rehabilitation service provider, such as the person's school or workplace, in order to enable them to receive the rehabilitation they require (for example, flexible office hours or additional tutoring to make up for missed classes) or as a direct component of their rehabilitation programme (for example, changes to the working environment or to the person's job description).

[22] Committee on the Rights of Persons with Disabilities, general comment No. 1 (2014) on equal recognition before the law, para. 41.

[23] See also Committee on the Rights of the Child, general comment No. 12, para. 100.

[24] Ibid., paras. 22, 23 and 25.

[25] Ibid., para. 101.

[26] A/HRC/34/58, paras. 65–66; see also A/73/161, paras. 58–60.

3. Availability and affordability

41. Habilitation and rehabilitation services in all rehabilitation disciplines as well as assistive products should be made available in adequate quantities to fully meet existing needs. In many countries, there continue to be serious gaps in the provision of rehabilitation services, including concerning the availability of professionals.[27] In addition, persons requiring certain types of rehabilitation can be further disadvantaged because specific services are underrepresented.[28]

42. The Committee on the Rights of Persons with Disabilities has repeatedly highlighted the lack of certain types of rehabilitation services, such as recovery-oriented and community-based rehabilitation services for persons with psychosocial disabilities (CRPD/C/POL/CO/1, para. 24; and CRPD/C/MKD/CO/1, para. 26), rehabilitation support in places of detention (CRPD/C/POL/CO/1, para. 27), rehabilitation services for women and girls with disabilities exposed to gender-based violence (CRPD/C/BGR/CO/1, para. 38; and CRPD/C/PHL/CO/1, para. 31), and medical rehabilitation for persons with disabilities, in particular those with chronic, genetic and rare diseases (CRPD/C/BGR/CO/1, para. 54).

43. In their strategic planning, allocation of funding, professional training and procurement policies, States must ensure that rehabilitation services and assistive products are available for a broad spectrum of persons with disabilities. They should also ensure their equitable geographic distribution so that rural or remote communities are not excluded. States must adopt a gender-sensitive approach to developing and implementing rehabilitation programmes, as women and girls with disabilities often face additional barriers in accessing rehabilitation services and assistive products.[29]

44. Rehabilitation services and assistive technologies and devices should be affordable to persons with disabilities, who often face higher living costs in general. Universal health coverage should include access to essential rehabilitation services and assistive technologies and devices. States should use the WHO "Priority assistive products list" to guide their procurement. States should legally ensure that health insurance covers essential rehabilitation for persons with disabilities. In Slovenia, for example, access to assistive devices and their maintenance are covered by the national compulsory health insurance system. In Ireland, persons with disabilities may be eligible for a medical card that gives access to free assistive products and community care services, among other entitlements.

45. Digital technologies can help to make home-based rehabilitation more available and affordable. The Internet has been used to provide a wide range of rehabilitation services, including psychosocial support and counselling, speech and language therapy, cardiac rehabilitation, and remote assessments to provide home modification services.[30] The Internet also facilitates the creation and operation of peer support groups, which in themselves are an effective solution to address both the costs and the availability of certain categories of rehabilitation. However, the use of digital technologies must also respect the right of persons with disabilities to privacy as set out under article 22 (2) of the Convention, under which States parties are required to protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.

4. Accessibility and access to rehabilitation in the community

46. States should ensure that all rehabilitation services and health-care services and programmes are fully accessible to persons with disabilities, whether they are delivered publicly or privately.[31] This includes accessible infrastructure, equipment and information

[27] *Realization of the Sustainable Development Goals by, for and with Persons with Disabilities: UN Flagship Report on Disability and Development 2018*. Available from www.un.org/development/desa/disabilities/publication-disability-sdgs.html.

[28] For example, physical therapies tend to be more commonly available than other interventions, such as speech and language therapy. See also A/73/161, para. 24.

[29] Committee on the Rights of Persons with Disabilities, general comment No. 3 (2016) on women and girls with disabilities, para. 57.

[30] WHO, *World Report on Disability* (Geneva, 2011), p. 119.

[31] A/HRC/34/58, paras. 51–52; see also A/73/161, paras. 56–57.

and communications. All information and communications related to the provision of rehabilitation services and assistive devices must also be made accessible through the use of sign language, Braille, accessible electronic formats, alternative script, Easy Read formats and augmentative and alternative modes, means and formats of communication, including non-verbal communication. This includes awareness-raising campaigns and general information about available services, instructions and forms to request services, the websites of service providers, user manuals for assistive products, and communications between rehabilitation personnel and individual users.

47. Under articles 25 and 26 of the Convention, the need is emphasized for rehabilitation services to be provided as close as possible to people's own communities, including in rural areas. In practice, however, rehabilitation services in communities are often scarce or unavailable, and where they do exist they tend to be concentrated in urban areas.[32] Accessible transport must be guaranteed to bridge this gap. The pressing need to develop community-based rehabilitation services with equitable geographic coverage should be reflected in the allocation of financial resources, training programmes for rehabilitation professionals and labour policies (for example, creating additional incentives for rehabilitation professionals to stay in or relocate to rural or remote communities). Community-based inclusive development has proven a successful strategy for improving access to rehabilitation services and assistive products in low- and middle-income countries, including in rural communities. Community-based inclusive development fosters and relies on a participatory and inclusive approach to rehabilitation, in particular by promoting peer support.

48. States must be strategically committed to – and have a specific action plan for – deinstitutionalization, which must include the creation and expansion of adequate and appropriate community-based rehabilitation services. New investments in rehabilitation services should be channelled into the development of rehabilitation services that are human rights-based. The provision of high-quality community-based rehabilitation services and assistive products must also be recognized as one of the positive measures that States need to take in order to abolish these discriminatory practices. Those services should include interventions specifically designed to help individuals overcome the negative consequences of institutionalization, such as learned helplessness and psychological traumas caused by psychological, physical or sexual violence experienced within the institution. For instance, in the former Yugoslav Republic of Macedonia, rehabilitation is integrated into deinstitutionalization programmes to prepare children and adults with disabilities for living in the community.

5. Participation

49. In accordance with article 4 (3) of the Convention, States must actively involve and closely consult organizations of persons with disabilities, including organizations representing children with disabilities, in the development and implementation of legislation, policies and other public measures. Participation by persons with disabilities, however, is not only a legal obligation but also a matter of good governance (A/HRC/31/62, paras. 25–33). It is an overarching principle whose application is not limited to legislative and policymaking processes but extends to all aspects of the planning, organization and delivery of rehabilitation services.

50. Persons with disabilities can provide crucial first-hand information about their rehabilitation requirements, the barriers that they face, their experience of rehabilitation services and the effectiveness of proposed solutions and suggest alternatives that work for them in their environment. Moreover, participation raises awareness about future and existing laws and policies within the disability community, enabling more people to benefit from them. Some States have established permanent mechanisms for involving persons with disabilities in policymaking. For example, the Danish Parliament set up a disability council that advises Parliament and other public bodies and monitors the implementation of

[32] WHO, *WHO Global Disability Action Plan 2014–2021: Better Health for All People with Disability* (Geneva, 2015), para. 40.

legislation and policies related to persons with disabilities. In Germany, organizations of persons with disabilities provide recommendations that delineate the responsibilities of different rehabilitation providers. When consulting with persons with disabilities, policymakers should ensure that they gather views across a wide spectrum that are representative of the diversity of the disability community, including in terms of age, gender, geographic location and rehabilitation requirements. Steps should be taken to reach out to and meaningfully engage with those persons with disabilities who are usually excluded, such as women and girls, children, older persons, persons with intellectual or psychosocial disabilities, autistic persons and deafblind persons.

IV. Implementation measures

A. Policy and legal framework

51. States should put in place a legislative framework for the establishment, organization and delivery of comprehensive, coordinated, multidisciplinary and inclusive rehabilitation services (see, for example, CRPD/C/MKD/CO/1, para. 44). When the State has chosen to address rehabilitation services primarily in the framework of health legislation, it should ensure that their non-health aspects are equally recognized and funded. To this end, it is advisable that, where appropriate, rehabilitation is further addressed in labour, education and social protection legislation and in laws and policies establishing a general framework for the protection of the rights of persons with disabilities. States should avoid framing their general law and/or policy on the rights of persons with disabilities around rehabilitation, as the latter is just one among many strategies that contribute to their inclusion, as recognized in the Convention.

52. Legislation on rehabilitation should introduce minimum requirements for the quality of services and entrench a human rights-based approach to their provision, including with respect to free and informed consent, non-discrimination, availability, affordability, accessibility, access in the community and participation. The legislative framework for rehabilitation should include oversight and accountability mechanisms with regard to the quality of rehabilitation services. It must include effective remedies to allow persons with disabilities to obtain adequate redress for violations of their rights in the context of rehabilitation. For complaints relating to rehabilitation in health settings, a judicial or quasi-judicial body is needed rather than purely administrative mechanisms (A/69/299, para. 17).

53. States should develop rehabilitation policies that emphasize participation and inclusion as the underlying principles and the aims of rehabilitation. Rehabilitation policies should prioritize early intervention and promote a comprehensive and individualized approach to service delivery, access to accessible, adequate and affordable assistive devices and technologies, the integration and decentralization of rehabilitation services, and the availability of services as close as possible to communities, including in rural areas (A/73/161, para. 52).[33] It is good practice to adopt an evidence-based national plan on rehabilitation that covers key aspects of rehabilitation provision such as leadership, financing, information, service delivery, products and technologies, and the rehabilitation workforce. [34] Rehabilitation legislation and policies should be developed with the participation of persons with disabilities, including children, by closely consulting with and actively involving their representative organizations.[35]

B. Coordination

54. The cross-sectoral nature of rehabilitation means that a number of State agencies can be involved in its provision, including those working in the fields of public health, social

[33] See also WHO, *World Report on Disability*, p. 105.

[34] Ibid., p. 105.

[35] Article 4 (3) of the Convention on the Rights of Persons with Disabilities.

protection, employment and education.[36] Effective coordination improves the functional outcomes and reduces the costs of rehabilitation services. It allows for a more effective and user-friendly referral system and enables persons with disabilities to receive the full scope of rehabilitation services that they need in a comprehensive manner. When several providers are involved, coordination also helps ensure the continuity of care.[37]

55. States should establish a coordinated, efficient and user-friendly referral system that ensures that a person with disability can have timely access to high-quality services. In low-income countries, community-based inclusive development has proven to be a successful strategy for bringing rehabilitation activities to communities and facilitating referrals to more specialized rehabilitation services.[38] Models relying on not-for-profit organizations and charities do not absolve the State from its obligation to ensure that rehabilitation services and assistive products are available and affordable.

C. A multidisciplinary and trained rehabilitation workforce

56. The availability of personnel skilled in multiple rehabilitation disciplines is instrumental in providing high-quality rehabilitation services that fully meet the diverse requests of persons with disabilities.[39] The need for a multidisciplinary rehabilitation workforce is implicitly recognized in article 26 (1) of the Convention, under which rehabilitation services and programmes are required to be based on the multidisciplinary assessment of individual needs and strengths.

57. A skilled multidisciplinary workforce requires adequate training. Professional education at the university level is typically required to gain qualifications in specific disciplines such as physiotherapy, occupational therapy, prosthetics and orthotics, psychology, and speech and language therapy. In addition, many countries have responded to the severe shortage of rehabilitation personnel and limited financial resources by introducing mid-level programmes that train multipurpose rehabilitation workers in a range of disciplines or profession-specific assistants that provide rehabilitation services under supervision. A third level of training that helps improve access to rehabilitation in rural areas is for community-based workers who can work at the intersection of health and social services to provide basic rehabilitation.[40] Training should be aimed at ensuring the human rights-based approach to rehabilitation of persons with disabilities, as described above, to reflect the elements discussed above to contribute to the implementation of the Convention. The inclusion of content on the social, political, cultural and economic factors that affect the health and quality of life of persons with disabilities can make the curriculum more relevant to the context in which rehabilitation personnel will work.[41] Training programmes should be accessible and inclusive to enable and encourage persons of disabilities to train as rehabilitation personnel.

58. In some countries, rehabilitation personnel are predominantly men. This can negatively affect access by women with disabilities to rehabilitation services. States should take specific measures to ensure better gender balance in the rehabilitation workforce, including by facilitating women's access to training programmes and mainstreaming gender in employment policies.

D. Funding mechanisms

59. States should develop funding mechanisms to ensure adequate access to affordable rehabilitation services for all persons with disabilities. This is usually achieved through a combination of various proven solutions such as public funding, health insurance, social

[36] WHO, *WHO Global Disability Action Plan 2014–2021*, para. 41.
[37] WHO, *World Report on Disability*, p. 114.
[38] See www.who.int/disabilities/cbr/en.
[39] WHO, *Rehabilitation in Health Systems*, pp. 14–15.
[40] WHO, *World Report on Disability*, pp. 110–111.
[41] Ibid., p. 112.

insurance, public-private partnership for service provision, and reallocation and redistribution of existing resources.[42] The Sustainable Development Goals include an explicit commitment to achieving universal health coverage (target 3.8). When designing and implementing universal health coverage, States should ensure that it covers rehabilitation and assistive products (A/73/161, para. 55).

60. It is good practice to allocate designated funding for rehabilitation services within the State budget that are sufficient to ensure equitable access to services of the same quality for all users, including for persons with disabilities living in poverty.[43] Policymakers should consider and measure the broader positive economic impact of investing in rehabilitation, such as increased participation in labour markets and education, longer independent living and fewer or shorter hospital admissions.

E. Awareness-raising

61. In accordance with article 8 of the Convention, States must adopt immediate, effective and appropriate measures to raise awareness regarding persons with disabilities and their health and rehabilitation needs. Awareness-raising campaigns must adopt a human rights-based approach, promoting persons with disabilities as rights holders and not as patients or objects of charity and care. In this regard, public fundraising campaigns in support of rehabilitation services or public delivery events of assistive devices and technologies can reinforce a charity approach and a pathologizing view of disability (A/73/161, para. 69). General awareness-raising campaigns should aim to inform end users of the available services and their rights, and more personalized campaigns should aim to change the attitudes of rehabilitation professionals and families towards a human rights-based approach to disability.

F. Research and data

62. Reliable high-quality research and data are necessary for the development and implementation of effective evidence-based rehabilitation policies and programmes. Under article 31 of the Convention and Sustainable Development Goal 17, States parties are called upon to make available high-quality, timely and reliable data, disaggregated by gender, age, disability and other characteristics forming the basis for discrimination, in order to identify gaps and improve policy formulation. Such data remains scarce.[44] States should increase rehabilitation-related research, especially in priority areas identified by WHO, such as the types and impacts of different service delivery models, governance structures and financial allocation; cost-benefit analysis of rehabilitation; and facilitators and barriers to accessing rehabilitation.[45] States should also increase research on the development of affordable assistive products (Convention, art. 4 (1) (g)). Wherever possible, research should be led by researchers with disabilities, be participatory and include the views of persons with disabilities and their representative organizations in all phases. States should collect disaggregated data on people's rehabilitation requirements and the types and quality of rehabilitation services provided. Expenditure data on rehabilitation services should be disaggregated from other health-care services.[46] States should ensure the accessible publication and systematic dissemination of research results and data so that clinical

[42] Ibid., p. 122.

[43] WHO, *Rehabilitation in Health Systems*, p. 22. The Committee on the Rights of Persons with Disabilities has expressed concern that the income criteria for eligibility for rehabilitation services put an undue financial burden on persons with disabilities, and recommended that such criteria be eliminated (CRPD/C/POL/CO/1, paras. 45–46).

[44] WHO, *Rehabilitation in Health Systems*, p. 33.

[45] Ibid.

[46] WHO, *World Report on Disability*, p. 123.

practice can be evidence-based and people with disabilities can influence the use of research,[47] and for the purposes of monitoring and accountability.

V. Conclusions and recommendations

63. **Habilitation and rehabilitation are a set of interventions designed to optimize the functioning of individuals with impairments in interaction with their environment. Their purpose is to contribute to the independence of persons with disabilities and their participation in society. Forms of habilitation and rehabilitation include health- and non-health-related interventions. The fact that habilitation and rehabilitation are contained in a stand-alone article under the Convention increases their visibility as an important strategy for ensuring the participation of persons with disabilities in society. However, achieving maximum functioning is not enough to ensure the meaningful participation of persons with disabilities in society, as there are attitudinal and environmental barriers that prevent it. Consequently, habilitation and rehabilitation should not be misinterpreted as the only strategy to achieve that goal.**

64. **The organization, provision and delivery of comprehensive services that are voluntary, non-discriminatory, available, affordable, accessible, community-based and participatory is consistent with a human rights-based approach to the habilitation and rehabilitation of persons with disabilities. Further, habilitation and rehabilitation programmes and services must be tailored to the individual and should include early intervention for children with disabilities. States should ensure the development, availability and provision of assistive products as well as peer support as essential elements of habilitation and rehabilitation services.**

65. **There is a pressing need to scale up habilitation and rehabilitation services for persons with disabilities, particularly in health settings and other relevant contexts such as education and employment. Such efforts should be made as part of broad policies that are inclusive of persons with disabilities and their rights.**

66. **In implementing the provisions of article 26 of the Convention, it is recommended that States parties should establish or strengthen:**

(a) **A policy and legal framework that provides for comprehensive, high-quality habilitation and rehabilitation services that are voluntary and guarantees equal access for persons with disabilities, while promoting a person-centred, rights-based and participatory approach to rehabilitation that is gender- and age-sensitive;**

(b) **Coordination mechanisms for a comprehensive approach between State agencies in implementing high-quality habilitation and rehabilitation services, given their cross-sectoral nature, including agencies working in the fields of public health, social protection, employment and education;**

(c) **A multidisciplinary and trained habilitation and rehabilitation workforce, requiring adequate training that promotes a person-centred, gender- and age-sensitive perspective and a human rights-based approach to disability;**

(d) **Funding mechanisms to provide equitable and adequate access to habilitation and rehabilitation services through a combination of various proven solutions such as public funding, health insurance, social insurance, public-private partnership for service provision, and reallocation and redistribution of existing resources;**

(e) **Awareness-raising through immediate, effective and appropriate measures, with all campaigns focusing on a human rights-based approach to disability and not framing persons with disabilities as patients or objects of charity and care;**

(f) **Research and the collection of data that is habilitation- and rehabilitation-related, disaggregated by people's habilitation and rehabilitation**

[47] Ibid., p. 121.

requirements, types and quality of habilitation and rehabilitation services provided, gender, age and disability, especially in priority areas identified by WHO, with systematic dissemination of the results.