Title: CBR workers as key contributors to Best Practice Guidelines for Rehabilitation

Authors: Lynn Cockburn, Ezekiel Benuh, Alexa Bramall, Emmanuel Anjonga, Shirin Kiani, Timothy Fanfon, Che Manasseh, Amasinda Grace, Mukong Nicholas, Evelyn Lukong, Kenchi Joseph, Jacques Chirac Awa

Presentation for the 5th CAN Conference (Community Based Rehabilitation Africa Network), 1st June – 5th June 2015, Kenyatta International Conference Centre, Nairobi, Kenya

Welcome, and thank you for your interest in how we have been developing best practice guidelines to improve rehabilitation services in Cameroon. This is a long-standing project, and CBR workers have been involved in all aspects of the project. 10 years ago we began a process of trying to improve rehab services using multi-pronged approach to improve knowledge and service provision. We gradually brought together people from several organizations (i.e. BCDSSR, SEEPD) to do this work, and the funded part took place from 2009 to 2012, with more work continuing in the years that followed.

Our context: Similar to many other places in Africa, we have an emerging but small rehabilitation system. There is a public system (government) which includes very little attention to rehab. Services for people with disabilities are seen as under the Ministry of Social Affairs. Rehab programs are generally funded by NGOs. CBC started rehab program ~50 yrs ago working with people with leprosy, then CBM came in to fund vision programs and there is a small well established CBR program. There are a few other organizations, such as SAJOCAH. So there is a history but not developed in big ways. There is also a significant shortage of healthcare workers to implement strategies, and very little to no research conducted about rehabilitation. Also a growing number of Disabled people's organizations. Historically, there has been a significant lack of communication between these groups, and very few opportunities to disseminate information. We have very limited access to books, internet, and continuing education.

Existing practice guidelines are not always usable in the NWR because of our lack of resources and the poverty that people live with. The culture does not support "book learning".

To deal with these issues, we decided to develop guideline documents for our local use. We started with a list of 25 priority topics, narrowed that down to 10 and in the end, we developed 5 Guideline Documents. They are:

- Stroke Rehabilitation
- Vocational Rehabilitation
- Assessing Children with Visual Impairment
- Assessing Children with Hearing Impairment
- Family Centred Practice

We also adapted some of the WHO CBR Guidelines for our local context.

So how did we do it?

We had several meetings and conversations to ask important questions: What is Good --- Better --- Best? How do we know what to do in our work? What is good practice? What is the best we can do right now, with what we know and what we have?

One of the answers was: We need guidelines and recommendations

So to do this, took the efforts of many, many people over about 3 years. Efforts of probably about 100 people or more.

- Local and global
- Practitioners, managers, and students

We are grateful for funding and support from several sources

- CBM Australia
- SEEPD - CBC Health Board
- ICDR-Cameroon, U of Toronto, Canada
- Centre for Inclusion Studies, Bamenda

Before going further, we should say a bit more to answer the question: **What are Best Practice Guidelines (BPG)?**

One definition is "systematically developed statements to assist practitioner and [client] decisions about appropriate health care for specific clinical circumstances" (Field, 1992). Guidelines can: Maximize services; A resource for moving toward equity because they lead to more consistent service provision; bridge the gap between what we 'know' and what we 'do';

They are also a way of engaging in Knowledge translation, that is making information usable in practice.

Process of Guideline Development

We spent several months deciding on a good process, and that is captured in a circular diagram that has many stages.

- We formed working groups
- Decided on the scope of the guidelines
- Searched academic literature
- Identified local practices
- Selected articles relating to good practice in Africa or similar contexts (e.g. Asia).
    - Articles from developed countries were reviewed but usually not selected for developing these guidelines as recommendations often did not match the Cameroonian context.
- Lots of discussion in working groups to match the academic evidence to the local situation

This is an **example of a Scope statement**:

> Objectives: To provide best practice guidelines for the early stages of vocational rehabilitation services. This includes identification, assessment, counseling and orientation to vocational rehabilitation, and referrals to VR services. Health care settings: Community based rehabilitation.
>
> Target population: All persons with disabilities of working ages - approximately 14 to 45 years, but up to 60 years can be included.
>
> Description of target group not included: Children with disabilities below 14 years, older adults above 60 years of age.
>
> Diseases or conditions: Persons with hearing impairments, visual impairments, cognitive impairments, mobility impairments, and chronic mental health conditions.

Intended users: All service providers working in vocational rehabilitation (mainstream and those specialized in disability), students of special needs teachers training centers, researchers, church leaders, traditional leaders, Cameroon Ministries such as Social Affairs and Public Health.

Clinical specialties: CBR workers, vocational rehabilitation workers, other health and social services workers

All of the best practice guidelines have a number of specific recommendations: for example, the vocational rehab guideline group developed more than 25 recommendations plus reference to WHO CBR guidelines. Examples:

- Criteria should be used to identify a person who is ready for vocational rehabilitation
- Families need to support enrollment of disabled family member; CBR worker should be clear on family roles.
- Give individual choice versus choosing stereotype trades based on disability type

Quote from a CBR worker: "*I have learned a lot about the importance of starting at the beginning… of looking at what type of results we want, and what impact Vocational Rehabilitation has on Quality of Life – Not just training people for the sake of training them and then thinking about results. But what they want in their own life."*

We also have to talk about our **awareness of the WHO CBR guidelines**. When we started this project, the WHO guidelines were not available, then they became available. So it was decided to try to adapt the WHO CBR guidelines for our context. We have done the Empowerment and Health components.

Challenges to developing and using Best Practice Guidelines

- Takes time and money to do
- Working habits – not used to using current information
- Access to resources – very limited
- Communication difficulties – so working together can be challenging
- Financial implications and getting enough funding to do the training and the work
- Organizational barriers – managers don't understand the purpose. Some people did not understand the process and did not get behind the initiative.

Opportunities related to Best Practice Guidelines

- Interest and need for improved services recognized by local practitioners and disability organizations
- Can make significant contribution to emerging healthcare, education & rehabilitation systems
- Ignite interest in other developing countries in Africa or with a similar context

Thank you – there is much more that could be done, and we look forward to hearing your responses and questions.