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### **DISABILITY: PREVENTION AND REHABILITATION IN THE CONTEXT OF THE RIGHT TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH AND OTHER RELATED RIGHTS**

The United Nations Organization estimates that there are approximately 600 million persons with disabilities world wide, some 400 million of whom are in the developing countries. The Region of the Americas has roughly 60 million persons with disabilities.

Longer life expectancy, the increase in noncommunicable diseases, emerging and reemerging diseases, growing violence, armed conflicts; accidents of all types, and the use and abuse of alcohol, tobacco, and banned substances are among the main causes of disability. Thus, there is no clear decline in their prevalence in the general population. The result will be greater demand for care in services and programs that up to now have been insufficient.

This document suggests that the problem of disability must be approached as a social responsibility and not as an individual one; a view that is grounded in the recommendations of the 2005 World Health Assembly (Resolution WHA58.23), which recognize the need to promote and protect the human rights of persons with disabilities, among other recommendations. This document can serve as an important tool to help the Executive Committee learn about the situation of persons with disabilities in the Region and consider different strategies for disability prevention consistent with international instruments and guidelines that promote the right to the enjoyment of this highest attainable standard of health<sup>1</sup> and other related rights of the referred persons. The Executive Committee is requested to offer its comments and suggestions about the proposed approach to disability prevention and the comprehensive rehabilitation of persons with disabilities.

<sup>1</sup> The Member States of WHO adopted important principles in regard to public health that are enshrined in the preamble to its Constitution. Hence, the Constitution establishes as a fundamental international principle that enjoyment of the highest attainable standard of health is not only a state or condition of the individual, but "... one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition ...". The Constitution was adopted by the International Health Conference, held in New York from 19 June to 22 July 1946 and signed on 22 July 1946 by the representatives of 61 States. The International Covenant on Economic, Social, and Cultural Rights (UN), in turn, protects "...the right of everyone to the enjoyment of the highest attainable standard of physical and mental health..." (Article 12), and the Protocol of San Salvador (OAS) protects "the right to health" (Article 10). Moreover, health protection as a human right is enshrined in 18 of the 35 Constitutions of the Member States of PAHO (Bolivia, Brazil, Cuba, Chile, the Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, and Venezuela).

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## Introduction

1. On 25 May 2005, the 58th World Health Assembly of WHO adopted Resolution WHA58.23: Disability, including Prevention, Management, and Rehabilitation, which, among other things, urges the Member States of WHO "... to develop their knowledge base with a view to **promoting and protecting the rights and dignity of persons with disabilities** and ensure their full inclusion in society, particularly by encouraging training and protecting employment." The resolution also calls on the Member States to guarantee appropriate medical care and rehabilitation for persons who require it and to facilitate access to assistive technologies; strengthen national programs and strategies designed to implement the Standard Rules; promote prevention, early intervention, and identification of disabilities; and foster community rehabilitation programs in primary health care. It should be underscored that in Resolution WHA58.23, the World Health Assembly urges the Member States and the Director "... to participate actively and constructively in the **preparatory work for the United Nations comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities**,<sup>2</sup> in order that it may be adopted by the World Health Assembly as a matter of priority."

2. The Pan American Health Organization considers that it is necessary to approach the problem of disability as a social responsibility and not as an individual one; and aware of the recommendations issued by the World Health Assembly in 2005 regarding the need to promote and protect the human rights of persons with disabilities, especially their right to the enjoyment of the highest attainable standard of health, submits this document as an important tool that will help the Director-General of WHO report to the 60th World Health Assembly "on progress in implementation of this resolution... through the Executive Board," (Resolution WHA 58.23) as requested in the resolution.

## Basic Concepts and Definitions

3. The 54th World Health Assembly, held in May 2001, adopted the new International Classification of Functioning, Disability, and Health (ICF), whose aim is "... to provide a unified and standard language and framework for the description of health and health-related states..." (1)

4. The ICF is based on integration of the medical and social model, with a view to linking the various dimensions of human functioning through a biopsychosocial approach that offers a coherent vision of the dimensions of health: biological, individual, and social. Within this framework, the conceptual changes introduced with the ICF include:

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<sup>2</sup> Resolution 56/168 adopted by the General Assembly of the United Nations, A/56/583/Add.2, 19 December 2001.

***Functioning and Disability***

5. “**Functioning**” is a generic term that includes body functions and structures, activities, and participation. It indicates the positive aspects of the interaction between an individual (with a “health condition”) and his context (environmental and personal factors).

6. “**Disability**” is a generic term that includes impairments in body functions and structures, activity limitations and participation restrictions. It indicates the negative aspects of the interaction between an individual (with a “health condition”) and his context (environmental and personal factors).

***Body Functions, Body Structures, and Impairments***

7. “**Body functions**” are the physiological functions of body systems, including psychological functions. “Body” means the human organism as a whole, and thus, the mind is included in the definition.

8. “**Body structures**” are the anatomical parts of the body such as organs, limbs, and their components.

9. “**Impairments**” are problems related to body functions or structures, such as significant deviations from the norm, associated with the biomedical status of the body and its functions or a loss of such functions or structures.

***Activities and Participation vs. Activity Limitations and Participation Restrictions***

10. “**Activity**” is the execution of a task or action by an individual. It represents the individual’s perspective with respect to functioning.

11. “**Participation**” is an individual’s involvement in a life situation. It represents society’s perspective with respect to functioning.

12. Activities (like participation) are classified in the following domains: (a) learning and applying knowledge, (b) general tasks and demands, (c) communication, (d) mobility, (e) self-care, (f) domestic life, (g) interpersonal interactions and relationships, (h) major life areas, (i) community, social, and civic life.

## **Other Basic Concepts**

### ***Rehabilitation***

13. Rehabilitation is an ongoing process designed to achieve the fullest possible restoration of the functional, physical, psychological, educational, social, professional, and occupational aspects of an individual with a disability to assure his reintegration as a productive member of the community, and to promote measures aimed at preventing disability. (OPS, 1998) (1)

### ***Comprehensive Rehabilitation***

14. Coordinated, individualized organization of systems and services in society and the environment whose primary objective is to prevent, minimize, or reverse the consequences of functional losses or alterations and influence the factors that impede full participation. (2)

### ***Disability Prevention***

15. A series of inter-programmatic and intersectorial activities aimed at identifying risk factors that result in the deterioration or impairment of health, preventing the deterioration of health from causing functional limitations, or minimizing the impact of health impairments, promoting healthy lifestyles and health protection. It includes primary, secondary, and tertiary prevention of disability. (3)

### ***Quality of Life***

16. *“Quality of life” is an individual’s perception of his situation in life within the context of his culture and values, as well as his objectives, expectations, and interests* (OMS, 1994). Speaking about the quality of life leads to the WHO concept of health as *“A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”* An individual’s health impairment and its sequelae will not only have physical or emotional repercussions but will affect his activities and participation.

### ***Rehabilitation Services***

17. Within the framework of the right to the enjoyment of the highest attainable standard of health, and according to Rules 2 (Medical Care) and 4 (Rehabilitation) of the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities (4), effective medical care and rehabilitation services should be guaranteed to this population group. Health services should provide for the evaluation, early detection, and treatment of impairments through multidisciplinary teams; moreover, persons with

disabilities should be considered in all health programs and health initiatives. Rehabilitation services should be accessible to all people and should offer the assistance that will enable them to reach and maintain optimal levels of functioning and autonomy, tending to any type of disability and getting the people with disabilities and their families involved in the rehabilitation process.

### ***Intersectoral Approach***

18. Responding to the real needs of groups of people with disabilities calls for an intersectoral approach to ensure that these responses are comprehensive, bearing in mind that needs will be determined by the dimensions of the affected functioning/disability: Biological (body), the individual's perspective on functioning (activity) and society's perspective on functioning (participation), always interacting with the context (environment/personal factors) and related to a health condition.

### ***Prevalence and Causes of Disability***

19. The identification, characterization, and reporting of new and known cases of disability at a particular time and place will yield the prevalence. The causes are multifactorial and will depend on the dimensions of the human functioning affected (body functions, body structures, activity, and participation).

### **Analysis of the Situation of Persons with Disabilities in the Region of the Americas**

20. The United Nations Organization estimates that there are approximately 600 million people with disabilities worldwide, 400 million of whom are in the developing countries. The Region of the Americas has roughly 60 million people with disabilities.

21. Longer life expectancy, the increase in noncommunicable diseases, emerging and reemerging diseases, growing violence and armed conflicts; the use and abuse of alcohol, tobacco, and banned substances; and accidents of all types are some of the main causes of disability. Thus, there is no clear decline trend in their prevalence in the general population. This will result in greater demand for care in services and programs that up to now have been insufficient. The demographic and geographical distribution of disabilities has a significant impact on society. Persons with disabilities constitute 10% of the general population, and disabilities are estimated to impact 25% of the total population. Disabilities affect not only the people who have them but those who care for them, their families, the community, and anyone who supports community development (5-8).

22. Given the population growth indices in Latin America and the Caribbean, a significant increase in the number of persons with disabilities is anticipated, especially

when maternal and child care is deficient and there is a high level of accidents and physical injury and mental health damage from violence.

23. Around 50% of persons with disabilities in the Region are of working age. Given the high levels of poverty and unemployment in the general population, as well as the clear link between poverty and disability, the situation of persons with disabilities in the Region is critical. Most are unemployed or excluded from the labor market. In Latin America, the disability prevalence figures vary widely; in Peru, for example, the figure reported by the national prevalence study is on the order of 32%, while in other countries it ranges from 10% to 13% (Ecuador, Venezuela, and Colombia). In Central America, the figures are around 18% (5-8).

24. With the recent adoption of the International Classification of Functioning, Disability, and Health (ICF), the countries are beginning to conduct prevalence studies using this classification as the technical foundation. To date, national studies based on the ICF have been conducted in three countries, Chile, Ecuador, and Nicaragua, and another is under way in Panama. A household survey with a disability module based on the ICF was conducted in Uruguay, and Argentina's national study was based on the earlier International Classification of Impairments, Disabilities, and Handicaps. Other data on the Region are reported by the censuses of Costa Rica, Mexico, Panama, and Venezuela, with the limitations that they represent in terms of characterizing disability and the fact that the information tends to be limited to severe or permanent disabilities. Cuba, El Salvador, Honduras, Paraguay, and Peru have conducted special studies that target only major urban areas or are not based on the ICF. In Colombia, there is continuous recording of disability data at the municipal level, based on the ICF; and more recently, a disability module was created for the National Census, also based on the ICF.

25. According to the most recent disability studies, the national prevalence of disability in Nicaragua is 10.3%, 56% of which is female; of the total population with disabilities, 60% live in urban areas. The most affected age group is 20 to 59 years, representing 47%. Some 45% have not completed even a year of schooling. The most common disabilities are related to mobility, communication, and participation. In Chile, the national prevalence is 12.9%, 2.5% of which is severe; 58.2% is female, and 83.3% urban; the most affected ages are 30 to 64, representing 51%. In Chile, disability is twice as common in the poor population, and 1 in every 2 persons with a disability has not completed basic education.

26. In Ecuador, the national prevalence is 12.1%, 51% of which is female, and the most affected group is 20 to 64 years, representing 51%. Some 80% indicate a health condition as the cause of their disability. Other general data include Argentina, for example, where 20.6% of households have at least one person with a disability; Costa

Rica, with a prevalence of 5.3% (2000 Census); Cuba, with 3.2% (severe disability); and Uruguay, with a 7.6% prevalence of disability.

27. Despite the diversity of data and methodologies used, the trend is toward the use of international technical reference tools such as the ICF. All the studies have yielded very important data that give us an idea of the situation: of the 60 million people with disabilities in Latin America and the Caribbean, approximately 25% are children and adolescents; some 2% to 3% of the population with disabilities has access to rehabilitation programs and services; half of those injured in traffic accidents are young people aged 15-34; the population aged 65 and over with a disability accounts for a high percentage; 2% to 3% of newborns have severe impairments, and 6%-8% of children are high-risk. Only 20%-30% of the school-age population with disabilities attends school, and only 5% finish primary school. Girls with disabilities experience even greater discrimination. Children with disabilities are subject to more violence and abuse than any others and are often institutionalized.

### **Enjoyment of the Highest Attainable Standard of Health, Other Human Rights, and Citizen Participation of Persons with Disabilities**

#### ***Health of Persons with Disabilities vis-à-vis the Exercise of Human Rights***

28. According to several international organizations, persons with disabilities frequently encounter obstacles to the enjoyment of their basic human rights and fundamental freedoms. (9) For example, the presence of barriers (*de facto* or *de jure*) that limit access by persons with disabilities to health and rehabilitation services and their freedom of movement in public buildings; lack of employment opportunities; their exclusion from educational systems; their subjection to medical or scientific experimentation without their informed consent; the lack of assistive devices that would permit them to vote; and the existence of substandard living conditions in public health institutions can jeopardize their physical and mental health and other basic human rights, often with irreparable consequences. (10)

29. A certain degree of physical and mental health is necessary for the exercise of basic rights and fundamental freedoms and, thus, participation in the civil, social, political, and economic life of a State. At the same time, the exercise of these human rights and freedoms is essential for persons with disabilities to enjoy physical and mental well-being fully<sup>3</sup> (10).

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<sup>3</sup> Lawrence Gostin has referred to this link, especially in the context of the well-being of persons with mental disabilities.



***Disability and Rehabilitation Policies, Plans, Legislation, and Practices vis-à-vis Human Rights***

30. Disability and rehabilitation policies, plans, legislation, and practices can be instruments that protect the basic rights and fundamental freedoms of persons with disabilities, or they can be instruments that hinder the exercise of basic rights related with physical and mental well-being, such as those mentioned above. (11)

31. Notwithstanding, the application of human rights instruments in the context of health is still very limited. It is therefore important to make current international human rights standards, especially the above mentioned international and regional guidelines, an integral part of policies, plans, legislation, and practices related to disability in general, its prevention, and rehabilitation (11). Bearing this in mind, in 2001 the Directing Council of PAHO asked the Member States to update "...legal provisions that protect human rights of people with mental disabilities ...” (12)

**General Human Right Instruments**

32. Some countries in the Americas have enacted disability legislation that specifically protects some of the basic human rights and fundamental freedoms of persons with disabilities<sup>4</sup>. In the majority of Latin American and Caribbean countries, the human rights and freedoms of people with disabilities are also protected (in some cases) by general laws also applicable to the rest of the population (constitutional, civil, penal, labor, or procedural laws, among others) that guarantee only some of the fundamental rights and/or freedoms of the people in question. (13)

33. The general human rights instruments established by international law, in contrast, recognize that all human beings are born free and equal in dignity and rights<sup>5</sup> (14-15) and protect all people without distinction of race, color, sex, language, religion, political opinion, national or social origin, property, birth or other status<sup>6</sup> (16-21). Persons with disabilities are protected by instruments such as:

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<sup>4</sup> Argentina, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, the United States, and Venezuela have passed laws that specifically protect some fundamental human rights and freedoms of persons with disabilities.

<sup>5</sup> Article 1 of the Universal Declaration of Human Rights and the Preamble to the American Declaration of the Rights and Duties of Man.

<sup>6</sup> According to the standards set forth in International Human Rights Law, “other status” applies to discrimination based on disability.

***United Nations System for the Protection of Human Rights***

- *Universal Declaration of Human Rights* ( (14);
- *International Covenant on Civil and Political Rights*<sup>7</sup> (16);
- *International Covenant on Economic, Social, and Cultural Rights*<sup>8</sup> (17);
- *Convention on the Rights of the Child*<sup>9</sup> (18);

***Inter-American System for the Protection of the Human Rights***

- American Declaration of the Rights and Duties of Man<sup>10</sup> (15);
- American Convention on Human Rights<sup>11</sup> (19); and
- Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights, or Protocol of San Salvador<sup>12</sup> (20), among others.

34. It is important to mention that Article 18 of the Protocol of San Salvador refers specifically to the protection of persons with disabilities, establishing that the States Parties commit to undertaking specific programs, such as work programs, consistent with their possibilities; providing special education to their families; considering the specific needs of this group in their urban development plans; and encouraging the establishment of social groups in which the referred persons can enjoy a fuller life. According to this article, the purpose of this special State protection is to enable the person with a disability

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<sup>7</sup> Entered into force on 23 March 1976 and ratified by Argentina, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, the United States of America, Uruguay, and Venezuela.

<sup>8</sup> Entered into force on 3 January 1976 and ratified by Argentina, Barbados, Bolivia, Brazil, , Canada, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

<sup>9</sup> Entered into force on 2 September 1990 and ratified by Antigua and Barbuda, Argentina, Bahamas, Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela.

<sup>10</sup> 199 OAS res. XXX. OEA/Ser.L.V/182 doc. 6 rev.1, p.17 (1992).

<sup>11</sup> Entered into force on 18 July 1978 and ratified by Argentina, Barbados, Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominica, the Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Trinidad and Tobago, Uruguay, and Venezuela.

<sup>12</sup> Entered into force on 16 November 1999 and ratified by Argentina, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Panama, Paraguay, Peru, Suriname, and Uruguay.

“... to achieve the greatest possible development of his personality ...” (underlining is ours).

35. In the Region of the Americas, the rights of the aforementioned group are also protected by the *Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities*<sup>13</sup> (21) (hereinafter the Inter-American Convention on Disability), adopted by the General Assembly of the Organization of American States (OAS) on 8 June 1999. This convention contains very important guidelines that can serve to guide the Member States of PAHO in the formulation of their plans, policies, legislation, and practices. Nevertheless, even though the Convention creates a Committee to follow-up the commitments acquired by the States Parties, this Committee has not yet discussed the progress made in this area by the referred States.

### **International Guidelines or Standards**

36. These guidelines also pertain to international law and are for the most part declarations, recommendations, and reports issued by the United Nations General Assembly, the UN Commission on Human Rights, the UN Committee on Economic, Social, and Cultural Rights, the Inter-American Commission on Human Rights (OAS), the World Health Organization (WHO), and the Pan American Health Organization (PAHO), among others.

37. Unlike the general treaties on human rights ratified by the Member States of PAHO, these standards are not binding. However, they lay out important guidelines that can be incorporated into national plans, policies, legislation, and practices related to disability, its prevention, and rehabilitation. Moreover, they are an important guide for interpreting the basic rights and fundamental freedoms of persons with disabilities enumerated in the aforementioned international and regional treaties on human rights. The value of these standards lies mainly in the general consensus reached by the Member States in the United Nations General Assembly or other organs that it is necessary to promote and protect the human rights of people with disabilities, and in the end, their effectiveness will depend on how much the States and organizations implement these guidelines (22). The most important standards or guidelines include:

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<sup>13</sup> Entered into force on 14 September 2001 and ratified by Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Mexico, Nicaragua, Panama, Paraguay, Peru, and Uruguay.

***United Nations System for the Protection of Human Rights***

- *Declaration of the Rights of Persons with Mental Retardation*<sup>14</sup> (23) (Currently “persons with intellectual disabilities” in keeping with international standards);
- *Declaration on the Rights of Disabled Persons*<sup>15</sup> (24) (Currently “persons with disabilities” in keeping with international standards);
- *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care*<sup>16</sup> (25);
- *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*<sup>17</sup> (4)
- *General Comment 5. Persons with Disabilities*<sup>18</sup> (26); and
- *General Comment 14. The Right to the Enjoyment of the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social, and Cultural Rights)*<sup>19</sup> (27)

***Inter-American System for the Protection of the Human Rights***

- *The Declaration of Caracas (PAHO/WHO)*<sup>20</sup> (28); and
- *Recommendation of the Inter-American Commission on Human Rights (OAS) for the Promotion and Protection of the Rights of the Mentally Ill*<sup>21</sup> (29)

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<sup>14</sup> Mainly establishes that persons with intellectual disabilities have the same rights as other people, including medical care, education, training, and rehabilitation.

<sup>15</sup> Some of the rights referred to in this Declaration are medical care, education, employment, humane treatment, and judicial guarantees.

<sup>16</sup> Include guidelines for establishing national mental health systems and evaluating their practices. They refer to the human rights of persons with mental disabilities, especially in the context of psychiatric institutions.

<sup>17</sup> Their purpose is to “...ensure that girls, boys, men, and women with disabilities, as members of their societies, may exercise the same rights and obligations as others ...”

<sup>18</sup> This comment of the Committee on Economic, Social, and Cultural Rights analyzes the obligations of States with respect to equal rights for men and women before the law, rights relating to work, social security, protection of the family and mothers and children with disabilities, freedom of movement; the enjoyment of physical and mental health; education and participation in cultural life; and enjoyment of the benefits of scientific progress.

<sup>19</sup> In this Comment, the United Nations Committee on Economic, Social, and Cultural Rights analyzes the content, scope, and obligations of the Member States deriving from Article 12 of the International Covenant on Economic, Social, and Cultural Rights (The right to enjoyment of the highest attainable standard of health). The Committee establishes that the right to the highest attainable standard of health is closely related to and dependent on the exercise of other human rights such as life, non-discrimination, equality, freedom from inhumane or degrading treatment, the right to association, assembly, and movement, food, housing, employment, and education. It refers to persons with disabilities as a group whose vulnerability calls for special relatively low-cost programs that offer access to health facilities, goods, and services without discrimination.

<sup>20</sup> Proposes the reform of legislation on mental illness according to international human rights commitments, and the creation of community-based mental health services.

## **PAHO/WHO Initiatives for Approaching Disability and Rehabilitation: New Challenges**

### *Strategic Approaches*

38. Health promotion and disability prevention: Prevent disabilities from chronic diseases or minimize their incidence; detect risk factors that lead to disability; and promote healthy lifestyles.
39. Medical care and comprehensive rehabilitation: Promote greater equity in the delivery of rehabilitation services at all levels; detect and treat children with impairments or developmental delays early on; and carry out interventions to address the needs of vulnerable groups: children, older adults, indigenous people, women, and landmine and disaster victims.
40. Community integration: Consolidate the Community-based Rehabilitation Strategy (CBR); promote the active participation of persons with disabilities, their families, and organizations to help achieve a quality of life consistent with human dignity; promote the Accessible-Communities-for-All Strategy (universal access).
41. Scientific and technological development: Establish public policies for the production of accessible prostheses, orthoses, and assistive devices and develop simplified technologies; set up programs to train rehabilitation professionals; and promote research on rehabilitation.
42. Inclusion and socioeconomic integration: Promote equal employment opportunities for persons with disabilities and contribute by integrating persons with disabilities into the workforce in keeping with their potential.
43. Integrated and inclusive education: Enroll persons with disabilities in the regular education system; promote education in how to live together with differences; set up school health services that meet the needs of children with disabilities and children at risk.
44. National rehabilitation boards: Promote social responsibility in the matter of disability; encourage municipalities to participate in the implementation of Accessible Cities for All; promote defense of the rights and dignity of people with disabilities; and promote the development of public policies to address the problem of disabilities.

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<sup>21</sup> Urges States to “promote and implement, through legislation and national mental health plans, the organization of community mental health services to achieve the full integration of the mentally ill into society...” The original text was drafted in Spanish and refers to “persons with mental disabilities”.

45. Epidemiological approach to disability: Consolidate disability and rehabilitation information systems; define parameters for epidemiological surveillance of disability; and disseminate and utilize the ICF.

46. In conclusion, the multiple causality of disability and the complexity of the factors that interact to produce disabilities compel us to search for and identify approaches and strategies that will facilitate an integrated response. This must be accomplished through programs and public policies that respond to the needs of people with disabilities and promote their rehabilitation and social integration, especially by addressing this issue in all development initiatives conducive to human well-being.

47. This vision therefore involves inclusive development, understanding this to mean *the definition and implementation of socioeconomic and human development activities and policies aimed at securing equal opportunities and rights for all people, regardless of their social status, gender, and physical, intellectual, or sensory condition or race.* (30) Hence, it is necessary to promote interaction among cooperation and development agencies to standardize criteria and engage in a permanent collaboration that will generate synergy to potentate their actions and prevent *ad hoc* or isolated activities.

#### **Action by the Executive Committee**

48. The Executive Committee is invited to offer its comments and suggestions on the approach presented for preventing disabilities and achieving the comprehensive rehabilitation of persons with disabilities.

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