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I declare that I have no conflicts of interest.

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Staff skills not staff types for community-based rehabilitation

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The AfriCAN conference,[1] of the Community Based Rehabilitation African Network, in Oct 26–29 in Abuja, Nigeria, has been chosen to launch the new guidelines on community-based rehabilitation[2] that aim to improve the lives of the estimated 650 million people living with a disability, with over 80% of these residing in low-income countries and most being greatly impoverished.[3] The development of these guidelines is a considerable, and impressively inclusive, achievement. They have evolved through wide consultation, including the International Disability and Development Consortium (a global consortium of 25 international non-governmental organisations), International Labour Organization, UNESCO, and WHO's Disability and Rehabilitation Team.

The guidelines have five major components: health, education, livelihood, social development, and empowerment (figure). They also focus on community-based rehabilitation in some special scenarios, including HIV/AIDS, leprosy, mental health, and in crisis situations. The guidelines recognise that chronic and acute episodes of illness, congenital and accident-related impairments, and mental health problems all constitute a huge swathe of difficulties in human functioning and require (re)habilitation to enable people to live in and contribute to their community.

This vision is ambitious, innovative, and challenging, and requires engaging rehabilitation with public health. Public health has traditionally focused on the prevention of mortality, morbidity, and disability, with few public health professionals working with people with disability[4] or having the opportunity to inculcate the UN Convention on the Rights of Persons with Disabilities (UNCRPD).[5] The new guidelines also cross well-established boundaries (health, education, transport, welfare) and require the development of an evidence base for how to work across these sectors, and in contexts and through processes quite different from where the evidence has accumulated[6]—eg, addressing depression associated with an amputation experienced by a civilian stepping on a land mine in Angola.

The worldwide shortage of health workers trained conventionally as in the developed world also applies to rehabilitation, especially in low-income countries.[7] However, there is now good evidence for the clinical efficacy[8] and economic value[9] of mid-level cadres. Recognition of the interdependence of health in the new guidelines means that, to do justice to their clients, rehabilitation workers will need to develop the skills to work across sectors (figure). So the human resources challenge relates not only to the number of rehabilitation

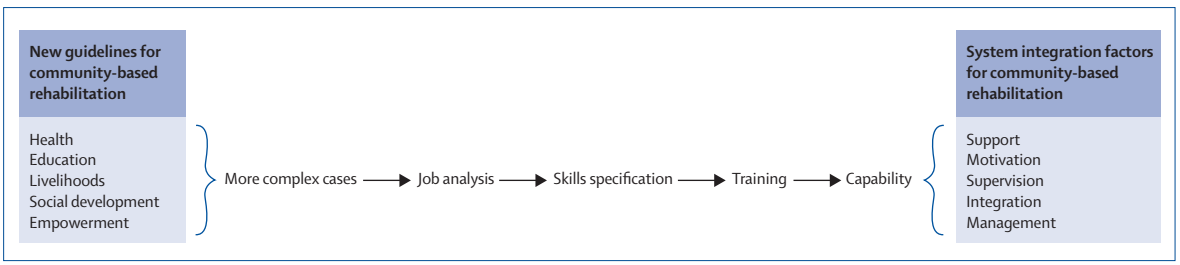

Figure: **Integrative staff skill-mix requirements for community-based rehabilitation and important associated factors for system integration**

workers available but also to the much broader skill set they will need to implement the new guidelines.

The term skill-mix is often taken to refer to the combination of health professionals in a team, whereas here we argue for a much greater skill-mix within the individuals who will be generalists and required to integrate a client's problems across very different domains, often in isolated resource-poor settings. While some rehabilitation and community health workers already do this to some extent, none are engaged in the expansive role required for effective implementation of the new guidelines. A new mid-level cadre of rehabilitation worker should be developed, on the basis of requirements of the new guidelines. It will be crucial to think less about staff types and more about staff skills,[10] with a new cadre whose roles are defined through systematic job analyses[11] to identify the core skills necessary to address the work to be done, work that no existing cadre is trained for. They will need to be insulated from extant health-professional rivalries, hegemonies, and territorial infighting—luxuries that can ill be afforded in most countries. WHO and other multilaterals will need to advocate for and esteem the distinctiveness of the new rehabilitation workers, though policy support, independent but integrated and supported practice, and a dedicated line of funding. Developing systems of training and supporting capable, motivated, well-supervised, and managed rehabilitation workers will be critical.

Inculcating community-based rehabilitation into public and global health cognisance; creating an evidence base that tells us how to work across sectors, contexts, and processes; and developing a new cadre unencumbered by atavistic health-profession baggage is a challenge. Morality, pragmatism, and humility will be key, but success will be evidenced by enhancing the lives of millions among the world's largest and perhaps most disadvantaged minority—people with disabilities.

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