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When the Wheelchair Is Not Enough: What Capabilities Approaches Offer Assistive Technology Practice in Rural Argentina

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Abstract: This article considers the lives of disabled people requiring assistive technology who live in contexts of urban poverty. Provision is often constrained by a range of contextual factors which seem outside the scope of health and rehabilitation services. We critically reflect on health, rehabilitation, and capabilities approaches. We explore both rehabilitation and capabilities approaches with posture and mobility practice in an area of urban poverty in Argentina. Contrasting rehabilitation and capabilities approaches to a composite posture and mobility case provides a range of insights. Rehabilitation approaches start with the individual as the locus for intervention. Capabilities approaches reframe interventions such as posture and mobility in terms of the freedoms they offer, and highlight the barriers or capability gaps that must be addressed to achieve outcomes. We conclude that capabilities approaches give practitioners the scope to go beyond posture and mobility processes and attend to the other factors, across the ecosystem, that prevent people from realizing their freedoms. To address capability gaps, a broader scope of practice for health practitioners may include consumer empowerment strategies; partnering with the community; and systemic advocacy with duty holders able to address systemic barriers.

Keywords: capabilities approaches; rehabilitation; assistive technology; wheelchair; poverty; outcomes

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1. Introduction

This paper explores assistive technology (AT) and its capacity to realize personal freedom for people experiencing poverty and disability. Specifically, we ask: what might capabilities approaches offer AT practitioners working with persons with posture and mobility limitations in one region of rural poverty in Argentina?

To answer this question, we compare and contrast the concepts of health and of capability. We then provide a brief background regarding Argentina, the province of Salta, and its unmet need for health and related supports. Through a composite case study, we explore the factors at play in achieving outcomes (freedoms) and closing the capability gap for individuals and communities in Salta. We discuss the implications of our learnings for other settings where socioeconomic factors compound individual factors in creating a capability gap for people living with disability. We conclude with a call for capability-informed assistive technology practice.

1.1. Concepts of Health and of Capability

The World Health Organization conceptualization of health can be understood through the International Classification of Functioning, Disability and Health (WHO ICF) [1]. The WHO ICF Framework (Figure 1) provides an individualistic view of human lives. In this,

people have body structures and functions which enable them to engage in daily activities and higher-order participations. The ability to be active and participate in life may be impacted by health conditions, or by the context in which people live, which includes environmental factors and personal factors. Environmental factors are broadly defined, and include services, systems, and policies; support and relationships; attitudes; and the built and natural environment. Personal factors remain undefined in recognition of the diversity and individuality of the human experience and wide variability among cultures, but include gender, age, educational level, and coping styles [2].

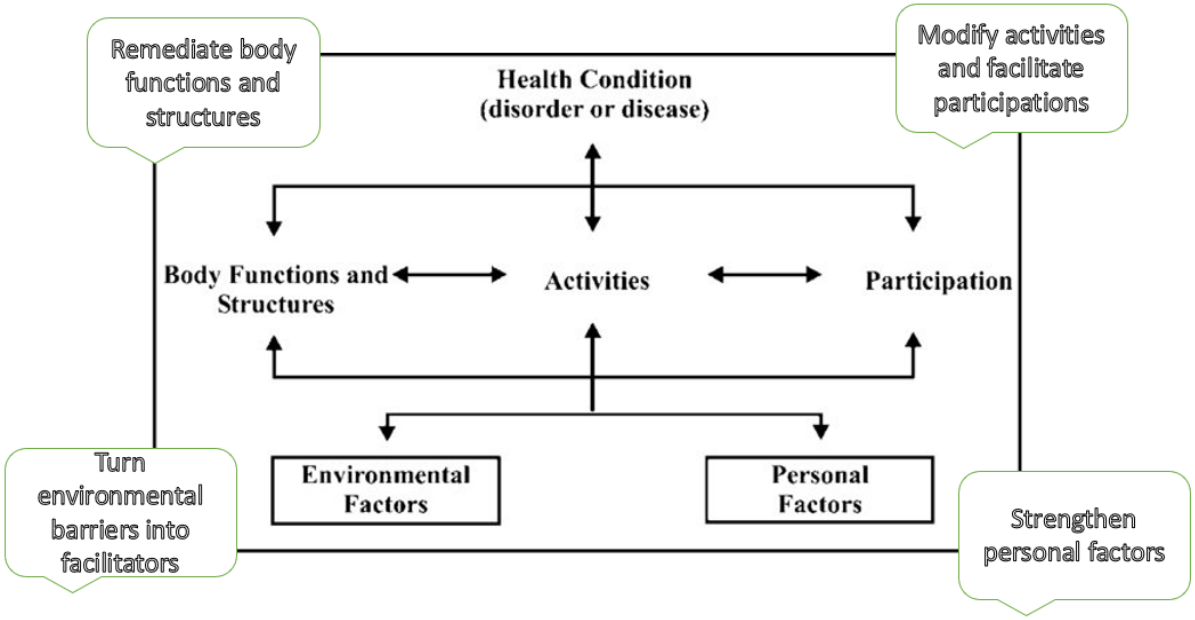

Figure 1. World Health Organization's International Classification of Functioning, Disability and Health [1] and the role of health professionals. Note: the images were collected by Asistiva with full written permission for use.

Health professional interventions may include remediation techniques; compensating for functional limitations; and adapting activities, technologies, or the environment, and these are displayed as boxes in Figure 1. The field of health which governs these interventions is rehabilitation. Assistive technology (AT), such as posture and mobility products and services, are seen as rehabilitation interventions [3]. Rehabilitation is defined as '*A set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment*' [4] *(pviii).*

An implication of working within the rehabilitation model is the focus on intervention at the individual, rather than environmental, level. Practice guidelines state that the environment should be considered. This often means practitioners comprehend the person's context, but addressing this context is usually limited to home modifications; asking about local access; or suggesting, for example, that families tackle local barriers such as policies.

The parallel fields of human development and developmental economics underpin what has come to be called the capabilities approach (CA), as outlined by Amartya Sen [5] and Martha Nussbaum [6]. The human development world view focusses on expanding the richness of human life, rather than simply the richness of the economy in which human beings live. The developmental economic lens considers the role of society (or, to adopt ICF terminology, the barriers and facilitators present) in creating opportunities for people to realize their potential. Building on these foundations, CA considers the role of society in enhancing the capabilities of each and every person to achieve human wellbeing [6].

In a CA, the focus is not on deficit, but on what each person is able to do and to be (termed 'functionings') [7]. CA emphasizes not only on how humans actually function, but also what resources ought be used to support functioning and deliver choices and

capabilities '*to achieve outcomes that they value and have reason to value*' [5] (p. 291). To be able to function is to have human dignity. Choice, happiness, and dignity are critically important, and all aspects of human society and environments should uphold them [6] (p. X), realizing freedoms require both opportunities and internal capabilities.

For example, the capacity for a person to attend a community center rests upon the opportunities the society provides. Is there a community center for its citizens? Are particular groups, such as women or people with disabilities, able to attend? Are there safe ways a person can wheel, walk, or be transported to the community center? Nussbaum describes internal capabilities as personal characteristics, such as '*personality traits, intellectual and emotional capacities, states of bodily fitness and health, internalised learning, skills of perception and movement*' [6] (p. 23). Some people might additionally require specific accommodations in order to understand, and visit, the community center if they use a wheelchair or have a visual impairment. The combination of these (internal capabilities and opportunities) is necessary for participation at the community center to occur. These 'combined capabilities' create—or deny—opportunities for choice and action. Capability 'gaps' may arise between a person's internal capabilities and the opportunities presented societally.

This is one key difference between a health/rehabilitation approach and CA approaches: though both are concerned with human functioning, rehabilitation has the individual as the locus of action [3], whereas CA takes a societal perspective of the factors which support human functioning and the levers of change. This strong focus on the role of the economy and society, alongside people's own functioning and capabilities, places more emphasis on the role of duty holders to actually make changes 'beyond' remediating the individual, to achieve outcomes. Table 1 describes the different scopes, outcomes, and language used in health/rehabilitation and capabilities approaches.

Table 1. Comparison of scopes and outcome arenas of health approach and capabilities approach.

Rehabilitation Approach		**Capabilities Approach**	
Scope	Outcomes	Scope	Outcomes
Body structures and functions, and health conditions	Change made to body functions and structures to enable activities and participations	Body and personhood as source of functionings and capabilities	Capability gap filled for chosen outcomes by societal and individual functioning measures
Personal factors	Unclassified, known to be important		
Activities and participations (nine chapters)	Usually measure independence in performing a task or role or resources used to achieve	Considers what freedoms are available from which to choose	Choice and happiness Wellbeing and dignity
Environment and contextual factors	First focus is changing individual to manage in environment, then change environment on individual basis. Little engagement with contextual factors (availability of resources, e.g., policy, funding) and valuable factors for the person	Economy and society as responsible agent, enabling full use of functionings and capabilities	Creation of freedoms and happiness for all people according to their functionings and choices

CA has been considered and applied in a range of related fields, such as social policy [8,9] and housing [10]. Scholars within health research suggest CA offers a paradigm shift [11]; for example, by supporting the differentiation of personal, social, and environmental conversion factors within health promotion [12,13]. In the case of AT, researchers have discussed the relevance of CA in conceptual thinking about AT and AT market systems [14–16], in assistive product deployment [17], and in the identification of AT system

'gaps' [18]. Recent AT product narratives describe networks of actors, as well as enablers and barriers, across entire AT supply chains. Though these do not reference CA explicitly, reading the narratives through a CA lens clearly indicates the way in which duty holders impact the realization of human potential [19,20]. This Special Issue illustrates a range of current explorations; for example, robotics [21] and comparative studies [22].

Theory underpins what individual practitioners do, and the systems in which they work. The brief summary above illustrates the conceptual value of CA in AT and related fields of research. We will explore the impact on practice offered by CA in contrast to health models after this introduction to the Argentinian context.

1.2. Argentina, and Access to Assistive Technology Services in Chaco Salteño

Argentina is situated in the global south, and its cultural landscape includes the influence of Spanish and Italian immigration (1850–1950) along with indigenous peoples. The population of 45 million live across 23 provinces within a vast topography of plateaus, mountains, plains, and prairies. Health and rehabilitation centers are few in number and are located in larger centers (Figure 2).

Figure 2. Region of Argentina, of Salta Province (arrow), and of Chaco Salteño (star).

Socio-politically, Argentina has strong universal health care laws. However, they are not equitably applied, resulting in inequity across regions and causing poorer outcomes for Argentinians living in areas of rural poverty. A range of services, systems, and policy

barriers exist. In terms of policy: people living with disabilities theoretically have access to the CUD (*CUD, Certificado único de discpacidad*) or 'disability card', which is the fundamental facilitator of access to healthcare services. In terms of systems: to obtain this card and be recognized as a person with a disability, a visit to the municipal center is required. If people do not register, then the unmet need for support is not measured. Barriers exist to registration; for example, travel from rural areas is unaffordable for most families who do not have private vehicles, and the local bus transport, where available, is not wheelchair-accessible. In terms of services: once a person has registered and has a recognized right to service with their disability card, the supports available to them in their region may be insufficient, as discussed below.

The northern province of Argentina is Salta, which includes Chaco Salteño (Figure 2, marked with star), a subtropical rural area which is the most vulnerable region in the province. Approximately 20 different indigenous ethnic groups reside in the region [23]. Specific challenges include the lack of infrastructure, such as no potable water and no paved path of travel between homes or through the community. Access to services such as health and education is difficult, with long distances and poor or non-existent public transport (see Figure 3). The municipality aims to deliver services within walking distance, but this does not help people who require a wheelchair for mobility due to the lack of pavements, and unpaved roads, as well as the problems obtaining wheeled mobility products and services.

(**a**) (**b**)

Figure 3. Local environs and wheeled mobility products which can traverse unpaved ground. (**a**) Local environs. (**b**) Wheeled mobility on unpaved ground.

Some healthcare services exist; however, there is no public provision for specialized assistive technology and rehabilitation, such as posture, seating, and mobility services. This is a significant problem given the volume of people in need of such services. Thirteen percent (70,000) of the population of Salta's capital have a disability, and of these, 39% have a physical disability (27,000 people). Only 23,000 receive the CUD disability card for access to health services [24]. Statistics are not published for the Chaco Salteño region, but are likely to be comparable or higher (*estimated: 3,320,000; with handicap: 43,160; with motor handicap: 16,832*). Until recently, people with a disability in Chaco Salteño faced a 6 h trip to the city to obtain the CUD card necessary to be eligible for disability services.

From a sociocultural perspective, people are generally disempowered with poor health knowledge, minimal resources, and low self- advocacy. Typically, people hold some specific personal beliefs (indigenous) about health, and have a strong commitment to family and to the participation of all, including community members with disabilities, but have a lack of knowledge about rights and a low self-belief in personal capabilities. For the community of Chaco Salteño, we can see there are many barriers to receiving universal health care. One way in which unmet needs are addressed is through civil society actions. This includes different non-government organizations (NGOs) providing services, usually in isolation from each other, and without co-ordination within the district.

This paper draws upon experiences of the second author (SC), a physiotherapist and expert in posture and mobility from Buenos Aires, the capital city of Argentina. Authors 3 (MVB) (a physician) and 4 (HMO) (an occupational therapist) are experienced practitioners in neurological rehabilitation, and work for the Local Public Rehabilitation Center. Interventions in the area of posture and mobility usually include posture and mobility supports for daily activities, such as sitting, bathing, and moving around. Wheelchairs are frequently recommended, with the aim of people being able to hold a position which is comfortable, and to avoid health complications, as well as being able to move around their home or community. The overall goal of interventions is not just that the person is aligned with a straight axis, but that the person is doing all that they want as a participant in their community.

As Chaco Salteño is an area of significant unmet needs for services, SC runs voluntary posture and mobility clinics through a charity: Asistiva [25]. Working through community partners and taking a capacity-building approach with local staff, SC delivers posture and mobility services within local communities. This involves assessing people for wheeled mobility and seating needs, troubleshooting where people are using inappropriate equipment, and the difficult task of positioning people well using a limited set of donated assistive products. This may involve adapting donated products or finding money to purchase products. SC aims to both address direct need, person by person, as well as to train local health agents in the assessment, selection, fitting, maintenance, and use of assistive products, based on community-based rehabilitation principles [26]. Asistiva has conducted multiple visits in the last 5 years, providing wheelchair services, and product provision for 45 persons, as well as running six training clinics for local agents (see Figure 4). Consistent with rehabilitation approaches, Asistiva measures success on a range of points, from the lack of abandonment of AT through to participation outcomes. However, many of the contextual factors in Chaco Salteno strongly influence potential outcomes, and are outside the scope of practice of health practitioners. This situation has led to this paper and to the question: what might a capabilities lens offer assistive technology practice in rural Argentina?

Figure 4. Asistiva clinics: community-based rehabilitation principles at work.

2. Approach

The four authors represent a physiotherapist from the Asistiva clinic (SC), and a local occupational therapist (HMO) and physician (MVB) from Salta Rehabilitation Hospital in Argentina. The first author is an occupational therapy researcher contributing to the study

design, theoretical analysis, and academic writing. Through a series of online meetings across time zones, we:

1. Reviewed writings on rehabilitation and CA.
2. Cross-walked concepts and vocabulary between rehabilitation approaches and CA.
3. Constructed a composite case study representative of recent clinics.
4. Through storytelling, Argentinian colleagues worked through evaluation and planning utilizing rehabilitation approaches and CA with their Australian colleague.
5. Together, created this manuscript.

3. Results

3.1. AT Practice through a Rehabilitation Approach and a Capabilities Approach

Florencia is 22 years old and lives with her parents and three younger brothers in a shared dwelling in Chaco Salteño. Florencia has a health condition, being diagnosed with hypoxic ischemic encephalopathy and resulting spastic diplegic cerebral palsy. Asistiva worked with Florencia using the rehabilitation approach, and subsequently reflected upon the practice possibilities through CA. We explore the differences in these approaches below.

3.1.1. Rehabilitation Approach with Florencia

Assessment and evaluation take the following forms:

- Body structures and functions: Taking the usual health approach, the AT practitioner works with Florencia, the local staff, and the family to assess the primary impairment, and any body structures and functions that are related with the functional limitation; these include tone, range of motion, and any asymmetries. Based upon this assessment, SC identifies a wheelchair is needed to deliver positioning outcomes, such as aligned seating for head control and hand function, for comfort, and to avoid secondary complications. However, the available wheelchairs are not fit for purpose, and the service has gaps in the prescription (no cushion), fitting, training, maintaining, and follow up.
- Activities and participations: Participation is assessed in terms of the individual and the family, considering suitable activities for her age and her interests. Florencia wishes to join in music and dancing workshops for teenagers within her community. It is apparent that Florencia's family and friends also do not know how to facilitate her participation.
- Environment: An environmental scan demonstrates that Florencia is unable to access school or dancing, as she has not had a suitable wheelchair, and she cannot get to these activities due to the lack of accessible streets and the lack of any transport.

Management plan and actions take the following forms:

- Address body structures and functions by recommending a wheelchair: As provision is limited, set up a donated wheelchair. Recommend ongoing AT service provision in the area, noting that this is limited, as there are few trained workers and no AT service. Recommend utilized health care services to maintain health, noting that access may be difficult.
- Make recommendations regarding activities and participation: Suggest participations of school and dancing; however, recognize that the lack of community infrastructure means Florencia cannot get to school and dancing. Recommend that the family do self-advocacy to improve access and infrastructure.
- Environment: Identify accessibility barriers at home and local access barriers, such as unpaved streets, narrow doors, and uneven floors. Inform the family and local staff that changes are needed to facilitate Florencia´s life engagement.

Table 2 summarizes the scope, hoped outcomes, and achievements using a rehabilitation approach with Florencia.

Table 2. Florencia with the rehabilitation approach.

Scope	Hoped Outcomes	Actions Undertaken through the Health Approach to Achieve Outcomes
Assess body structures and functions Evaluate positioning	Improved body positioning: bed, chair, self-care, and communication Maintain function over time and as needs change	Recommend wheelchair Set up donated wheelchair Recommend ongoing AT service provision (note the lack of referral pathways) Recommend use of health care services to maintain health
Activities and participation	Mobile at home/local area Mobile without strain on parents Engage in chosen participations (school; dancing)	Suggest participations of school and dancing. Recommend family do self-advocacy to improve access and infrastructure.
Environment	Florencia can access home and community with her wheeled mobility. Florencia attends community activities (dancing, school)	Identify accessibility barriers: home Identify accessibility barriers: community Inform family and local staff that changes are needed to facilitate Florencia's life engagement

3.1.2. Capabilities Approach with Florencia

Sen argued for four components in assessing capability, with the aim of uncovering and upholding who Florencia is, and what she wants to do and to be [27,28].

- Individual differences in the ability to transform resources into valuable activities: This starting point enables the AT practitioner to consider: does Florencia have self-direction? Can she shape her own destiny and be part of her community? These overarching questions lead to specific questions for Florencia as a young woman and citizen of Chaco Salteño: does she have friends? How can she relate with them? The assessment of Florencia's functionings, both physical and as a member of her family and community, results in a wheelchair recommendation, but equal attention is paid to the structural barriers that prevent her realizing her full capabilities.
- The multi-variate nature of activities giving rise to happiness: The focus on functionings and the capability gap between what Florencia does and wishes to do uncovers that Florencia feels emotionally and physically isolated, as she cannot be a student and have the appropriate health services. Florencia spends the whole day sitting between the kitchen and the front porch listening to her relatives that come in and out of the home.
- A balance of materialistic and nonmaterialistic factors in evaluating human welfare: Barriers to Florencia's choices include a lack of resources for assistive products, such as wheelchairs; a lack of programs for recreation, education, social interaction, for people with mobility limitations; an inaccessible health clinic; the distance to the dance class; and a lack of public transport (a small community bus is not accessible).
- Concern for the distribution of opportunities within society: Understanding these issues for Florencia also raises the likelihood that these are issues for others, and that this isolation is related to the reality that society does not value the lives of people with disabilities.

The process of assessing capability led to the following management plan and actions. Wheeled mobility is an essential facilitator of Florencia's wellbeing; therefore, multilevel actions are taken at individual and at systemic levels to deliver mobility outcomes and to address any capability gaps. A donated wheelchair is set up, and local workers are taught how to set up, maintain, and repair, thereby establishing ongoing AT service provision. Willing local partners are enrolled in the relevant internationally accredited wheelchair skills training course [29], so that they can have their skills recognized, and be able to

work with other individuals like Florencia. Local partners are also involved in systemic advocacy to receive more suitable wheelchairs for the region. To improve the resource situation, political advocacy is undertaken with local stakeholders to the government. The rights-based case is made about the unmet need in Chaco Salteño for access to health services, as well as access to appropriate wheelchairs to provide support and wheeled mobility in the environment. These actions address Florencia's needs and also address the unmeasured, unmet need for other disabled persons within the community.

Table 3 summarizes the scope, hoped outcomes, and achievements using CA with Florencia.

Table 3. Florencia with the capabilities approach.

Scope	Hoped Outcomes	Actions Undertaken through the Capabilities Approach to Achieve Outcomes
Body and personhood as source of functionings and capabilities	Body functioning is maximized for comfort and to support capabilities Florencia expresses the 'doing and being' that she values Florencia is motivated to take steps towards 'doing and being'	Recommend wheelchair: • Set up donated wheelchair • Work with local partners to receive more suitable wheelchairs Assist to obtain disability card
Considers what freedoms are available to choose from	Local services, systems, and policies fill the capability gap, and enable access to school, to health, and to dancing class for all children like Florencia	Implement ongoing AT service provision by training local workers. Political advocacy with local stakeholders to the government to make health care services accessible. Facilitate attitudes (family, community) which recognize Florencia's right to choose
Economy and society as responsible agents, enabling full use of functionings and capabilities	Local services, systems, and policies act to enable Florencia to achieve the functionings that she values by providing sufficient resources (disability card, infrastructure in community/society, to enable full mobility)	Political advocacy with local stakeholders to the government to deliver disability card to all people with unmet need in area. Pooling resources to build community infrastructure, as unmet need is no longer unknown.

4. Discussion

Rehabilitation approaches, as typified by the WHO ICF, and capabilities approaches, could be said to be covering similar terrain, but with different terminologies. Both consider the person, their goals, and the role of resources and broadly defined environments as barriers or enablers to achieving those goals. However, as the worked case example above demonstrates, interventions undertaken through the capabilities approach are more dynamic than those undertaken in the rehabilitation approach. Realizing or achieving Florencia´s freedom required intervention beyond the provision of posture and mobility products and services. The key interventions supported by a capabilities-enabled approach included:

- Local empowerment: Only provide voluntary services if key local stakeholders are involved; for example, the local social worker. Collaborate with champions at a regional level (in this case, health professionals from the Public Rehabilitation Center in Salta City (Physician and OT)). Involve willing local actors, such as local handicap (disability) agencies. Support capability building, e.g., local people gaining wheelchair certification.
- Systems strengthening: The broad lens of capabilities approaches encourages the inclusion of stakeholders well beyond health and disability, including social ministry services, such as environment, indigenous, education, recreation, and employment.
- Government engagement: Recognizing the drivers of government policy is another strategy. An objective of government is to promote rights through inclusive development. Asistiva and local partners such as the Public Rehabilitation Center in Salta City presented a 'good news story' in the form of the posture and mobility clinics.

The resulting dialogue achieved a policy change, and the necessary documentation to receive a disability card can now be completed in the local communities through outreach services from the government. Another tangible outcome is that some government officials from the Health and Social Ministry now come to Chaco Salteño three times per year to provide a wheelchair service provision: evaluating, fitting, training, and monitoring the programs. Further political advocacy with local stakeholders to the government is under discussion. This includes pooling resources to invest in bulk-purchasing some of the AT products needed. This also includes improving the infrastructure (terrain) that currently does not support full mobility.

Such systemic advocacy or political practice has not traditionally been the role of allied health professionals, as can be seen from the rehabilitation literature [30,31]. We suggest, certainly for the subset of allied health professionals who work as AT practitioners, that this is an essential extension to our work both in low- and middle-income countries, and in other settings where inequitable AT provision is evident. This principle is consistent with the directions suggested by global AT policy actors, such as AT Scale and GDI Hub [32]. The engagement strategies discussed above are fundamentally about citizens like Florencia, but work at systemic levels rather than just on an individual level [33]. By doing so, the individual need is understood in the context of what society provides. Actions to pivot services, systems, and policies in order to meet the needs of one will likely also address the unmet needs of the community.

The United Nations Human Development Index suggests that people and their capabilities should be the ultimate criteria for assessing the development of a country, and offer indices to evaluate how societies provide opportunities and choices for people [34]. Rehabilitation practitioners may find it useful to include these metrics when evaluating our work as a way to measure impact.

5. Conclusions

Integrating CA into rehabilitation and AT services will reinforce the perspective that the final goal of inclusion is the freedom of each individual to make their own choices in life, independent of the 'help' they need to achieve a function. The profound difference that this article attempts to describe is not a change in scope for the AT practitioner, but rather a more holistic starting point and a focusing of effort. The starting point with rehabilitation is independence and autonomy, whereas the starting point with CA asks: what do you want to do and be, and how might our scope of practice enable this and address any capability gap? This occurs by the AT practitioner providing the opportunity for the person to state their preferences and beliefs, to support choice-making. Concurrently, the AT practitioner explicitly asks about the role of society in contributing to, or minimizing, capability gaps, thereby enacting the social model of disability. Where societal barriers exist, the capabilities approach enables AT practitioners to see these as within the scope for action.

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