



WORKING IN LESS RESOURCED SETTINGS



Guidance for Allied Health Professionals

Compiled by members of:

**ADAPT, Communication Therapy International (CTI)
& OT Frontiers**

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ACRONYMS

ADAPT – Chartered Physiotherapists in International Health & Development	MSF – Medecins Sans Frontieres
AHP – Allied Health Professional	NGO – Non Government Organisation
APT – Alternative Paper Technology	NHS – National Health Service
CBM – Christoffel Blind Mission	OT – Occupational Therapist
CBR – Community Based Rehabilitation	PT - Physiotherapist
COPM - The Canadian Occupational Performance Measure	QoL – Quality of Life
COT – College of Occupational Therapists	RCSLT – Royal College of Speech and Language Therapists
CP – Cerebral Palsy	SLT – Speech & Language Therapist
CPD – Continuing Professional Development	SCI – Spinal Cord Injury
CSP – Chartered Society of Physiotherapy	SDG – Sustainable Development Goal
CTI – Communication Therapy International	TBI – Traumatic Brain Injury
DFID – Department for International Development	VSO – Voluntary Service Overseas
EMT - Emergency Medical Team	WCPT – World Confederation of Physiotherapists
FCO – Foreign & Commonwealth Office	WFOT – World Federation of Occupational Therapists
HCPC – Health & Care Professions Council	WHO – World Health Organisation
HI – Handicap International	UKEMT – UK emergency Medical Team
ICF – International Classification of Functioning, Disability and Health	UKIETR – UK International Emergency Trauma Register
ICRC – International Committee of the Red Cross	UNICEF – United Nations Children’s Fund
KSF – Knowledge & Skills Framework	
MHOR – Manual Handling Operations Regulations	
MRA – Mutual Recognition Agreement	



INTRODUCTION

Purpose of this Resource Pack

This booklet is intended for guidance for all Allied Health Professionals (AHPs) who plan to work in less resourced settings. However, many topics outlined in the following pages are relevant to good practice in any context. Less resourced settings are referred to in a range of ways, both in this pack and elsewhere, for example “developing”, “less developed” and “under-resourced countries”. Within this pack, these terms are used interchangeably.

We hope this pack is both INFORMATIVE and INSPIRATIONAL.

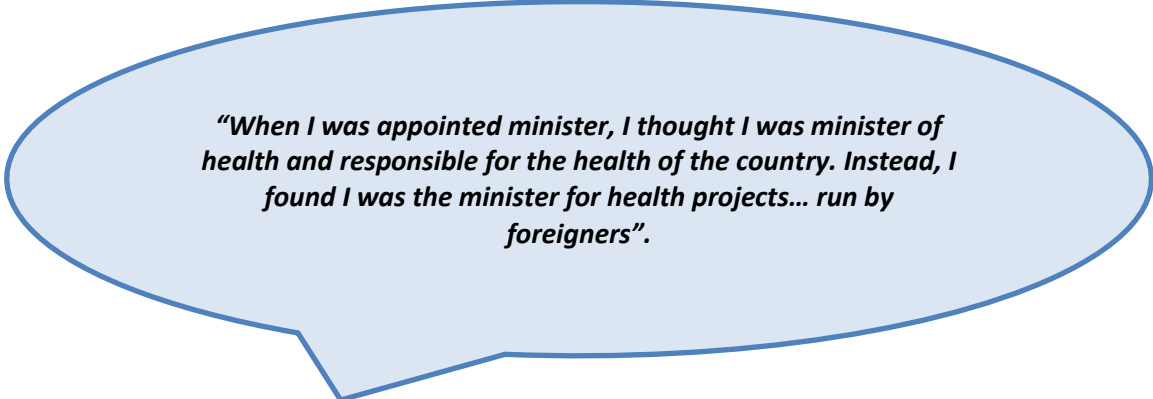
The professional networks, ADAPT, Communication Therapy International (CTI) and OT Frontiers and their members, who have worked in less resourced settings have joined forces to share their knowledge to produce this updated resource pack; (the original was produced in 2014) which should then provide a ready source of "tried and tested" information, designed to be easily accessible to both people preparing to undertake this work and for those currently working in the field.

Many of the examples given in this pack are paediatric ones with reference to Cerebral Palsy (CP). This reflects the experience of the contributors. We realise that the work of therapists reading this pack is much more diverse.

An essential principle underlying all sections of this pack is the importance of respect for the countries we visit and the people who live and work in them. This means challenging any assumptions we may have about:

- **The “best” way for local people to do anything. Our ways may not work in their context, or may simply be irrelevant; conversely, just because things are currently done in a particular way, this does not mean there should be no change.**
- **Who brings “expertise”, and who gains most from our involvement. When we offer our services in low and middle-income settings, we have a responsibility to strive to ensure that local people are the principal beneficiaries. However, we often find that the same people have at least as much to teach us as we have to offer them.**

Whilst this is an old quote, it has as much relevance in 2017 as it did in 2007.



“When I was appointed minister, I thought I was minister of health and responsible for the health of the country. Instead, I found I was the minister for health projects... run by foreigners”.

A former Mozambique minister of health, quoted in: Nigel Crisp (2007), Global Health Partnerships: the UK contribution to health in developing countries. Available at <http://www.thet.org/hps/resources/publications/lord-crisp-report-2007-1>

Content

The information contained in the Resource Pack is not exhaustive, but merely reflects what has been found to be most useful and relevant to date. Details presented here are accurate at the time of writing; however, situations change and details can quickly become out of date, so please do not rely on information without checking it for yourself first. A hard copy will be available to buy at cost price and further additions may be printed in the future, but an electronic version (which will be updated more regularly) will be available on all the professional network websites for you to download free of charge. The joint committee relies on its readers to keep us informed and up to date, so please send in any additions or amendments.

Email your comments/suggestions to:

ADAPT: adaptenquiries@gmail.com

CTI: CTImembership@yahoo.com

OT Frontiers: enquiries@otfrontiers.com

ADAPT

ADAPT is a professional network recognised by the Chartered Society of Physiotherapy. ADAPT supports members and facilitates information exchange in order to contribute to the development of effective physiotherapy services worldwide in a manner that promotes an understanding of global healthcare and development issues and which is socio-economically and culturally appropriate.

<http://www.csp.org.uk/icsp/adapt-international-health-development>

ADAPT maintains a database of members and countries they have worked in. You can contact any of these members for advice, especially if you want to find an organisation in a particular country to volunteer in.

They also send regular bulletins of appropriate opportunities and vacancies to members. Vacancies are posted on the ADAPT iCSP forums and discussion boards:

<http://www.csp.org.uk/icsp/adapt-international-health-development>

ADAPT are also on Facebook. Search for [“ADAPT: Chartered Physiotherapists in International Health and Development”](#).

Communication Therapy International (CTI)

Communication Therapy International (CTI) aims to support professionals, including Speech and Language Therapists, from high income countries to maximise the impact of their work with people with communication disabilities in low and middle income countries. CTI holds annual Study Days and has online resources, useful links, job opportunity posts, reports from international projects, a Blog, Facebook page and a wealth of experienced and enthusiastic members.

<https://comtherapint.wordpress.com> or

www.facebook.com/communicationtherapyinternational

OT Frontiers

OT Frontiers is a network of occupational therapists based in the UK who have an interest in occupational therapy in low and middle income countries. We aim to promote an understanding of how as UK occupational therapists we can most

appropriately apply our practice in the context of these countries. Whenever possible we collaborate with our overseas colleagues in projects that they undertake.

Many of our members have experience of practice in low and middle income countries. Therapists and students who are considering working overseas for the first time are welcome to write to us with enquiries or to come to our meetings. We also welcome enquiries from therapists currently working overseas.

Website: <http://www.otfrontiers.co.uk>

Contact us: enquiries@otfrontiers.com

The website has information about our activities, meetings, news (including occasionally volunteering opportunities) and resources.

A joining form can be found on our website on the '**get involved**' page, or else write to enquiries@otfrontiers.com



SECTION 1:

**THINKING
ABOUT
WORKING
ABROAD**

Different types of working in less resourced settings.

There are many opportunities for AHPs to work in less resourced settings, paid and unpaid.

Some of these may be short term, i.e. for 2-5 weeks whilst others may be more medium to long term; 6 weeks to a year or more.

Some of these include:

- Working in clinical settings.
- International Development
- Teaching and training
- Emergency settings
- Management
- Student volunteer

Whilst these are discrete headings, on many occasions you may have to take on different roles and tasks that you had not anticipated. Be prepared.

Language, terms, and the contexts in which allied health professionals can contribute

The terms “**development, emergency, humanitarian, rehabilitation, inclusion and community based rehabilitation**” are the language of this sector. This section will explain what the terms mean, how they fit together and the contribution allied health professionals can make.

International Development

What is meant by **International Development** is expressed in the United Nations Sustainable Development Goals (SDGs) (2016)

Whichever role you adopt, an awareness of these goals is useful to remember.

There are 17 SDGs, with number 3 being about health,

“ensure healthy lives and promote wellbeing for all at all ages.”

Within this goal, specific reference is made to mental health and wellbeing, universal health coverage, research for health, and health workforce strengthening.

Against a history in which “millions ...have been denied the chance to lead decent, dignified and rewarding lives,” the SDGs envisage a “world free of poverty, hunger, disease and want, where all life can thrive...with equitable and universal access to quality education at all levels, to health care and social protection, where physical, mental and social wellbeing are assured.” Recognising that for international development to be complete and sustainable the SDGs address economic, social and environmental issues. (United Nations, 2017).

Rehabilitation

The SDGs were preceded by the Millennium Development Goals which achieved huge improvements in the first years of the 21st century. For example extreme poverty globally decreased from 47% in 1990 to 14% in 2015 and between 2000 and 2013 the tuberculosis mortality rate fell by 45%. (United Nations 2015). In this context and with globally ageing populations more people are living with long-term conditions, meaning that the healthcare sector is turning attention from saving lives towards improving health and wellbeing throughout the life course. Allied health professionals have a significant role to play in medical **rehabilitation**.

Inclusion

Alongside these achievements of the early 21st century the United Nations brought into international law the Convention on the Rights of Persons with Disabilities in 2008, which affirms the rights of people with disabilities to “full and effective participation and inclusion in society” (Article 3c) (United Nations, 2008). Many people with disabilities do not require medical rehabilitation yet are excluded from full participation through attitudinal and environmental barriers. Allied health professionals have a role to support the attitudinal and environmental changes needed to enhance the **inclusion** of people with disabilities, including those who do

not require medical rehabilitation. People with disabilities are mentioned under goal 4 of the SDGs on education, goal 8 on employment, goal 10 on political inclusion, goal 11 on access to transport and to green and public spaces. (United Nations, 2017).

Community Based Rehabilitation

Community Based Rehabilitation (CBR) is a strategy for both extending the availability of rehabilitation in low and middle income countries and for supporting inclusion initiatives.

Back in the 1980s the World Health Organisation (WHO) recognised that there is no realistic prospect of there being enough allied health professionals to reach all the people who will need them. In response it devised an approach in which allied health professionals would train village community workers and family caregivers in basic rehabilitation skills. This would both increase the number of people providing services and make them available to rural communities. Community services are backed up by good referral to the professionals for oversight, training and to manage the more difficult cases.

As the approach to inclusion has grown CBR has become more about inclusion in general, rather than just about rehabilitation. CBR now includes a wider range of people promoting the rights of people with disabilities for inclusion in health, education, livelihoods (earning a living), social activities and promotion of the rights of people with disabilities. Medical rehabilitation is still a vital component within CBR and allied health professionals can also support the more general inclusion initiatives. (World Health Organisation, 2010)

Emergency and Humanitarian Work

AHPs have a significant role also in **emergency** settings. These are situations which result from hazards such as natural disasters, conflict, disease outbreaks and industrial accidents. In the short term populations suffer societal disruption, increases in mortality and morbidity due to infectious diseases, acute malnutrition, trauma and displacement. Health infrastructure may be damaged and disrupted or, in the case of displacement of populations, absent.

National states do not always have the resources to provide the necessary assistance and so other actors may assist. It is this assistance in the situation of emergencies which is referred to as “**humanitarian**”. (World Health Organisation, 2013).

The consequences of emergencies can continue for years for both affected individuals and for society. Individuals may carry long-term physical or lasting mental health effects. Health infrastructure may have been undermined or pre-existing health services may not be sufficient to cope with the additional needs. As acute humanitarian intervention subsides actors ensure that sustainable provision is reconstructed or put in place for those individuals and for health systems. In this way, humanitarian work transitions into **development** in post-emergency situations.

Training

Often the most sustainable thing you can do is teach someone else how to do your job or selected parts of it. You need to make sure they can do this well before you leave! Lots of work is carried out that is called “training”. However, it’s only training if, in the end, people can use it without you.

Why go abroad?

The reasons people choose to volunteer or work abroad vary and could either be personal or professional, e.g.

- encouraged by a colleague or friend’s experiences
- inspired by a particular country or international situation of need,
- want to accompany a partner with an international job
- have the opportunity to realise a lifelong dream.

In gaining experience abroad the benefits to you personally as well as professionally are numerous.

A desire to make a difference

The most common reason for therapists wanting to volunteer or work abroad is the desire to make a difference. Media exposure to large scale natural disasters and

conflicts, as well as on-going massive health inequalities means that many people are more aware of the need for quality rehabilitation services and disability prevention in many countries. People are prepared to give time, skills and money to know that their contribution will make a difference whilst at the same time, help local people develop and create their own solutions.

Explore the world

Having a vocational profession, which is transferable to almost every setting in every corner of the world, is a huge asset. Working as a therapist overseas is often a wonderful way to:

- experience different cultures
- learn about the complexities of disability and rehabilitation in other countries
- become part of a new community.

As a therapist you are afforded the time to really get to know host countries, communities and individuals.

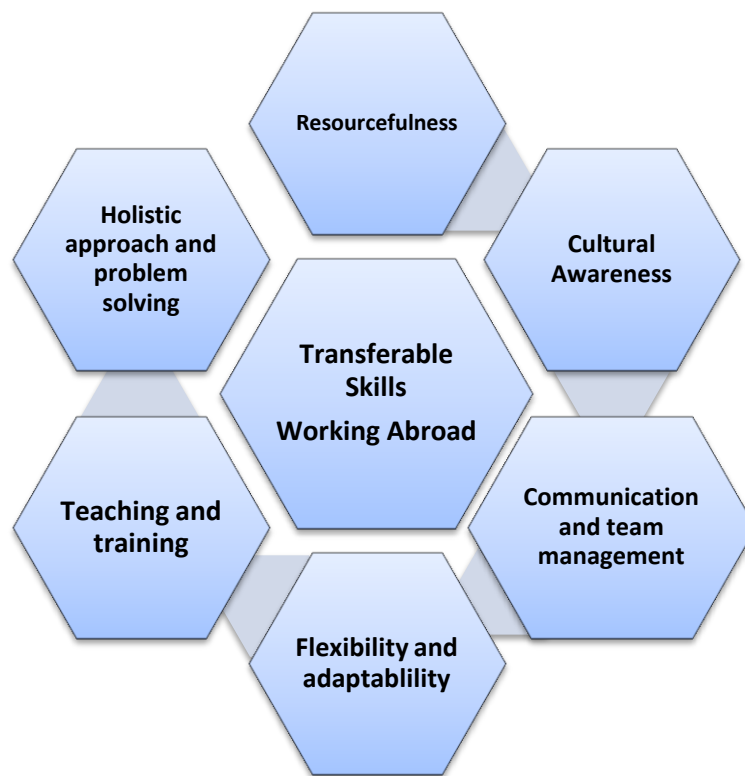
To develop transferable skills

Working within cultures and communities that are not our own, often with few resources and under stressful circumstances, we develop skills which are highly desirable in all areas of practice, and particularly to Health Service managers.

These include:

- resourcefulness,
- adaptability,
- independent thinking,
- communication skills,
- time management
- and above all respect for other cultures.

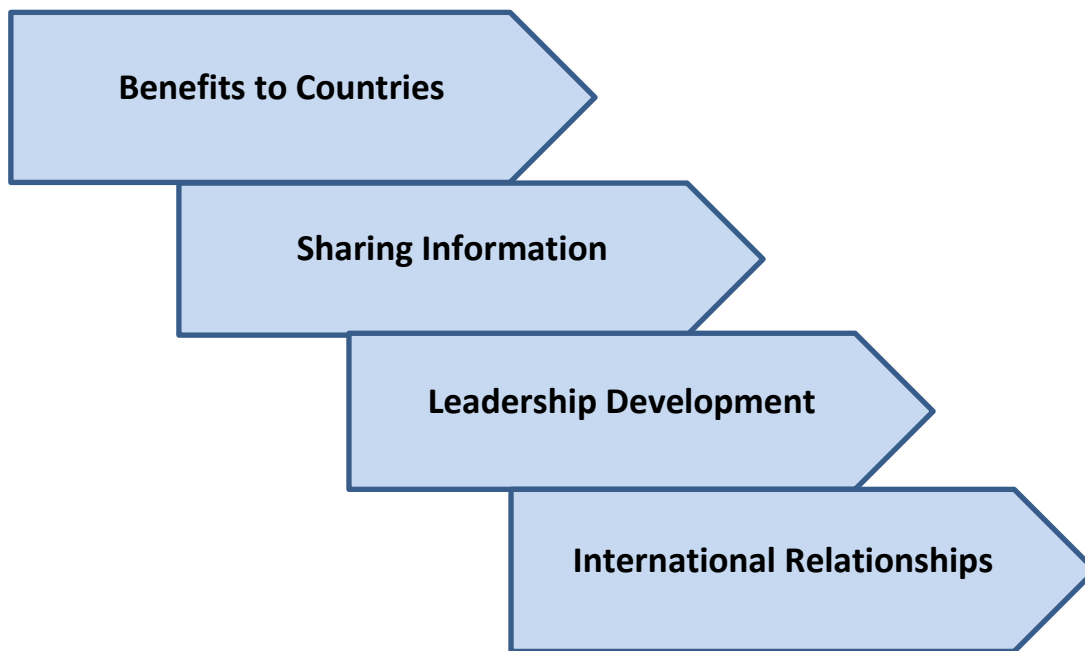
In an increasingly multi-cultural UK society these skills have been formally acknowledged as exceptionally relevant in today's NHS.



Many people wishing to work abroad for longer periods worry about the impact on their long term career in the UK. It can be difficult to persuade managers, or indeed yourself that time working in another country will benefit the UK workplace, patients and your own professional development.

The Department of Health has produced the useful document, ***The Framework for NHS Involvement in International Development (2010)***. The Framework states that international work offers healthcare professionals the opportunity to ‘develop a range of hard and soft skills such as clinical, managerial, leadership, cultural and educational skills, which are beneficial to and transferable to the NHS’ (DH, 2010).

The All-Party Parliamentary Group on Global Health also produced a report in 2013, entitled “Improving Health at Home and Abroad: How Overseas Volunteering from the NHS benefits the UK and the World.” This report clearly sets out why the UK should support global volunteering from within the NHS.



A toolkit has now been developed to provide NHS employers with evidence of professional development and the benefits brought back to the NHS.

The toolkit provides a framework to collect evidence of knowledge and skills gained from international links work in a way which directly relates to the NHS Knowledge and Skills Framework (KSF) for annual appraisal, the NHS Leadership Framework for leadership development and requirements of the Royal Colleges for accreditation of international project work for Continuing Professional Development (CPD).

The toolkit for CPD, “Building a Caring Future” can be found at:

<http://www.thet.org/hps/resources/publications/building-a-caring-future>

‘Working in developing countries gives us all a new perspective on our own lives and offers us new ideas for the future. It is about respectful and equal co-development where we each have something to learn and each have something to teach – and about building the future together.’

(Lord Nigel Crisp, 2010 – Working with Humanitarian Organisations, Royal College of Nursing)

How long do you want to go for?

If you require time off work, or need to hand in notice, ensure you are aware of what is required of you from your manager.

Most organisations taking short term volunteers will request a minimum commitment of two weeks in order to have a meaningful experience for both host and visitor.

Some organisations sending therapists to assist in training programmes, such as MAITS (www.maits.org.uk), may require less time commitments.

International Non-Governmental Organisations (NGOs) in emergency work offer short term assignments starting from 2 weeks, often with the possibility of extending. For development work a longer term commitment is required, both for paid NGO posts and also for Voluntary Service Overseas (VSO) roles – at least one year is often required.

Is this voluntary, or do you expect to be paid?

Historically, those working in the humanitarian field did so as an unpaid volunteer. For many current short term voluntary positions you will be required to fund your own travel and visa costs, and may need to pay small amounts for food and board with your host. Ensure you know your personal budget for these trips. There are a number of bursaries and funds available for those making trips abroad which are worth exploring.

See: Resource Section – Grants

Nowadays, many humanitarian organisations realise that to attract qualified and high quality staff basic remuneration and living costs need to be covered. Often this remuneration will be on a scale dependent on position and experience. It is worth exploring what these salary scales are, whether they include accommodation costs, travel and insurance, in particular medical emergency cover and whether you can commit to the terms.

'Treating the same clients three times a week, getting to know the families and visiting their communities, not only was I able to learn about aspects of their home lives, I could then think of ways to include the child with disabilities into that home life. The trust and the openness of the families allowed me to really understand the practical difficulties families with a disabled child experienced in rural Tanzania. I would never have been invited to share food, take part in harvesting mangos or built up such deep trust with communities had I simply been travelling through. This was a real privilege of my role.'

Volunteer Physiotherapist, Tanzania (6 months)

Are you qualified and registered to practice in your host country?

- This is a vital question. As a student you are not able to practice as a therapist unsupervised in any country. You must have formal supervision set up prior to departure, you must ensure your host organisation is aware you are a student and this applies until you formally graduate as a therapist. (More on this in Student Section).
- As a qualified professional, you are able to practice in most low and middle income countries, but (if your profession is recognised in the country) contacting the relevant professional associations, where they exist, will establish whether you need to be registered in order to practice. If you are travelling as an independent volunteer it is up to you to establish this. Not all NGOs are aware that AHPs need to register in country; you may have to find out about this and inform your employing NGO.

Physiotherapists:

You should hold a current license to practice in your home country (i.e. for the UK you should be registered with The Health and Care Professional Council HCPC). Check the local registration requirements of the country

For further information on your ability to practice abroad, and specific information for national associations the World Confederation for Physical Therapy (WCPT) has an extensive list of contact information on their website:

<http://www.wcpt.org/members>

Occupational Therapists:

An OT will need to be currently registered in his/her own country, i.e. with HCPC in the UK, and will need to contact the local OT association if available or WFOT for more information. Further, it is likely you will also need to be registered with the local health professions council/board or equivalent.

To find out if there is an OT Association in your country of interest go to:

<http://www.wfot.org/Membership/CountryandOrganisationProfiles.aspx>

There you will find if your country of interest has an OT Association. Select your country and you will find the contact information for the OT Association of that country.

The World Federation of Occupational Therapists (WFOT) recommends 2 years post qualification experience before working in another country.

<http://www.scribd.com/doc/199553520>

Speech and Language Therapists:

You should hold a current license to practice in your home country (i.e. for the UK you should be HCPC registered). Check the local registration requirements of the country you intend to visit. SLTs have Mutual Recognition Agreement (MRA) countries. It doesn't give you the right to practise there but recognition of your professional body membership.

http://www.rcslt.org/speech_and_language_therapy/working_outside_the_uk/mra

'The agreement enables full members of one association to join any of the others. Please note that the MRA is not intended to facilitate formal immigration

requirements. Please also note that each country and – in many cases – states within each country have regulatory requirements separate to the membership of the professional association (as in the UK, where the RCSLT is the professional association but the HPC is the regulator).’ accessed 10.2.14.

Professional Liability Insurance for SLTs: This does now extend to overseas work.

However, Registered SLTs need to contact the insurance company via the Royal College of Speech and Language Therapists (RCSLT) and inform them of the proposed country of work. There may be limitations or exemptions including areas within certain countries, due to safety and/or instability as agreed with the Foreign Office advice. SLTs need to keep relevant paperwork on file.

CTI strongly recommends that you have at least 4 years’ post-graduation experience before starting to work in a low-income context. Therapists with less experience than this will need supervision on-site from a suitably experienced Speech and Language Therapist. Alternative supervision arrangements (e.g. via internet/telephone, or with a different profession) are suitable only for experienced Therapists.

Professional Networks

Being a member of your profession specific network for those working internationally gives you access to a wide network of colleagues already working abroad, as well as placement opportunities advertised to members.

International Job Boards

These will post many of the short or long term salaried positions, either in development or humanitarian emergency response sectors. Often these jobs will require 3-5 years clinical experience, and ‘field’ experience, which often means these are not suitable for those seeking a first time position abroad. However, organisations seeking volunteers may also post here so it is also worth a look.

See under ‘Resources Section’

Physiotherapy Specific:

Go-PT www.go-pt.net

A social network for physical therapists and NGOs who share the goal of helping resource-limited populations get the rehabilitative services they need. Often link NGOs with Physiotherapists seeking positions.

World Confederation of Physical Therapy <http://www.wcpt.org/node/29331>

Occupational Therapy Specific

World Federation of Occupational Therapists

There is a section on the OTION website (which is part of the WFOT website) which feature available job opportunities and postings abroad. OTION also carries useful conversations about international working. The resource centre also has useful resources for working as an OT in developing countries.

<http://www.wfot.org/Classified/JobOpportunities.aspx>

And OTION (which is part of the WFOT) <http://otion.wfot.org/viewtopic.php?id=3>

Broaden your CV – what skills are needed to work abroad?

Knowing what skills are needed for the roles you seek will help you refine your CV.

Generally skills include:

- Relevant professional experience. This differs between posts, but should include a strong background in all core specialities and a good grounding in paediatrics, especially if you intend to work in a community setting, may be useful.
- Ability to work effectively in resource-poor settings, e.g. without high tech aids and equipment and often without formal assessment materials.
- Strong teamwork and interpersonal skills, as well as proven flexibility and adaptability
- The ability to cope in stressful situations
- Experience and strength in delivering training and mentoring.
- Language skills, or aptitude are an advantage
- Endless patience!

Post Graduate Courses

There are a myriad of courses available to those interested in global health and humanitarian work, they vary from a one day 'So you think you want to be an Aid Worker?' to a year full time Masters' Degree.

The major institutions offering some the most recognised courses are listed below, but this list is by no means complete. Please tell us if you know of any other institutions within the UK that offer Post Graduate Courses.

Please see 'Resources Section' for links.

Experience with migrant communities in UK

Many people find it difficult to secure their first position abroad. Having experience working with ethnic communities within the UK itself will provide you with skills of inter-cultural working and should enhance your chances of employment success. There are organisations working in most major UK cities with refugees and asylum seekers, as well as with a variety of migrant communities – becoming involved in any of these organisations would prove invaluable experience.

Learn a language

Language skills are a huge advantage, as availability of translators in many positions is scarce.

Arabic, French and Spanish are three of the most useful languages.

If you have even basic language skills, looking to those countries first would be sensible. For example in the response to the earthquake in Haiti, therapists who had basic French skills were sought after to assist in the rehabilitation efforts.

Russian is very useful throughout Central Asia (Russia, Uzbekistan, Kazakhstan, Kyrgyzstan, Tajikistan (limited) and the Baltic States (Ukraine, Armenia etc).

A useful site for learning the more commonly spoken languages, such as Spanish, and Kiswahili, is www.duolingo.com which is free.

NB: For further student placement information please see the Student Section of this document.

The remainder of this pack will help you to think through these and other questions.

Why not?

This is a genuine question. It is valuable to consider the disadvantages as well as the advantages as this will help you to make better-informed decisions about the right time, places and ways for you to get involved. Here are some examples of topics to consider:

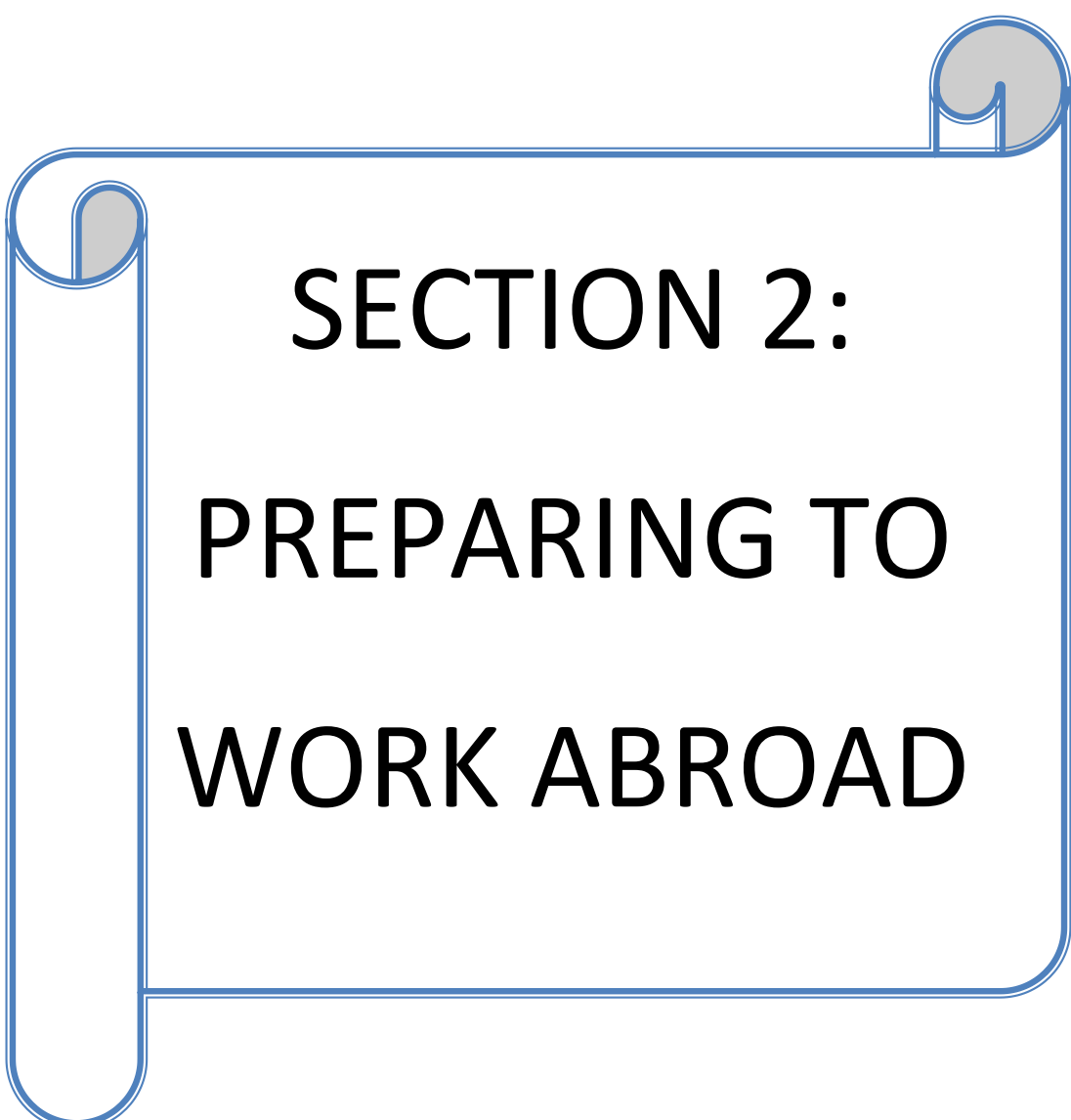
- **Personal matters:** for example, will your personal relationships be put under excessive strain?
- **Security and Safety:** Do you think you personally could fit in with the local culture and environment? Also check the foreign office travel advice if you are unsure of the current situation in the country you intend to visit
- **Clinical experience:** Are your clinical skills sufficiently well developed at home for you to manage the additional challenges of working in a low-income context?
- **Relevant skills to support local priorities:** Can you offer something that is genuinely wanted and needed in the country you intend to visit? Are you sure this cannot be provided by someone more local than you? Remember, we should aim to enhance local care. We do not want to undermine it, overburden it, distract it from more urgent priorities, or make it dependent on us.
- **How well has the project been set up?** For example, have clear and realistic goals been agreed with the host organisation?

Please also remember that you do not have to travel to participate. There are a lot of projects within the UK working with disadvantaged groups, refugees or asylum seekers. You can also contribute by getting involved with ADAPT, CTI or OT Frontiers.



Key Points:

- **Ensure you have the right clinical competencies**
- **Talk to ethnic communities in UK**
- **Research properly.**



SECTION 2:

PREPARING TO

WORK ABROAD

PROFESSIONAL CONSIDERATIONS

Above all else, you must research your host country thoroughly before setting off so that you are able to safely practice your profession sensitively and effectively.

Personal expectations may be high when anticipating a trip abroad either for a short or long duration but what you can do may be over-estimated. Local needs may be very different from what you expect and therefore not all forward preparation may be successful. While professional knowledge is a valuable asset, the most important mind set is to be flexible and adaptable to local needs.

Don't jump straight in. Allow yourself plenty of time to learn about the country and the people you plan to work with. Many health and educational services in less-resourced or remote regions follow a Western model but this may actually be inadequate or inappropriate in local contexts. Try to focus on mutual learning and participation with your local colleagues where appropriate rather than attempt assessment of needs and interventions based on external models.

The following points will help you focus on some basics in your preparation:

Local structures

- **Talk to previous visitors** to gain information on the local area, previously identified needs, previous work carried out locally, resources available, and how things work. Members of ADAPT, CTI and OT Frontiers might be able to help you with this.
- Contact the national professional OT/PT/SLT association if there is one and become a member.
- **Find out who requested the post you are going to and why.** What do they imagine you will be doing, and what do they want the outcome to be?

- **Read up on the country's health policies, its health needs and priorities and its wider development strategy.** What are the recommendations of international bodies (e.g. WHO, UNICEF) for your clinical area/profession?
- **Learn about the country's healthcare and education systems and structures.** How well established are they? Where are the provisions? Who runs them? Who accesses them? Who does not access them? Does your profession exist? How is it viewed by others? What other professions exist locally and how does that affect your work? E.g. are there generic roles such as rehabilitation worker? It is important to understand how disability services are structured locally under ministry of health or social welfare, such as community based rehabilitation
- **Find out about the local services,** existing relationships between them (e.g. joint training/campaigning initiatives/referral pathways) and any useful contacts both within and outside the organisation you will be working with. This will enable you to take a broader approach and a number of differing ideas may emerge. This may lead to cross organisational links and facilitate referrals where appropriate and thereby strengthening existing local networks. .
- **Find out about professional requirements locally.** This will give you an initial idea of the standards you might expect. Which professions have protected title? What are the training, licensing and monitoring requirements if any? This varies enormously from one setting to another and between disciplines within the same country, so it's important to make no assumptions. You could find yourself working with individuals who are more highly qualified than you are, a teacher who did not complete secondary school, a social worker who is fully qualified after training for 3 months, or someone with the same job title as you but no formal training. Are there different levels of training within the same profession (e.g. diploma and degree holders)? Is there elitism and hierarchy? Often local people who do not have qualifications are, by virtue of experience, highly competent rehabilitation practitioners.
- **Be advised by local colleagues,** qualified and unqualified, about how to operate in this working environment which is unfamiliar to you. Get advice from local staff about:

- who to approach for what.
- what past overseas volunteers have done,
- what barriers to expect, e.g. the impossibility of travelling around Eid festivals
- beliefs about disability etc.
- previous experience of volunteers;
- etiquette and procedures, for example around referrals between services/consulting colleagues/working across different organisations;
- **Gain information about the people you will be working with**, with regard to their professional background and/or level of experience in your field. This will enable you to plan an appropriate level of training if that is what you are there to provide, or appropriate levels of collaboration and discussion if you are there to help with service provision
- **Try to gain some understanding of your organisation** – the internal structures and hierarchies; knowing this in advance will make your work easier. If you start to learn about this on arrival, don't be too quick to judge what you hear, see and are told. Sometimes the real situation takes a while to emerge!
- **Be sensitive to local hierarchies:** these can be very important and they may be different from the ones you are familiar with at home.
- **How are 'volunteers' regarded locally?** The idea of a "volunteer" is not easily understood everywhere and the experience of volunteers is not always a happy one. Here are some illustrative and cautionary quotations about volunteers from members of South African communities:

- **"It's OK if they want to come, but I don't know why they are here."**
- **"They are building buildings while our children are dying."**
- **"They are here to help us? I thought they were here to learn."**
- **"Yes, we want them to come again ... but because they bring money!"**

Cited by Erik Nelson in *Listening to Community Voices in International Service*, available at <http://globalsl.org/2014/01/27/listening-community-voices-isl/>

- **Be sensitive to the impact of your presence as an external visitor.** Western presence may increase credibility of local services but will that remain when you leave? Equally, your presence may create tensions. Alternatively, being a “naïve” outsider may allow you to effect change that a local person would not have the confidence to approach – but try to consider any negative effects this may have
- **Identify your client group** as much as possible before setting off and skill up in any unfamiliar skill/knowledge area. For example, it might be useful to be aware of the incidence of common diseases. However be prepared to check out and revise on arrival.
- **Find out which languages and dialects are spoken** in the area around your project and which is the language used in education. An informative site is www.languagesgulper.com as it has detailed descriptions of the main languages of the world.

N.B. If no specific job is available, then part time volunteering is a good way to start as in addition to helping the community you can gain insight into local infrastructures, local parenting, cultural and language issues and identify potential needs on an ongoing basis.

Networking within ex-pat communities especially if they are small is invaluable as often it generates information on representatives of NGOs and specific health related charities/groups. Embassies often have funds available for projects which may be related to disability but checks need to be made on individual aims so that applications /proposals can be written with these in mind. Face to face meeting/personal introduction to ambassadorial staff members before making a proposal/application for funds will also help.

Embassies often also have an overview of the education and health systems of countries which is very useful if information is not centralised. One key question about education is to discover whether ‘critical thinking is encouraged’. If not, this has implications and repercussions for both the local community. It is important to be aware of this from a cultural perspective. E.g. was it ever encouraged and if so when did it stop?

Resources, assessment tools and intervention methods

Importing materials from home may be of limited value in your new environment.. Assessment tools may be invalid or irrelevant, and therapeutic materials may not be meaningful to your clients. Furthermore, how sustainable can your contribution be if it relies on imported resources?

Take any basic literature that can be of practical rather than academic use.

There are many resources that may be useful to you – please look in the Resource Section for further information.

Take teaching materials with you that you might use to deliver participatory training

Learn about new approaches, e.g. CBR, Participatory Rural Appraisal

Don't take too much assessment/treatment material. Try to use local objects/toys in the market or local shops. If you have access to funding think of using it to commission local artisans to make equipment or toys to your specifications.

You could take some assessment materials as examples from which to develop locally and culturally appropriate versions.

Find out about the local level of literacy and drawing style: what is the literacy rate and what style of drawings are people used to? This will help you design your materials. It is always better to get a local person to draw pictures than to draw them yourself.

Take a laptop to store and adapt materials as you go (if access to power).

Find out from local people about child rearing customs, social roles, and views on disability to inform your assessment and intervention methods. Look at approaches to play and adult/child interaction styles before embarking on a play based programme. Find out which stages of development or social competencies are particularly noted in this society and will therefore be points of concern for parents, teachers, medical staff or clients.

Small wind-up torch for looking in mouths (especially for SLTs) and a head torch for personal use.

Supervision/CPD

Just as at home, you will need arrangements for supervision, mentoring and CPD. If direct supervision is not available, try to find someone from home who has experience in the country you are working in. These may take different forms from those you are familiar with at home but they are just as important to ensure you continue to work to a high standard and also to help you to look after yourself:

- How will you deliver **evidence-based practice** if the research to date has examined very different populations/contexts for care?
- You may come across **clinical conditions** that do not exist at home
- How will you ensure you continue to develop **relevant skills** at a high standard?
- You may encounter many **ethical dilemmas** - how will you manage these?
- You will hopefully have many positive experiences but you may also experience some things you find **personally or professionally distressing**. How will you manage these?
- **Supervision** can take a range of forms. Depending on your level of experience and clinical area of work you could consider:
 - Skype
 - Email
 - Other instant messaging
 - Phone (from many countries it is relatively cheap to phone the UK)
 - Peer supervision.
 - Supervision by someone from a different profession
 - In any case, try to avoid working in isolation if possible
 - Try contacting CTI/Adapt/OT Frontiers if you need to find someone who can supervise from home. Both ADAPT and OT Frontiers run a Buddy system to provide support for therapists in the field.
 - For internet or telephone supervision you will need to ensure before you travel that adequate facilities exist. Internet connections are extremely problematic in some areas.
- It may seem obvious but ensure before you travel that you and your supervisor/mentor are both fluent in a shared language.

- If it's your first trip, one important aspect of CPD will probably be developing an understanding of the local context and your role within it. This can be formal and informal. Start before you go, and continue to learn throughout your stay. You can continue your learning when you return to prepare you for future visits! Keep a record,

reflect on it, reflect on the results and likely impact of what you do, and use this to identify what else you need to know.

Other useful CPD may include:

- Keeping up to date with **debates in the area of international development, and with local and regional development issues and initiatives**. It's highly valuable to look at discussions that go beyond your own profession.
- The World Health Organisation and UNICEF have useful websites as a starting point.
- Reading research papers relating to **other low-income countries**
- Attending **local training/conferences**, including those that may be delivered by/targeted towards disciplines other than your own. This can be extremely valuable: you may learn about the topic but you can also learn about the levels of existing knowledge/provision and also about local training styles.
- Ask any **previous visitors** for information before you go and for advice on specific topics you need to explore.
- Ensure you know about CPD and practice requirements to retain your professional body and HCPC registration

PERSONAL CONSIDERATIONS

Planning your trip

Take time to research the country you are visiting – consider:

- Cultural issues – especially religion and issues around sexuality.
- Customs - especially for greeting and eating
- Appropriate dress for work and socialising
- Environment in which you will be living – rural /urban

- Climate – different seasons
- National holidays and meaning of the celebration / religious or political context
- Basic local language, especially greetings
- Security and health. The place to go for reliable security information is the **Foreign and Commonwealth Office** (FCO) (e.g. whether the country or district is a safe destination); it also has information on health and entry requirements to most destinations. Be aware that security situations can change at short notice. <https://www.gov.uk/foreign-travel-advice> Sending and host organisations may not be very aware of the security implications for foreigners.
- If you are going for several months or more than a year you may wish to arrange to pay voluntary National Insurance contributions in order to maintain the value of your state pension. <https://www.gov.uk/voluntary-national-insurance-contributions/who-can-pay-voluntary-contributions>
- If you are going to be away for some time and you are not on ‘pay as you earn’ tax, you will need to make arrangements to ensure that your tax returns can be submitted.
- The WHO fact sheet on the top ten causes of death in the world is also useful to review to be more aware of the health status of the people in the area where you may be working - <http://www.who.int/mediacentre/factsheets/fs310/en/index2.html>

Your Survival Guide to Safe and Healthy Travel

“Travel is fatal to prejudice, bigotry and narrow mindedness”

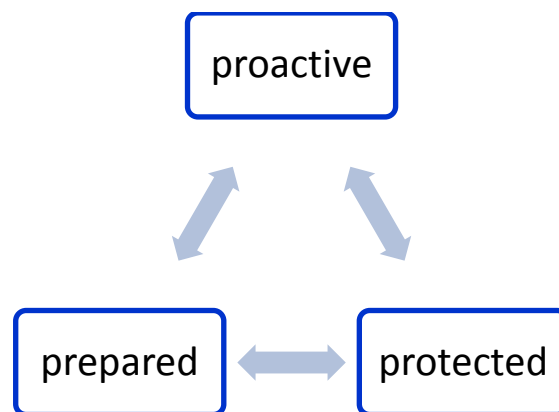
Mark Twain

There are many documents and books to guide you in preparing for your planned trip abroad – this is a summary of some key points, which are based on different professionals’ experiences abroad – every person will have different experiences, of course, but look through this to see if it helps you in your planning or advise to others.

Key issues – the 3 P’s – being Prepared, Protected and Proactive!!!

Being prepared – focuses on your health—and the health of others—while you are planning to travel and working abroad. Be sure you have up to date information on Vaccinations, Medication, Contract, Insurance, and Passport

Being protected and proactive – focuses on your health—and the health of others—while you are travelling and working abroad. **The 3Ps:**



Check out information on up to date disease outbreaks and trends in your area of travel, plus other problems (violence, unrest etc.)

Look at the global prevalence of certain diseases and link with the area you are going to work in. Think about your Personal Safety and be clear on safety and security issues when working as a humanitarian worker.

As soon as you arrive, or before you go, identify what doctor and dentist you will go to and what their hours are before you need them because if you are ill you may not be able to look around to find one. A good place to find out about safe dentists and doctors is the local Embassy or High Commission, or else ask local European expatriates what doctors and dentists they go to. Remember that when you visit a doctor or dentist you may have to pay at each visit.

Ensure that you have detailed plans for any serious/medical emergencies. Also, give your friends and family at home, contact numbers of at least two people you will be working with and vice versa.

Vaccinations

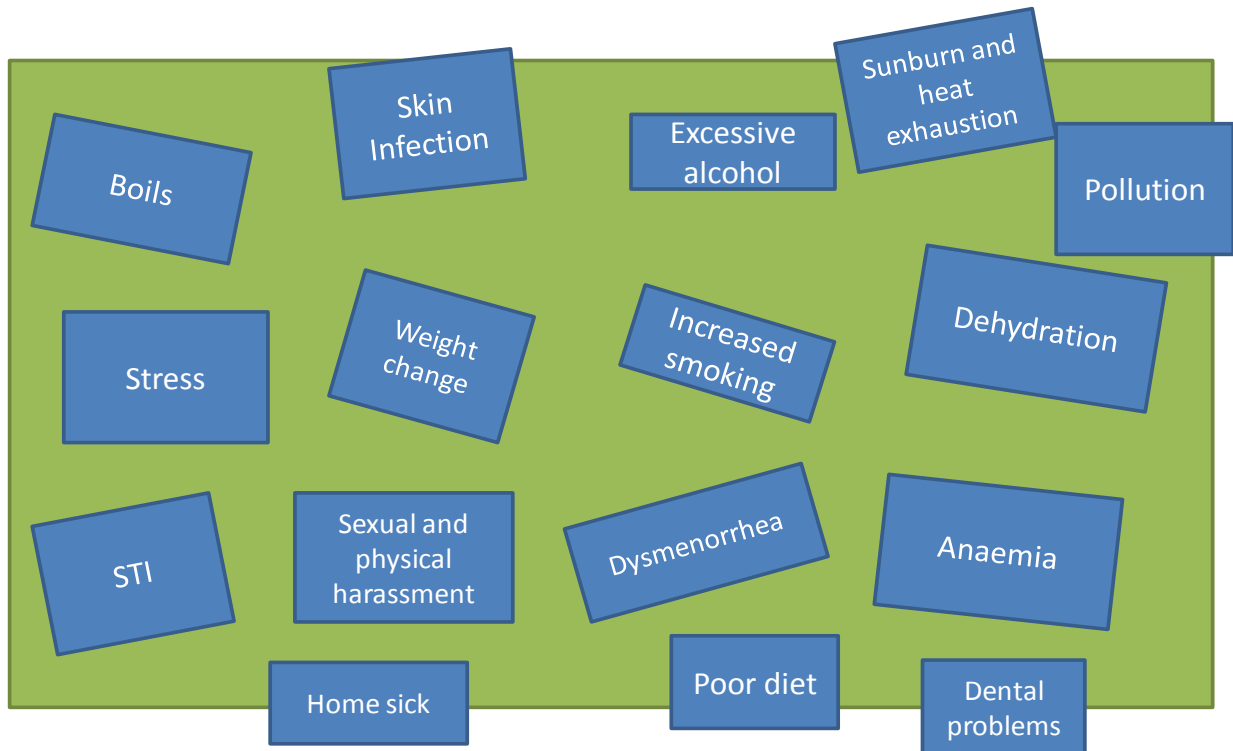
Get advice from your GP re vaccinations

- GPs advise on vaccinations for trips to specific regions/geographical location and can sometimes provide the vaccinations. If the vaccination is not available at your GP, advise to contact a private health clinic in your area.
- Important to be thinking about this well in advance as vaccination regimes may take many weeks, e.g. typhoid vaccinations were in short supply in the UK in 2012-13
- Check out **NaTHNaC** – special site for health professionals <http://www.nathnac.org> - to find out what vaccinations you might need
- Here are 2 other useful sites:
CDC <http://wwwnc.cdc.gov/travel/page/traveler-information-center>
WHO <http://apps.who.int/ithmap/> - this interactive map is very useful and informative
- Take a copy of your vaccination booklet with you and Yellow Fever Certificate if travelling in the affected area or travelling from one area to another.
- Some countries allow you to take small packs of sterile needles which may be needed in an emergency.

Top 10 communicable diseases to be aware of and protect you from them

- Diarrhoea,
- Typhoid fever,
- Hepatitis A and B,
- Malaria,
- Cholera,
- Tetanus,
- Meningococcal Diseases/ meningitis,
- Tuberculosis,
- Japanese Encephalitis
- Rabies
- Polio

Other risks of travelling



Often the other risks of working abroad come from your changing lifestyle and living conditions – it is easy to fall into bad habits and not realise that you are getting tired. Try planning a daily routine which includes keeping fit, finding ways to relax and put things in perspective is important, as often you get too involved in the work and forget about yourself.

Medication

- Consult your GP or local pharmacist
- Take enough medication for the time away
- Make sure you get a dental check before you go
- Inform your organisation of your medical issues
- Find out if your medication is available in country
- Check <http://www.nathnac.org> for advice about anti-malarial etc.

- Medicines sold locally may be out-of-date or ineffective because of not having been stored properly. Get your medicines from a reliable source, such as a GP who works for a western High Commission.

Contact and travel arrangements

- Be proactive to make sure you have all your documentation in time
- Sign your contract before you go
- Get your air tickets in time and check them
- Know where you are going and who to meet when you arrive at your destination
- Know where you are living and basic living conditions
- Pack for the climate you are going to live in or find out if you can buy things in the area.
- Know your luggage allowance for each part of your journey (e.g. to African countries it may be double or treble the usual, plus hand luggage. On the other hand, if you are using a local or regional carrier for part of your trip the allowance for that provider may be very low)
- Take cash for taxi fares or excess baggage costs US \$ are usually best in most countries).
- Make sure you know how emergency money can be sent to you if needed.
- Take some gifts for your new colleagues
- Extended family is very important in many African and Asian societies, your new colleagues may appreciate very much seeing photos of your family.
- Register with your local embassy. For information, check the Foreign & Commonwealth Office (FCO) website <https://www.gov.uk/foreign-travel-advice>
-

Insurance Cover

You need to consider:

- Travel insurance (such as flights, luggage and your health when overseas).
- Professional liability insurance

- Check who has to pay for the insurance cover if going with an organisation. Be aware that if going to a country against the travel advice of the FCO, normal travel insurance may not be valid.
- Organise to cover full travel and medical cover, including medi-vac.
- Make sure it is for the correct time period
- Keep copies of the insurance policy with you and leave a copy with someone in your home base
- Keep receipts of any expenses incurred in the field – e.g. for X ray, scan , medication

Passport, Visa & Work Permit

- Make sure your passport is valid before leaving. It should be valid for travel for 6 months after planned return date? Also make sure you have many free pages empty to put stamps for travelling
- Check if you need a visa before leaving UK – if so it can take several weeks, sometimes months to get one so plan ahead. Also check what type of visa you need, as there are often different categories (tourist, business, etc). The UK's Foreign Office website is a good starting point for information – see: www.gov.uk/foreign-travel-advice
- For some countries you will also require a work permit – again, ensure you allow plenty of time to research this and the procedures for obtaining one.
- If you need to go to the police to register on arrival , keep the registration document for departure
- Have 6-8 passport photos of yourself in case needed
- Have letter of invitation and address of your organisation or contact at hand for border control
- Have a pen at hand to fill in papers
- Have correct money for your visa if needed
- Try to keep your passport in a safe place during your stay and put a copy in another place

Common Sense – some tips

- Boil it, bottle it, purify it, peel it, cook it or forget it!
- Take packets of oral hydration tablets. Practice good hand hygiene at all times where ever you work
- Avoid motorbikes and wear a seat belt in a car/truck
- Avoid excessive alcohol and illegal drugs

- Be aware of crime hot spots

Prevention is better than Cure – avoiding bites and stings!

- Long sleeves and trousers, especially at dusk and dawn
- Insect repellent
- Use mosquito nets in endemic regions. Many mosquito nets in hotels or hostels have holes in them; take some tape to cover the holes! Tuck the bottom of the mosquito net underneath the mattress once you are in bed.
- If in rural areas eradicate standing stagnant water
- Use prophylaxis when advised – but be aware it only suppresses symptoms does not prevent infection

Personal Safety – mostly common sense...

- Tell/text someone where you are going/what are you going to do
- Leave non-essential valuables at home – travel light
- Avoid carrying bags at night and being alone
- Make copies of all important documents and store on USB
- Don't take photographs of sensitive buildings/areas
- Avoid public demonstrations and walk away from fights
- Learn your way around or try to look like you know your way around!
- Get recognised by locals to build up safety network

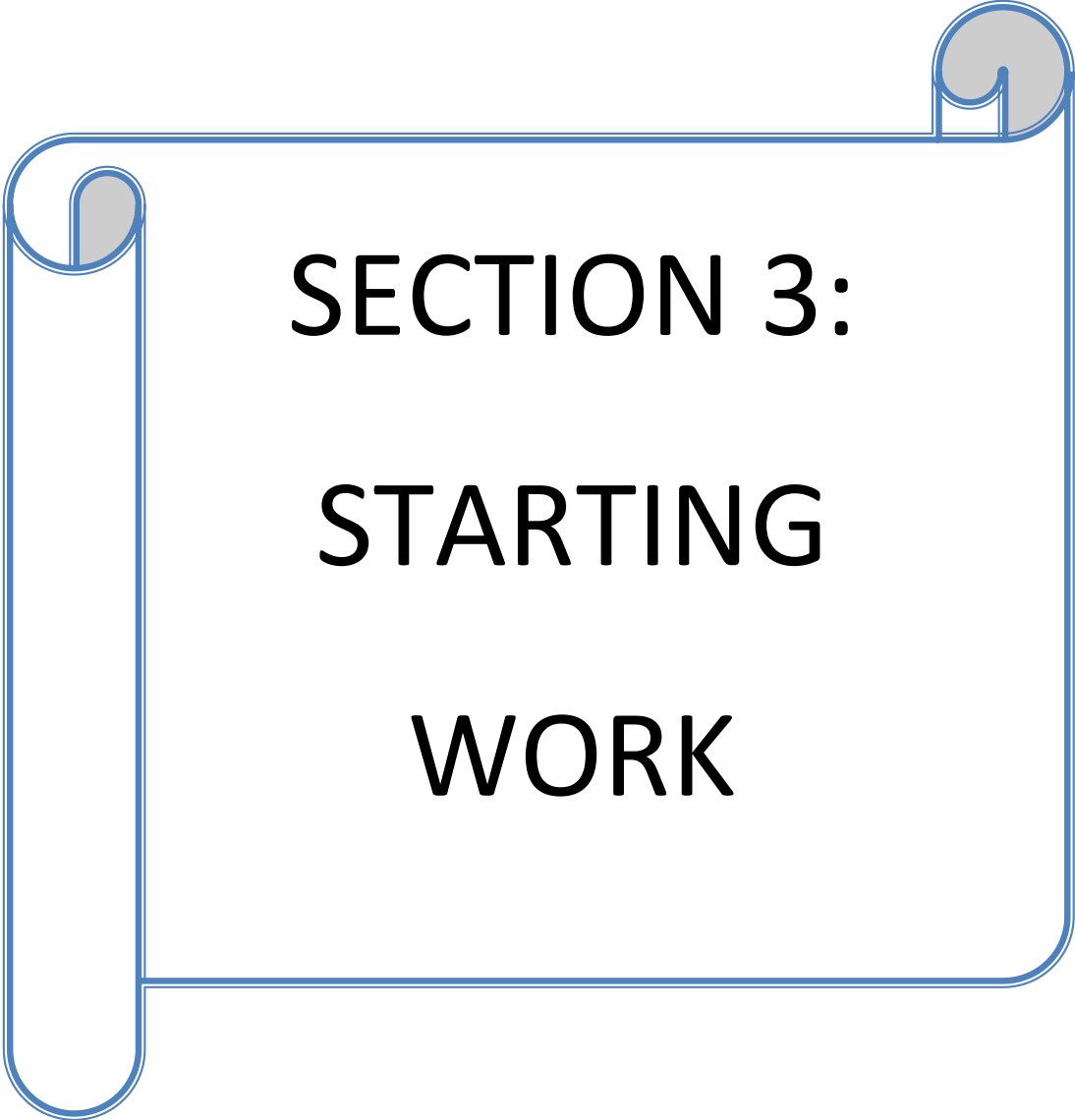
Remember that it doesn't matter how long you have lived somewhere and how you dress, you are always a foreigner and a visitor in this area/country – respect that!





Key Points:

- **Gain as much information as possible about the local structures including the services and the healthcare systems.**
- **Gain an understanding of cultural issues.**
- **Talk to people who has visited the area before.**
- **Consider the resources you might need**
- **Arrange for some form of supervision whilst abroad**
- **Don't forget to consider your own health and safety**
- **Don't forget professional and personal**



**SECTION 3:
STARTING
WORK**

REST (if you can), ACCLIMATISE and take stock before you start!

Accommodation

- Make your accommodation your 'home' while respecting the local culture and customs

Getting to know your new environment

- Arrange a guided tour of your local area
- Accept invitations from local people to have dinner, go on an outing – might feel like hard work at first but will definitely help with the process of fitting in, learning the language and making friends
- Watch and listen e.g. learning people's names

Local telephone with emergency numbers

- It will probably be cheapest for you to buy a local mobile sim card and a Pay As You Go contract. Your sim may need to be registered with the police and you may need to return it before you leave the country.
- Always carry a list of essential contacts and their phone numbers, such as the contacts at your organisation and local emergency numbers

Be discreet with personal possessions

- Be discreet with expensive possessions. Be considerate when using your camera, laptop, iPod etc.as not everyone is able to afford such items. In fact lock away possessions if at all possible. One hostel manager said "Don't tempt our girls" However, taking photos provides one of the opportunities for giving back. Our colleagues, clients and their families may really appreciate having copies of photos.

ALWAYS GET CONSENT BEFORE TAKING ANY PHOTOS.

Look after yourself

- Look after your physical and mental health; seek help earlier rather than later.
- Treat yourself to luxuries sometimes – but be discreet about doing things that cost a lot in a poor country.
- Be a smart traveller with a heightened awareness about security risks
- Once In-country read the local daily papers. This will help you understand your context and especially the security situation.

- Very early on visit your local Embassy or High Commission if possible. Make sure you know where they are and how to contact them and that they know who you are, where you are and how to contact you. Let them know when you leave (or will be away for extended periods). They are there for you to go to in an emergency. They also have a duty to look after you if a security situation arises, which can happen very quickly.

Encountering challenging financial issues

Need to consider

- Do patients and relatives pay for care, food and hospital accommodation in public and private settings and how much?
- Is there a culture or expectation of 'money changing hands'? This may occur when seeking permission to run projects for example. The British Government strongly advises against this practice.

Care and local information when recommending equipment or tests e.g. hearing test, wheelchair, such as:

- Are there adequate testing facilities available?
- Do families have to pay and how much?
- Is the family able to pay and how to discuss this with them?
- Do you have good local support to address these issues?
- What do solutions cost? E.g. Cochlear implants may cost US\$ 20, 000
- What is the availability of appropriate post- operative support?
- How will equipment be maintained? Who will pay for this? An example may be a donated hearing aid which becomes useless when the batteries cannot be replaced because of the cost to the family.

Expectations

- Pace yourself and be realistic about how much you can achieve.
- Be aware of cultural and communication issues e.g. passive audience/ lack of feedback
- Be positive about speaking and learning the language, it all takes time
- Find a mentor who will help and advise you about cultural, work and personal issues

- Keep positive and be patient – it can be very hard to appreciate why things are done a certain way but it is important to reserve judgment and remember that you are a visitor.
- You will have dilemmas to resolve but remember your professional standards and ethics.

For example, if you use photographs/videos of clients ensure you have their *informed* consent for the way you use the material. Similarly, if you take your own photographs/videos of clients/colleagues ensure you have their informed consent for the intended use of the material. You would do this at home and it is no less important when you are working abroad. “Informed consent” will require you to explain the way you intend to use the material and what for – e.g. in a local information leaflet / on a website to promote an activity or organisation / to train people locally / as evidence of your work to the funder / for future fundraising. You will need to be confident that your subjects understand this and understand any disadvantages as well as advantages.

- Have fun! Make sure you plan some time to take a break and travel while you’re there.
- Enjoy life! You are so lucky to be a wanted visitor with skills that are needed in another country.

Additional considerations:

Sustainability of role

Cultural Awareness

Your attitude and approach

Child Protection

Transferring skills through training

Working in a Multi-Disciplinary Team

Developing a Service Model

Sustainability of Role

To make your trip both useful and enjoyable you will want to feel that what you are doing is worthwhile. It is also important to think about how the work that you carry out will continue after you have left. (See also: transferring of skills through training)

See below a suggested form for AHPs to record achievements, innovations, challenges so when a volunteer leaves a placement, there is a record (for future volunteers) things have already been tried so that the wheel is not always being reinvented. This form has been used in India and has proved helpful.

Summary of Volunteer Input	
Name of Volunteer:	
Date of volunteering:	
Type of mission: (PT, OT, SALT.):	
<u>Objective of your mission:</u>	
<u>Of your input into the programme, what do you think worked?</u>	
<u>Why?</u>	
<u>What did not really work?</u>	
<u>Why?</u>	
<u>What helped?</u>	
<u>Limiting factors/problems?</u>	
<u>Resources left?</u>	
<u>Suggestions for the future</u>	
<u>Date:</u>	

Cultural Awareness and Safety

When planning to work outside of the UK, some of the most frequently asked questions relate to understanding the context of a new working environment as well as accepting different ways and methods of working.

It is important to be prepared but in reality, you only begin to understand what it is like to be in a different environment and culture when you are there. When working outside of your cultural framework it is interesting to look at things through different eyes and this provides for a stimulating and challenging experience. The more aware we are of the cultural context we live and work in, the more meaningful our work is.

Often the first barrier to cross is to put aside opinions and misconceptions based on our own life experiences. Keeping an open mind helps but this must not compromise the professional status or standards of the work, which sometimes come as difficult issues to resolve.

Culture can be defined as:

'The shared sets of values, attitudes, beliefs, and behaviours that help to define us as individuals and that refer to the shared attributes of one group. Comprises of all the things we learn as part of growing up including:

- Language
- Religion
- Traditions

Being **culturally competent** implies having the skills and capacity to work effectively with culturally diverse clients.

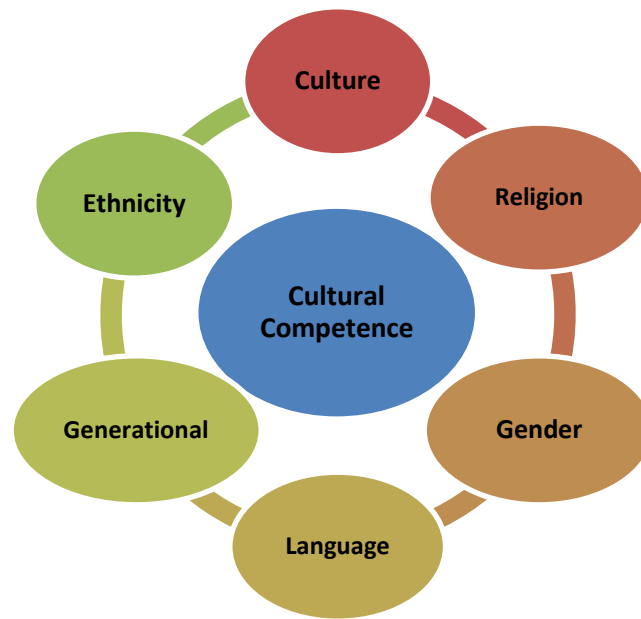


Diagram to show topics related to building cultural competency

If we look at working in the field of rehabilitation and disability in different locations, whether urban or rural, developed or developing, whether low, middle or upper income levels, our starting point is to observe and make an assessment of the environment we are working in.

Some challenges:

- Working in areas where the local community is suspicious of you and the work you do
- Working in isolated areas, without close support or a mentor
- Working in areas with limited understanding of rehabilitation
- Working where there has never been a physiotherapist, occupational therapist or speech and language therapist
- Working with therapists from a different training or cultural background. A number of expatriate therapists find themselves working alongside therapists of their own profession who have trained in other countries. Significant clinical tensions sometimes arise and are not resolved by sincere efforts at resolution and good clinical reasoning. It is important to be aware that there may be differences in the underlying science and evidence taught in various countries.

- Working where you have to make all your equipment with local materials
- Working where few people understand your language
- Working with interpreters. Does the interpreter understand technical terms/introduction to a new concept? Does he/she translate what you say or what he/she finds acceptable to translate?

Many issues faced in working and living abroad are the same as those found by people working in the UK.

Physiotherapy - The CSP has useful resource packs on working in the UK, parts of which can be applied for working overseas. The CSP Managing performance issues website on <http://www.csp.org.uk/documents/managing-performance-issues-cultural-competence> shares points relevant to any cultural context and can be applied overseas.

WCPT 60th anniversary publication is now available on <http://www.wcpt.org/publications>. It is an interesting report in this context as shows background of the evolution of the physiotherapy profession abroad and gives a professional perspective to the on-going work this 'field'. There are a lot of professionals who provide support for fellow colleagues throughout the world to help them with their problems.

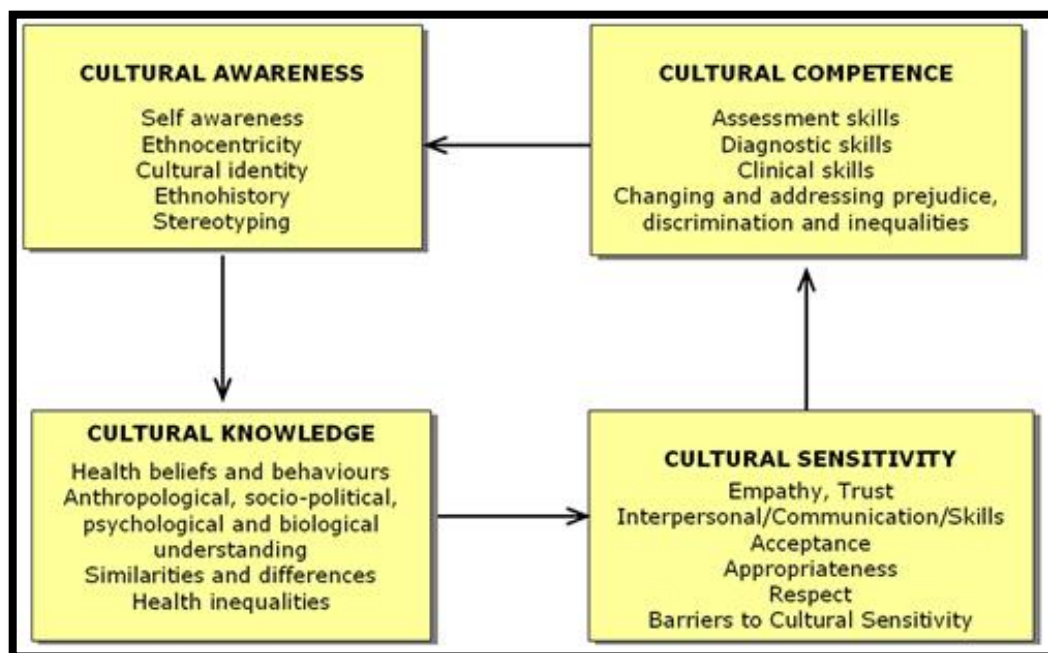
Ethnicity and Disability Fact Book has some useful sections to look through on <http://www.mdaa.org.au/publications/ethnicity/information.html>. This document looks at some particularly relevant issues, such as the role of culture, religion and disability, with references to superstition, informal and formal belief systems and looks at the cultural dilemmas of stereotyping and labelling and misconceptions on disability, which affect the way to work in different settings.

Our culture shapes how we see the world and make sense of it. Culture influences all of our behaviours and interactions. Our culture also mediates how we make sense of disability and respond to people with disability.'

‘Culture is not static - it is constantly changing and responding to shifting environments and circumstances. Within each culture there are many subcultures, which means that beliefs, values, attitudes and behaviours are often not fully shared amongst all the people from a culture.’

Papadopoulos, Tilki and Taylor cultural competence model is well used in training nurses and breaks down cultural competence into 4 sections:

See this link: www.ieneproject.eu/download/Outputs/intercultural%20model.pdf



This model highlights that cultural competency comes, evolves and changes over time – it is an ongoing process.

More on Papadopoulos’s model: http://www.ieneproject.eu/learning_intro.php

So to summarise:

- Cultural proficiency comes from being culturally aware.
- Cultural competency looks not only at culture, but ethnicity, religion, gender, language, impairment and generational issues
-



- Critical awareness relies on knowledge , skills development and organisational support
- Basic skills needed – respect, communication, understanding and engagement
- Developing cultural competence requires: an open attitude, self-awareness and awareness of others, cultural knowledge and cross cultural skills and to be able to adapt in any context.

Cross cultural communication

Another important issue, to consider building up a better understanding of the cultural context, is the methods of communicating. The list below may be of interest to help build up a repertoire of communication skills. Often you are working through an interpreter, so communication has to be direct, to the point and structured to make sure that you get the main points across and likewise the main points are translated back to you.

- Ask questions and listen to the answers – obvious but often it does not happen!
- Distinguish perspectives – are you looking through the same window!
- Build self-awareness – be comfortable with what skills you want to offer and how you want to deliver them

- Recognise the dynamics of the place you are based – other issues come into play in the planning of your work – low staff motivation and salary, a community that is suspicious of you, poor transport for people, poverty of families, endemic bribery and corruption in many countries etc.
- Beware of stereotyping people – e.g:
 - ‘All therapists from ‘Brumbak’ have no experience’*
 - ‘Most families have no interest in their children’*
 - ‘Most of the injured are too lazy to follow their rehabilitation programme’*
- Respect differences – e.g. therapists may have done the same treatment for years and when you introduce something new, there may be a conflict of ideas; there needs to be a compromise and not a denouncing of the way they worked previously.
- Try to be honest – give praise when it is due – not all the time
- Be flexible – the patients do not come for their appointment but all come at the same time – work around this as maybe they have walked for 3 hours to see you
- Think twice – be prepared for the unexpected as it often happens, so useful to have a plan B and C

Cultural safety

It is important to practice in a culturally safe way. The aim of treatment is that patient’s feel “culturally safe” that is they feel that their engagement with therapy will be consistent with their practices, rather than those of the therapist.

An approach for minimising misunderstandings.

“Cultural assessment” is an approach which should help a therapist understand

- a. how the patient perceives their illness / disability and
- b. what their expectations of therapy are

The following questions can be used to help gain a deeper understanding of their views and expectations:

- What is the problem/condition?

- What caused the problem/condition?
- What course do they expect it to take?
- What are the expected consequences?
- How do they expect it can be addressed through healthcare and what outcomes are they hoping for?

A mutually acceptable treatment plan if the therapist and patient have different views.

Having listened to the patient's perceptions the therapist can outline his/her perceptions and expectations for the patient. Then a plan which makes sense to both the patient and the therapist can be agreed. This may involve a degree of accommodation on the parts of both the patient and the therapist.

Our overseas host colleagues are probably our best cultural mentors and brokers.

They will be able to explain the local culture to you. They are also able to explain to patients how rehabilitation therapies work.

Approaches to help us make sense of our confusion or feelings of conflict.

You are likely to encounter incidents or situations which you either struggle to make sense of or which seem to you to be simply "wrong". The natural reaction may be to regard the incident / practice as wrong and work to correct it. Changing an approach may sometimes be the appropriate response.

A considered response is preferable to an unconsidered reaction. It is important to be aware your own cultural biases including the values and the assumptions that you bring to the situation. By changing your perspective to the local context you may then see that the situation makes sense in context and that it is we who need to adjust, or having given the situation consideration, we may still feel that this is something which needs to be changed. At least if we then opt for the change scenario it is a considered response, rather than an unconsidered reaction.

Reflective logs are an ideal way of approaching these disorientating situations.

Your attitude and approach.

- Wherever you go you will be working alongside local colleagues who are more knowledgeable than you are about the local situation. Take advantage of this and learn from them.
- Find out who has been doing the jobs relevant to your work. Be careful not to undermine them by stepping in and taking over. Your job is to support them and help them and their colleagues / bosses to value the skills they have, as well as to help develop them further.
- Try and learn some of the local language. No one will expect you to be perfect. But they will appreciate you making an effort.
- Be prepared to broaden your focus beyond your professional role and understanding of disability and health issues. You may have to take on different roles and tasks that you had not anticipated. Although it could be daunting at first, it will enrich your experience.
- Being flexible in your approach will help you to be accepted and work more effectively as a team member.
- Be sensitive to disparities in income and opportunities between you and co-workers, families, etc.
- Be prepared to say 'I don't know'. Don't feel you have to be an expert all the time. But show that you can think on the job and try to find out the answer or try out possible solutions!
- Remember to seek advice from your colleagues.
- Try to find someone you can be honest with and who will be honest with you.
- For most people, you will take away more than you leave behind.

Hopefully you will be working in a team, or at least with one other person. You will obviously have prepared yourself for the project. But it is important to remember the following.

- Take time to observe and find out. Don't jump in!
- Try to ascertain the needs of the project and the people involved
- Be prepared to modify your goals and activities and be flexible.

- Keep learning, keep listening and discussing. Remember you are in a partnership.
- Start where the organisation is and try to move forwards together;

Child and Vulnerable Adult Protection

Whilst Child protection may be at its infancy in many countries organisations such as UNICEF often lead in promoting policy changes at government level. The key questions are:

- Is child protection enshrined in law and how well are the laws implemented and monitored at the front line? Professionals should be prepared to encounter situations that can be very difficult and have no easy solution especially if Social work is in its infancy or non-existent.

Possible issues that may arise include:

- No regulation of health or education professionals in place.
- No foster or adoption systems in place
- Vulnerable adults or children living on the streets without protection
- Vulnerable adults being married as a solution to long term care where no welfare system exists
- Institutionalised care for children and/or adults with disabilities (possible associated attitudes of shame towards disability amongst local populations).
- Unhelpful or dangerous practices e.g. ‘local healers’;

Reporting any concerns can be problematic. It is vital to know who to report your concerns to from the outset of the project. Who is your line manager? Sometimes the foreign health professional can be seen as the ‘problem’ and asked to leave or be deported.

Finding local solutions and local relationship building is key.

Be prepared for situations which may be dealt with in a very different manner than you are used to and also not being able to do very much about them.

Whatever you do, document all your actions.

Transferring skills through training

From day one you should be thinking about what will happen when you leave. The project needs to be able to continue without you whether you are there for two weeks or two years.

Training as mentioned previously is only useful if the people you have trained can use it without you.

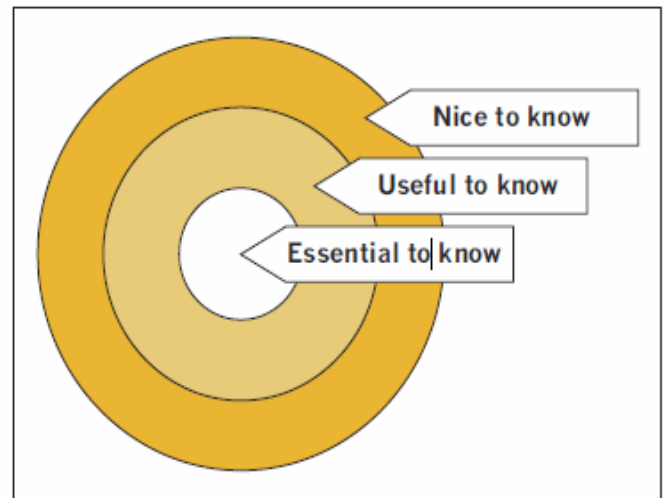
- Which people will you be passing on skills/knowledge to and how will they use their new skills and knowledge?
- What teaching and learning methods are they accustomed to, what do they feel comfortable with, and what works? There may be different answers to these questions! For example, didactic approaches in a formal training room may be customary, but they may not work. Informal workshops and group work may also feel threatening unless very tightly structured to some of the participants.
- If you deliver training, it usually is a good idea to provide certificates. They are valued by trainees and it enables you to clarify the specific topic and level of training and the competencies your learners have demonstrated. This can help to reduce confusion later.
- Be ready to transfer skills “on the job”. Demonstration and learning ‘in situ’ often gains the best results. Don’t worry about teaching in a “cook book” approach. In other words you may sometimes need to teach someone what to do in a practical way without too much of the detailed theory. Try to think of a local analogy for what you are suggesting.
- Always work with your colleagues to think about how they will actually implement any training. As an outsider it’s impossible to understand many of the barriers that prevent changes in practice.

Imagine a foreigner coming in to the NHS and trying to change things!

- Try to be aware when any change you suggest may go much deeper than you might at first think – e.g. asking people to give feedback in particular way might be counter to all their previous experiences and be very challenging. Ask local people how they usually do

this – is your way really any better for meeting their needs? If you are sure it is, allow time to provide the support needed to use it. Agreed ownership of any change is a key ingredient for any change to take place.

- Think carefully about the appropriateness of what you teach and transfer. Ask yourself, is it relevant to the local situation, and is it likely to be used when I have gone. The following diagram can be useful to help you remember this.



- It is very important that the methods, content and materials you use are culturally appropriate. E.g., some cultures may not be as familiar with using pictures, or toys.
- Be practical. It may not be possible to carry around a lot of equipment or to carry out formal assessments.
- Use local resources; develop resources with your co-workers
- Don't work in isolation. Talk about what you are doing and use every opportunity to transfer skills.
- Understand what local facilities and resources already exist and make sure they are being utilised; help people to access them and to lobby for improvement.
- Strengthen existing links and make new ones with other local organisations and individuals who will be useful to the project. If they do not exist already, set up networks between local groups.
- Don't promise to do things for the project after you have left that you don't think you will realistically be able to (e.g. very long term financial support), do the things you do promise – e.g. sending materials or information etc.
- Try to make sure that disability services are linked in with other types of services locally such as health and education and social services, employment and inclusion programmes.
- Be aware it may take time for a local colleague to give an honest answer as they may not wish to give offence or 'lose face'. Local colleagues may be reluctant to admit they have

not fulfilled certain tasks (e.g. taking a medical history) or that they do not fully understand what is required because of 'losing face'.

Working in a Multi-Disciplinary Team

In its usual guise multi-disciplinary working means working in a team with other professions bringing together of different skills, knowledge, opinions and practices to provide comprehensive and holistic care for the patients we work with.

The most familiar model of multi-disciplinary team (MDT) working is probably one where the team is made up of individual professions each with fairly well defined disciplinary boundaries and awareness of their own role within that team. However, the idea of multi-disciplinary working in low resourced settings takes on different dimensions compared to other settings, for example multi-disciplinary may go beyond the traditional disciplines and include community health workers, family members or traditional medicine practitioners. It is important to consider the role that these people may play in healthcare provision and how we can work effectively with them.

Being able to be clear about our scope of practice may be severely tested in low-resourced environments, potentially bringing up ethical questions about whether it's OK to go beyond our usual scope of practice in situations where your best may be better than nothing. There may also be issues of cultural understanding that impact on how the team operates, language issues, wealth differentials within the team, and it may be harder to define your role within that team in a different cultural context, and to know what is expected of you. Are you supposed to be the expert in the team, but where does that leave the knowledge and contributions of local staff – do they feel side-lined by your presence?

Make sure you have a united vision amongst your team and decisions are supported. Be aware of group dynamics especially when they may be culturally different from your own. As an example, in some cultures, younger colleagues may not be able to contribute their ideas when senior colleagues are present but can do so in a one to one situation. There may be gender disparities that are not apparent to begin with. Make sure everyone has a chance to contribute and feel part of the team.

Perhaps the other extreme of working in a low-resourced setting is the absence of a MDT, of being isolated from professional colleagues. Or perhaps the MDT is geographically spread and you have colleagues to call on via email or Skype – what are the challenges associated with this type of relationship and for your own practice?

The process of being part of an MDT anywhere brings challenges and lots of successes, but being part of an MDT in low-resourced settings produces different dynamics and new things to think about, and highlights the need to be reflective in our practice.

Learning the local language can greatly help team integration as you show you are trying to understand and be part of the local culture. It has been called the ‘hand of friendship’.

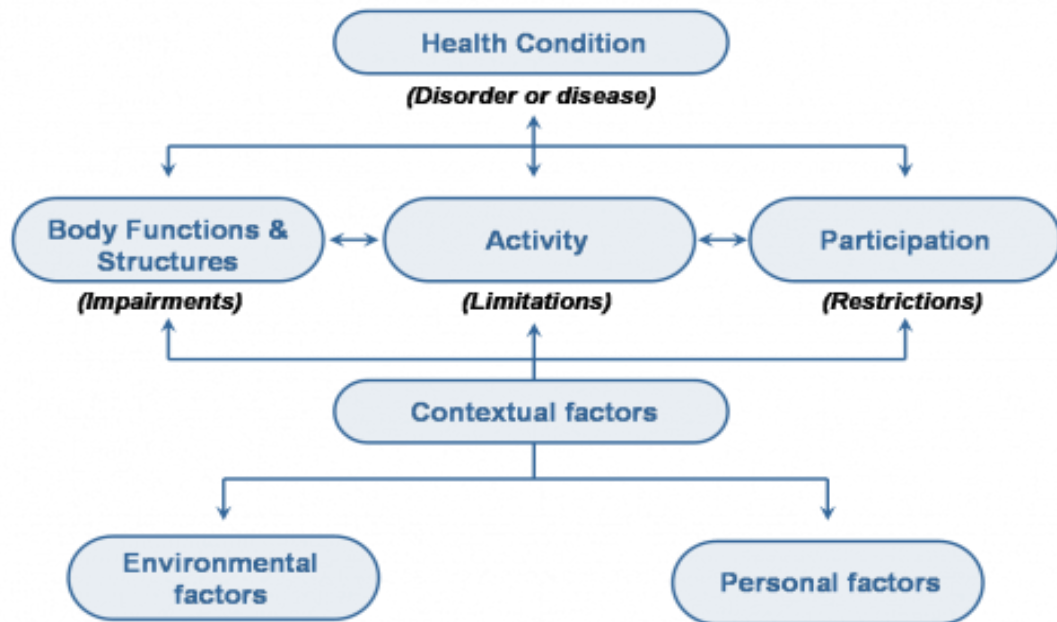
Choose your battles: what is important and what can you let go? Remember no project or situation is perfect. You may be in the MDT for a very short time, so think carefully how you can ‘make a difference’.

There is an excellent video on YouTube (35 mins) on working in a MDT in a less resourced setting. It is well worth studying as it is applicable to all.

https://www.youtube.com/watch?v=W7eB_KGKBjw&feature=youtu

Developing a service model

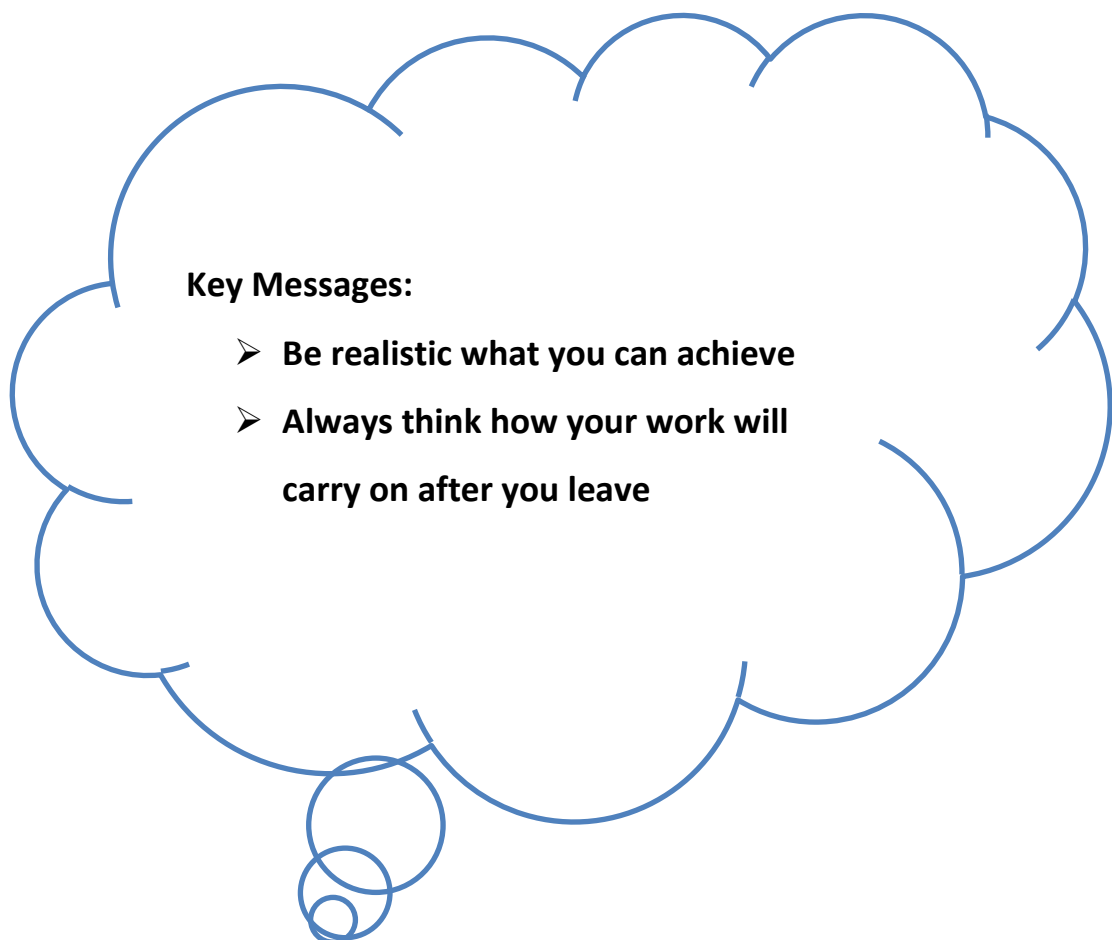
- Understand your hosts’ service objectives and how you can contribute towards these in your work.
- Remember to agree your targets with local partners, to ensure they are relevant and that local partners have a stake in them (so increasing likelihood of sustainability)
- Be mindful to use only locally available and affordable materials and equipment that local artisans have the wherewithal to repair or replace.
- If you have ideas for service development ask your hosts how they might be incorporated into the department’s operation.
- Avoid using a medical (purely impairment focussed) model or too much technical vocabulary. Consider the needs of the client in a more holistic approach using a social model of care. Increasingly the ICF's psychosocial model is being used as a way of structuring intervention worldwide <http://www.who.int/classifications/icf/en/>

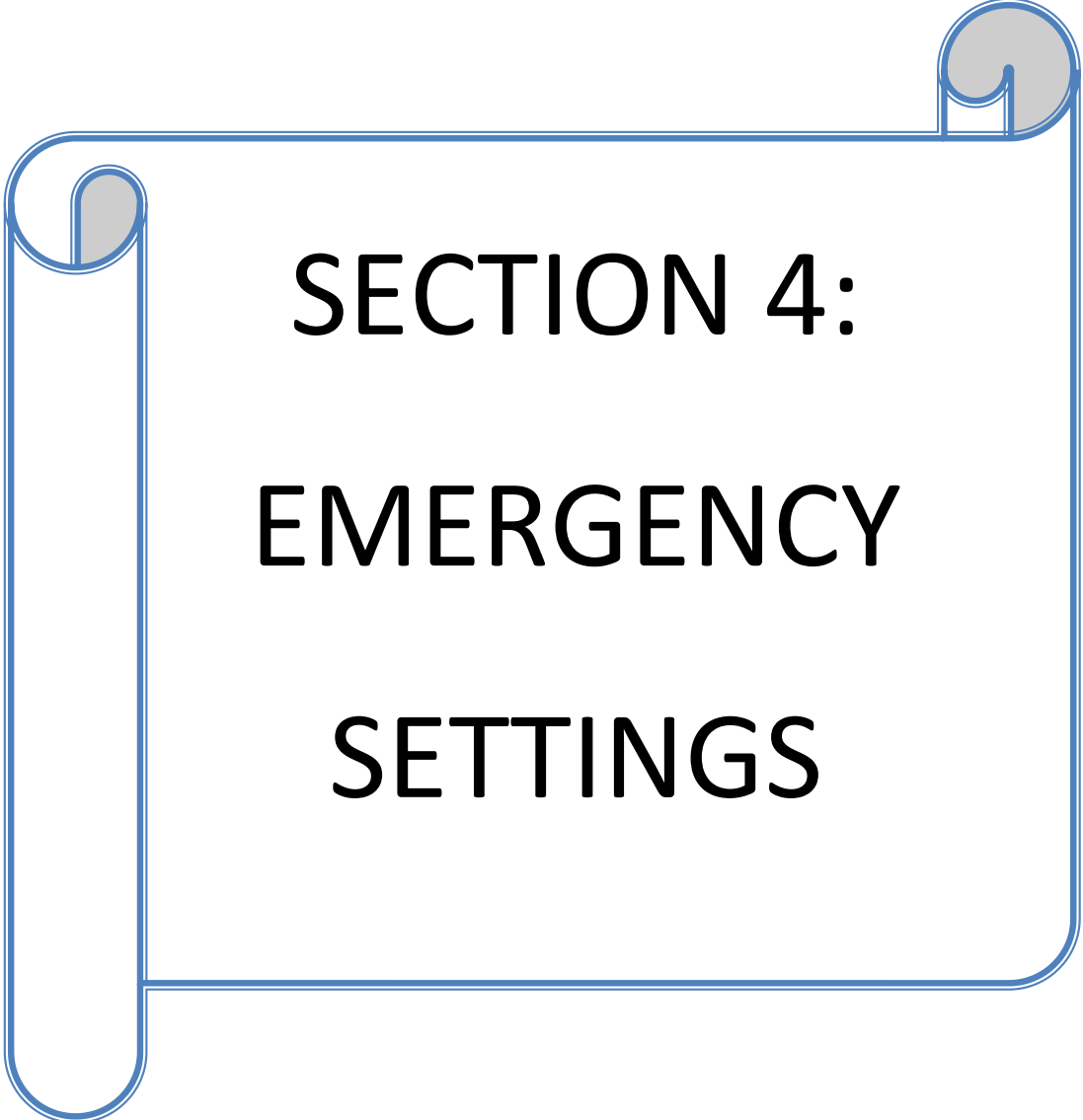


- Remember that many of your clients/clients' relatives may not have received much schooling and may not understand concepts of anatomy or physiology let alone the specifics of your professional discipline. Find out how functional processes are described in the local language and how difficulties are traditionally explained. Use this information as a starting point for talking about your work.
- Take into account other potential factors affecting priorities in the community that may influence the delivery of your programme (e.g. gender, age, poverty or power issues, stigma, local politics, etc.). For example our western society strongly values individual autonomy. Many other societies have collectivist world views in which the family or community decision about something like treatment aims takes precedence over an individual's wishes.
- Don't be prescriptive. Needs will change and evolve.
- Ensure that your way of working fits in with local practice such as whether or not people make appointments, whether practical / hands-on work is not appropriate for colleagues of certain rank/gender.
- You will need to be able to respond to what is asked of you even if you do not agree that this is the best idea/approach. Diplomacy is of the essence. . Work out if there are some

things with which you cannot /will not comply and be able to give your reasons tactfully but clearly. Check it out with a trusted local colleague first.

- Be prepared to develop ideas on a day to day basis.
- Understand how your joint work with your partners will be evaluated and how that will be communicated to stakeholders such as department colleagues, service users, and managers and who will communicate it.
- Consider how to get honest feedback. Be wary if local partners agree to everything you suggest: it could be because they don't want to offend you or because they don't want to turn down any offers of support, even when these are not appropriate.
- Be careful about suggesting a home visit as culturally this may be a new concept and may be viewed with suspicion/hostility. In these circumstances it's probably safest to avoid altogether unless you have a trusted local colleague who can negotiate and explain the reason for the visit appropriately.
- In some cultures it is inappropriate for a single man to visit a home if the husband is away whilst in others a woman may visit a woman but only if the man leaves the house.





**SECTION 4:
EMERGENCY
SETTINGS**

An Emergency is a serious, unexpected, and often dangerous situation requiring immediate action and follow-up in terms of extra-ordinary measures. The Emergency Threshold is normally determined by mortality rates, usually a crude mortality rate of 1 per 10 000 per day, or as an under-five mortality rate of 2 per 10 000 per day.

Work in Emergencies can take many forms. This section is designed to introduce you to the types of roles that are available, and the particular challenges of working in this environment. Therapists can be involved in responding to emergencies, but can also be involved in preparing for disasters – “**disaster risk reduction**” or in longer term disaster recovery work. Responding to emergencies can often sound fast paced and exciting, and while this can be the case, it can just as easily become bureaucratic, slow and frustrating. It can also involve significant hardship, working long hours, sleeping in tents surrounded by mud and flooding, with limited access to drinking water and fresh food. Alternatively it might be quite physically comfortable, staying in a guesthouse and arriving by 4x4. Whatever the circumstances, it will always challenge your emotions and your conscience, and it is important to prepare yourself properly, and to only work with organisations with a strong track record of this kind of work.

This section is intended as a short introduction only. **Key guides are available as follows:**

[Responding Internationally to Disasters: A Do's and Don'ts Guide for Rehabilitation Professionals.](#) To find this: Just type the above into a search engine

[WCPT \(2016\) The Role of Physical Therapists in Disaster Management.](#)

The World Federation of Occupational Therapists has information which refers to disaster management.

<http://www.wfot.org/Practice/DisasterPreparednessandResponseDPR.aspx>

The World Federation of Occupational Therapists also has information and resources on disaster preparedness and responses specific to occupational therapy on their website under the “resource centre” tab / sub tab “disaster preparedness and response”. It also has a page on disaster preparedness and responses

<http://www.wfot.org/Practice/DisasterPreparednessandResponseDPR.aspx>”

There is no such thing as a typical emergency. The most common sudden onset disasters that physiotherapists and occupational therapists are called upon to respond to are earthquakes, as they have a high ratio of injuries compared to fatalities. Other sudden onset disasters such as tsunamis and typhoons do sometimes create a high number of injuries, but generally result in high mortality/low injury. Disease outbreaks such as Ebola have also revealed an unanticipated need for rehabilitation support once the outbreak has subsided. Slow onset disasters, such as drought, floods, famine, or mass migration, may also require input from rehabilitation professionals. Conflicts may also result in high numbers of dead and injured, as well as creating huge numbers of refugees and internally displaced people. The most vulnerable, such as the elderly, injured and people with disability, are often the least able to flee.

Some examples of emergency deployments:

Typhoon: An occupational therapist from Handicap International coordinated the establishment of a disability and vulnerability focal point following 2013 Typhoon Haiyan in the Philippines. This involved providing immediate and long term rehabilitation to those affected, ensuring the inclusion of people with disability in the emergency response, and re building the capacity of decimated local facilities.

Earthquake: Physiotherapists and Occupational Therapists from organisations including Handicap International and CBM provided rehabilitation and equipment in hospitals and camps following the 2010 earthquake in Haiti. They also provided long term training and capacity building for local staff. Organisations like MSF and the Red Cross also sent physiotherapists to work as part of their surgical field hospitals.

Conflict: A physiotherapist working for a medical INGO increased the capacity of a surgical hospital during the 2011 conflict in Libya, while PT and OT working for IMC

carried out needs assessments, capacity building and provided trauma and disability trainings for local staff.

Migration: A physiotherapist worked with Handicap International with refugees in Northern Iraq to identify and support those fleeing conflict who had increased vulnerability.

Vulnerability during Emergencies:

We should always consider the protection of the most vulnerable in both the planning for and response to emergencies and it is the responsibility of all individuals and agencies to ensure their emergency response is inclusive. People with disability can be particularly vulnerable during emergencies, and ensuring their inclusion spans both emergency and development work. They are vulnerable for many reasons, at the core of which are the links between: disability, a lack of social inclusion and poverty. People with disability may not be able to access warnings, evacuate or access relief services and may lose essential equipment or support. People with long term conditions and the elderly can also be very vulnerable during an emergency. Limited access to medication exacerbates illness, while conditions like diabetes leave individuals at a higher risk of wound infection. Many programmes by organisations including Handicap International, Help Age and CBM are aimed at developing inclusive Disaster Risk Reduction plans for nations and communities, but all therapists working in this sector should be aware of the importance of not neglecting vulnerable groups.

Pathway from injury to recovery and types of rehabilitation services

In emergencies resulting in high volumes of trauma, frontline surgical and medical hospital services tend to focus on life saving care. If available, complex trauma cases may be referred to tertiary or specialised hospitals, but in the first days and weeks of an emergency (or longer in a conflict) health facilities are likely to be overflowing. This can result in early or uncoordinated discharges of patients with ongoing rehabilitation needs, to camps, back to the community or sometimes to unknown destinations. Existing rehabilitation resources can become stretched and unable to manage a surge in cases, particularly in countries where the rehabilitation of major trauma injuries

such as Spinal Cord Injury (SCI) and amputation are managed by a small number of specialist professionals. For mobile populations and refugees, follow up can be even more complicated. Early rehabilitation, patient education and the rapid provision of mobility devices is therefore critical, but so is increased coordination between medical and rehabilitation actors, as well as those involved in camp management and protection.

Role of short term rehabilitation professionals in crisis orthopaedics and neurology

The main injuries in an emergency are complex fractures, Peripheral Nerve Injuries (PNI) and wounds. Other injuries such as Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI) need long term management which is often not available within the health service in a crisis. People with lifelong conditions may be moved from facility to facility. Identifying them and coordinating their care is essential. Cohorting, particularly for SCI patients, is recommended.

Pain management

Pain is a significant problem for most of the vulnerable and injured people in an emergency context, and surprisingly is often neglected. Rehabilitation professionals can support pain management, but can also work as part of a team to optimise pharmacological management, for example for neuropathic pain conditions.

Humanitarian Workers can face additional risks and stresses in an emergency situation:

- Exposure to the environment that precipitated or sustains a crisis or event, such as a natural disaster or conflict
- Working long hours under adverse or extreme conditions, often in close contact with the affected population
- Damaged or absent infrastructure, including availability of food, water, lodging, transportation, and health services

- Reduced levels of security and protection particularly where affected populations become desperate.
- Stress, ethical, and moral challenges related to the event and the resource capacities of the situation. Arrange to have a colleague or friend support you, as it is well documented that stress and deteriorating health status can be a problem for humanitarian workers. A recent study of Red Cross workers showed that:
 - >40% found the experience more stressful than expected.
 - 35% report that their personal health status deteriorated during the mission.

Large scale international responses to disasters, though sometimes successful, have also been beset by problems. Medical responders (including international rehabilitation responders) have lacked the appropriate skills or equipment, do not coordinate properly, and leave too soon. All these factors not only reduce their impact, they also at times undermine an effective local response. The WHO has now introduced a classification system for all health responders to disasters, called the Emergency Medical Team (EMT) Initiative. Any rehabilitation responders wanting to respond to disasters must be part of teams registered with WHO or an organisation with an established presence in that country already. International teams must meet standards relating to equipment, length of stay, licensure and training. More information on the EMT initiative is available here:

<https://extranet.who.int/emt/page/home>

International organisations that work in emergencies and recruit rehabilitation professionals include (but are not limited to) CBM, Handicap International, ICRC, International Medical Corps, Johanniter International, MDM, MSF, and Motivation. In the UK, Occupational Therapists and Physical Therapists who are interested in emergency response are encouraged to join the UK Emergency Medical Team (www.uk-med.org). The UKEMT is a consortium consisting of DFID, UK-Med, Handicap International and the UK Fire and Rescue Service. Through the UKEMT, rehabilitation professionals can access free humanitarian training, as well as clinical training on rehabilitation in austere environments run by Handicap International. They are then selected to join rotational on call clinical teams. The UKEMT now also includes the

world's first dedicated disaster response rehabilitation team, increasing opportunities for rehabilitation professionals to deploy to disasters.

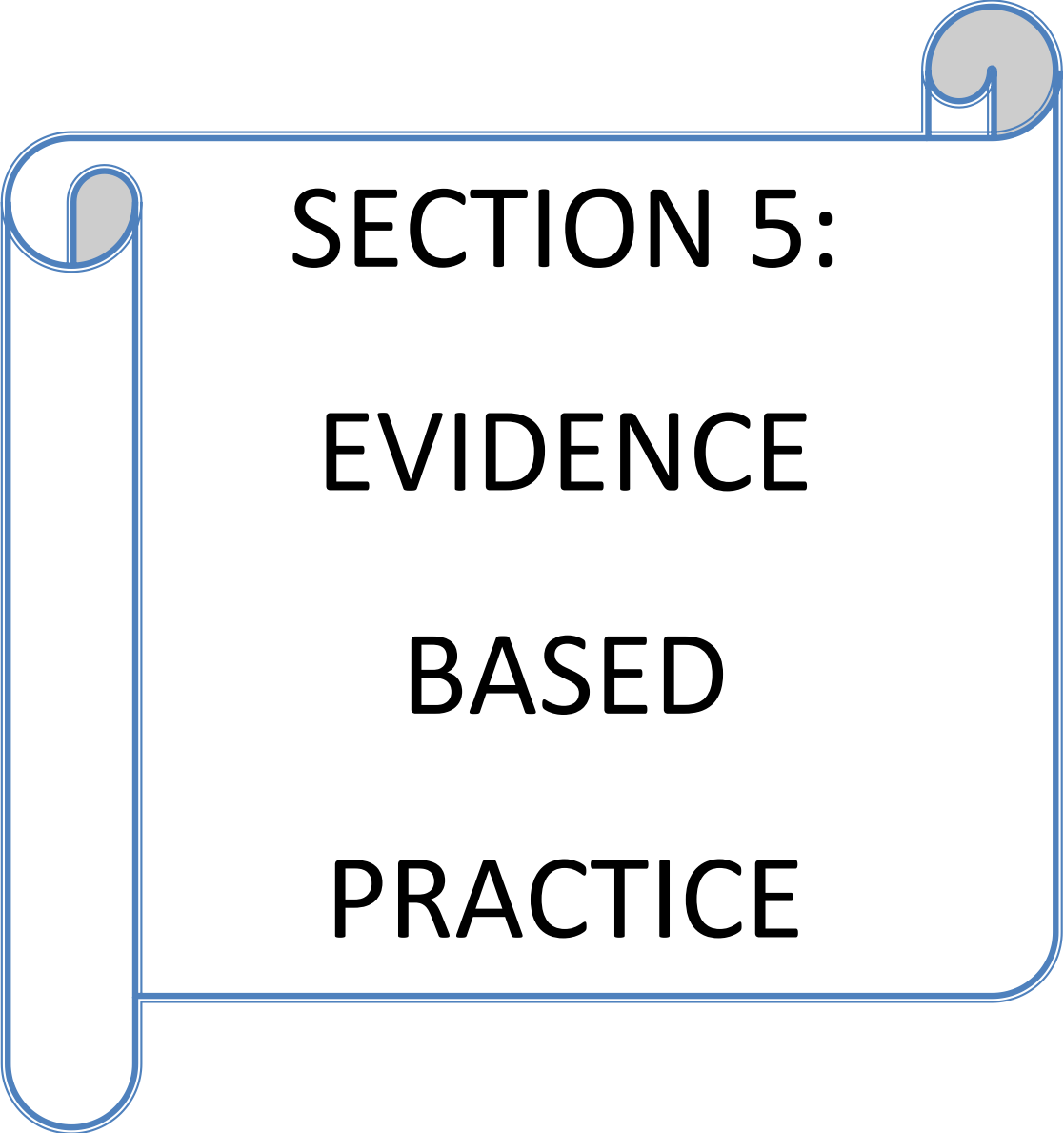
Important considerations:

1. Don't be a disaster tourist! If not in the affected area at the time of the disaster only travel with an invitation and only work for an existing national organisation or an international organisation with a track record of responding to disasters.
2. Be realistic about the technical role - read the project documentation and talk to teams in the HQ and field; work with what you have and plan for next steps
3. Respect security and communication strategies; follow the rules, even if you feel they are not relevant, as they are there for your safety. Be sure not to put other people at risk because of your actions.
4. Take care of physical and emotional health of self and others; if you are not well/sick – then say to your team and follow medical advice; if you or others feel stressed or depressed/ dreams etc, talk to others in your team to find a way to debrief
5. Travel with the right equipment, stay for more than just a few weeks, and have a defined role that supports not undermines the national response.
6. Be prepared to work long hours under extreme stress and at times in a challenging living environment.
7. Be prepared to respond and adapt to difficult situations; aim to focus on the work in hand as PT/OT, but often you have to deal with complex situations which means a change of plan
8. Be aware of the agencies and networks; these agencies form the foundation of the humanitarian responses in a crisis with funding and activities and can help you to build up referral networks to support patients/clients.
9. Rehabilitation in emergencies needs to be promoted – 3 key messages to promote the work
 - Be aware of pathway from injury to recovery and types of rehabilitation processes
 - Identify role of rehabilitation professionals in crisis, orthopaedics and neurology
 - Recognise the role of rehabilitation in pain management



Key Messages:

- **Don't be a disaster tourist**
- **Be realistic about the technical role**
- **Respect security and communication strategies**
- **Take care of physical and emotional health of self and others**
- **Be prepared to respond and adapt to difficult situations**



**SECTION 5:
EVIDENCE
BASED
PRACTICE**

Evidence Based Practice

There are lots of debates about evidence-based practice, what it means, what it is and whether it matters.

There are lots of definitions of evidence-based practice.

'Evidence-Based Practice (EBP) requires that decisions about health care are based on the best available, current, valid and relevant evidence. These decisions should be made by those receiving care, informed by the tacit and explicit knowledge of those providing care, within the context of available resources'

CSP 2017

EBP requires bringing together clinical expertise, patient preferences and the best



research evidence, and each may vary in importance depending on the context. These are all equally important, one is not better than the others, and they should all be integrated into therapy.

Source: Dawes & Summeskill (2005) cited in Chartered Society of Physiotherapists (2017)

This means that evidence can include research findings, clinical opinions, patients' perspectives or service audits.

These debates are as relevant for those working overseas as for those working in the UK if not more so. Allied Health Professionals need to demonstrate a respect for

thoughtful, critical and evidence based interventions by working in line with current thinking that is as much as possible supported by research and international consensus, while still being aware of, and respectful of, local resources and practices.

Developing clinical expertise

There are many ways you can develop your clinical expertise, whether this is through:

- **using research (see below)**
- **attending training course and study days**
- **colleagues or social networks**
- **reflecting on your practice.**

This may be particularly important when working in a low-resourced setting as you may be working with conditions you are less familiar with or in environments that are different from those you are used to.

You can actively create evidence through your clinical practice, particularly if you are thorough about recording diagnosis, treatments, outcomes and reflections.

Knowledge is not something that you should wait to be discovered, rather try and play a role in forming a relevant body of knowledge.

- This means that undertaking a robust and thorough **service evaluation or audit**, for example, could act as a piece of evidence about the value of a particular set of interventions. These need to be appropriately and thoroughly documented, analysed, reported on and disseminated.
- **Case studies** are also a good opportunity for reflecting on your clinical practice, thinking through what has worked and what hasn't and why. They also provide a piece of evidence about the efficacy of clinical practice and can contribute to developing clinical expertise.
- **Colleagues and social networks** are also great sources of evidence and opportunities for developing clinical expertise
- **Using research in your practice.** Research that has already been conducted can also be used as a way of informing your practice whilst working overseas. This involves

integrating research into clinical practice, which is sometimes termed knowledge transfer. Research is sometimes criticised for being divorced from on the ground clinical work, but a good example of transferring research to practice is the use of **outcome measures**, such as the Berg Balance Scale, which have been developed in a research environment and now have widespread use in clinical practice. Strategies to help you use research in your practice include:

- Making an effort to access relevant research publications
- Critically analyse and summarize relevant research findings (there may be useful tools for each discipline to help you do this, for example the CSP recommends the Critical Appraisal Skills Programme (CASP). See: <http://www.csp.org.uk/professional-union/library/bibliographic-databases/critical-appraisal> for more details).
- Thinking about what you have learnt and how this may influence your practice
- Reflecting on any changes made to your practice based on the use of research finds
- Considering whether you can you forge any links with researchers and encourage them to translate their findings for clinical practice?
- Thinking about whether you could you develop some form of peer-support for reviewing evidence

This may be harder if you do not have Internet access whilst overseas so try and gather some materials in preparation for your trip. You may find that there are other sources of useful research connected to overseas working alongside your professional journals. Useful sources of research on disability, public health and working in low-resourced settings include:

Handicap International: <http://www.asksource.info/>

Physiotherapy journals: <http://www.csp.org.uk/professional-union/csp-publications/physiotherapy-journal-services>

Disability and Global South Journal: <https://dgsjournal.org>

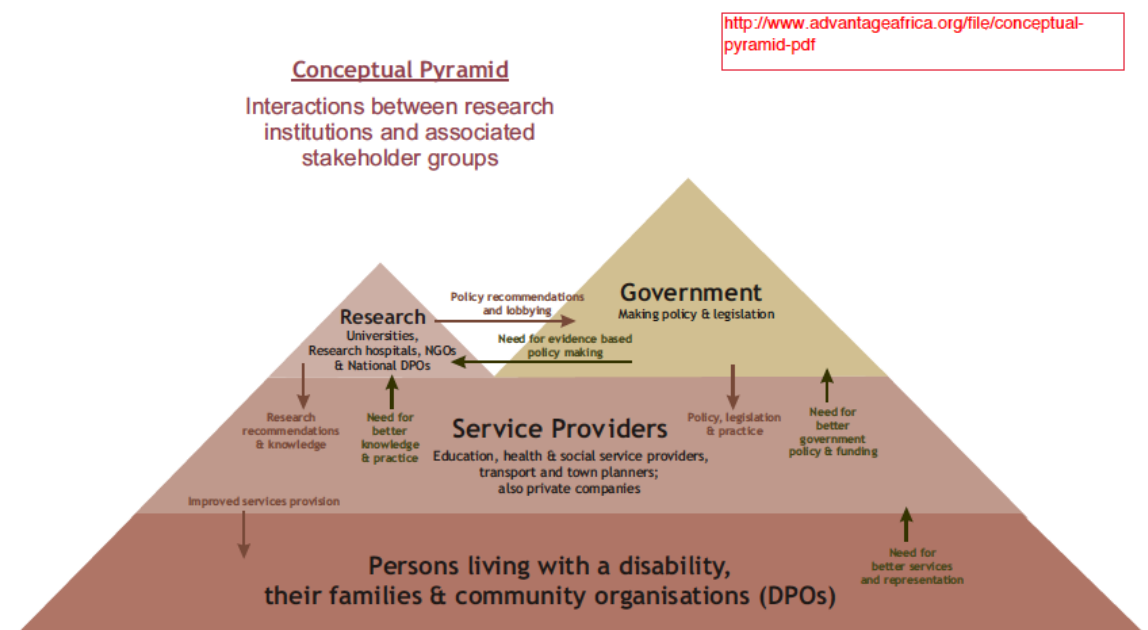
One key resource of current evidence based practice in Occupational Therapy is available via the COT website: <https://www.cot.co.uk/occupational-therapy-evidence-fact-sheets>

Valuing patients' preferences

Valuing patients' views, opinions and preferences is integral to the work of all therapists and is equally important when working in low-resourced settings. However the nature of health systems in different contexts may place the patient in a role in which they are not normally used to being asked their opinions or viewpoints. Be prepared:

- Communicate with your patients in a way that encourages them to voice their perspectives, particularly if working through an interpreter.
- To work with patients over a more prolonged period of time to encourage them to build a relationship with you that nurtures them as an active partner in their therapy.
- To build in patients' opinions into your practice in more formal ways, for example through the use of service evaluations, patient feedback or patient and public participation forums. Again these would need to be appropriately and thoroughly documented, analysed, reported on and disseminated.

Best research evidence



Source: With many thanks to Advantage Africa

Doing Research

'If research is to fully reflect the experiences of disabled people, then disabled people should be involved from the outset in formulating research questions, developing methodology, interpreting results and drawing conclusions'

Farmer & Macleod 2011:6

Conducting research in the UK or overseas is usually a specialized endeavour that requires particular skills, knowledge and training. The basic approaches to research are usually covered through undergraduate curricula, and the majority of therapists have an understanding of different types of research, for example: literature reviews, qualitative and quantitative research.

Quantitative versus qualitative research

A significant difference between quantitative and qualitative research is the types of data that are generated and the overall approach to the research. For example qualitative research is often used to gain a richer understanding of a particular topic, through people's viewpoints and perspectives, whereas quantitative research may be used to generate numerical data, quantify attitudes and behaviours and consider causal connections. Research is important because it allows us to understand a situation in more depth to be able to develop appropriate policies and practices. Research such as an audit or monitoring and evaluation may help us to work out what is working well and what is not.

All research should be conducted with moral and ethical principles in mind and should be subjected to an ethical review process. This may include demonstrating how participants are protected from harm during research process, i.e. the process through which you will gather informed consent, what you will do with the data and how it will be published considering anonymity and confidentiality.

The process of doing research should however be subjected to greater ethical scrutiny than just the completion of the ethics form. This is particularly the case when working with people with disabilities and in low-resourced settings, and often brings to the fore questions about who has the power to decide what research is conducted and how it is done, as this quote shows:

'Research can dis-empower disabled people by placing knowledge in the hands of the researcher who interprets evidence and makes recommendations on their behalf'

Barnes 2003 cited by Farmer & Macleod 2011: 19

These concerns may be exacerbated when doing research with disabled people in low-resourced settings where there is greater potential for the researcher to leave and take away the knowledge gained from the research and the possibility of reproducing exploitative power relations between developed and developing countries (Grech & Goodley 2011).

Researchers working in both disability studies and low-income contexts have sometimes turned to **participatory research** in an effort to promote inclusive research that is driven by the participants. This is not without its own critiques, but proponents of participatory methods claim that they offer a form of research that is more driven by the participants, and often utilize more accessible tools such as mapping, drawing and ranking (e.g. Wickenden & Khembavi-Tam 2014).

There are also practical aspects to consider when undertaking research in a low-resourced setting. This may include language skills required and the use of interpreters, how you are going to get access to participants for the research, questions over whether or not to remunerate participants for taking part in your research, understanding cultural difference and maintaining your own health, safety and wellbeing whilst conducting the research.

Some examples of studies that relate to working in Low Resourced Countries:

1. One example focuses on a Training programme for parents of children with cerebral palsy, The Getting to Know Cerebral palsy programme, available to download from:
<http://disabilitycentre.lshtm.ac.uk/getting-to-know-cerebral-palsy/>

The programme was recently evaluated using a standardized Quality of Life (QoL) questionnaire. This was found to be a practical and appropriate tool to look at the outcome of an intervention in a less resourced country. It considers the wider impact of disability.

<http://disabilitycentre.lshtm.ac.uk/files/2014/07/Ghanacountry-reportfinal.pdf>

- Key findings from the study indicate that the priorities to consider in less resourced countries may be different from those we might think about in better resourced countries.
- The dignity of caregivers increased as they saw that they and their child were valued.
- The level of malnutrition amongst children with CP was recognized as an important outcome measure.
- Assistive devices were valued however their usage was fraught with difficulties.
- This particular study found that children with CP were nearly 15 times more likely to die than children in the standard population of developing countries.

The above key findings highlight the different focus needed by AHPs working with children with cerebral palsy in less resourced countries

2. Barton C et al (2017) A Mixed Methodology Pilot To Evaluate The Impact Of Postural Support Via Appropriate Paper-Based Technology (APT), On The Participation And Quality Of Life Of Young Children With Cerebral Palsy In Kenya.

This pilot study focused on interventions for children with cerebral palsy in rural Kenya and looked at the perceived benefits of simple postural support, seating and standing devices made using the techniques of Alternative Paper Technology (APT). APT is a much cheaper and sustainable means of making postural equipment for children in low resourced settings. As an outcome measure the study used the Family Impact of Assistive Devices Technology Scale (FIATS -AS).

Other references include:

3. **Kirsten A Donald et al (2014) Pediatric Cerebral Palsy in Africa: A Systematic Review.** Seminars in Ped. Neurology

4. **Pediatric Cerebral Palsy in Africa: Where Are We? Donald KA, et al (2015)** Journal Child Neurology. 2015 Jul; 30(8):963-71.

5. American Academy of Cerebral Palsy and Developmental Medicine Update (2014). This is a comprehensive view of the evidence base for children with CP.

[www.uptaonline.org/resource/resmgr/.../AAPDM Update fall conf ped.pptx](http://www.uptaonline.org/resource/resmgr/.../AAPDM_Update_fall_conf_ped.pptx)

6. **Novak I. (2014) Evidence-Based Diagnosis, Health Care, and Rehabilitation for Children with CP.** *J Child Neurol* 29: 1141-1156

7. *Bridging the gap between applied disability research and the application of research findings to benefit persons with disabilities* (2015) Advantage Africa..

<http://www.advantageafrica.org/file/discussion-paper-on-the-gap-between-research-and-practice-pdf>

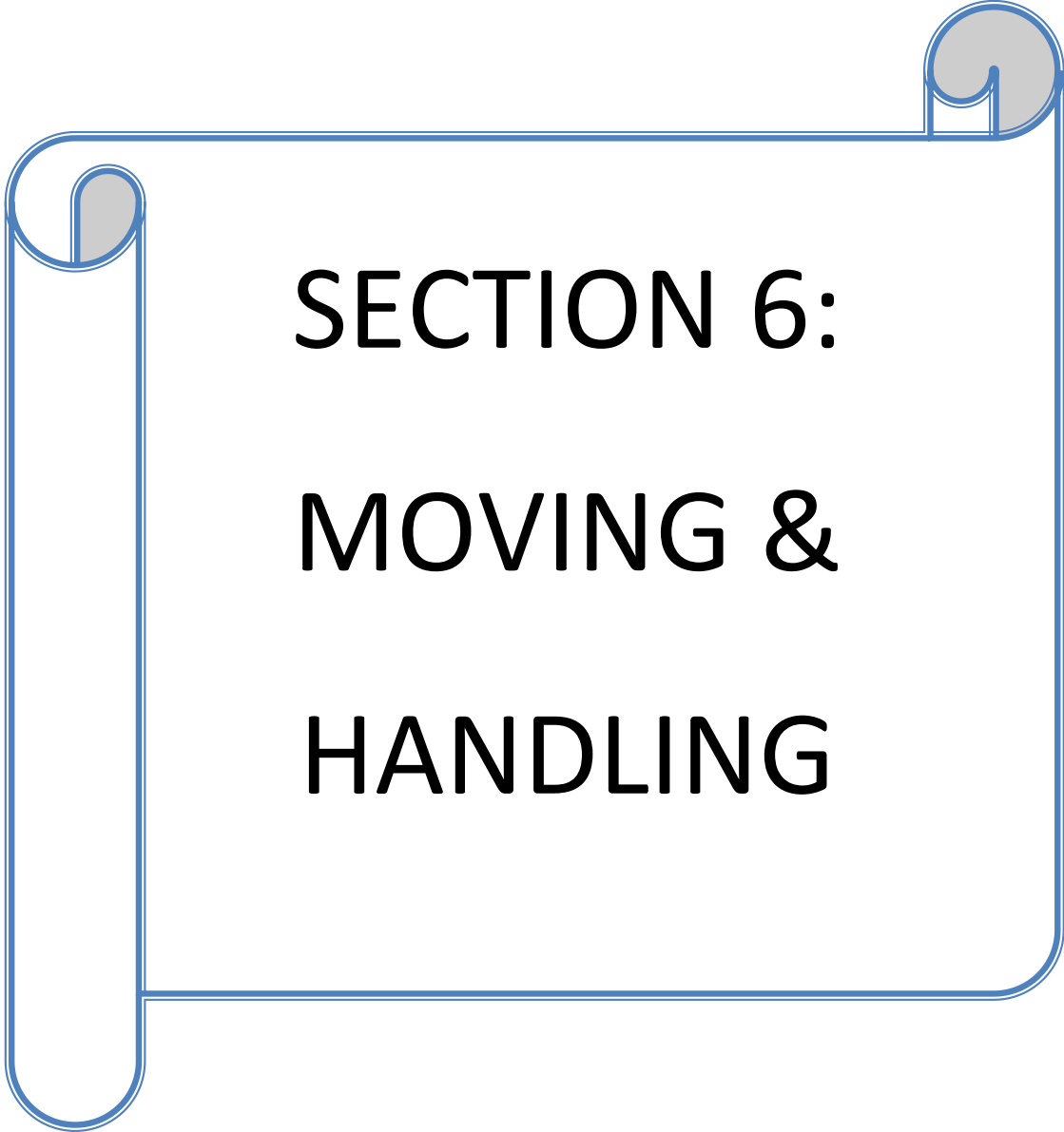
8. Leonard Cheshire Disability, 2013. Research toolkit for disabled people's organisations: How to undertake and use applied research. Leonard Cheshire Disability and Inclusive Development Centre. [https://www.leonardcheshire.org/about-](https://www.leonardcheshire.org/about-us/publications/latest-publications-download/research-toolkit-for-disabled-people)

[us/publications/latest-publications-download/research-toolkit-for-disabled-people](https://www.leonardcheshire.org/about-us/publications/latest-publications-download/research-toolkit-for-disabled-people)



Key Messages:

- **Evidence based practice is just as important when working overseas.**
- **Evidence based practice is diverse, incorporating clinical expertise, patient values and preferences and research evidence.**
- **People with disabilities should be involved in deciding what research would be useful and in planning its implementation and dissemination.**
- **It is important that professionals engage in evidence based practice and actively seek out opportunities in their particular field and context.**



**SECTION 6:
MOVING &
HANDLING**

Moving & Handling in Low Resourced Settings

Definition of manual handling:

“Any transporting or supporting of a load (including the lifting, putting down, pushing, pulling, carrying or moving thereof) by hand or by bodily force”.

Manual Handling Operations Regulations 1992 (as amended) (MHOR)

In the good old days (or bad old days) depending on your viewpoint; we bent down low, twisted, lifted, supported, carried and dragged any number of inanimate objects during the course of each day. As therapists, we did whatever we needed to do to rehabilitate our patients. We considered it important for everyone involved with our patients **‘to do as we do’** in order to maximise quality of movement and function. The majority of therapists who train in UK/Europe are now steeped in European Health and Safety protocols. Moving & Handling is no exception. **Legislation underpins our professional practice.**

Since 1992 when the Moving & Handling Operations Regulations came into force, the majority of health care professionals have had to change the way they work when moving and handling their patients.

Regulation 4(1) of MHOR sets out a hierarchy of measures to reduce the risks of manual handling.

AVOID any handling procedures so far as is reasonably practicable.

ASSESS any procedures that cannot be avoided

REDUCE the risk of injury so far as is reasonably practicable.

<http://www.hse.gov.uk/> accessed 3.6.17

There has been a greater emphasis on considering not only the patient/client but also their family/carers as well as the health and safety of the treating therapist/s. This proved controversial at first, but over the two decades manual handling performance

has improved greatly; mainly due to the explosion of mandatory training and the availability of quality equipment to ensure that everyone involved is as safe as possible.

Unfortunately, this does not apply to the majority of low resourced settings where sometimes, outdated and frankly unsafe practices still occur. The harsh realities of poverty, overcrowding, local politics and corruption, customs and economics mean that some health care professionals who work hard to rehabilitate their patients are unlikely to have had the appropriate moving and handling training or have access to the equipment/resources required.

However, this does not mean that we can condone and accept 'poor handling' when working in low resourced settings. As therapists, we must endeavour to maintain standards but spend time sharing 'best practice' and **always** use 'safe 'principles of handling'. Assuming there is no equipment available, and no funding for larger pieces of equipment, wherever possible, encourage the use of 'low tech' equipment that can be made locally or transported easily (see low tech equipment)

The following information may be obvious to you; however, the colleagues you are working with may well have acquired the same theoretical knowledge as you, but may not have had the same practical training for many reasons (see working practices)

The TILE jigsaw

As health care professionals we are trained to **Risk Assess** any therapeutic intervention using **TILE** or **LITE**.

Task – what you plan to do

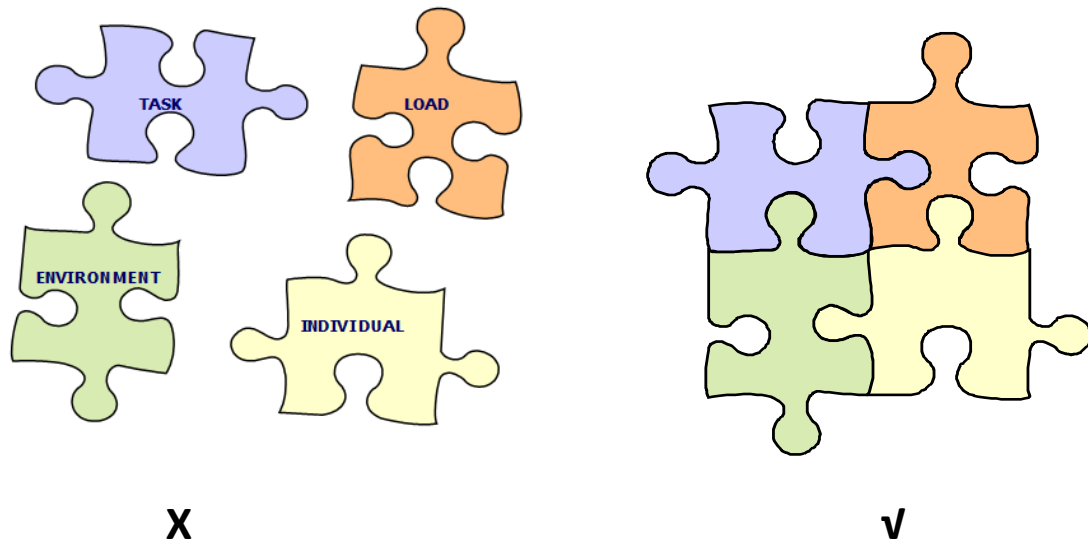
Individual – yourself or the people working with you

Load – the client/patient or inanimate object

Environment – how the environment you are working in affects your treatment, e.g. in a clinic or in someone's home.

During training sessions, TILE is often shown as a jigsaw of different pieces, each one representing one strand of Risk Assessment. Like a jigsaw, all aspects of risk

assessment are interlinked and should not be seen in isolation. We need to make balanced decisions which take account of safety for the client and staff but also enable us to meet the needs of the client. This is not always easy.



Principles of handling

Once you have looked at all the factors, you then need to **plan** the task (get equipment or help if needed), **communicate** so that everyone knows what is happening and finally make sure the client is **prepared** for the task.

Once this is done, always follow '**safe principles of moving & handling**'. This must apply whichever setting we are working in. Just because there is not a hoist available or a particular piece of equipment that you feel is necessary, as therapists we cannot abandon our patients, but we have to think of the 'best' possible alternative and that may include '**lifting**' a patient (something quite alien to us in UK). In some cases, you may need to get the help of several other people. Please remember if you are getting help from unqualified or untrained staff, it is important that you train them first in that particular manoeuvre and ensure they feel confident in helping.

If lifting is deemed appropriate, it is important that everyone knows 'how to lift'.

Know how to lift.

- **HANDHOLD** - secure comfortable grip, keeping as much of your hand and arms in contact with the load as appropriate for the load.
- **FOOT POSITION** - wide stable foot position (base) close to the load, leading foot forward in the direction of movement. Lift load between your knees if placed at a low level.
- **BACK IN LINE** - keep a naturally upright position wherever possible. Avoid twisting, bending, reaching or jerky movements. Look forwards when lifting and keep 'nose over toes'.
- **ARMS CLOSE** - keep the load close to your body, with elbows tucked in.
- **BODY WEIGHT**- use momentum to reduce lifting strain. Use your body weight and strong leg muscles to move a load e.g. pulling and pushing movements.
- **KNOW HOW TO CARRY**
 - keep the load close to your body
 - make sure you can see where you are going
 - plan rest pauses or use trolley. Do not carry for long.
 - do not twist; turn with your feet NOT your back
- **KNOW HOW TO SET DOWN THE LOAD**
 - stand close to where you plan to set down
 - split the lift if lifting above head height.
- **KNOW HOW TO PULL AND PUSH**
 - use your body weight and leg muscles.

LIFT SMOOTHLY, AVOID JERKY OR UNSUSPECTED MOVEMENTS.

Working Practices – how are they different?

- **Getting close to a patient.** In many countries, it is culturally unacceptable for a woman to get close to a man or vice versa. This immediately raises problems when moving or handling a patient as the therapist is unable to fulfil one of the basic principles, i.e. getting as close to the load (patient) as possible. You may

need to get help from another member of staff who is the same gender as your patient.

- **Little or no equipment.** There is often little or no equipment at hand. Be prepared to be adaptable and use everyday objects to help, e.g. a plastic bin liner to help slide a patient.
- **Lifting patients is the norm** in many low resourced settings. Don't say 'you're not allowed to lift' a phrase I have heard many times in UK. Try to reduce the risk as far as is reasonably practicable and teach safe principles.
- **Room full of patients and carers.** It is usual in many low resourced settings for patients to arrive all at once and wait to be treated. They often wait in the same room as you are treating a patient. It can often be distracting and you can feel rushed. Don't compromise your standards. You are seen as a role model so ensure 'best practice' at all times when handling a patient.

Training

Moving and handling is integral to everyday life. If your mission is to train therapists, CBR workers, carers or patients themselves, training is much more effective when done practically. This way you have to work with the resources you are given (or have brought).

In my opinion, just teaching techniques to a group of people is not very effective. It is not personal enough. **Problem solving** everyday activities and therapeutic activities works much better. This way you can demonstrate safe principles of handling in real situations and with real people; this can sometimes be quite a challenge (as it can be in the UK too when visiting someone in their home)

When training, you are aiming to ensure that the person or people you are working with become '**competent**' at handling in a range of situations,

Competency is not just a 'tick box' exercise and cannot be achieved in a single training session. To be fully competent; one must be confident in their own ability, (not over confident) be able to explain, demonstrate and understand the different ways of moving and handling and have the ability to use the skills effectively. This requires practice as well as understanding the basic principles

Small handling aids

Small handling aids are extremely useful when working in less resourced settings. Not only can they be put into your suitcase when going out on a mission (and left for therapists to use when you have gone), but they can often be made 'in country'. All equipment should be 'fit for use' and maintained properly.

Suggested equipment includes:

Handling belt

Essentially a handling belt has several handles sewn into a padded belt. It is attached around the client's waist and the handles provide a better grip when moving a person (rather than grabbing clothing) and helps maintain a better posture for the handlers. **It should NOT be used as a lifting device.** It is used to facilitate various transfers, including sit to stand, transfers from bed to chair, chair to chair or just for general positioning.

Handling belts come in all sizes and cost between £15 and £45 depending on the model



Slide sheets

Slide sheets are designed for **sliding** transfers and repositioning. They are made of very low friction material, which are placed underneath a person. This allows for an independent or assisted **sliding** movement in one or more directions across a level surface. Slide sheets come in various sizes and shapes and each of them serves different purposes.

There are many slide sheets on the market and can be purchased for as little as £20.

Some sheets are tubular whilst others come in the form of 2 flat sheets (with or without handles). There are uni-directional slide sheets and there are also disposable slide sheets which are used for one person only and cannot be washed.

Tubular slide sheets



Flat slide sheets



Transfer board

A transfer board is usually made of laminated wood and facilitates day to day functional transfers such as bed to chair, wheelchair to commode and wheelchair to car. They are used for patients who are unable to do a standing transfer and they are most effective when the patient has some core stability and upper limb function. They can be used with or without a small slide sheet



Manual Transfer Sling

A manual transfer sling allows a child/young person to be lifted safely by two or more people. This type of sling has been designed for moving a client/patient in a difficult situation where a hoist is not accessible. However it should only be used if there is no other alternative. There are a couple of companies in UK that make these slings; they are much cheaper and much more portable than a hoist.



Silvalea Manual Transfer Sling

<http://www.silvalea.com/catalogsearch/result/?q=manual+transfer+sling>

(Thanks to Silvalea Ltd for allowing us to use their images)



Promove sling <https://www.promove.uk/>

(Thanks to Promove.co.uk for allowing us to use the images)

Self-lifting blocks

Bed blocks are used by people with enough upper limb strength who want to lift themselves up from the bed.

This may be necessary to relieve pressure under the buttocks, to assist in moving up and down the bed, or to help in positioning a bedpan. It may be possible to raise yourself by several centimetres from the bed using these blocks



All of the equipment described, will fit into an average suitcase and is easily transportable.

Key Messages:

- **Don't compromise standards just because you are in a setting where there are few resources.**
- **Competency is not just a 'tick box' exercise and cannot be achieved in a single training session.**



SECTION 7: COMMUNICATION

Communication is a basic human right.

Communication happens when we understand what is being said to us and respond and when we express our thoughts, needs and feelings so they can be understood.

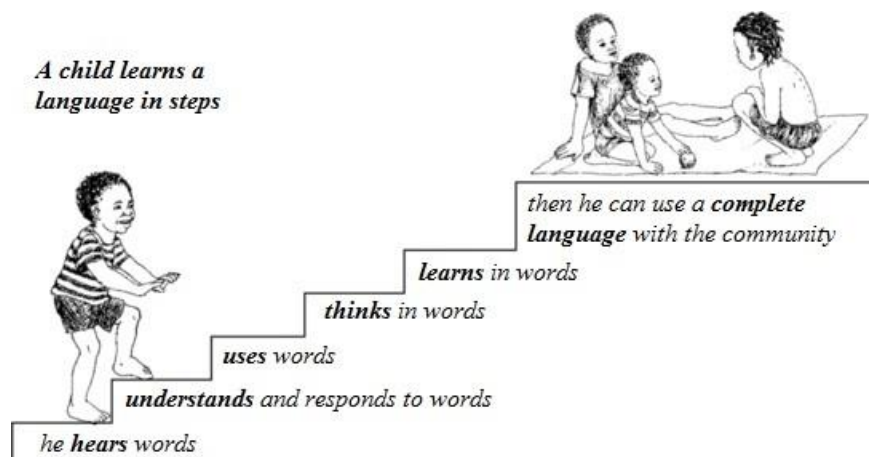
(Hesperian Health Guides)

Some of the ways we can communicate:

- Talking
- Smiling
- Pointing
- Laughing
- Facial expressions – grimace, pain, happiness
- Body movements
- Drawing
- Reading
- Writing
- Singing
- Use of computer, tablet or assistive device.

There are many reasons why we need/want to communicate:

- Establishing relationships and making friends
- Exchanging information, communicating ideas and giving directions
- Communicating needs and wishes
- Developing thinking skills e.g. helping us to remember, make plans, solve problems
- Becoming happy and successful members of our community



Promoting communication

Every AHP has a part to play in promoting and supporting communication.

To promote universal language and communication development, good practice leaflets can be downloaded from The Communication Trust

www.communicationtrust.org.uk or from the resources listed below and modified for local structures and needs with the help of local colleagues. Key messages can be modelled, demonstrated or illustrated and used as wall displays or handouts.

When working in a low resourced country, find out about the local level of literacy and drawing style. It is always better to get a local person to draw pictures than draw them yourself.

Reinforcing communication

AHPs may also find themselves in situations where for example:

- Therapy or hygiene techniques need reinforcement
- Pupils would benefit from understanding routines or transitions.
- Behaviours, such as poor listening and attention, are reducing effective therapy,
- Parent/s carers have exercises or daily living routines to remember over several months

Simple visual cues and repetition make communication and therapy more effective.

For example:-

- Putting a Hand Washing symbol near a tap
- Using lots of natural gesture
- Drawing (e.g. workshop tool storage or a bed-chair transfer sequence)
- Holding or demonstrating an object when talking about it in training
- Touching an arm that needs moving
- Giving choices using objects or photos/drawings`



Extra support for communication

AHPs who may be working in situations without the support of SLT colleagues may come across children and adults who need extra support to communicate their needs perhaps

because of neurological impairment, visual impairment, hearing loss and /or learning difficulties.

Specific training or spending time with SLTs working in rehabilitation units or schools with pupils with complex needs and/ or hearing loss prior to departure is invaluable if you think you may be working with people with communication difficulties. In the field, these contacts may be your source of help and support.

AHPs can ask for advice from CTI or MAITS or experienced SLTs working in the Region.

MAITS is an international disability charity which improves access to healthcare and education services by providing capacity-building to health and education professionals working in the mainstream and disability sectors in under-resourced countries. MAITS can be asked if an expert Trainer is available to come out on a short term assignment to help you. This is most useful in situations where co-workers or communication partners can be trained too.

Where there is no SLT support, AHPs may investigate setting up extra supported communication systems in partnership with parent/s, carers, other professionals and the child or adult in need.

























The following resources and considerations may be a helpful starting point.

- AHPs should take a holistic and functional view of communication. It needs to work for the individual or organisation. Always bear in mind the local culture and ensure resources are easily obtainable, inexpensive and replaceable.

Simple works best. Think no tech or low tech.

- It is not generally recommended that AHPs in low resourced countries request, import or investigate HiTech communication aids as often electricity and batteries are expensive and limited. Maintenance may be very problematic leading to frustration, guilt and disappointment. As cheaper solar powered communication devices and Apps are produced, the situation may well change.
- Supported communication such as signing or communication board needs 'everyone on board' for it to work and usually takes time, hard work, reviewing, revising and patience for it to be effective.

Examples of Communication boards used in the Philippines.

 Hi! Ako si Jacob.	 Good bye!	 Thank you!	 Kain
 Oo	 Masaya	 May mosakit	 Inom
 Hindi	 Malungkot	 Gali!	 Laro
 Gusto ko	 Ayaw ko	 Kuha	 Aakyat ng hagdan.
 Milk	 Water	 Pagkain	 Baba ng hagdan.
 Baso	 Spoon	 Break	 Wala sa board!

wag	ayaw	gusto	kain	inom	tulog	ako	ko	akin	ang	isa	lahat	dami	na	po	at/saka
hindi	may/roo	kailanga	tulong	tingin	kita	kami	namin	amin	sa	una	buo	iba	pa	e	kasi
oo	wala	punta	uwat	alis	dating	tayo	natin	atin	ng	laki	taas	hirap	din	ba	kaya
sige	ano?	bukas	patay	pasok	daan	ikaw	mo	iyong	mga	ganda	lekas	bago	naman	ay	kung
ah...	sino?	kuha	bigay	balik	lagay	ka	kayo	inyong	ni	layo	lapit	mahal	lang	ito	o
ha?	saan?	gamit	gawa	dala	abot	siya	niya	kanya	si	muna	ulit	agad	nga	diyan	pag
sandali	ilan?	basa	sulat	akala	alam	sila	nila	kanila	kay	ngayon	minsan	sana	daw	doon	para
wow	paano?	tama	sabi	tawag	salita	iyon	ito	gali!	baka/sig	pwede	parang	pala	labas	pero	
hala	bakit?	bili	maging	sama	mahal	kita	ni(ong)	nito	sakit	sigurado	dapat	talaga	man	loob	tapos

When considering how to help, think about

- **How successfully the person**

- Indicates their needs, wishes, likes and dislikes
- Signals Yes/No
- Shows pain, hurt, distress or pleasure and enjoyment
- Understands the intention of others and can anticipate what may happen
- Shows their understanding and knowledge

- **How successfully other people**

- Interpret the person's words, vocalisations, body movements, gestures and behaviours.
- Value and respond to the person's existing communication methods
- Observe local ways of communicating and ask local colleagues for advice. For example, are there unacceptable gestures? How do people indicate an object? Pointing may be considered rude.
- Remember it is inappropriate to use UK Signing systems such as Makaton unless they have been specifically designed for a language or country.
- Look at the communication environment. Are noise levels too high? Do people give enough time for individuals to process information and respond? There are guidelines at www.icommunicatetherspy.com
- Explore how information is recorded and presented locally. In areas of low literacy there may be familiar visual strategies in place.
- Last but not least, find out about supported communication which is already being used locally by asking colleagues and contacting relevant organisations.

The following organisations and resources provide practical and functional suggestions:-

International Society for Augmentative and Alternative Communication (ISAAC)

<https://www.isaac-online.org>

Communication Matters www.communicationmatters.org.uk has useful booklets 'Other Ways of Speaking' and 'Getting Started with AAC' which include 'Designing and using alphabet charts' 'Using low tech systems when pointing is difficult' and 'Using low tech systems'

Royal National Institute for the Blind www.rnib.org.uk has an Effective Practice Guide: Communication: Complex Needs

The Total Communication Resource Pack-East Sussex County Council 2014

The book **Disabled Village Children** has visual examples of communication aids which can be used with individuals with normal hearing and communication difficulties as well as those with hearing impairment (see Resources section)

Let's Communicate (WHO Iris 1997), by Helen House and Jenny Morris, has a wealth of practical information on communication, assessment, goal planning, cerebral palsy, hearing loss and complex needs –a 'must' for AHPs . Free download.

<http://apps.who.int/iris/handle/10665/63851>

The Stroke Association www.stroke.org.uk has useful advice (e.g. Helping Someone with Communication Problems) that can be modified for partners/carers of adults with communication difficulties who have suffered head trauma. The advice may be equally applicable to children and young people.

Action on Hearing Loss www.actiononhearingloss.org and **National Deaf Children's Society** www.ndcs.org.uk both have information about being good communicators and listeners with hearing impaired people.

Christoffel Blind Mission www.cbm.org is an international development organisation committed to improving the quality of life of persons with disabilities in the poorest countries of the world.

Deafness

In low resourced countries, Deafness can have a devastating impact on the child / adult (affecting speech, language and communication, education, employment, mental health and quality of life).

According to WHO (February 2017)

- over 5% of the world's population has disabling hearing loss (328 million adults and 32 million children)
- 80% of people with moderate to profound hearing loss live in low - and middle - income resource countries
- Less than 3% of people with disabling hearing loss in low resource countries have a

hearing aid

- More than 30 million hearing aids are needed annually in developing countries, together with services and staff to fit them, but current annual provision is less than 1 million (Holly Robinson 2016)

Where you can go for help (would depend on the locality and resources available):

- local deaf persons who are able to support, teach and provide insight into some challenges experienced by deaf people
- Interpreter / Communicator
- Families with deaf children
- National Association of the Deaf (or other group run by the deaf)
- 'Special Education programmes' or Schools for the deaf
- Audiologists, ENT and other health professionals (Hesperian Health Guides)

Helping Communication – Total Communication

The Total Communication approach explores and incorporates the use of a wide range of strategies to encourage / support what is easy, works well and can be adapted to suit the needs of the child / adult in their particular community:

- personal gestures
- objects
- pictures
- sign language
- lip reading
- finger spelling
- drawing
- reading
- writing

“Deafness is a community issue”

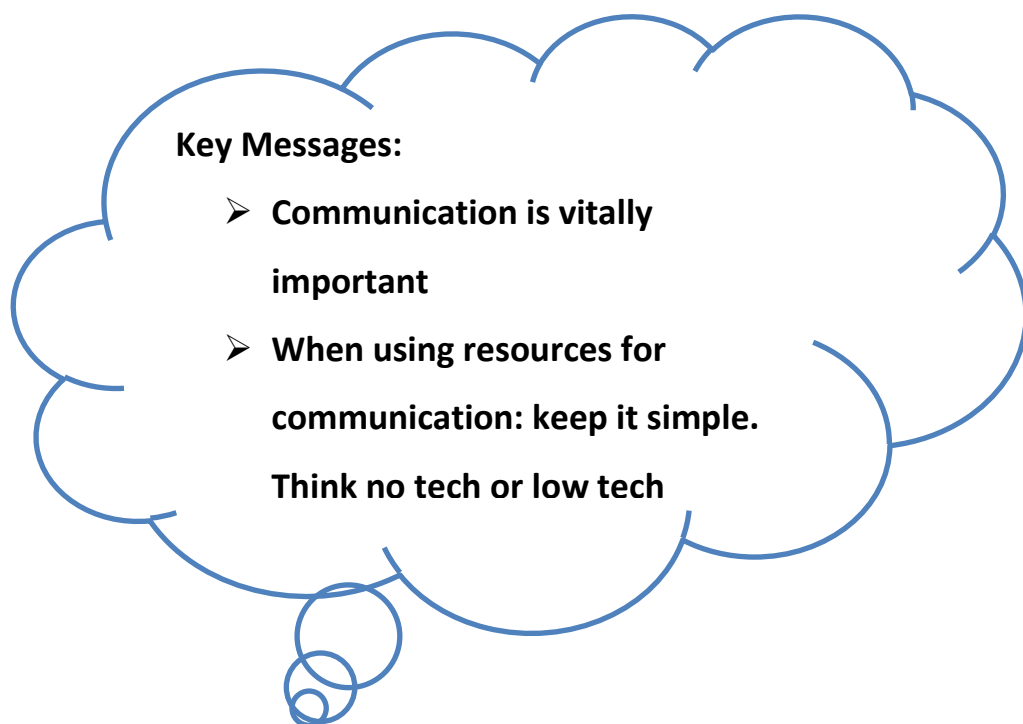
Holly Robinson (Yale Global Health Review 30 Oct 2016) observed that “By simply educating family members on the importance of developing communication with their deaf children, researchers observed a significant improvement in deaf children’s ability to engage with the community and participate in society. This has major implications for the mental health of the deaf, as it allows children to develop in a fully supportive environment.”

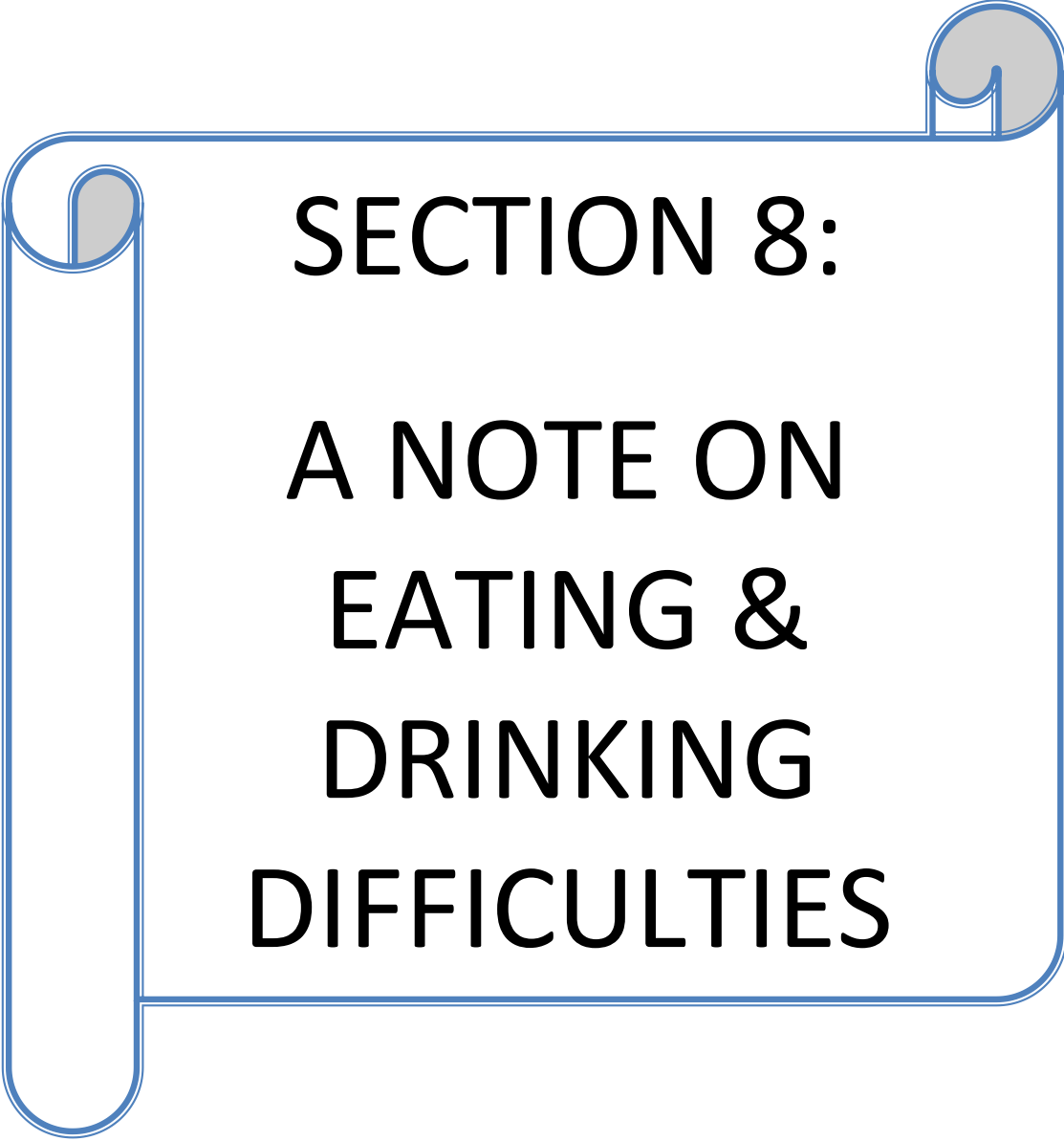
Useful Organisations/Resources

Deaf Children Worldwide (National Children’s Deaf Centre)

Sound seekers www.sound-seekers.org.uk currently has multiple projects in five African countries with an overriding aim of helping deaf people in some of the world’s poorest communities to learn and earn.

Audiology Without Borders (articles in the Hearing Journal).





SECTION 8:

**A NOTE ON
EATING &
DRINKING
DIFFICULTIES**

Eating and Drinking Difficulties

These include difficulties with chewing and swallowing (dysphagia) as well as food aversion.

Management of feeding and swallowing difficulties (dysphagia) in LMICs is hugely under served and is an area of exceptional need. Many therapists visiting low-income countries will find themselves being asked for advice about managing eating and drinking difficulties. Therapists should be aware that dysphagia management without the multi-disciplinary team, without the technology for assessment, without equipment for therapy and rehab and often without finances for the family to adapt will be challenging and require flexible and innovative thinking. This can be stressful and often distressing work. With this knowledge, any professional needs to carefully assess the situation and decide if they are competent and confident enough to work in a situation in which someone's health and life expectancy can be compromised. You should also consider the fact that you may not have the same medical back-up as you would when working at home. Advice needs to be particularly sensitive to the local context. It is a good idea to work collaboratively with a local colleague from a related profession, e.g. OT, dietician/nutritionist and to liaise with other SLTs with relevant experience in low-resourced settings.

Ideally, a detailed assessment and intervention should always be undertaken by a dysphagia-trained professional. If no-one is available, you should carefully consider whether you have the competency to be involved and at the very least, seek advice from a specialist either by phone or on-line (if there is internet access).

Basic areas to consider, not an exhaustive list:

- **Attitudes and culture** of food/ drinking in that country/ socioeconomic group/ religion. Right vs left hand, textures and consistencies etc.
- **Team members:** link up with any SLTs in the country that are experienced with dysphagia (if available). Team should include Respiratory/Chest physician, Physio (as a minimum) and can also include: Nurse, OT, Dietitian, Psychologist, Counsellor as appropriate. You may be working in an area where there are no other specialist

healthcare professionals, but there may be community health workers. Working with generic healthcare workers where they exist, and family members is essential.

- **Diagnosis** and general medical background of the person- expectations of prognosis (progressive, improving, fluctuating, static) to plan next steps for that client and agree who is to review and what they are likely to suggest. Mobility of the patient, chest infections.
- **Dentition:** dental problems, undiagnosed oral health problems.
- **Oral care:** Mouth care is essential, particularly for people with dysphagia to prevent aspiration pneumonias.
- **Saliva Management.**
- **Weight Loss.**
- **Positioning:** of person with dysphagia and the person assisting/ feeding them.
- **Method of delivery of food/ drink and utensils:** e.g. hand over hand assistance, adapted cups, spoon size, shared plates etc.
- **Timing and amounts:** of delivery of bolus/ sip. Timing of meals/ snacks. Timing of dysphagia advice/ management/ therapy.
- **Food/ drink types available and Food Preparation.** There is an effort for an internationally agreed structure of food and drink consistencies. You should be aware of recognised and agreed consistencies in your own country. (UK: drinks 1/2/3, foods C/D/E).
- **Response to coughing and choking.** Client/ patient and carer/ helper.
- **Non- oral feeding:** if available or not. Ongoing costs of non- oral feeding vs costs of recurrent aspiration pneumonias.
- **Access to Videofluoroscopy (or not):** 'gold standard' for assessment of dysphagia.
- **Risks:** dehydration and malnutrition, aspiration pneumonias, compliance etc.

Competencies

SLTs:

CTI recommend that SLTs working with people with eating and drinking difficulties/ dysphagia in other countries including LMIC have at least Specialist Dysphagia

Competency (C). They should also bear in mind that their new working situation may expose them to environments or clients which are unfamiliar to them and that this may affect their competency level. For example, as stated in the RCSLT Dysphagia Competency and Training framework: ‘a therapist who has worked in dysphagia, but is now working with a new dysphagia patient/client group e.g., from adult acute to paediatric acute’ would be at level B Foundation Dysphagia Practitioner. In this example, online support from CTI members who have level C and above Dysphagia Competency or overseas Dysphagia Specialist Practitioners with LMIC experience would be recommended to help the practitioner’s management of dysphagia clients.

Other AHPs Competencies:

Please restrict yourself to management that you are confident and competent to deliver- for example Physios and OTs should be confident to position the client/patient for eating and drinking and help facilitate self or assisted feeding. Dietitians should be confident to recommend appropriate foods with nutritional and calorie intake appropriate to the client/ patient and their difficulties. They may feel confident to advise on textures of foods as recommended by SLT.

Even if you are not a specialist in this field, there are low-tech universal guidelines that staff and caregivers can be trained on. A range of resources can be found at www.maits.org.uk/resources. Get in touch with Communication Therapy International or and MAITS (www.maits.org.uk) for further information.

The information below focuses mainly on children, but the same principles apply when supporting adults.

Basic information you can share with others:

- 1. The importance of being able to eat and drink ‘well’**
- 2. Identifying difficulties**
- 3. What caregivers can do to help – Universal Guidelines**

1. The importance of being able to eat and drink 'well'

Eating and drinking are a matter of survival and fundamental to everything else about the individual. Difficulties with eating and drinking lead to stressful mealtimes for the individual and caregiver, and forceful feeding methods are often used out of desperation. Longer term consequences include malnutrition, dehydration, chest infections, poor overall health and increased overall burden of care. If not managed, they can significantly shorten an individual's life. Simple strategies can make all the difference.

2. Identifying difficulties

Individuals at particular risk are those with a developmental physical disability such as cerebral palsy or cleft lip/palate or an acquired disability following a stroke or head injury or due to a progressive neurological condition. Ageing and dental problems are also a factor. Some children have an aversion to food either because they have been intubated or may be on the autistic spectrum.

What physical feeding difficulties may look like:



Problems managing food in the mouth:

- Excessive drooling
- Spillage of food from the mouth (sometimes pushed out by tongue thrust)

Problems swallowing food the right way and problems with digestion:

- Coughing and choking
- Several goes at trying to swallow something

- Signs of pain in face, face changing colour, tears in eyes (food has gone down the wrong way – is ‘aspirated’)
- Regurgitation
- Child noticeably uncomfortable or upset
- Food refusal

General signs and symptoms

- Recurring chest infections and generally poor health
- Underweight, with no other reasons
- Mealtimes taking longer than should
- Difficulty transitioning from puree to mash
- Unable to eat same amount as other children in one sitting
- Increased secretions
- Dehydration (passing urine less often, urine is a darker colour)

(i) What caregivers can do to help – Universal Guidelines:

- Hygiene: Follow good hygiene practices – caregiver and child.
- Familiarise the child to the feel, smell and taste of food in fun ways, if needed. Give smaller meals more often: high nutrient and calorie content; smooth texture (no ‘bits’ but not too runny).
- Drink: Give small sips of water throughout the day (minimum 1 litre per day).
- Communication: Encourage child to eat, using positive words.
- Position: Support child in an upright position with the chin slightly down (use special seating where possible).
- Utensils: Use a small cup (lid of baby’s bottle or medicine cup) and small spoon, made of strong plastic.
- Feed sensitively: Give small mouthfuls, slowly, watching & pausing.
- NEVER FORCE. Help the child to learn to feed themselves.
- Be vigilant: Go to the doctor if child is malnourished, dehydrated, has a chest infection, frequent vomiting, fits (epilepsy)



Easily available resources:

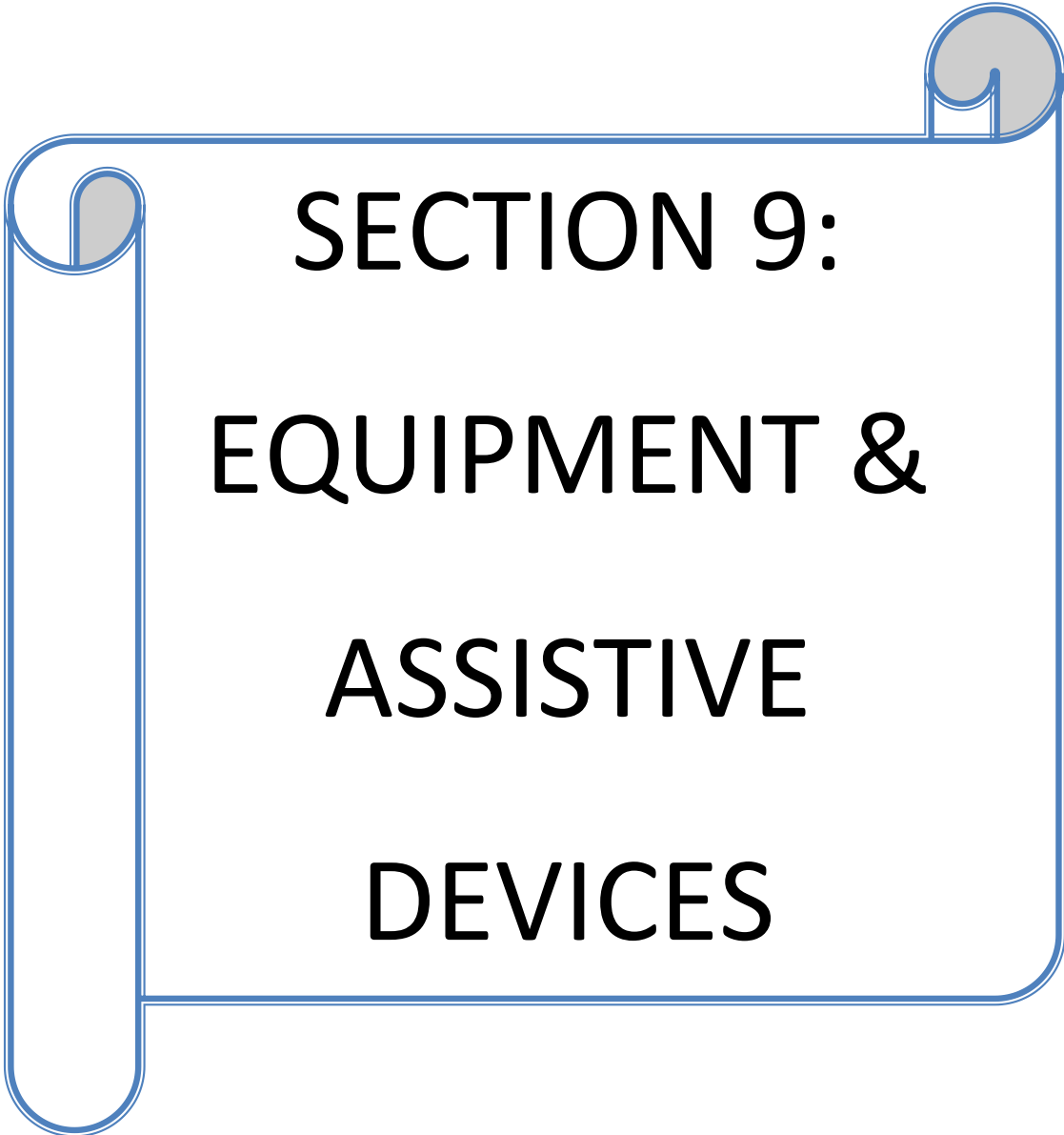
- Working with Infants with feeding Difficulties: A training programme for healthcare staff in low-resource settings. By H. de Silva and M. Asir. Published by MAITS (available free of charge at www.maits.org.uk).
- Working with Children with Eating and Drinking Difficulties: A training programme for healthcare specialists in low-resource settings. By M. Adams and J. Pettigrew. Published by MAITS. Available on request from info@maits.org.uk
- Collection of informal resources: www.maits.org.uk/resources
- Disabled Village Children: A guide for community health workers, rehabilitation workers, and families By David Werner
- Let's Communicate series of guides published by WHO/ IRIS- the handbook on Cerebral Palsy (number 5) has a Feeding and Nutrition Section pages 50- 57 with advice on positioning page 53- 54. <http://apps.who.int/iris/handle/10665/63851>

Although information available for LMICs is for children with cerebral palsy, the general principles may apply to children and adults with all types of difficulties (not just CP).



Key Messages:

1. You can help to raise the awareness of the importance of addressing eating and drinking difficulties.
2. Even if you have little training yourself, you can help by sharing simple universal guidelines with caregivers.



**SECTION 9:
EQUIPMENT &
ASSISTIVE
DEVICES**

EQUIPMENT/ASSISTIVE DEVICES

As AHPs we use assistive devices to support the habilitation and rehabilitation of individuals with disabilities. These range from a wheelchair, to a communication aid, to a means of enabling someone to be fed or toileted.

So whether you are a Speech and Language Therapist, a Physiotherapist or an Occupational Therapist, this section will have something for you.

The use of equipment and assistive devices by AHPs is dependent on clinical need, the training, experience and imagination of the therapist, but is also critically determined by supply and appropriateness. That is, it is context dependent.

In the West we are used to professionally designed off-the-shelf equipment often supported by state provision. In low-resourced situations assistive devices are often not available; in addition, western equipment may not be appropriate. For example lightweight wheelchairs are not robust for stony terrains in rural Africa or Asia.

Therapists need to find other means of provision.

The importance of equipment provision is now being recognised

In recent years, the right of people to equipment and the inadequacy of supply has received high level recognition.

The World Health Organisation recognises that “Assistive technology is the tool, and often the first step to ensure people with disabilities are equal beneficiaries of and contributors to any development process”.¹

“It estimates that only 1 in 10 of those who need an assistive device have access to what they need. This is particularly the case in low resourced settings. Production is

low and often of limited quality. There is a scarcity of personnel trained to manage the provision of such devices and technologies”

In low and middle resourced countries, only 3% of the population in need have access to hearing aids.

http://www.who.int/phi/implementation/assistive_technology/global_survey-apl/en/

The United Nations in “The Convention on the Rights of Persons with Disabilities” has now recognised access to assistive technology as a human right and has called for international cooperation to improve its access (Article 32).”

In response, the “WHO is developing a flagship programme – **Global Cooperation on Assistive Technology (GATE)** – in partnership with UN Agencies, international organizations, donor agencies, professional organizations, academia, and organizations of and for persons with disabilities.

Government and non-government agencies from around the world are collaborating with the WHO to:

- develop national policies and programmes on assistive devices and technologies with a focus on human resource development
- create a database on availability of appropriate assistive devices and technologies.

As AHPs working and supporting work in low and middle income countries we need to be aware of these initiatives and work together with them.

In 2016 the WHO produced the **Priority Assistive Products List**. This defined 50 priority assistive products. They are regarded as an absolute necessity to maintain or improve an individual’s functioning and which need to be available at a price the community/state can afford.

http://www.who.int/phi/implementation/assistive_technology/en/ (accessed [12/07/17](#))

A recent study evaluating a training programme for mothers of children with Cerebral Palsy in Ghana found that assistive devices such as bespoke chairs or standing frames, enhanced the caregivers' ability to work, and facilitated social inclusion for the child, in play, school and within the family and community. The equipment also promoted the child's development by, for example, improved mobility, trunk stability and head control. However, there was dissatisfaction at the sizing and durability of the devices and while they were considered valuable, a third were not being used because of problems.

<http://disabilitycentre.lshtm.ac.uk/files/2014/07/Evaluating-the-impact-of-a-community-based-parent-training-programme.jpg>

Provision of equipment and assistive devices in low-resource contexts

While the GATE programme is extending supply, it will take time before equipment and assistive devices will be routinely available and in the meantime AHPs will continue to need to find alternative ways of ensuring provision for our clients.

Key issues identified around the use and availability of equipment and assistive devices

Assessing the clinical need for an assistive device does not change with geography, **however** selecting and providing a device which will be appropriate to the cultural, physical and economic environment, is context dependent and subject to....

- **Availability of supplies that are already in existence locally.**
- **Awareness of their use and value**
- **Sufficient means for monitoring, to allow for growth in the case of children, and to avoid pain, and discomfort.**
- **Sustainability of supply**
- **Suitability in terms of 'fit'- economic, cultural and with regard to the physical environment**
- **Durability, spare parts and facilities for maintenance and repair**

Affordable equipment can sometimes be found locally

It is always worth asking around to find if there are items available in local shops and markets that may also be suitable

Often everyday items available in clients' homes may be suitable or can be adapted.

For example,

- Plastic cups may be lighter weight and have larger handles for people with impaired hand function.
- Many countries have a favourite national board game which can be used to develop fine-motor co-ordination skills or to aid communication, and enable social and cognitive retraining.

Certainly, items bought locally have the advantages of being familiar and culturally appropriate, they blend in, are easily replaceable and more affordable. Many items will be suitable, but not all. It is important to consider critically the construction and type of materials used with respect to safety. For example, small parts could come adrift and become choking hazards for infants and small children.

Sustainable Availability

The issue of sending rehabilitation equipment overseas is a constant source of debate as AHPs and their associates are faced with the pros and cons of being involved in sourcing, sending, using, adapting and maintaining equipment in the international setting.

Importing equipment or assistive devices or the materials to make them relies either on donors or on contracts. Donors may or may not be able to sustain supplies in the long term. Imported items may be subject to customs and duties and take a long time to obtain.

The debate therefore, around 'Should we send equipment abroad?' is not a straightforward issue and the answer to the question is probably – it depends on the context.

The type of international activities that attract donations – not only equipment – is complex and links with voluntary and non-voluntary sectors, including the

humanitarian and private sectors, with varying commitments and time lines, which need to be reflected on in this debate

There are western non-government organisations that recycle and supply equipment. This can be a useful and more sustainable source but thought must be given to when the equipment is, or is not, appropriate to the socio-cultural and physical environment in which it will be used. **PhysioNet** is an organisation which recycles assistive devices for low and middle income countries, assistive devices such as wheelchairs, walking frames or Pedro boots for children <http://www.physionet.org.uk/>

Every year at the ADAPT conference, the participants have a debate. In 2014, their debate focused on whether we should be sending equipment abroad. Whilst this was directed at physiotherapists, the comments are relevant for all health care professionals

Debate: Should we be sending Equipment Overseas?

The next 2 examples were used to help address this debate.

CBR Setting

An organisation had been working with the Ministry of Health to develop community rehabilitation services for children with differing disabilities in the town and surrounding villages, mainly with mobility and communication difficulties. National rehabilitation services had been institutionalised in 2-3 special centres where children with disability and caregivers attended an intensive set of physiotherapy sessions focusing on passive exercises, wax and electrotherapy. The children returned home to continue some basic exercises without any mobility aids to develop their balance, standing or walking skills. With the donation of models of corner chairs, wedges, K walkers, Pedro boots, leg splints etc., the local staff were trained to assess and measure a child for the use of the equipment and then use local materials to make this basic equipment to support the children's development. Then the parents were encouraged to also copy the relevant equipment to use in the home setting.

Emergency Setting

After an earthquake, 5 containers of adult one size wheelchairs arrived in the affected area sent from abroad as a donation to support the injured and disabled to a small community NGO. The donation was very welcome as people were in desperate need. The distribution of wheelchairs was a challenging activity as none of the staff were trained to assess, measure or know how to use them. So wheelchairs were given out as soon as they identified people with mobility needs. Clearly many of the wheelchairs were not well suited for the individual, being too wide or long and high for the person to be able to use it as a mobility aid. None of the wheelchairs were suitable for children or for people with complex injuries, such as SCI, TBI, persons with double amputee and these people remained isolated in their tents and shelters.

PROS & CONS OF IMPORTING EQUIPMENT

PROS	CONS
<ul style="list-style-type: none">• If one piece of useful equipment is provided, it can be copied locally and reproduced using local materials• Clinically for local staff it opens up and/or strengthens a greater number of treatment options• Improves the quality of life for people that otherwise they wouldn't have.	<ul style="list-style-type: none">• Equipment has the potential to do more harm than good if people are not clear how to fit/use or maintain it.• Not a sustainable process as donations tend to be random and not based on demand from the LMIC• Often delivery and distribution of equipment is coordinated by a non-technical person• Better to support the local economy and resources in LMIC.• Many children and adults need continued provision of specialised equipment so providing on a one off basis is not a useful solution

Suitability in Terms Of 'Fit'-

Economic, Cultural and with regard to the Physical

Environment

Is the item or the materials from which it is made, affordable for families and services locally?

Western supplied equipment will be too expensive for many families. However, there are communities in most countries who can afford high end equipment and private hospitals which can provide it.

There are in some countries well-established and well supplied prosthetics workshops, however it can be difficult to obtain supplies of thermoplastics for hand splinting.



Plaster of Paris can be an alternative splint-making material.

Wood for construction is often available, yet in many low and middle income countries posturally supportive wooden chairs are still too expensive for many families. The wood used is often hard wood which can be difficult to work and heavy. An alternative approach for posturally supportive seating is so-called **Appropriate Paper Technology (APT)** made of recycled cardboard. The resulting assistive devices can be made to meet the most complex postural needs of children with cerebral palsy, the devices are robust and cheap, however the techniques need to be well learnt and production can be time-consuming. Future training programmes for assistive device provision should recognise the role of postural management to enhance participation, ease parent handling and contribute to development, as well as helping combat weakness and the development of postural deformity. Follow up should include monitoring of pain or discomfort and adjustment of the assistive devices as the child grows and develops.

Examples of equipment for children with cerebral palsy using APT



Supportive Adapted Wheelchair



Standing Frame



School Desk



Supportive adapted chair

Information about APT including courses in the UK for therapists to learn the method is on the People Potential website.

<http://www.peoplepotential.org.uk/appropriate-paper-technology>

Is the item or material suitable for the immediate environment?

APT items will need to be kept indoors when it's wet.

A home visit will ensure that there is space in the home for an item.

The visit will confirm whether there is somewhere appropriate to put the item, for example to prop an inclined standing frame.

Western wheelchairs may not be sufficiently robust for the stony, uneven terrain of rural Africa and Asia and won't last. A range of wheelchairs has been designed specifically for these environments and supply mechanisms have been established.

Motivation is a British non-government organisation which has pioneered the design of a range of wheelchairs suitable for low and middle income country contexts.

<https://www.motivation.org.uk/>

When selecting an appropriate wheelchair, consider the user's lifestyle and environment. Srinvas' hospital transfer chair didn't last long on the uneven ground around his home. Today, he uses a Motivation Rough Terrain wheelchair to help farm his land. Wheelchairs providing postural support for children with cerebral palsy can enable function and help prevent deformity.



© Motivation

The World Health Organisation has produced in-depth information on wheelchair provision for low and middle income countries, covering assessment, design, supply and training.

<http://www.who.int/disabilities/publications/technology/wheelchairguidelines/en/>

Can the device be maintained and repaired?

If an assistive device cannot be repaired or replaced, the user will have been enabled for a short time, only to then tantalisingly lose that newly experienced independence.

Donated chairs from industrialised countries tend to break easily in the rough conditions in most developing countries. Replacement parts are usually not available locally.

Some assistive devices by their nature will have a limited life. An example would be pressure relieving cushions which cease to have therapeutic value as they wear out. Equipment which falls into disrepair can become useless or dangerous, such as hoist slings, wheelchairs or hoists. It is important that the users of assistive devices and the therapists providing them have the information to recognise these limitations. The therapists may decide it is better to avoid certain items.

Repair requires a supply of the right spare parts and know-how. Some hospitals have workshops which could undertake repairs and some basic repairs can be done by local artisans, e.g. a bicycle repairers, carpenters or tailors, with appropriate training.

Standard battery powered devices and toys may not be feasible to use.

In general, it may be better to avoid sophisticated equipment which local personnel are not familiar with and where spare parts and the know-how to repair them are not available.

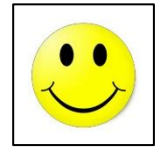
Two excellent resources which between them discuss further, issues around using and making equipment and assistive devices are

- **D.Werner “ Nothing About Us Without Us”**
- **V.Alers, R.Crouch “Occupational Therapy an African Perspective”**

See Resource Section

Is the item culturally appropriate?

We use pictures to communicate when teaching and in communication devices. However, the pictures will be based within a cultural context. We may think, for example, of using a smiley face picture to communicate or reward success in therapy, yet it may not be understood everywhere.



Likewise, drawing a star as per the Israeli flag will not be culturally appropriate in the Arab world.

It is all too easy to assume that something will be understood and acceptable.

We need our host colleagues to help us understand what is and is not appropriate.

Designing and making equipment and assistive devices locally – make it yourself!

With imagination, it is possible to make very effective aids for daily living and posturally supportive seating using locally available materials and even waste products. Appropriately designed, locally made equipment and assistive devices can be more suitable culturally and more sustainable in terms of the environment, supply and maintenance.



A waste plastic bottle used to make it easier to turn a tap on and off, for people with weak hands.

An African OT once pointed out that if we think differently we can recognise more of what is around us as being of therapeutic value. For example, she suggested using cold porridge for tactile stimulation.

For assistive devices made of wood or metal, such as a corner seat or seating adaptations, local artisans, carpenters, metalworkers and tailors, can provide advice on suitable materials and construction methods.

In our experience artisans who have been involved in the design and making of an assistive device very often continue to supply equipment on an ongoing basis, providing a new supplier to the local AHPs.

Ensuring equipment and assistive devices will be used!

- Explaining the purpose of the assistive device and so bringing it into regular use by an individual or caregiver is a critical component in the provision of assistive devices and equipment, which is often overlooked.
- Equipment and assistive devices may not be used if their use is ill- understood or considered culturally inappropriate by a family.
- Host colleagues are likely to be able to give guidance about possible barriers to acceptance.
- Home visiting always helps
- It is important to talk through and check perceptions and expectations of what a piece of equipment are for and how it can be used with the user or caregiver. For example, we may assume that parents play with their children but in some communities, it is not usual for adults to play with children.
- If local therapists and therapy assistants are familiar with newly introduced equipment and assistive devices they are more likely to 'Own them', recognise their role and use them in the longer term.

Outcome Measures

We need to monitor the usefulness of our services and of the role that assistive devices play. There are now tools for this:

In relation to children

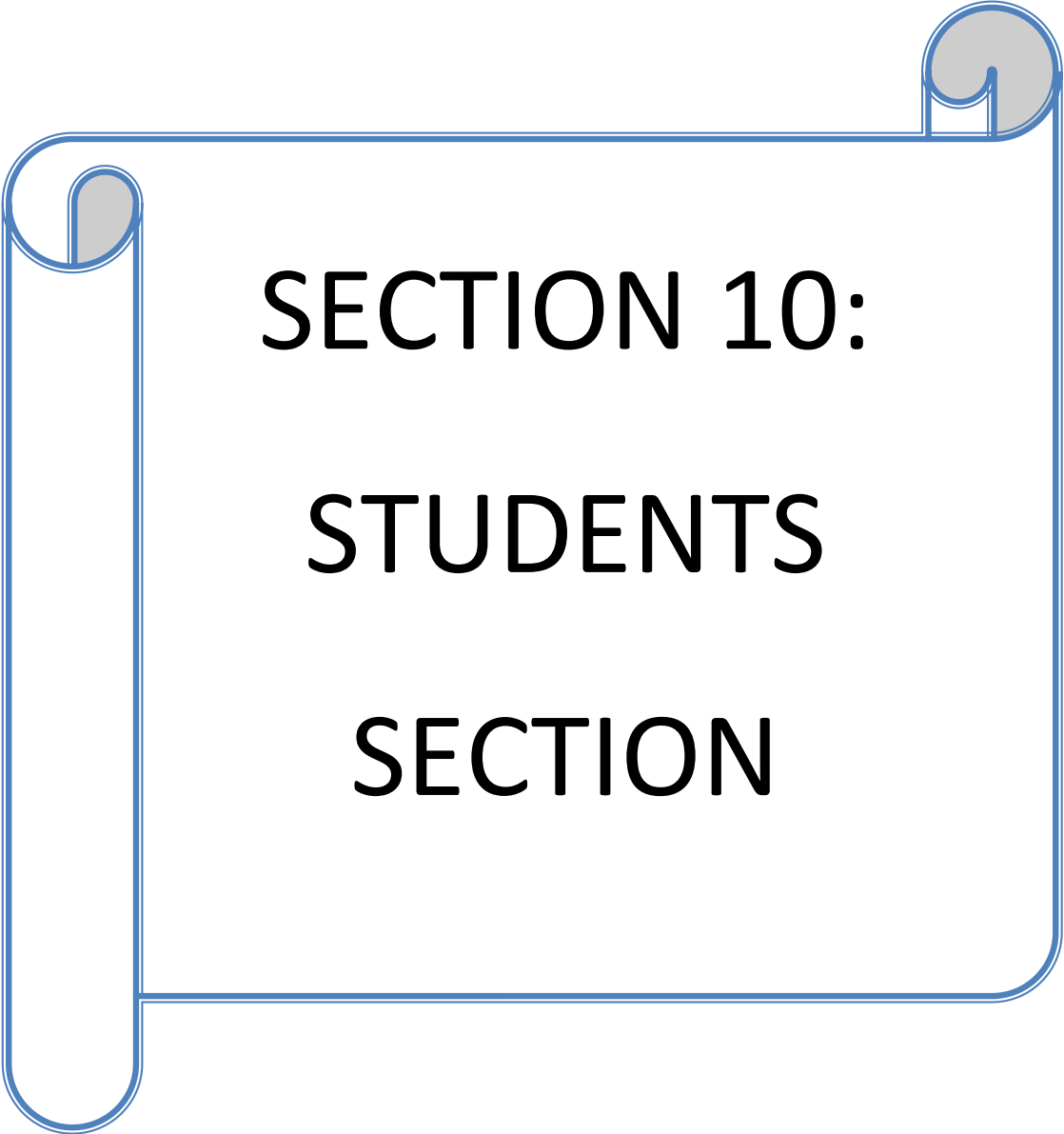
- Ryan et al (2006) The new Family Impact of Assistive Devices (FIATS)
- Chiarello et al (2016) Child Engagement in Daily Life: a measure of participation for young children with cerebral palsy.

In relation to Adults:

- The Canadian Occupational Performance Measure (COPM)
<http://www.thecopm.ca/>

Key Messages:

- **Access to appropriate assistive devices is now recognised as a key priority for individuals with a disability.**
- **Suitable assistive devices and equipment may be available in-country. Encourage information sharing on locally sourced low-cost Aids.**
- **Where unavailable, they can be designed and made locally through collaboration between local and overseas therapists, users, caregivers and local artisans.**
- **Ensure the equipment is appropriate and safe to use and can be maintained.**
- **Ensure there is a training process in place.**
- **Most importantly - work together with recipients**



**SECTION 10:
STUDENTS
SECTION**

Thinking of working abroad?

AHPs are likely to gain both personally and professionally from working overseas but the purpose should be to facilitate function and inclusion for people with disabilities.

There are usually two main reasons why students choose to go abroad.

1. Seeking a placement abroad, either an official elective as part of their university course or just to gain experience during their holidays.
2. To work abroad following graduation either on a voluntary basis or paid.

Other reasons why a student may wish to go abroad may include:

1. Accompanying a partner
2. Have family and friends abroad
3. Travel and adventure
4. International experience
5. Personal development
6. Study
7. Clinical work

It can be quite difficult for students to find appropriate work abroad. Please be understanding. Although as visitors we probably gain at least as much as our hosts, the interests of the host country must always come first. Providing opportunities for students, places demands on a host organisation that can be unmanageable in some low-income contexts.

It can also be quite difficult for students to find appropriate work abroad due to the supervision that needs to be provided for students. Nevertheless, there are opportunities to find student placements abroad. The first port of call should be your university which might have established links to organisations and hospitals abroad. Fellow students who went through placements abroad are also a good source of information as it will help you to draw on previous experiences.

There are lots of small organisations/charities who welcome general volunteers but they are not likely to appear on the top pages when you do a search online but might require a thorough search to identify these.

There are also gap year organisations and of course independent projects as well as planned electives. A second language is always an advantage and it might involve significant costs (£200 - £500 per week).

Here are some examples of organisations that may be able to help you'

<http://www.worktheworld.co.uk/>

<http://www.challengesworldwide.com>

<http://www.globalvolunteernetwork.org/>

Make sure you keep documentation from your university, such as your course transcripts, details of the curriculum, course/programme/module handbooks and university student handbooks. These will be essential if you work internationally at a later stage – you will almost certainly need to provide your original documents, or certified copies, during the application process.

You should also keep in touch with your personal tutor/reference provider after graduation, because they may have to be approached for references.

If you prefer to secure a placement via an agency, such as:

- Work the World <http://www.worktheworld.co.uk>
- Projects Abroad <http://www.projects-abroad.co.uk>

Please consider that you need to pay for their services and air fares are not usually included.

Physiotherapy students:

The CSP developed resources for its student members which can be found in the following link: [http://www.csp.org.uk/professional-union/careers-](http://www.csp.org.uk/professional-union/careers-development/employment/working-internationally/volunteering-electives)

[development/employment/working-internationally/volunteering-electives](http://www.csp.org.uk/professional-union/careers-development/employment/working-internationally/volunteering-electives)

CSP student members are covered by the organisation's insurance subject to conditions outlined in the respective documents <http://www.csp.org.uk/professional-union/practice/insurance>

If you are not yet qualified (or even if you are but have not yet received your HPCP registration) you must **not** work (paid or unpaid) as a physiotherapist.

Speech and Language Therapy students:

CTI do not recommend that student Speech and Language therapists work abroad unless with a supervised university project.

Private arrangements are also not recommended. CTI strongly recommends the following guidelines for student Speech and Language Therapists:

If you have not qualified at home, you must **not** work (paid or unpaid) as a Speech and Language Therapist elsewhere, either. This will require scrupulous care in how you present yourself to others who may not appreciate that you are unqualified.

Before travelling during the pre-registration year, an SLT should fulfil **all 3** of the following criteria:

- 1. You should have successfully completed at least 50% of your pre-registration training course**
- 2. AND you should have successfully completed at least two clinical placements in your home country, including one with adult clients and one with children.** This applies regardless of your expected area of clinical practice overseas, as patients are often not filtered through clear clinical pathways
- 3. AND you should have robust arrangements for clinical supervision in person on site throughout your period of overseas work.** Your supervisor should have at least four years' post qualification experience. Skype/email/telephone supervision is not appropriate for students.
- 4. Students must not provide dysphagia care in a low income context unless under the supervision of an SLT with at least four years specialist dysphagia experience. See note on Eating and Drinking Difficulties Section.**

Occupational Therapy students:

- If you have not yet qualified and received your HCPC registration, you must **not** work (paid or unpaid) as an Occupational Therapist anywhere in the world. See the College of Occupational Therapists code of ethics preface clause iv and standard 5.1. <https://www.cot.co.uk/sites/default/files/publications/public/CODE-OF-ETHICS-2015.pdf>
- The College of Occupational Therapists offers guidance on international placements for BAOT student members which can be found here : <https://www.cot.co.uk/students/international-placements>

You will need to check with your university about arrangements for international placements as they may or may not offer them. Your university may have exchange programmes in place for international placements. Some universities may expect you to meet certain standards before going on international placement.

Regarding insurance

Information about professional liability insurance for occupational therapy students is available on the website

<https://www.cot.co.uk/independent-practice/briefing-66-professional-indemnity-insurance-baot-members>.

Discuss also with your college as they may have arrangements.

If you are going to arrange a placement for yourself, make sure you have enough time to organise it. Some companies can arrange them for you; however, this can be a very expensive option. Many countries where OTs are practicing have a local OT association. Contact local associations to find out what support they can provide in finding and supporting you in a placement. See

<http://www.wfot.org/Membership/CountryandOrganisationProfiles.aspx> to find contact details for OT associations

Professional Liability Insurance (PLI)

Physiotherapists: As a CSP member you are covered for temporary work abroad (except Australia, USA and Canada) as long as you hold a full membership, the

placement is on a temporary basis and you are registered and licensed to work as a physiotherapist in the host country.

Speech and Language Therapists: The professional liability insurance provided by the Royal College of Speech and Language Therapists **does not** extend to overseas work.

STUDENT EXPERIENCES

Physiotherapy student

In 2015, I spent four weeks in a rehabilitation clinic in Pokhara, Nepal and the overall experience was amazing as I treated local patients with a range of different conditions, met healthcare professionals and students from around the world, experienced physiotherapy in a low resource setting and explored the local area during my free time.

When completing an elective through a third-party company, a significant fee is often involved. A portion of these fees will be donated to the clinical site you are at and given that most electives are in low resource settings, this revenue stream is well received by the sites and they will happily welcome students to ensure a continuation of the funds.

It is important to strike a balance between spending time at the clinical site and meeting the requirements asked of you and enjoying the non-clinical activities. There may also exist the opportunity to attend outreach projects or to visit other clinical sites that are known to your supervisor or local elective manager, which can really add value to your time overseas (for example, whilst in Nepal, myself and a group of other students from the house had the opportunity to visit a [leprosy hospital](#) – a unique and memorable experience)

Unlike clinical placements in the UK, local staff are not duty bound to guide your learning or provide teaching, so the amount of clinical experience achieved is entirely down to the student. It is of course advisable to be as proactive as possible to gain the most from your time there, but when you consider factors such as language barriers and clinical inexperience, it is easy to see how a student can become a passive observer whilst on an overseas elective.

Another factor to consider is how the more relaxed atmosphere of an overseas elective can potentially lead to a drop in ethical or professional standards, as there will be no formal assessor or guidelines for performance directing you. It is important, therefore, to act as if on a clinical placement in the UK and maintain the level of service and professional standards expected by students in the UK.

It will probably also be the case that you will experience treatments and approaches to care and rehabilitation that are different to those practised in the UK. One such experience in Nepal was the prolific use of electrotherapy in the clinic. Every patient received electrotherapy of some sort whether indicated or not. This led to a discussion about the validity of using electrotherapy on all patients and the lack of evidence around electrotherapy. Our supervisor responded with the simple answer that because the patients have such little faith in manual therapy and exercise prescription alone, they must be provided with an electrotherapy modality for them to feel that they are receiving treatment, thereby ensuring participation with therapy. This demonstrated to me the need to be understanding towards local beliefs and attitudes towards healthcare as circumstances in countries such as Nepal are very different to those in the UK and care must be taken not to be dogmatic in the application of Western practices over those practised in the low resource nation, especially if such practices cause no harm to the patient (as was the case with the use of electrotherapy in the clinic I was based at).

I would recommend an overseas elective to anyone wishing to experience physiotherapy in a different setting to the UK.

If you are currently considering volunteering overseas, please see the Useful Resources section on the [ADAPT website here](#) for ideas on projects and locations.

If you have already decided that an overseas elective is for you, the following points may be worth considering:

- If going through a third-party company, they will always say that the placement is great – they are trying to sell it to you! Ask to be put in touch with someone who has done the placement before to see how they found it. Look for a company who is honest and upfront with putting you in touch with previous students

immediately, as a delayed response may suggest something has gone wrong previously.

- Get a named contact that can personally and consistently deal with your application so that you are not passed from person to person each time you contact them.
- Ensure that you choose a specific placement in a well-established clinical site so that it meets what you are looking for.
- Ensure that the clinical site is used to having foreign students at their location. Is it developed for students with a structured programme?
- Whenever possible, give feedback to both the supervisor and the company as to how the elective could be improved so as to make it more enjoyable for subsequent students.

Post-stroke upper limb rehabilitation



Electrotherapy



Pros:

- Opportunities to meet and network with healthcare professionals from around the world
- Gain clinical experience
- Language barriers can help develop non-verbal communication skills and strategies
- Working in a low resource setting develops problem-solving skills

Cons:

- Can be very expensive if a third-party company is used
- Not knowing the language presents an opportunity for learning, but it can impede effectiveness of treatments
- Quality and consistency of supervision is variable
- Potential to become a passive observer if not proactive

Occupational Therapy Student

My first experience of volunteering abroad as a student was not linked to my university; rather it was with a student run charity. I volunteered in a country in Eastern Europe over my summer break from university. This experience gave me professional and personal skills for the future, as well as fantastic memories. I've had the opportunity to reflect on the great experiences, as well as some of the difficulties I experienced during that placement, namely the issues of supervision and sustainability.

Although a formal supervision structure was in place, it was not always sufficient to deal with the clinical, cultural and safeguarding issues that arose on a daily basis.

Adequate supervision is necessary to ensure safe clinical practice, and even more so when you are working as a student in what might be an unfamiliar culture.

The sustainability of this project was an issue that was commonly discussed however solutions were difficult to identify and put in place. During my time volunteering I was grappling with the issue that the support we offered was only available during the summer months and by students.

When I qualified as an occupational therapist I had the opportunity to complete another volunteer placement, in a different country in Eastern Europe, this time for a period of 6 months. Due to my previous experience I was mindful to research the charity that offered the placement. During the interview process I asked about supervision and sustainability. I was reassured when the charity were able to answer my questions, giving clear advice on these issues demonstrating that this was something that they valued. On this placement I was offered formal supervision with a

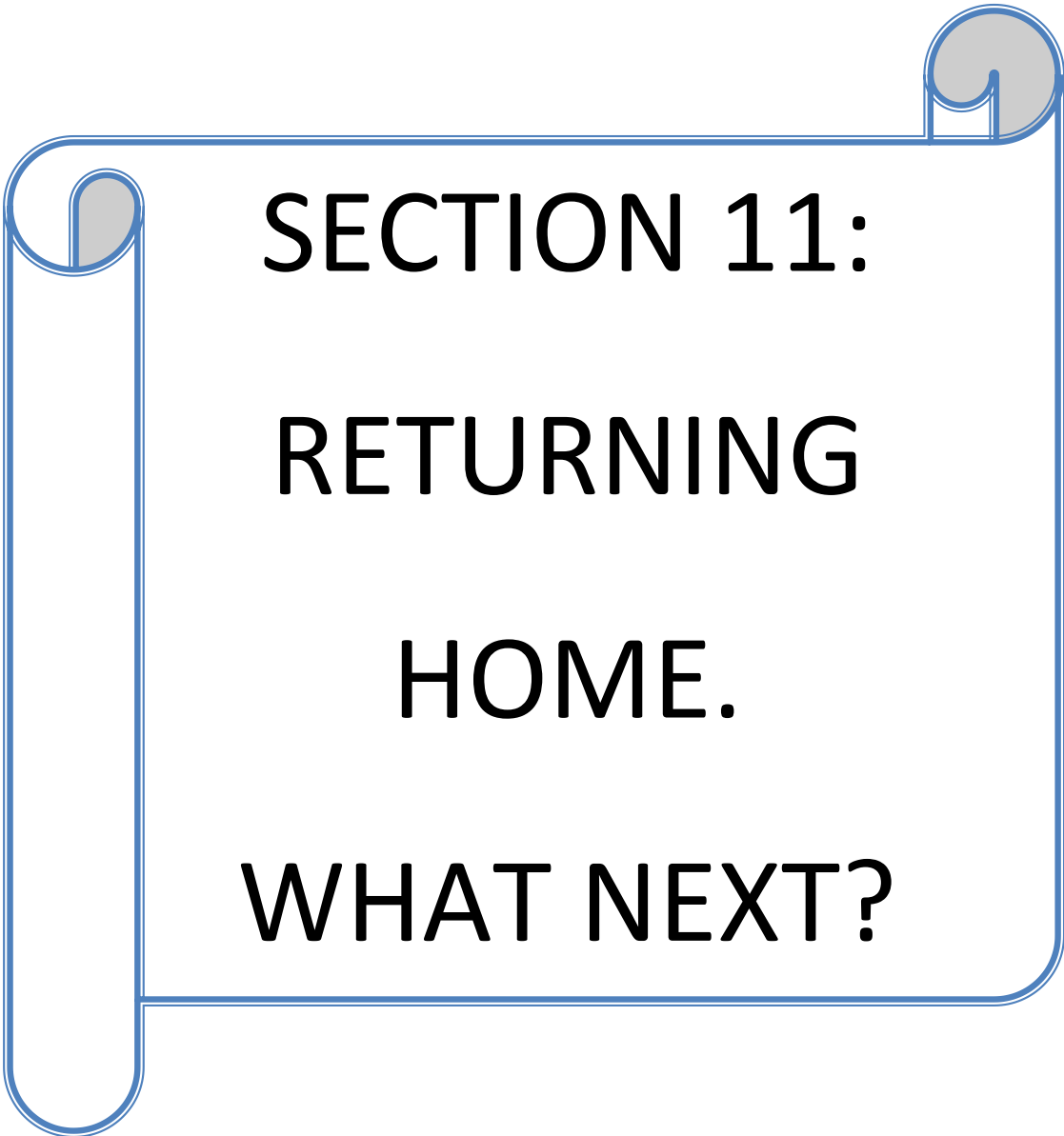
local occupational therapy lecturer. This was very important as my supervisor was not only able to offer clinical guidance, but also ensure that the project and my practice were informed by local knowledge and experience, making it more culturally safe and relevant. Sustainability of the project was ensured by referring into and working alongside a newly established local occupational therapy practice.

I would urge students that are considering a placement abroad to ask questions and research the supervision offered and the sustainability of a placement.



Key Messages:

- **Research properly before embarking on a placement**
- **Try to contact a student who has done a similar placement before**
- **Check you have suitable supervision**



**SECTION 11:
RETURNING
HOME.
WHAT NEXT?**

You may find that although friends and colleagues want to hear about your experiences, they may appear disinterested. This is due to them not being able to understand the situation you have been in. There are plenty of other people who would like to hear about your experience.

Your work does not have to stop at this point.. You can maintain links and provide continued support through organisations such as **CTI, ADAPT and OT Frontiers.**

Other organizations such as VSO provide returned volunteers support groups. To find out more, look on http://www.vso.org.uk/groups/supporter_groups

You don't have to have worked for VSO to join and it can link you up with people worldwide.

Try not to keep the knowledge and experience you have gathered through your time abroad to yourself.

Try contacting local charitable organizations or trusts interested in donating money to developing projects overseas, talk to special interest groups, submit articles to relevant newsletters and magazines or just talk to friends and colleagues at work – they may not realise that working in low and middle income countries can be so rewarding for both their personal and professional development.

Think about what you've learned and how you can apply it to your own work.

Share this with your colleagues and your manager. Try to educate them about the benefits of international volunteering to the UK workforce – for example, see the report of the All-Party Parliamentary Group on Global Health, Improving Health at Home and Abroad: How overseas volunteering from the NHS benefits the UK and the world, July 2013. Full report and executive summary available at:

<http://www.appg-globalhealth.org.uk>



SECTION 12: RESOURCES

As a starting point the OT Frontiers, CTI and Adapt websites have Resource sections such as specific professional vacancies, how to find work, relevant organisations and charities, manuals, past Study Day Reports and lots of information.

This Resources section includes the following sections:-

- **Grants available for travel and work/volunteering/study**
- **Relevant Post Graduate Courses**
- **Voluntary and/or salaried roles**
- **Specific International Organisations working in Disability Rehabilitation**
- **Human Rights & Disability**
- **Working in Emergency settings**
- **Guidelines / frameworks**
- **Condition Specific Resources including books and journals**
- **Therapy specific resources**

Grants Available

- **MAITS** provides grants to UK based individuals who have an existing relationship with an organisation overseas and are looking for some extra funds to help with a training visit. Please visit <http://www.maits.org.uk/latest-opportunities/>
- The **Joe Jeans Memorial Fund** provides funding for students to undertake an overseas elective placement. Please visit <http://www.csp.org.uk/publications/joe-jeans-memorial-fund-scholarships>
- The **Baroness Robson Travel Scholarship Fund** has been created to assist CSP members travelling overseas for educational or research purposes. Two awards of up to £3,000 each are made annually. <http://www.csp.org.uk/publications/baroness-robson-travel-scholarship-fund>
- The **CSP's International Development Award** supports the enhancement of physiotherapy through international education and development projects between the UK and physiotherapy members of the World Confederation of

Physical Therapy (WCPT) member countries in the developing regions.

<http://www.csp.org.uk/publications/international-development-award-ida>

- The **CSP's International Lecture Fund** is available to support applicants presenting at overseas physiotherapy-specific or relevant international conferences or meetings with the exception of the WCPT Congress.

<http://www.csp.org.uk/publications/international-lecture-fund>

- **The Winston Churchill Memorial Trust:** www.wcmt.org.uk/about/who-are-we-funding-of-travelling-fellowships-and-bursaries.html provides grants to British citizens, resident in the UK, to travel overseas to study areas of topical and personal interest, to gain knowledge and bring back best practice for the benefit of others, their profession and community, in the UK.
- **The Jack Petchey Memorial Fund** www.jackpetcheyfoundation.org.uk/ provides a grant of up to £300 for people aged 16 - 25 from London or Essex to undertake voluntary work abroad.
- **The Arrol Trust** provide grants to young people aged 16-25 looking to broaden their horizons through travel, possibly in the form of gap year or voluntary projects. Call 0131 299 1212
- **RCSLT Minor Grants:** provides grants of up to £500 to assist SLTs in their continuing professional development, e.g. attending conferences, undertaking specialised training or conducting research into speech and language therapy.
- **The COT's International Travel Award** available to BAOT members www.baot.org.uk
- Charities supporting individual disability areas sometimes offer financial support to experienced therapists for overseas work. Try exploring their websites

Relevant Post Graduate Courses

London School of Hygiene and Tropical Medicine www.lshtm.ac.uk/

Short Courses, professional Diplomas and Masters Degrees registry@lshtm.ac.uk

Liverpool School of Tropical Medicine <http://www.lstmliverpool.ac.uk/learning--teaching>

Short Courses, Professional Diplomas and Masters Programmes

The UCL Institute for Global Health <http://www.ucl.ac.uk/igh/teaching>

Short Courses, Professional Diplomas and Masters Programmes

UCL Leonard Cheshire Disability and Inclusive Development Centre

<http://www.ucl.ac.uk/lc-ccr>

Short Courses, Professional Diplomas and Masters Programme

Manchester Metropolitan University <http://www.rihsc.mmu.ac.uk/>

Institute for Health and Social Change Disability Studies

University of Leeds, Centre for Disability Studies, Centre for Disability Studies

<http://disability-studies.leeds.ac.uk/>

Institute of International Health and Development <http://www.qmu.ac.uk/iid/Default.htm>

The University of Manchester School of Social Sciences

<http://www.socialsciences.manchester.ac.uk/>

London School of Economics, Department for International Development

<http://www.lse.ac.uk/internationalDevelopment/home.aspx>

RedR www.redr.org.uk

Provide short courses for relief workers, including some introductory courses for newcomers

Voluntary and/or salaried roles

Additional sources of possible vacancies

Ethical Volunteering Information www.ethicalvolunteering.org.uk

Leaflet on points to consider when volunteering.

World Service Enquiry www.wse.org.uk

Information and career advice to people who want to volunteer or work in International Development

Reliefweb <http://reliefweb.int/jobs>

Majority of NGOs (national and international) will use this to place advertisements for roles both voluntary and salaried. Use search terms such as 'disability' and 'rehabilitation' as well as profession specific.

UN Jobs <http://unjobs.org/>

Devnet <http://www.devnetjobs.org/>

International Development and Consulting roles

Bond <http://www.bond.org.uk/jobs> is the UK membership organisation for NGOs working in International Development. It has 450 members including academics, trade unions, funders who network to make international Development more effective.

Charity Jobs <http://www.charityjob.co.uk/>

Handicap International www.handicap-international.org.uk

Largest International NGO recruiting physiotherapists and occupational therapists for work in both emergency response and development settings. Roles can be clinical, training or project based, and are either voluntary with monthly allowances, or salaried dependent on experience.

UK International Emergency Trauma Register visit www.uk-med.org to register

The UK International Emergency Trauma Register (UKIETR) coordinates the rapid deployment of a trained surgical team when required by the Department for International Development (DFID) drawn from across the UK. Membership is focused on surgeons, anaesthetists, emergency physicians, emergency nurses, operating theatre staff, paramedics, physiotherapists and occupational therapists. Handicap International are integrating Physiotherapists and Occupational Therapists into the register, as well as providing them with essential training. All UK based HCPC registered therapists are able to join, with priority given to those with acute and

trauma related experience. Deployments are for 2 weeks, and uniquely, UK posts are backfilled by DFID during deployment. For more information visit www.uk-med.org/trauma.html or email: peter.skelton@hi-uk.org.

Ripple Africa www.rippleafrica.org.uk may have volunteering vacancies for AHPs working with a CBR worker in Malawi with disabled children and families.

CBM www.cbm.org/vacancies

This is an international disability organisation that works primarily through local partners. CBM recruit for positions in development and emergency settings, most often requiring a degree of international experience within the rehab or disability sector.

Voluntary Services Overseas (VSO) www.vso.org.uk

VSO is always looking for qualified AHP professionals with between two to five years' post-qualifying experience including experience of working with disabled people and, ideally, experience of managing or training others. VSO positions have a strong emphasis on mentoring, coaching and providing on-the-job training.

HealthProm www.healthprom.org who carries out small projects in Eastern Europe, Afghanistan, Russia and Central Asia and may have volunteering opportunities

MAITS – Multi-Agency International Training and Support www.maits.org.uk

Focuses on development primarily by capacity-building amongst health and education professionals working in the disability sector in under-resourced countries – people mainly working with children with cerebral palsy, intellectual disability and autism, as well as some within the mental health sector and working with stroke. Looking for OT, PTs and SLTs with over four years' experience, available for short term trips to deliver training packages to low resourced countries.

Disability and Rehabilitation

UNICEF <http://www.unicef.org/disabilities/>

WHO World Health Organisation www.who.org

The WHO publishes many documents of interest to AHPs such as:-

- CBR Guidelines (2010) <http://www.who.int/disabilities/cbr/guidelines/en/>
- Assistive device and technologies
<http://www.who.int/disabilities/technology/en/>
- Disability and Rehabilitation <http://www.who.int/topics/rehabilitation/en/>
- Guidance notes on Disaster and Emergency Risk Management for Health Rehabilitation in Emergency Medical Teams (EMTs)
<https://extranet.who.int/emt/resources>
- WHO & World Bank (2011) *World Report on Disability*
http://www.who.int/disabilities/world_report2011

Human Rights and Disability

Disabled People International <http://dpi.org/>

Human Rights Watch <https://www.hrw.org/topic/disability-rights>

International Disability Alliance (IDA)

<http://www.internationaldisabilityalliance.org/en>

International Disability and Development Consortium (IDDC)

<http://www.iddcconsortium.net/>

UNITED NATIONS www.un.org/

A wide range of publications including

- United Nations, 2008. *Convention on the rights of persons with disabilities*.
<http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf>

- United Nations, 2015. *The millennium development goals report 2015 summary*.
- United Nations, 2017. *Transforming our world: the 2030 Agenda for sustainable development*.

<https://sustainabledevelopment.un.org/post2015/transformingourworld>

- UN Convention on the Rights of Persons with Disabilities (2006)

<http://www.un.org/disabilities/default.asp?navid=14&pid=150>

Working in Emergency settings

Disability and Risk management for Health

<http://www.who.int/hac/techguidance/preparedness/disability/en/>

WHO Disaster, disability rehabilitation

http://www.who.int/violence_injury_prevention/other_injury/en/disaster_disability.pdf

Global Health Action Disability and health-related rehabilitation in international disaster relief <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160807/>

UNHCR <http://www.unhcr.org/pages/4a0c310c6.html>

World Health Organisation, 2013. *Emergency response framework*. Geneva,

http://apps.who.int/iris/bitstream/10665/89529/1/9789241504973_eng.pdf?ua=1

Women's Refugee Commission

<http://womensrefugeecommission.org/programs/disabilities>

Guidelines / frameworks

HM Department of Health (2010). The Framework for NHS Involvement in International Development available at:

<http://www.thet.org/hps/resources/publications/theframework-for-nhs-involvement-in-international-development>

Condition Specific Resources

Cerebral Palsy

Children with Cerebral Palsy: a manual for therapists, parents and community workers. Archie Hinchcliffe (2007) from archiehinchcliffe@googlemail.com

CEREBRAL PALSY AFRICA www.cerebralpalsyafrika.org.uk Training, low cost resources, Community Group information in Africa.

Getting to know cerebral palsy: a training resource for facilitators, parents, caregivers and persons with cerebral palsy <http://disabilitycentre.lshtm.ac.uk/getting-to-know-cerebral-palsy>

Therapy in Action. This is a video by CP Africa & Purple Productions to help teaching therapists and CRB workers in African countries. It is a teaching tool but should not be used without the teaching notes which accompany the video. Available from Archie Hinchcliffe archiehinchcliffe@googlemail.com. This a very useful guide for therapists who are training community workers about Cerebral Palsy. <http://www.maits.org.uk/resources/a-guide-for-community-workers/>

The India Institute of Cerebral Palsy www.iicindia.co produces information leaflets on cerebral palsy and accessible publications.

Spinal Cord Injury related

eLearnSCI www.elearnSCI.org

Provides learning modules as an introduction to the basic principles of SCI management appropriate for all members of the MDT

Haiti SCI working group www.haitisci.org

Educational SCI resources

Clubfoot related

Global clubfoot <http://globalclubfoot.org/>

Sensory Impairment

SENSE INTERNATIONAL at www.senseinternational.org.uk is a charity for developing understanding of deaf/blindness. Useful links plus information on communicating with deaf/blind people, Rubella and deaf/blindness, etc.

Books and Journals

Hesperian books is a publisher of the following online books

<http://hesperian.org/books-and-resources/>

- ***Disabled Village Children: A guide for community health workers, rehabilitation workers, and families. It is often translated in the country of use.***
- ***Where there is no doctor: A village healthcare handbook for Africa***
- ***Manual for those involved in primary healthcare and health promotion around the world***
- ***Helping health workers learn***
- ***A health handbook for Women with disabilities***
- ***Helping children who are blind***
- ***Helping children who are deaf***
- ***Nothing about us without us. A guide for community health workers, rehabilitation workers and families***

CBR Africa Network (AfriCAN) publications <http://www.afri-can.org/publications.html>

- ***CBR: A Participatory Strategy in Africa***
- ***CBR as part of community development***
- ***CBR: Inclusive Policy Development & Implementation***
- ***CBR Stories from Africa. What can they teach us?***
- ***Linking CBR, Disability and Rehabilitation***

Turning the World Upside Down. www.ttwud.org.uk An initiative to learn from community programmes in less resourced countries especially in mental health and club foot areas.

“The Dream of Inclusion for All” available to order from Enablement www.cbrtraining.com

Disability, CBR and Inclusive Development Journal (formerly Asia-Pacific Disability Rehabilitation Journal) <http://dcidj.org/>

Disability and Rehabilitation Journal <http://informahealthcare.com/loi/dre>

Disability and Society <http://www.tandfonline.com/loi/cdso20#.UvUU1PI v9g>

Assistive Equipment and Toys

Play and Toy Making books

- ‘Play Helps’ (1996) ‘More Play Helps’ by Roma Lear for simple play equipment
- ‘We can Play and Move’: A manual to help disabled children learn to move by playing with others by Sophie Levitt and Deborah Birkett (1987)
- ‘Creative Play Activities for children with Disabilities’ by LR Morris and I Schulz (1989)

Appropriate Paper based Technology (APT): www.paperfurnitureenterprise.com

Using recycled paper to make toys, equipment, seating aids for disabled children.

The book: Assistive Cardboard Equipment using Appropriate Paper-Based Technology (APT). Jean Westmacott (published 2015)

People Potential www.peoplepotential.org.uk A pioneering charity using appropriate paper or cardboard based technology for assistive equipment where resources are limited. Runs courses in Hampshire such as ‘Designing for Active Learning and Play’, ‘Make a Toy Weekend’, ‘Appropriate Disability Design’

Uhambo Foundation www.uhambofoundation.org.za Works to remove barriers and inequalities for disabled children and their families in South Africa. Works with Shonaequip to provide the correct mobility assistive devices for children as well as recycling, repairing and reinventing equipment.

Motivation www.motivation.org.uk This is a UK charity aiming to develop inclusive communities by providing mobility for disabled people through training and technical design centres, which provide various types of wheelchairs in mainly Africa and Indian Sub-Continent.

Adaptive Design Associates www.adaptivedesign.org is based in New York with small centres in South America where custom made solutions are designed and fabricated for children with disabilities. Training courses in New York. They have lots of ideas especially for seating.

WHO 2008 What is an appropriate wheelchair.pdf

WHO UNICEF 2015 Assistive-Tech-Web pdf Wheelchairs in less resourced settings

WHO 2010 Wheelchair fact sheet

Disability Resource Centres

Global Disability Rights Library (GDRL) <http://www.widernet.org/egranary/gdrl>

GDRL seeks to build a bridge between global information sources and millions of people with disabilities, advocates, and policymakers around the world by making it easier for them to access hundreds of thousands of educational and organizational resources on disability rights, whether or not they have access to the Internet.

MIUSA Inclusive Disability and Development Resource Centre

<http://www.miusa.org/idd/resources>

This resource centre offers practitioners and policy makers straightforward and effective tools for inclusion that can be integrated into their existing framework

Source www.asksource.info

An International Online Resource Centre designed to strengthen the management, use and impact of information on disability and inclusion in development and humanitarian contexts. It is primarily intended for use by practitioners and academics. Distributes quarterly E-Bulletin of latest resources.

SLT Resources:

LET'S COMMUNICATE: A Handbook for People Working with Children with Communication Difficulties. www.who.int/iris/handle/10665/63851 It is based on their work in Zimbabwe as SLTs and containing sections on communication, assessment, goal planning, learning difficulties, hearing loss, cerebral palsy, multiple disorders, speech difficulties, communication in everyday situations, working in groups with parents, play, linking with education. It has lots of training ideas and handouts. It is beautifully illustrated and useful for **all AHPs**

International Journal of Speech-Language Pathology, 2013; 15(1).

This issue of IJSLP applies the WHO World Report on disability (2011) with communication

disability and focuses on underserved populations in the Majority and Minority world including people in Australia, Bolivia, Brazil, Ghana, India, Malaysia, South Africa, Viet Nam, Togo, Uganda, UK and US.

ELKLAN www.elklan.co.uk for training resources and practical books/handouts/ on wide range of topics e.g. AAC, Hearing loss, Autism etc. Pictures may be inappropriate but excellent content which cuts down 'thinking time' and can be adapted easily.

THE LONDON BILINGUALISM SIG www.londonsigbilingualism.co.uk is a very valuable source of information on assessment, cultural considerations, working with interpreters and intervention

Communication and Hearing Disorders' by Sheila Wirz and Sandy Winyard (1993) is a hard to find book on the practical management of people with communication disorders in under-served countries.

CALL Scotland at www.callscotland.org.uk have information on literacy, access and communication through alternative and supported communication.

CLEFT LIP and PALATE ASSOCIATION CLAPA at www.clapa.org.uk Information and advice on cleft palate, treatment, feeding equipment.

CPLOL

This is the Standing Liaison Committee of SLTs/Logopedists in European Union which represents 35 professional organisations including RCSLT in 32 countries including Bulgaria, Romania.

ASIA PACIFIC SOCIETY OF SPEECH, LANGUAGE AND HEARING www.apsslh.org

This organisation represents professional associations of SLTs around the Pacific Rim providing useful networks for any SLT working in this area.

INTERNATIONAL ASSOCIATION OF LOGOPEDICS AND PHONIATRICS www.ialp.info

The IALP is the oldest worldwide organisation of professionals and scientists involved in communication, voice, speech - language pathology, audiology and swallowing. It coordinates Committees on critical areas of science and practice. E.g. multilingual and multicultural affairs: dysphagia etc . Amongst many roles IALP holds Conferences such as 2017 Conference on Communication Difficulties in Underserved Populations including migrants and refugees.

American Speech and Hearing Association www.asha.org

There is a comprehensive Directory of Audiology and Speech-Language Pathology Associations outside of the United States on the ASHA website which can link therapists to valuable resources and information especially SIG 14 and 17.

The Ear Foundation www.theearfoundation.org.uk provides training courses, resources and general information on hearing impairment

Solar Ear www.solarear.com produce solar powered hearing aids.

Multilingual Aspects of Speech Sound disorders in children (2012) edited by Sharyanne McLeod, Brian A Goldstein. This is good for creating speech sound screen.

Physiotherapy resources

The Physiotherapist's Pocketbook E-Book, 2nd Edition by Karen Kenyon and Jonathan Kenyon Churchill Livingstone ISBN: 9780702039591

OT resources:

Occupational Therapy without Borders: Volume 1 Learning from the Spirit of Survivors

by F. Kronenberg, S S Algado and N Pollard (2001) Churchill Livingstone

Occupational Therapies without Borders: Volume 2 Towards an ecology of occupation based practices by F. Kronenberg, N. Pollard and D. Sakellariou (2010) 2nd Edition Churchill Livingstone

Occupational Therapy-an African Perspective by V Alers and R Crouch. Developed by the OTARG Regional Group and obtainable from www.crouch-trust.org.za

Council of Occupational Therapists of the European Countries COTEC www.cotec.org

World Federation of Occupational Therapists **WFOT** www.wfot.org.uk

Umbrella organisation for Regional Groups of OTs which include :-

- **OTARG Occupational Therapist Africa Regional group** www.ORTARG.org.za
- **APOTRG Asia Pacific Occupational Therapy Regional Group** www.APOTRG.org
- **AOTRG Arabic Occupational Therapy Regional Group** www.AOTRG.org
- **ACOT Association of Caribbean Occupational Therapy** www.ACOT.org

- **CLATO Confederacion Latino Americana de Terapeutas Ocupacionales** www.CLATO.org has an online Course and downloadable PDFs: Disaster management for OTs and Working as an OT in Another Country

Research into International Work

Barnes, C. (2003) What a Difference a Decade Makes: reflections on doing 'emancipatory' disability research *Disability & Society* 18 (1), 3-17

Chartered Society of Physiotherapy (CSP) (2017) What is evidence based practice?
[online] Available from: <http://www.csp.org.uk/professional-union/practice/evidence-base/evidence-based-practice/what-evidence-based-practice> [Accessed 29th March 2017]

Farmer, M. & Macleod, F. (2011) Involving Disabled People in Social Research
Guidance by the Office for Disability Issues [online] Available from:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321254/involving-disabled-people-in-social-research.pdf [Accessed 29th March 2017]

Grech, S. & Goodley, D. (2012) Doing Disability Research in the Majority World: an Alternative Framework and the Quest for Decolonising Methods *Journal of Human Development, Disability, and Social Change* 19(2) 43-55. [online] Available from:
<http://riiph.gc.ca/en/revue/journal-19-02-2011-04> [Accessed 29th March 2017]

Wickenden, M. & Khembavi-Tam. G. (2014) Ask us too! Doing participatory research with children in the Global South *Childhood* 21 400
<https://www.ucl.ac.uk/igh/research/a-z/related-docs-images/ask-us-too-article>
[Accessed 29th March 2017]

The Chartered Society of Physiotherapy. Start here and follow the links:
<http://www.csp.org.uk/professional-union/practice/evidence-base/evidence-based-practice/what-evidence-based-practice>

The College of Occupational Therapists: <https://www.cot.co.uk/research/evidence-based-evidence-informed-practice>

Partners in Evaluation: Evaluating Developmental and Community programmes with participants by Marie Therese Feurestein 1987 : Macmillan Educational. On-line.

Development Studies Association www.devstud.org.uk Academic teaching and research policy and practice in international development

London School of Hygiene & Tropical Medicine: International Centre for Evidence in Disability www.lshtm.ac.uk Current and past research summaries: Seminars:

Grech, S. & Soldaric, K.(eds) (2016) *Disability in the Global South: the critical handbook* Switzerland: Springer

ADAPT also have a bank of research available on their website:

<http://adapt.csp.org.uk/>

Leonard Cheshire disability and inclusive development centre:

<http://www.ucl.ac.uk/leonard-cheshire-research/research>

Institute of Development Studies: disability and development

<http://www.ids.ac.uk/idsresearch/disability-and-development>

International disability and development consortium:

<https://www.iddcconsortium.net/>

World Health Organisation (WHO) Disability and Rehabilitation:

<http://www.who.int/disabilities/en/>

University of Leeds Centre for disability studies: <http://disability-studies.leeds.ac.uk/research/>

If you have used this Resource Pack, we need your help! In order to keep it up-to-date and useful we need your comments and suggestions and contributions.

Please play your part - complete this questionnaire and send it to any member of the relevant Committee or email lesleygillon@hotmail.com

- What sections of the Resource Pack did you find most useful?

- Are there any sections of the Resource Pack that you feel could be omitted?

- Do you know of resources that are not included in the present pack that would be useful for other people to know about? If so, please send us full details.

- Is the information given in the Resource Pack accurate and up-to-date? If not, are you able to up-date it?

Thank you

From: The Team.

1ST Edition 2014

2nd Edition: Revised 2017

