PROCEEDINGS

OF THE

JULY 2006 BAMENDA CONFERENCE ON DISABILITY AND REHABILITATION

Baptist Center, Nkwen – Bamenda
North West Province of Cameroon
28th and 29th July 2006

TABLE OF CONTENTS

A INTRODUCTION *3*
A.1 KEY MESSAGES EMERGING FROM THE CONFERENCE? **4**
B ADDRESSES *5*
B.1 PROVINCIAL DELEGATE OF HEALTH **5**
B.2 PROVINCIAL DELEGATE OF SOCIAL AFFAIRS **6**
B.3 KEYNOTE ADDRESS **7**
C SESSIONS *10*
C.1 DISABILITIES IN THE NORTH WEST PROVINCE **10**
C.1.1 TYPES OF DISABILITIES: 10
C.1.2 LIVING WITH DISABILITIES IN THE NORTH WEST PROVINCE 12
C.2 CURRENT ISSUES **14**
C.2.1 THE BURDEN OF TERMINAL DISABILITY (PARAPLEGIA) IN CAMEROON 14
C.2.2 HIV/AIDS AND DISABILITY 16
C.3 PHYSICAL THERAPY **17**
C.3.1 PHYSIOTHERAPY PRACTICE AN OVERVIEW 17
C.3.2 STROKE REHABILITATION 20
C.4 EPILEPSY **21**
C.4.1 EPILEPSY: A FACTOR OF DISABILITY: PROSPECTS FOR CBR 21
C.4.2 A PREAMBLE OF ASODI AND THE PHENOBARBITAL TRIAL ON OVER 500 EPILEPTIC ORPHANS/PATIENTS FOR SEVEN MONTHS IN NGIE SUB DIVISION MOMO DIVISION 23
C.5 GROUPS **24**
C.5.1 MOTHERS TRAINING GROUPS: 24
C.5.2 WIVES AND DAUGHTERS OF PEOPLE WITH DISABILITIES 26
C.6 KEY CONCEPTS **26**
C.6.1 THE ROLE OF NGO'S IN REHABILITATION OF PEOPLE WITH DISABILITIES IN CAMEROON 26
C.6.2 BEST PRACTICE AND EVIDENCE BASED PRACTICE IN REHABILITATION SETTINGS 28
C.7 COMMUNITY BASED REHABILITATION **29**
C.7.1 OCCUPATIONAL THERAPY: RELEVANCE & APPLICATION WITHIN CBR 29
C.7.2 USING & WORKING WITH CBR VOLUNTEERS: LESSONS FROM THE FIELD 31
C.8 PSYCHOSOCIAL ISSUES **32**
C.8.1 PSYCHOSOCIAL EDUCATION ON STRESS 32
C.8.2 THE ROLE OF SOCIAL WORKER IN THE REHABILITATION AND INTEGRATION OF PEOPLE WITH DISABILITIES 34
C.9 PROMOTING HEALTH **35**
C.9.1 PROMOTING HEALTH AND SOCIAL PARTICIPATION: 35
C.9.2 HEALTHY GESTATION TO AVOID DISABILITY IN CHILDREN 37
C.10 LEARNING FROM EXPERIENCE **39**
C.10.1 HANSEN'S DISEASE: THE MBINGO EXPERIENCE 39
C.10.2 PRESBYTERIAN COMMUNITY REHABILITATION SERVICES KUMBA 41
C.10.3 THE IMPORTANCE OF DOCUMENTATION IN REHABILITATION PROGRAMS 42
C.10.4 SPINE DISABILITY AND REHABILITATION 43
D SUMMARY AND PLENARY SESSION *44*
D.1 PARTICIPANTS' REMARKS AND EVALUATION **44**
D.2 THE NEEDS, CHALLENGES, PROBLEMS AND ISSUES IN ANTICIPATION **45**
D.3 PROPOSED SOLUTIONS: **46**
D.4 A SUMMARY OF THE RESPONSES OF 60 COMPLETE EVALUATIONS OF THE CONFERENCE **47**
E APPENDIX *48*
REGISTRATION LIST **48**

A INTRODUCTION

This small booklet represents a significant step forward in the field of disability and rehabilitation in the North West Province of Cameroon. Here you find a record of an exciting two day conference held in Bamenda, July 28 and 29, 2006.

On behalf of the conference planning committee, we wish to congratulate everyone who made significant efforts to ensure that this conference was a success. Events such as this only succeed if everyone contributes, and the contributions were many and varied.

The conference was opened with welcome addresses by the Provincial Delegate of Public Health, Dr. Ndiforchu, and the Provincial Delegate of Social Affairs, Mr. Asanji. We are extremely grateful to these two men of vision who encouraged the conference to hold.

Over 20 people presented on a variety of topics. The full list is included and each has a summary in the following pages. Their expertise was significant and contributed to the high quality of the event. Our sincere thanks to each and every one for taking the many hours to plan their presentations and to answer the many questions and comments that participants posed.

A number of people worked diligently behind the scenes to make sure that participants had materials and food, to moderate and record sessions, and to deal with other details that allowed the conference to proceed. Our sincere thanks to Chia Milton, Cynthia Fokwang, Takusi Daniel Watcha, Gavin Park, John Fokwang, Humphrey Akwar, Ngang Emmanuel and Mrs. Ngala Patience. Delicious food was provided by Madame Ngwayi Winifred from the Nkwen Baptist Health Centre Canteen, and we are very grateful for her efforts, along with her staff. They were faced with several challenges with the venue and the large number, but they were able to cope with the situation.

The conference would not have held without the support of Prof. Pius Tih, and the administration and staff of the CBC Baptist Centre and Health Board. Many, many thanks to all who had a hand in the details of running this conference – whether photocopying at the last minute, arranging chairs or providing an encouraging word.

We hope that as you read through this collection of proceedings you are inspired to continue your own work in this area. There are several ideas and recommendations collected here, and there is no shortage of work to be done. **Please note that the information and ideas in each presentation are those of the author and have not been endorsed specifically by the conference planners or undergone a peer review.**

Let us work together to ensure that this work is not lost, and that future conferences are even more successful than this one.

Sincerely, the Conference Planning Committee

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A.1 KEY MESSAGES EMERGING FROM THE CONFERENCE?

There are many People With Disabilities (PWD's) in our communities, but no matter the type of disability, they can still be functional with rehabilitation. Anybody plus everybody can become handicapped, so we should all consider the needs of handicapped people in our society. Tomorrow it could be you. That we have seen the need to collaborate and share and work together to help improve the services available and therefore the lives of PWDs in our society.

Rehabilitation, determination and hard work, communication, documentation and networking for a better community for the disables. Identification, communication, rehabilitation, documents.

Awareness and advocacy from people with disability. The causes of disability and the different methods of rehabilitation. The important role of the family in the process of rehabilitation.

Conference is on rehabilitation and disabilities. Non Governmental Organizations (NGO) should come together with a common goal to assist the disables. That people should not look at the disabled as misfit in the society because they equally have something to offer to society. All units (non-governmental) organization should amalgamate to achieve a common goal to assist the disabled.

The conference was all about disabled persons, their rights, problems and challenges faced on daily basis. We also looked on type of services to be given them.

That disability is not inability. That we should share with the disabled. The disabled should be empathized with so that they feel free enough to interact.

Man was born equal before God. People without disabilities should work hand in glove with those who are able because disable today might have been among the healthy ones of yesterday and the healthy ones of today may be impaired tomorrow. We should serve each other in justice and peace.

That having a disability does not mean that people cannot do or achieve things. Disability is a problem but not a curse. Women should not hide or be ashamed of their children with disabilities.

The message that came from this conference is that if people are well educated, some of these complications of disability can be prevented or treated at the early stage of diagnosis.

We have identified many disabled, but we can't adequately serve all of them. Disability is not inability. Encourage interaction between the disabled. Respect for the right of the disabled. Families should be well aware of rehabilitation.

We have come from various institutions / NGOs to learn how we can take care of the disables with terms of rehabilitation. The conference has created awareness of what is happening around us and how we can better care for the disables.

Raising awareness between the disables and the society. Education on HIV & AIDS to the disables. Documentation should be implemented in the process of rehabilitation. Disability is not inability.

The general notion of togetherness which will alleviate segregation amongst the abled and disabled and thus create good interaction among mankind. Educate people about the causes and prevention of disability. Encourage and reassure the disabled.

That disabled persons are equals in opportunities and rights. Disability is not inability. That people living with disabilities should not give up the fight for their rights and should be part and parcel of the mainstream of the society.

Working in a network. Need a government center for the disable in the N.W.P. Let NGOs that work with people with disabilities be faithful and pass to them as it is in fear of God.

How to live with disability. Integrate the disable persons into the community. We should stop stigmatization of disable persons and encourage them to work for their benefit.

Disability and situational analysis

Happy to hear about cooperation and networking in the conference more especially how the disabled can join together and be as one. New ideas have been achieved. The conference has created a forum where the disabled are recognized and have come to know each other, especially associating with the international bodies. The lesson on documentation and rehabilitation has run a long way to enlighten us how we can keep information and what to do so as to be noted or included in statistics. In the conference we have know some NGOs that we can pass though to be more associated.

Education and rehabilitation should be a continual process, giving the increasing of disabilities in our country.

B ADDRESSES

B.1 PROVINCIAL DELEGATE OF HEALTH

Dr. Ndiforchu spoke very eloquently as he addressed the assembly to open the conference. The following is a summary of his remarks

Dr Ndiforchu welcomed the participants to the conference and reiterated its importance. He stated that despite the comments made by the conference planning committee that this was a "low budget" event, he believed that in fact, it is an event rich in resources, energy and ideas, and that therefore it was not truly a low-budget occasion. This is a conference that will have an impact throughout the country, not only in the Bamenda area or the NWP.

The Delegate recognized the tremendous work that had been done by the conference organizers and the presenters to make the conference happen, and thanked all of them for their efforts. The need for information about disability issues and rehabilitation practices is important for all public health work, and he stated that he looks forward to reading more about what comes from the conference. We can move forward only if we have information and a better understanding of what improvements need to be made.

Dr. Ndiforchu said that he hopes that this conference will provide the impetus to stimulate the implementation of existing policies and to develop new policies. He recognized the impact of HIV/AIDS on disability issues, and that this is a specific area that needs attention. In addition, there is a shift from infectious diseases to chronic diseases, such as cardiovascular disease and diabetes, so a conference such as this one comes at the right time to stimulate thinking and action in these areas as well.

The role of NGO's is also important as they are implementing much of the work in the area of rehabilitation and services for people with disabilities. Dr. Ndiforchu went on to remind participants that we can consider the implementation of policies as being a matrix, in which all stakeholders have a role to play.

Participants warmly applauded Dr. Ndiforchu when he pledged to inform the Minister of Public Health of the outcomes of the conference and to support those involved to implement key policies and strategies. The Delegate ended his remarks by wishing everyone a very good conference.

B.2 PROVINCIAL DELEGATE OF SOCIAL AFFAIRS

ADDRESS BY THE PROVINCIAL DELEGATE OF SOCIAL AFFAIRS NORTH WEST ON THE OCCASION OF THE OPENING OF THE 2006 BAMENDA CONFERENCE ON DISABILITY AND REHABILITATION HELD ON FRIDAY JULY 28, 2006

Ladies and Gentlemen!

I am greatly delighted and honoured to address this august assembly on the occasion of the opening of the 2006 Bamenda Conference on Disability and Rehabilitation. I would like to first of all thank the organizers of this maiden conference for choosing Bamenda for their venue.

The North West Province is one of the Provinces in the country with a high population of disabled persons. There are about 4000 persons with disabilities in the Province comprising the physically disabled, the Blind, the Hard of Hearing, the mentally disabled and persons with learning disabilities in that order of magnitude. Predominant causes of disabilities here comprise poverty, debilitating illnesses, and accidents. The situation of disabilities in the Province is therefore complex and preoccupying especially as community attitudes and traditional beliefs towards disabilities are still an obstacle to the rehabilitation of disabled persons.

However, commendable efforts are being made by private associations to alleviate these disabilities. Worthy of mention are the CBC Rehabilitation Services in Mbingo and Banso, SAJOCAH in Bafut and the CHRIST ADELPHIAN School for the Blind and Disabled in Mbengwi. There are many NGOs in this venture that I cannot enumerate here. The MINAS lauds their contributions in the rehabilitation of persons with disabilities.

The 2006 Bamenda Conference on Disability and Rehabilitation is an excellent initiative that will give enormous leverage in the rehabilitation of persons with disabilities in the North West Province. This conference shall be basically professional. The issues to be addressed and the papers to be presented are very attractive and relevant to the common but complex problems of disabilities and rehabilitation in the Province. The Ministry of Social Affairs is therefore greatly appreciative of this kind initiative of Professor Lynn Cockburn of the International Centre for Disability and Rehabilitation Toronto, Canada. I am confident that the outcome of this conference shall enormously improve the disability conditions as well as rehabilitation programme in the North West Province. I therefore exhort participants at this conference to fully assimilate the rich content of the presentations and have frank discussions of the topical issues that shall be raised.

LONG LIVE INTERNATIONAL SOLIDARITY
LONG LIVE THE REHABILITATION OF DISABLED PERSONS LONG LIVE THE MINISTRY OF SOCIAL AFFAIRS

Thanks for your keen attention.

THE PROVINCIAL DELEGATE

B.3 KEYNOTE ADDRESS

DISABILITY AND REHABILITATION IN THE NORTH WEST PROVINCE OF CAMEROON: – CHALLENGES AND PERSPECTIVES.

Peter Mue, CBMI Cameroon Country Coordinator

1. REHABILITATION AND DISABILITY – BASIC CONCEPTS

A: REHABILITATION

The process of restoring the highest possible level of confidence and dignity to persons with disabilities to enable them to live useful lives in the society. From this definition we can bring out some key aspects as follows:

Rehabilitation is a process: Meaning it is not an event but requires a structured and sustained approach to ensure the achievement of set goals within a timeframe.

Rehabilitation aims at ensuring the attainment of the highest possible level: This should be based on the individual's interest, abilities and capabilities. The rehabilitation process must be demand driven.

Confidence and dignity: Rehabilitation should aim at meeting the satisfaction of human need for empowerment and recognition within the family and society. The rehabilitation process should lead the PWD to full integration and participation in community issues.

B: DISABILITY

WHO proposes the following distinctions:

Impairment is any loss or abnormality of psychological, physiological or anatomical structure or function (e.g. a missing or defective body part, paralysis after polio). **Disability** is any restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being (e.g. difficulty in speaking, hearing or walking).

Handicap is a disadvantage for a given individual resulting from an impairment or a disability that limits or prevents the fulfilment of a role that is normal (depending on age, sex and social and cultural factors) for that individual (e.g. lack of access to employment for a person with a hearing impairment due to discriminatory attitudes).

In these definitions, impairment is defined objectively in terms of observable function, while disability and handicap are seen in terms of what is "considered normal" for an individual.

From the above definitions, Disability is seen to have both a medical and a social dimension that must be fully understood.

The medical model understands disability to be caused primarily by diseases, trauma or congenitally acquired. Here, the problem rests with the individual concerned and appropriate action focuses on medical treatment of the affected individual by qualified professionals.

The social model understands disability in a broader social context and to a large extent understands disability as being created by the social environment. This model focuses on full integration of individuals into society rather than only the provision of medical care.

In order to provide holistic rehabilitation services, both models should be embraced

2. GENERAL PROFILE OF THE NORTH WEST PROVINCE

Geographical and Administrative Areas

The North West Province lies in the Midwest of Cameroon between latitude 6^0 and 7.5^0N and longitude 8^0 and 9^0 E. It is bounded in the north and west by the Federal Republic of Nigeria, in the south by the South West Province of Cameroon, and in the East by the West and Adamawa Provinces of Cameroon.

The total surface area of the province is estimated at 17,500 km^2 with a population of 1,700,000 (from Health Census NID 2000) inhabitants as per health census. The average population density is 92 people per square kilometre

Administratively, the North West Province is divided into seven divisions and 31 sub divisions. Bamenda is the commercial and administrative headquarter of the province. The various administrative areas are illustrated in the following table:

Administrative Areas of the North West Province

DIVISION	HEADQUARTERS	No. OF SUB DIVISIONS
MEZAM	BAMENDA	5
NGOKETUNJIA	NDOP	3
MOMO	MBENGWI	5
MENCHUM	WUM	4
BOYO	FUNDONG	4
BUI	KUMBO	5
DONGA-MANTUNG	NKAMBE	5
TOTAL		31

Each subdivision corresponds to a municipal council governed by an elected mayor. Bamenda, the administrative headquarters has a government delegate overseeing the activities of the council.

Topography and Climate

The North West province has a variable landscape and forms part of the western highlands of Cameroon. It is a mountainous grassland with steep hills and deep valleys through which fast running rivers flow. The altitude varies between 1,000 and 3,000 metres above sea level with Mount Oku being the highest point. The vegetation is composed of savannah and mountainous forest.

There are many rivers and lakes that drain the province, which are often characterized by numerous rapids and waterfalls.

There are two main **seasons**, the rainy and dry seasons. The rainy season runs from March to October with June, July and August having the heaviest rainfalls. The dry season runs from November to February. The **average temperature** is about 22^{o}C

Communication

The road network in the province consists of 3291 km. Only about 6% of this length is tarred. The rest, which is not tarred, deteriorates badly in the rainy season.

Inaccessible areas of the province include:

1. Furu-Awa — Trekking from Esu
2. Bassa — Trekking from Njikwa
3. Akanuku — Trekking from Njikwa
4. Konda — Trekking from Oshie
5. Mbissa — Boat from Bambalang
6. Menka — Trekking from Widikum

Many communication channels exist in the province ranging from a town crier found in each village whose role is to carry messages in the local dialects to the community. Other channels include churches, local newspapers, “njangi” groups, socio-cultural and development groups. Radio and television are received in some urban areas whereas more than half of the population in the province resides in the rural areas.

Socio-cultural Aspects

Primarily people from diverse ethnic groups consisting of the Tikaris, the Widikums, the Ngembas and the Balis inhabit the province. Also accounting for a significant number are the Fulanis, Bamilekes, Hausas, Ibos and people from other ethnic groups of Cameroon and neighbouring Nigeria

Settlement pattern is mainly in villages and hamlets along riverbanks, roadsides that vary greatly in size from about 5 households to about 100 households in a village.

The traditional organisation of the province is in chiefdoms and fondoms which is highly respected by the people. The customs and traditions of the various chiefdoms and fondoms vary with the various ethnic groups. Their impact has a lot on the health status and needs careful study.

Economic Activities

Inhabitants of the province are predominantly subsistence farmers with the major crops cultivated being corn, beans, potatoes, cassava, colocasia, yams, plantains, bananas and groundnuts. Coffee and rice are the major cash crops of the area. The Fulanis, predominantly, also carry out cattle rearing.

There is only one plantation in the province – the Ndu Tea Estate now managed by the Cameroon Tea Estate (CTE). There also exists a few palm oil farms/mills in Teze and Widikum representing a small-scale oil production and some micro enterprises e.g. soap factory, dairy factory.

CHALLENGES OF REHABILITATION AND DISABILITY IN THE NORTH WEST PROVINCE

a. SERVICE PROVISION

Welfare versus rehabilitation: most projects have rather adopted a social welfare approach of service delivery. Most services are provided as a social responsibility to the individual or group of PWDs. They are often crisis driven and not self sustaining.

From the estimates of disability above, we observed that interventions could either be to cure, strongly reduce/eliminate the disabling effect or improve the life of the patient and/or the family. The first challenge for projects is to be able to make the distinction between these three categories so as to determine where to emphasize intervention.

b. KNOWING THE SCOPE OF THE PROBLEM

For the moment, there are significant numbers of organizations/projects dealing with disability and rehabilitation in the province. Each project is able to give statistics of the number of PWDs that they are taking care of. But the challenge for the moment is what amount of the problem we are presently solving. Is it 10%, 20% or 70%.

c. KNOWING INDIVIDUAL REHABILITATION NEEDS:

The term "needs" may be used in various ways.

- "*Felt needs*" are those verbalised directly or indirectly by the disabled person or his or her family or community, or needs observed over a long-term period, preferably by a community member.
- "*Expressed needs*" are those manifested by the disabled person and his or her family by the search for help in solving the particular problem.
- "*Assessed needs*" are the rehabilitation needs assessed by a person with professional training in rehabilitation. To be able to give a qualified opinion as to the likely outcome of rehabilitative measures undertaken in the disabled person's setting; the person carrying out this assessment must have experience from developing countries.

Most projects tend to neglect the "felt" and "expressed" needs and concentrate their intervention only on the assessed needs. Also, most experts (expatriates and nationals alike) do not take the trouble to visit homes and communities of disabled people when assessing needs and evaluating the likelihood of success of proposed interventions.

A DISABLED PERSON'S EXPECTATIONS OF REHABILITATION – FELT NEEDS

"1. Like any other individual or citizen of a country, the disabled person expects and hopes to get good education, suitable vocational training leading to eventual socio-economic rehabilitation so that he[/she] can lead an independent satisfactory life.

"2. To be provided with regular medical care to improve the functioning as far as possible as well as prevent the disability from deteriorating any further.

"3. To be helped and guided in his orientation and readjustment in the family, community and society with full participation.

"4. To actively participate in his[/her] own rehabilitation, deciding for himself[/herself] the goals that he[/she] wishes to achieve, it is essential that he[/she] is trained in accordance with his[/her] potential and inclination.

"5. To be provided with suitable aids and appliances that help to bring his[/her] mental and physical potential to the maximum.

"6. To be provided easy access to physical environment including rehabilitation services through removal of structural barriers and communication problems.

"7. To be placed in a suitable job after training where facilities and safeguards are provided for the basic adjustment of his[/her] disability in order to enable him[/her] to function to his[/her] maximum capacity.

"8. To receive evaluation and follow-up services till such time that he[/she] is fully settled with success in his[/her] job. This evaluation and follow-up is a combined and co-operative process between the disabled employee, the placement officer and employer."

3. PERSPECTIVES

SERVICE PROVISION

We need to move a step upwards from evaluations strictly based on numbers to an evaluation based on the quality of numbers and outcomes

Individual projects need to revisit or redefine their mission and become more focused

Projects should set up community based approaches for recruiting and following up clients

There is a great need to develop services in the area of mental illness and depression which is now proving to be an area of great concern for public health.

Organizations working in the area of rehabilitation and disability should look at each other as playing complementary rather than competitive roles.

COORDINATION

There is need to have a regional structure in charge of coordination of activities in the area of rehabilitation and disability. Such a structure will help government have a clearer picture of disability and rehabilitation in the province. The structure could also help in organizing and coordinating research and training and could play a lead role in advocacy for people with disabilities

C SESSIONS

C.1 DISABILITIES IN THE NORTH WEST PROVINCE

C.1.1 TYPES OF DISABILITIES: THEIR CONSEQUENCES AND THE NECESSARY ASSISTANCE FOR IMPROVED LIVING CONDITIONS

Mbakwa Tayong Thomas
Inspector of Social Affairs, Divisional Delegate of Social Affairs for Mezam

Dear Organisers,
Excellent people with Disabilities,
Distinguished Ladies and Gentlemen,

It gives me a lot of pleasure and honour to address this August audience today on a very sensitive and topical issue as quoted above. It is an issue of great importance that MINAS has always taken great interest in and concern for. That explains why the Hon. MINAS, Mrs Catherine Bakang Mbock, is presently emphasing the place of such persons in the Cameroonian society now and never and on how their living conditions should be improved upon. She has therefore launched a national campaign for the census of persons with disabilities which is presently on-going. I stand here to express my sincere gratitude to her endeavours and fight for the welfare of these our brothers, sisters, children and parents. I especially congratulate the organizers of this conference for creating such a forum and opportunity for us to educate the public on the needs, well-being, welfare and plight of people living with disabilities.

Honourable Ladies and Gentlemen,

Do you know that some of us who were not disabled yesterday are today impaired? Do you also know that those very able persons today can become disabled tomorrow? Then, why should the able today look scornfully on the disabled and why should they not give them the assistance they deserve? Possibly because of ignorance of so many things, including the types of disabilities and the types of assistance needed, and of course, the consequences of all these. This statement therefore leads us into the discussion on today's topic, which is broken into 3 main parts, namely:

I. TYPES OF DISABILITIES.

Gentlemen and Ladies of fortune, may we begin this discussion with the definition of the concept, disability, which implies a condition in which a person finds him/herself unable to use pmi or his/her whole body, brain, vision or hearing to function well. That is the inability for one's body or part of it to do a thing fully 01 completely or normally. The main cause of such a state can be a physical, mental, visual or hearing injury or illness, and for it to render a person disabled, it must be severe and permanent. But what types of injuries/illnesses are severe and permanent?

Four main categories are abound as follows:

a) **Physical Disabilities**. They concern and affect the entire physique of the victim or part of him/her. For example paralysis, bedridden, lameness, amputations, stroke, deformation, paraplegia (state of one being unable to move part of the body before the waist) severe hunchback, osteoarthritis (affection at joints that makes it difficult for one to move e.g. the knee), cripple ness, stammering.

b) **Mental-Disabilities**/Development-Deficiencies (DDs). They include insanity, mental retardation, epileptic, lunatic/imbecile.

c) **Visual Disabilities**. Examples are blindness, blurred vision, short-sightedness, long-sightedness and cataract.

d) **Hearing Disabilities**, implying Deafness, Dumbness and Dumbness-Deafness.

Above, Ladies and Gentlemen, are the major types of disabilities substantiated by very common examples. Statically speaking, see the present data on persons with disabilities in Mezam Division following a recent survey by the Divisional Delegate of Social Affairs (DDAS) Mezam. We know a medical Doctor would have a longer list but let's limit ourselves to this social appreciation of disabilities for their social consequences supersede the medical disadvantages.

SUB-DIVISION	. TYPES OF DISABILITIES					
	Physical	Mental	' Visual	Hearing	Others	Total
Bamenda Central	120	36	63	13	206	438
Bali	58	-	12 .	5	23	98
Bafut	57	20	78	5	22	182
Santa	35	45	5	68	3	156
Tubah	-	-	-	-	-	-
Total	270	101	158	91	254	874

II. SOCIAL CONSEQUENCES OF DISABILITIES.

One of the first and most glaring consequences of a disability in an individual is that of not functioning normally, **(physically, mentally or visually).** They thus render individual victims in a disadvantaged position of doing things well. Such persons therefore become unable to use. Their bodies, minds, hear or vision fully. For instance, such victims cannot move or move with difficulties, others can't see and some others are not capable to talk or hear or to talk and hear.

The next consequence is that of dependency on others to live, move or eat. They lack autonomy and self-esteem. There is therefore "mandiantism" (begging). Another is unproductively, socio-economically. This leads to discrimination, neglect, abandonment, isolation and even to physical elimination. Consequently too, there is starvation, disease and possibly death. Some others suffer from scornfulness, all sorts of abuses, stigmatization, traumatization and out-right frustration. One other major consequence is denial to right of marriage and to procreation. Generally, their human rights are abused and non-respected. All of the above produce very poor emotional and living conditions for persons with disabilities. .

Indeed, disabilities render their victims very disadvantaged to function well in society and amongst kings and kins. And for them to cope with life exigencies, they must be assisted in one way or the other, either physically, emotionally, materially or financially.

III TYPES OF ASSISTANCE TO PERSONS WITH DISABILITIES

The best support and assistance needed by this group of people is psychosocial assistance. We need to feel for them, give them emotional support, feel like them (empathy), comfort them, interact with them, play, eat and share ideas together with them. In fact, they need our affection, love and attachment to their person. The next other support to them is that of shelter, feeding, clothing, medical care, education and employment. Talking of education and employment, some of them when rewarded with these tools, they perform better than the normal human beings e.g. the Tala Andreas, the blind journalist, the Aimes, the Tezanos, and the list is inexhaustible. Truly speaking, it is far-more better to teach people with disabilities to catch fishes than the act of giving them fish everyday or every hour. The latter option is not helpful to them for it creates avenues for begging (mandiatism), laziness, unproductivity, more frustration and permanent dependency. Autonomy pays indeed and that is why one other assistance to them is to train them in in-come generating activities like public telephone booths, bee-farming, poultry-farming, piggery-farming, tailoring, hair-dressing, shoe-mending etc and to supply them with the material/finances as capital for once-and-for all, settling them according to their abilities and capabilities.

Distinguished Ladies and Gentlemen,

The aforementioned support and assistance to persons with disabilities are the cardinal ways of helping them out of their present Short-comings (functional wise) if we have to alleviate poverty amongst them, improve on their emotional and living conditions/standards, and to ensure their livelihood, survival, development, socioeconomic integration, productivity, autonomy and respect of their inalienable rights.

CONCLUSION

May I end here, **Ladies and Gentlemen,** on the note that man was born equal before God and himself. But certain forces of nature or man-made render somewhat they are and others what they ought not to be. This explains why some people are tall, others Short, some black, others white, some slim, others fat, some ugly, others beautiful or handsome, some poor, others rich, some living in water, others on land, some professional footballers, others amateurs, some musicians, others dancers, some Christians, others pastors, some fons, others subjects, some Lords, others servants and some men, others women while some are the boy-child, and the others are the girl-child. All of these classes are disadvantaged to each other and therefore jealous and envious of each other. And since society must function as a system with parts such that

when one of the parts is dysfunctional, the whole system crumbles, all of these classes of people are bound and obliged to function together for the good and benefit of all. Therefore, the so-called normal men/women in our society today must work hand-in-glove with those with disabilities for the good and betterment of mankind.

Finally **My Dear Brothers and Sisters,** Those of you who listened hard and attentively would be wondering why the word "Handicap" has not been used throughout my expose. Suffices to inform here, publicly and openly that the concept is outdated and now considered old-fashioned usage. That is why persons with disabilities is employed through out rather than handicapped persons for the latter expression is quite offensive, traumatizing, frustrating and most stigmatizing.

C.1.2 LIVING WITH DISABILITIES IN THE NORTH WEST PROVINCE

Mr. Nyincho Samuel

With all the protocol respected
Ladies and gentlemen,

Living with disability in the North West Province as we heard from the other speakers is difficult. We are faced with some challenges such as the geographical terrain, denial, stigma and inferiority complex. The latter three are words that surround the disabled persons around the North West province. Let me take denial first, when we look at disabled persons, I imagine the way I was feeling when I saw the way people in wheelchairs were struggling to get into the hall. You see, this is denial, and it's even in our education set-up. There are laws put in place to guide persons with disabilities. There should be free education and physical accessibility to schools but we still realize that some of the disabled persons are not going to school.

When I was leaving my house to my jobsite one day because I usually move with my guide and not my cane, I decided to move with my cane, somebody who was selling puffpuff and beans, concentrating on looking at me, stigmatized me and instead of putting beans on the plate, she had to put it on the frying pan. You see how stigmatization defeats our intentions.

Now lets look at inferiority complex, it comes at the point that society stigmatizes you, you deny your rights, curses you for being disabled and you look low on yourself. You cannot move, but we can defeat it. We can defeat it not so? Have I defeated it? I have to, because I am a parent of four. It's just to assure disabled persons that between the dark cloud there is always a silver lining and you have to struggle for it. We don't have to let denial, stigmatization, and inferiority complex reduce our dignity.

Miss Florence Limen

Good morning ladies and gentlemen, I am very happy to be among you for this powerful conference concerning disabled persons.

Disabled persons in Bamenda are the poorest of the poor. There is no monthly or yearly allowance given to the disabled from the government. Most of us are not well educated due to lack of sponsor, problems with mobility, and much poverty. Most of our school structures are not accessible for the disabled. Those of us who are educated find it very difficult to be employed due to discrimination against persons with disabilities.

The rights of disabled persons are violated. There is no constructed venue from the government for sporting activities for the disabled. There is no rehabilitation centre or facility for the disabled in Bamenda. Most of us can not expand our ideas or most of us have limited ideas due to lack of education. We are looked upon as beggars, witches, and wizards and many other stigmatizing terms. People feel that nothing good can come from us.

Our schools, hospitals, offices, markets, roads and houses are not accessible for those with physical disabilities. For example, the office of the Ministry of Social Affairs is on the second floor of a story building with many steps.

Disabled persons are well talented and intelligent people. But we need just a little push for the society in order to meet up with life.

Disabled women carry all the crosses on their heads, more than men. There is more a load on women. About 90% of disabled women are not married, and even in the ten percent that are married have not passed through the legal process. Some of us are raped. Most men that go out with a disabled woman are just out to destroy and not to construct for marriage. When a woman becomes pregnant, the man often disappears. The woman has to carry all the responsibility of raising the child. The man does not come during the day to have an open relationship with the women, in stead he will come in hiding in the night. Men feel shy to say that they are going out with a woman with a disability. Most of us are single parents and the reason is that they are afraid that menopause will get them before having a husband, so they have children when it is possible. When a man is coming to a woman, he is just coming to use her, not to contribute.

For disabled men, if they are doing something, if they have money, they can have any type of girl for marriage but without being upright with money, they cannot. The woman also is shy to be seen with a man who is disabled, and so will only come to him in darkness so no-one will see. When girls notice that a man has money, they will come and exploit him, not to provide assistance, and then go.

To conclude, we the disabled persons in Bamenda, support each other through networking, peer support. I teach you my trade or business, and you teach me your own. I teach you free, and you then go out and teach others for free also. We share our ideas together and look for solutions among ourselves. We are the comforters of each other. For example, a person who is blind uses his legs to support someone who is crippled, and the person who is crippled uses their eyes to support the person who is blind.

From this conference, we will be grateful if the organizers can look for possible solutions to solve the problems we have raised.

Thank you for listening and your concern.

Craft Production

Wanchia John Ngwa, the President of Special Needs Entrepreneur Group (SNEG)

I am also a resource person to this group and others to train people with disabilities.

SNEG is an association of persons with disabilities that empowers people with disabilities with different needs in Cameroon to be self-reliant and advocate for their rights.

Our vision is to create an atmosphere of self-reliance amongst people with special needs in Cameroon and to erase stigmatization against persons with disabilities and our goal is to enhance persons with disabilities from discrimination and dependence

We carry out the following activities in training: there are two training workshops: Cane and Embroidery.

Since many children with disabilities do not have equal rights in their homes to attend school like other children or learn a trade, and coupled with the rate of unemployment in Cameroon, people with disabilities are forced to use their hands in order to earn a living.

As a result of these unequal rights people with disabilities decided to come up with associations which have been helping them to develop skills in craft production.

Generally speaking, training people with disabilities is not an easy task because of the following reasons:

- To rally them to and from their homes needs a lot of expenses
- Access to raw material with which training is base is not an easy task
- Feeding during training sessions also posed problems since most of the time, the resource person working virtually on voluntary basis will be the one to provide for the trainees
- The nature of the workshop is not all that good to all the people with disabilities
- Lack of financial support to the resource persons and the sustainability of the program
- Lack of market for the finished products
- Lack of security both in their residence and the workshop
- Lack of modern equipment to facilitate mass production
- Lack of accommodation for those who have managed to be in urban areas training is effective

- Most of them do not know how to manage the limited resources at their disposal since they are half educated or illiterates thereby living from hand to mouth and need serious counseling before they can involve in craft production.

As proposed solutions to the above problems, we think the government should teach us how to catch fish by coming into the field to see what we can do and promote our skills. Also, international bodies who are interested in helping people with disabilities to eliminate poverty should send experts to work with us in the field of capacity building.

Since Cameroon has reached the completion point of the highly indebted poor countries, a special sector should be created to ensure the promotion of craft and other income generating activities which involve people with disabilities because it is not every person with disabilities who can do craft and support the existing craft association with grants to encourage them.

The roads leading to the suburbs should be improved upon for easy mobilization and creation of disability awareness and extension of income generating activities to those disabled persons as well as craft production.

International donors should create a market for the finished products.

Means of transportation should be provided to those craft associations for easy accessibility and training of those in the extremes.

Long live Craft Associations in Cameroon
Long live the Cameroon Baptist Convention
Long live the International communities
Long Cameroon

C.2 CURRENT ISSUES

C.2.1 THE BURDEN OF TERMINAL DISABILITY (PARAPLEGIA) IN CAMEROON

Introduction

- This study aims at assessing socio-cultural, economic and environmental determinants on the burden of disease.
- It criticises the notion that DALYs are used as gold standard for the assessment of burden of disease all over the world.
- These DALYs are compiled by expert panels and we question their selection procedure.
- The DALYs only consider age, sex and time of onset of disease in their measure
- Why should they be used as gold standard in assessing burden of disease all over the world
- Their members do not represent all corners of the world
- Therefore they should they be broadly applicable everywhere
- The definition of DALY
- DALY means Disability Adjusted Life Years
- These are the number of years that one lives with a disability and the number of active years of life lost due to premature death
- DALY is based on the egalitarian principle
- The sample and data collection site
- The sample of this work is made up of 20 paraplegics
- These data were collected in six communities in the NW Province (Kom, Bamali, Kedjomkeku, Benakuma, Bafut, and Banso)
- Most of the participants were interviewed in two institutions (Mbingo Baptist Community Based Rehabilitation Centre and SAJOCAH Bafut).

The inclusion criteria

- The disease chosen for the study is paraplegia which describes the paralysis of the lower portion of the body

- Age range was 20-45. This is the reproductive and productive age range
- The five years minimum was though of to be long enough for one to measure severity of the burden

The drive behind choice of disease (problem)

- Paraplegia in Cameroon is not yet considered a public health problem
- Paraplegics in the NW are limited in their economic and reproductive activities and are very dependent on their family members

Methodology (Qualitative data)

- In-depth interviews constituted one of the main methods used in collecting data
- The photo-voice method was used in photographing infrastructure and activities which patients cannot do due to paraplegia
- These data were analysed using Text Base Beta
- Semi-structured Questionnaire, ComQol (Comprehensive Quality of Life Scale), SF12, Data were analysed, using Epi-Info and SPSS

Causes of paraplegia in NW

- Falling from tree, deliver complication, Road accidents, Infection of the spine, Industrial accidents, TB of the spine, Lightening, torture, and snake bite

Cultural practices affecting paraplegia in the NW(belief in witchcraft)

- The belief in misfortune affecting wrong-doer is very evident and is an efficient means of social control and settling minor disputes. 12 paraplegic belief that witchcraft was diagnosed to be the cause of their problem. 8 considered their accidents to be natural but attributed their terminal nature to witchcraft.

Traditional marriage practices and its implication

- Payment of bride wealth is a prerequisite for full marital status in most of NW. If not children with the woman will never be those of the man. Paternity is sought in the woman's paternal family line. When the bride wealth is not completed, a misfortune might befall the family members. Most of the paraplegic conditions are associated with incomplete payment of bride wealth.

The impact of matrilineal succession

- In Kom where succession is traced on the mother's line, some male paraplegics are of the opinion that they were bewitched because they were to inherit the wealth of their uncles. They think that the witches thought they were going to die but death refused to claim them. This is why they are paraplegics.

Effects of the belief in witchcraft on family disintegration

- Families have disintegrated as a result of accusation. They accused are ostracised by the victims' family members and some are always at daggers drawn. The victims are considered as wizards and stigmatised and visits to their homes are forbidden

Impact of belief in witchcraft on health seeking behaviour

- The belief that the terminal nature of the disease is due to witchcraft forces them to seek for treatment only with traditional healers.
- Healers, therefore come and perform rituals before blood-letting their numb limbs instead of massaging them.

Possession of infrastructure and disease severity

- This is a paraplegic who has the opportunity to possess a wheelchair, but is not capable to drive in certain parts of the compound. He must be accompanied by someone
- This is a paraplegic who has the opportunity to possess a wheelchair and is able to sit on and climb down. she does not to be accompanied by someone

Disease Severity

- The development of urinary incontinence, The development bedsores, stinking environment, social isolation, perception of self as different, low self-esteem

The effects of physical environment on paraplegics

- In this type of an environment where there are no bridges, it would be pretty difficult for paraplegics to circulate even if they possess wheelchairs

The state of the environment (roads) and paraplegics

- In this type of an environment (roads), it would be pretty difficult for paraplegics to circulate even if they possess wheelchairs
- In this type of an environment (roads), it would be pretty difficult for paraplegics to circulate even if they possess wheelchairs

The state of the environment (toilets) and paraplegics

- The nature of toilets in some parts of NW is a major handicap to paraplegics. Going to the toilet is a natural exercise which is compulsory. This type of toilet is not adapted to paraplegics
- The nature of toilets in some parts of NW is a major handicap to paraplegics. This type of toilet is not adapted to paraplegics, since it is constructed further away in the bush
- Imagine a paraplegic going through these steps to reach this type of toilet. Not only it is out of the building, it entails climbing before reaching the toilet hole
- Though it is constructed in the house, it is still unadapted for paraplegics.
- "It takes me about 5 minutes to get to the toilet. I take the wheelchair until it get there and then I crawl until I am close enough. And then I lie down on my back and adjust my buttocks until my anus is facing directly in the hole and then I can use the toilet".

Well adapted environment (toilet) and paraplegics

- This lady uses her wheelchair to circulate in her house to the toilet found in the house.
- Squatting in a toilet that has a toilet chair is very easy to paraplegics who can sit

Well adapted environment (fire site) and paraplegics

- This paraplegic who can sit on and climb down from the wheel chair uses her well adapted fire site for cooking.

Conclusion

- Paraplegics suffer from cultural beliefs and practices in the NW
- Socio-economic status determine the burden of paraplegia
- Environmental factors like roads, toilets, determine the burden of paraplegia in the NW

C.2.2 HIV/AIDS AND DISABILITY

Dr. Awasom Charles

NB. The following note is not a direct presentation of Dr. Awasom and his words because he spoke mostly in pidgin, in a discursive manner and spoke, giving many practical examples.

Dr. Awasom said that the topic of HIV/AIDS involves everybody, likewise the issues of disability involve everybody – therefore we must be aware that the combination of HIV/AIDS and disability is something that we all need to be aware of. We are all affected here, either because we have it ourselves, someone in our family has it, or we know someone nearby. Many things are normally done in the dark. Homosexuals and drug users in Europe may be common for transmission, but it is none of our business. Dr. Awasom said things are changing and that AIDS is a big problem in Sub Saharan Africa. He estimates that North West Province has one of the highest rates of HIV/AIDS, estimated at 20% although the official rates may be seen to be lower.

Persons with disabilities are normal like any other person so HIV/AIDS affects them also. Persons with disabilities are just like everyone else, he said. He also said that if a physically disabled person cannot walk or the legs are not good for instance, the other part of him, that urge to have sex is always fine. This is a part of normal life, and people with disabilities should also be able to have sex. However, this can also make them more vulnerable to be taken advantage of.

The HI Virus causes disabilities such as damage to the spinal cord, nerves, muscles weakness, infections like TB of spine, and others. He also made mention of the fact that the anti-retroviral drugs can cause disability since they react differently with people. Examples could be:

- Numbness of legs
- Tumours – lymphomas
- Kaposi's sarcoma

What is the relationship between AIDS and Disability? Dr. Awasom asked. He said there is:-

- Stigmatisation
- Rehabilitation – workers have too much to deal with
- Occupational hazard for rehabilitation workers.

Dr. Awasom really emphasized that streamlining is important! AIDS is in and should be in everything that you do – the people you are working with need to be sensitized. Management of HIV/AIDS has to be part of

everything that we do. He asked all of the workers present and all of the people with disabilities to ensure that they are always thinking of HIV/AIDS when they are dealing with people with disabilities.

Further, more, Dr. Awasom said that people need to change their attitudes and traditional beliefs that AIDS is a curse from God. People need to fight the stigma and fight discrimination.

He made it clear that HIV/AIDS is preventable and treatable but not curable. He specified three ways by which AIDS could often be spread – through sex, mother to child, and through injections and blades.

He talked about the need for abstinence, fidelity and faithfulness, and if that is not possible, then the use of condoms.

This summary does not fully capture the full extent of Dr. Awasom's lively talk. He provided many excellent examples and used funny stories to get his points across. Everyone who was present very much enjoyed his talk, and many people asked for more from him in the evaluations.

C.3 PHYSICAL THERAPY

C.3.1 PHYSIOTHERAPY PRACTICE AN OVERVIEW

Nkwenti Alfred, C. CPT
Mbingo Baptist Hospital.

Physiotherapists are health care professionals who have undergone physiotherapy training in a university or higher institution and are licensed to practice physiotherapy.

PRACTICE SETTING

The physiotherapist can practice his or her profession in a broad range of inpatient, outpatient and community based settings, including the following:

- Hospitals {critical care, intensive care, acute care, and sub acute settings}.
- Outpatient clinics.
- Rehabilitation centers example **SAJOCAH**
- Homes.
- Education or research centers.
- Schools and playgrounds.
- Cooperate industrial health centers.
- Athletic facilities.
- Fitness centers or sports training centers.

Physiotherapists are committed to providing necessary and appropriate, and high quality health care services to both clients and patients. Patients are individuals who are recipients of physiotherapy care and direct intervention. Clients on the other hand are individuals who are not necessarily sick or injured but who can benefit from a physiotherapist consultation or advice or prevention services. The physiotherapist integrates the five elements of patients/client management, which are, examination, evaluation, diagnosis, prognoses, and intervention in a manner designed to maximize outcomes.

Def: Physiotherapy is the care and services provided by or under the direction and supervision of a physiotherapist. Physiotherapists are the only professionals (along with the physiotherapist assistant who is under the direction and supervision of the physiotherapist) who provide physiotherapy intervention.

The physiotherapist, provide services to patients /clients who have the following problems:

- Impairments
- Functional limitations
- Disabilities or changes in physical function and health status resulting from injury, disease or other causes.
- Impairment is defined as loss or abnormality of physiological, psychological anatomical structure or

function.

- Functional limitation is restriction of the ability to perform at the level of the whole person, a physical action, activity or task in an efficient, typically expected or competent manner. .
- Disability is the inability to engage in age specific, gender specific or sex specific roles in a particular social context and physical environment.
- They interact and practice in collaboration with a variety of professionals, including physicians, dentist, nurses, educators, social workers, occupational therapist, speech language pathologist and audiologist.
- They provide prevention and wellness services, including screening and health promotion and education that stimulate the public to engage in healthy behaviours. They provide preventive care that forestalls or prevents functional decline and the need for more intense care.
- Through timely and appropriate screening, examination, evaluation and intervention they frequently reduce or eliminate the need for costlier forms of care such as surgery, and also may stimulate or even eliminate institutional stay.
- They consult, educate, and engage in critical inquiry and administration.
- They direct and supervise physical therapy services including support personnel such as the physiotherapist Assistant and physiotherapist Aides.

ROLES IN PRIMARY CARE

Physiotherapists have a major role to play in the provision of primary care. As clinicians involved in the examination and in the evaluation, diagnosis, prognosis, intervention, and prevention of musculoskeletal and neuromuscular disorders, physiotherapists are well positioned to provide those services as members of the primary care team. On a daily basis, physiotherapists practicing at acute, chronic, rehabilitative and preventive stages of care assist patients/clients in the following: restoring health, alleviating pain, and preventing the onsets of impairments, functional limitations, disabilities, or changes in physical function and health status resulting from injury disease or other causes. The primary care team may function more efficiently when it includes a physiotherapist who can recognize musculoskeletal and neuromuscular disorders, perform examination and evaluations and intervene without delay. For patients / clients with low back pain, a physiotherapist can provide immediate pain reduction and programs for strengthening, flexibility, endurance, postural alignment, instruction in activities of daily living and work modification. Physiotherapists intervention may result not only in more efficient and effective patient care but in more appropriate utilization of other members of the primary care team. Physiotherapist functioning in primary care role delivering early intervention for work related musculoskeletal injuries; time and productivity lost due to injuries may be dramatically reduced. For certain chronic conditions physiotherapists are the principal providers of care within the collaborative primary care team. They are well prepared to coordinate care related to loss of physical function as a result of mussculoskeletal, neuromuscular, cardiopulmonary or intergumentary disorders. Through community based agencies (community rehabilitation services) they coordinate and integrate provision of services to patients /clients with chronic musculoskeletal and neuromuscular disorders.

SECONDARY AND TERTIARY CARE

Patients with musculoskeletal, neuromuscular, cardiopulmonary or intergumentary conditions frequently are treated initially by another health care practitioner and then are referred to physiotherapisst for secondary care. This secondary care is provided in a wide array of settings from hospitals to preschools.

Tertiary care is provided in highly complex and technologically base settings (e.g. heart and lung transplant services, bum units) or when supplying specialized services (e.g. patients with spinal cord lesions or closed head trauma) in request for consultation that are made by other health care practitioners.

SCREENING PROGRAMS FOR PREVENTION AND WELLNESS

Examples

- Identifying lifestyle factors (e.g. amount of exercise, stress, and weight) that may lead to increase risk for serious health problems.
- Identifying children who may need an examination for idiopathic scoliosis.
- Identifying deformities and disabilities in the community
- Identifying risk factors in the workplace.
- Pre-performance testing of individuals who are active in sports.
- Conducting pre-work screening programs.

TEST AND MEASURES COMMONLY PERFORMED BY PHYSIOTHERAPIST

Depending on the data generated during the history and system review, the physiotherapist may use one or more test and measures, in whole or in part, to help identify impairments, functional limitations, and disabilities and establish the diagnosis and the prognosis. Some commonly employed tests and measures are:

- Aerobic capacity and endurance (assessment of performance lance during established exercise protocols e.g. treadmill, "ergometer, 6-minute walk test, 3-minute step test etc)
- Anthropometric characteristics (measurement of weight, height, length, and girth measurement of body fat composition etc).
- Assistive and Adaptive devices (analysis of the potential to remediate impairment, functional limitation, or disability through use of device etc)
- Cranial nerve integrity (assessment of dermatomes innervated by the cranial nerve etc)
- Ergonomics and body mechanics (assessment of safety in the community and work environments etc)
- Gait, locomotion and balance (analysis of arthrokinematic, biomechanical, kinematic, and kinetic characteristics of gait, locomotion and balance using electromyography, videotape, computer assisted graphics, weight bearing scales, and force plates etc)
- Joint integrity and mobility (assessment of joint hypermobility and hypomobility etc)
- Motor function (motor control and motor learning) assessment of postural, equilibrium and righting reactions etc.
– Muscle performance (including strength, power and endurance analysis using manual muscle test or dynamometry etc)
- Neuromotor development and sensory integrity (analysis of reflex movement patterns, analysis of voluntary movement etc)
- Orthotic protective and supportive devices (analysis of effects and benefits while patient/client wears the device etc)
- Pain, Posture, Prosthetic requirement (assessment of muscle soreness etc)
- Range of motion (including muscle length) analysis of functional ROM etc.

Clinical indications are wide and varied, and may include the following: Impaired motor function, impaired muscle performance, impaired neuromotor development and sensory integration, impaired posture, impaired gait locomotion and balance, impaired joint integrity and mobility, pain, loss of limb or body part, abnormal body alignment, impaired aerobic capacity and endurance etc.

PHYSIOTHERAPIST INTERVENTION {DIRECT INTERVENTION}

These are the interventions normally employed by the physiotherapist after an initial examination and prognosis.

- Therapeutic exercises, including aerobic conditioning.
- Manual therapy techniques, including mobilization and manipulation.
- Wound management.
- Functional training in self-care and home management, including activities of daily living {ADL} and instrumental activities of daily living {IADL}.
- Prescription application, and as appropriate, fabrication of assistive, adaptive, orthotic, protective, supportive, or prosthetic devices and equipment.
- Electrotherapeutic modalities.
- Airway clearance techniques.
- Physical agents and mechanical modalities (infra red lamp, diatherapy, sonopulse)
- Functional training in community and work (job/school/play} integration or reintegration, including IADL, work hardening, and work conditioning.

Then physiotherapy intervention is usually followed by a re-evaluation, modification of treatment and finally discharge. In cases of disability there is a continuous follow up in the community.

C.3.2 STROKE REHABILITATION

Ndeme Levy, Physiotherapy Assistant
PRC Kumba

DEFINITION

- Result of a vascular accident in the Central Nervous System.
- Causes a neurological disturbance of function, often affecting 1 side of the body

Terms

- Hemiplegia – weakness 2 limbs, 1 side
- Monoplegia – weakness 1 limb
- Paraplegia – weakness 2 legs
- Paresis – some weakness, incomplete paralysis
- Plegia – complete/severe paralysis

Hemiplegia

- Most common type of stroke seen; Paralysis of 1 side of body, with partial or complete sensory loss
- 3 stages: - Flaccid/Floppy, Spastic, Recovery
- Caused by - Trauma, Decreased blood circulation, Disease
- Treatment - Medication, Physiotherapy

Types of Stroke

- Reversible Ischaemic Neurological Deficit
- Transient Ischaemic Attack
- Complete

Risk Factors;

- Hypertension, Smoking, Diabetes Mellitus, Heart Disease, Hyperlipidaemia/Hypercholesterolaemia, Excess Alcohol, Obesity

Signs & Symptoms

- Sudden or progressive onset, Hemiplegia initially flaccid
- Sensory loss
- Dysphasia
- Quadriplegia
- Disturbances of gaze & vision
- 'Locked-in syndrome'
- Hemianopia
- Ataxia

TREATMENT

Primary Prevention

Blood Pressure control
Stop Smoking
Diabetic Control
Obesity Control

Secondary Prevention

- As above plus medication

Rehabilitation

- "To help somebody to have a normal useful life again after they have been ill or sick for a long time."
- Involves physical & psychological rehabilitation
- Involves rehabilitation therapists, families & community rehabilitation workers
- Effects: on patient & family
- Loss or change in normal way of life
- Reduction in independence in activities of daily living
- Grief & loss
- Economic impact

C.4 EPILEPSY

C.4.1 EPILEPSY: A FACTOR OF DISABILITY: PROSPECTS FOR CBR

Besong Shakespeare, Senior Supervisor
PCRS Kumba

A. **EPILEPSY**:

What Is It?

- Brain disorder
- Least talked about disability
- Affects Individuals, Families and, Community

- ***Characteristics***

Repeated fits, short laps in attention, severe fits (grand mal), frequent convulsions, attacks are brief, sudden out electrical activity, changes in state of consciousness, involuntary strong contractions of limbs

- ***Causes***

Interruption in flow of nerve impulses in brain, any disorder in body system or mind, genetic predisposition, swelling of brain Tissue, trauma, parasites, substance abuse, infections, prolong maternal labour, febrile seizures.

- ***Precipitating factors***

Exhaustion, psychological stress, low blood calcium, sudden loud noises, intermittent lighting, banging splash music, ingestion of alcohol, height, vast body of water

Classification

Cause is unknown in 50% of cases

- Unknown origin begins 3-15 years
- <2 years is usually related to developmental effects:

-intrauterine
-birth injuries
-protracted maternal labour

- 25 years >are secondary to : -brain damage, tumor, trauma, any infections of the brain

Prevalence

- >80% live in developing countries
- 50 million people live with epilepsy in the world
- Racial differences have not been surveyed
- Environmental & social differences have been noted
- Cultural factors seem to be implicated but not yet confirmed

Preventive measures

Adequate prenatal & postnatal care, safe delivery , control of fever in children, prevention of brain injury by controlling blood pressure, using safety belts & helmets and proper care for children's play

Treatment

- Aims at preventing or reducing seizures
- Compliance with drug regime
- Dose is only reduced if the sufferer is free from fit within a minimum of 2yrs
- No sudden withdrawal of medication
- Up to 70% of new cases can be fit free if treated with anti-convulsants
- In Africa 80% of sufferers receive no treatment

When the sufferer should expect a fit

- Strange aura
- Sudden palpitation & drop in heart rate

- A passing electrical flow
- A passing body weakness
- An unexplained odour
- A sudden sharp pain in the head

What to do when a person suffers a fit

- Lay him/her in a safe place
- Place a folded cloth under the head
- Put a pad between the teeth
- Gently turn head side-ways
- Allow the person to sleep
- Be calm & encourage others not to panic
- Loosen tight clothing
- Do not try to stop jerky motion

It should be noted that epilepsy is not infectious

B. CBR STRATEGY

CBR programs can contribute immensely to improve health care & quality of life for people with epilepsy

The main objectives are:

- Increase awareness
- Promote the inclusion of people with epilepsy into regular health care system
- Find, refer & assess all those living with epilepsy
- Encourage them start medication
- Improve quality of life
- Stimulate sufferer to participate in community activities
- Children to attend school
- Adults to develop Livelihood activities
- Advocacy to improve knowledge about epilepsy
- CBR FW to collaborate with existing health & social services
- Stimulate activities of daily living
- Educate parents & teachers about the ability of people with epilepsy to learn

Under Control: Returned to School
Under Control: ADL Training
Under Control: Small Business Activities

C. ADVICE TO PEOPLE WHO SUFFER FROM EPILEPSY & THEIR FAMILIES

- Do not give the person any thing to drink or eat
- Do not stop the jerking
- In case of burns or severe injury take the person to health centre
- They should be seen by a medical Dr. to prescribe anti convulsant medication
- The Dr. only, might consider increasing or reducing or even changing the drug
- The drug regime must be strictly observed
- The medicine may initially make the person drowsy but the body will eventually adapt to it. Treatment must be continued for a long time. Often the person may need a life-long treatment
- Sufferer must not drink alcohol, smoke, or take barbiturates(stimulant drugs)
- Should not indulge in risky activities: bicycle riding, driving, swimming, use dangerous machinery or go near fire
- Epilepsy has nothing to do with demon possession
- It is neither infectious nor is it caught by coming in contact with the froth of a sufferer
- An epileptic can marry, have children & lead a normal life

C.4.2 A PREAMBLE OF ASODI AND THE PHENOBARBITAL TRIAL ON OVER 500 EPILEPTIC ORPHANS/PATIENTS FOR SEVEN MONTHS IN NGIE SUB DIVISION MOMO DIVISION

Ambanibe Jerome A. President

All Protocol respected,

Association of Orphans and the Disable (ASODI) was incepted on the 13th of July 1999 and legalized by the Government on the 11th of March 2003.

Its Objectives are:

- To rehabilitate Orphans and the Disabled persons,
- To provide basic needs to Orphans and the Disable, and to Health Educate the people of Momo Division. (It has a membership of 50).

Its Headquarters is in Teze-Ngie Momo Division.

We carried out a survey in Widikum, Ngie, Mbengwi Central and Njikwa Sub Divisions and found out that,

1. Widikum Sub Division has: 325 Orphans, 450 Epileptic patients and 70 disables.
2. Ngie Sub Division haslf60 Orphans_O Epileptic patients and 250 disables.
3. Njikwa Sub Division has 200 Orphans, 250 Epileptic patients and 70 disables.
4. Mbengwi Central Sub Division has 50 Epileptic patients.
5. Batibo Sub Division which is he largest in Momo Division has not been surveyed because we do not yet have a volunteer there. The rest of Mbengwi Central Sub Division has not been surveyed for the same reasons.

PHENOBARBITAL PROCEDURE AND TRIAL

A survey to know the detailed number if epileptic patients in Ngie Sub Division was carried-out by a door-to-door exercise through out the 19 villages that make up Ngie Sub Division. This took 5 volunteers Nurses and 15 coordinators. The exercise took 5 months form March to August 2003.

This revealed that 500 people were epileptic amongst them Orphans existed in Ngie Sub division.

A publication was made on the post newspaper N° . . . . Edition to create awareness.

In January 2004 a BBC documentary was made by Randy Joe Dah and it was broadcast on the 24th Jan 2004. Two training seminars were held one for the guardians/teachers of schools in Ngie Sub Division and one for the primary school children. All these seminars took place at Andek and Teze respectively and we had 205/250 participants respectively. These were to give an overview to care givers and give them the necessary first aid measures to be taken before/during and after a seizure and also to demystify local traditional believes and myths. On May 29th 2004 4 nurses and one medical doctor took medical histories from 300 Epileptic patients. (The rest 200 or more could not be there because there are in enclave areas of Ngie. Penetration was not possible). From these histories, we could deduce that 65% of the Epileptic victims suffer from grand mal seizures because it affects the whole brain and the entire body shocks within a seizure/fit.

While the remaining 35% suffers from petit mal and status epilepticus. It was also discovered from these medical histories that 70% of these victims suffer the seizures at night some going from two -seven or eight times everyday for those of status epilepticus while some suffer both day and night for 31 days.

Still from the medical history we could notice that ½ of the patients were living on herbs, ¼ had not taken anything and ¼ had changed from one medical drug to the other.

From these results, 75-80% who took 31 tablets of phenobarb every month and at bed times had just one or two seizures a week. But for the status epilepticus, who have 24 seizure a day and sometimes 4-8 seizures a week. This we have done for 7 months today.

It is worth mentioning here that the number of epileptic patients as well as Orphans keep increasing at an alarming rate. We even have new cases that are 2 years old. If care solution is not sort immediately a population that is between 40,000-60,000 in Ngie will be all infected one day by Epilepsy while Widikum and the rest keep increasing the same. Since 2001 we have loss 10 epileptic orphans 4 died in suffocation on the bed, 5 drowned and 1 died from complications fire burnt

Thanks to Saint John's Presbyterian Christians Los Angeles who came to Ngie saw the situation who are helping us to buy the drugs now but it is still insufficient just for Ngie, not to mention the rest 4 Sub Division. Thanks again to the World Bank who help with 500,000 us through P.T.G, North West.

Some research work was carried out in some areas of Batibo and Bandjoun in the West province and they revealed that cystycercosis which comes as a result of tape warm consumed from pigs is a cause in 65%

of the epileptic victims in the above area. However, we still need to find out in other areas so that accurate treatment plan will be established for the etiology and the prophylaxes sort.

Difficulties:

- Insufficient funds at our disposal
- Lack of health specialists as Volunteers to come and assist in situations. Transportation means is lacking so most work is done by trekking.
- We still need more capacity building both for coordinators volunteering and even to the medical staff in the above areas.
- We suffer from poor road network in the area.
- We lack electricity to carry on work in the area.
- Need for a medical research to do and determine cause through
- Children highly disabled, as they cannot go to school or concentrate, mental problems and dizziness / weakness.

C.5 GROUPS

C.5.1 MOTHERS TRAINING GROUPS:

A STRATEGY TO ENSURE THE CONTINUATION OF REHABILITATION OF CHILDREN WITH CP & PHYSICAL DISABILITIES AT HOME

Esung Elizabeth, Rehabilitation Worker
PCRS Kumba

NEEDS ANALYSIS

- Children with CP & physical disabilities referred to and treated at PRC Kumba.
- Cost: 1,200cfa consultation & card, 550cfa treatment per session plus 200-2000cfa transport each session.
- Treated in isolation by physiotherapy assistants: mothers may not learn, CBR workers do not know treatment plan.
- Attendance at PRC irregular, sometimes never
- CBR workers with limited training/experience
- Continuation of treatment at home haphazard
- Poor hygiene conditions at clients homes

PLAN & AIMS

- To start a Mothers Training Group
- To teach & encourage carers of children with CP & physical disabilities how to continue treatment at home on their own
- To facilitate carers to give/receive support to/from one another
- To teach CBR workers positioning, handling, exercises & approaches to working with children with CP & physical disabilities
- To ensure all identified children are seen by PT & OT
- Basic health care education

MOTHERS TRAINING GROUP

- Started in May 2005
- Held last Thursday every month at PRC Kumba
- Facilitated by PCRS project director & staff with input from PRC director & staff
- Encourages & teaches carers to carry out therapy on their own children
- Allows mothers to talk together about their children and their difficulties (support)
- Direct referral to orthopaedic workshop for aids/appliances

ACTIVITIES

- Positioning & handling
- ROM exercises
- Play as therapy

- Social interaction
- Toy-making
- Aids & appliances
- Feeding training
- Nutrition Talks
- Singing & prayer
- Mutual support, advice & counselling

OUTCOME
- Attendance between 6 – 15 carers/month
- Dedicated mothers who demand dates & attend regularly
- Mothers start group even if staff come late!
- Mothers teach & advise each other & new attendees
- Children make friends, interact & play together
- Staff see mothers continuing therapy at home
- CBR workers quickly learn skills & assisted to make, implement & revise treatment plans
- Repetition of teaching by PT & OT reduced
- Children assessed by professional, who otherwise may not be seen
- Home hygiene has improved

What do you do at the Group?
Mothers' Comments
- "They teach us to do exercises & massage with our children, because we can't afford to come every day for treatment at the centre."
- "We talk together and share ideas and our problems with each other."
- "Some of us have received aids such as walking frames or chairs which we use with our children at home."
- "We come to learn & practise exercises for our children; what to do & how to do it right. I meet other friends & discuss how they manage & cope & what they do with their children at home."

How has the group helped you?
Mothers Comments
"We learn from each other that we are not alone and we see other children much worse than our own."
"I now understand that my child is not a snake who has come to take his own share of my wealth, as other people used to say."
"Because of the group & exercises, my child is flexible. He is happy to meet with friends & likes to play with toys."
"I can see lots of changes in my child & at home I do exercises & my child is happy."

How has the group helped you?
CBR workers comments
"In the beginning, the mothers used to come & put their children down on the floor for us to do everything. Now they join in & help their own children & even each others children."
"Makes it easier to encourage mothers to do exercises at home with their children because they are comfortable having learnt what to do, they cooperate better."
"I have learnt how to handle position and do stimulation activities with the children at home."
"Can reduce number of visits because mothers are doing what we would do."

C.5.2 WIVES AND DAUGHTERS OF PEOPLE WITH DISABILITIES

Mrs. Ngwa Helen, President of the Wives and Daughters of Persons with Disabilities Solidarity Movement (WDPDSM)

With acknowledgement to the difficulties faced by persons with disabilities in this part of the world, which are stigmatization, social exclusions, inferiority complex and unemployment.

For the fact that disability is looked upon as a curse, we the wives and daughters of persons with disabilities have had this being extended to us. We have come to replace the missing rib and are challenged with double responsibility to support our husbands and parents in their area of disability besides home care. Since most of them are self-employed in the area of craft,

a) We the wives and daughters are forced to undertake training in craft so as to assist them.
b) With double responsibility, we always faced it difficult as one has to work both in the workshop and in the evening she is the same person struggling to prepare super and other night duties, which always make us tiresome.
c) Education is another challenged faced by us, as we struggle to see into it that our children are educated. In this domain, we are forced to work tooth and nail to see that our goal is obtained.
d) In the past we used to get some expensive comments from the public by calling us with the type of disability our husband/father has (e.g. blind man and woman).
e) When people have an idea that a woman is engaged to a person with disability, they will always try to discourage her by telling her, her children are going to be people with disabilities, some even believe that people with disabilities cannot satisfy us in bed, just to name a few.

These challenges are enormous and aggravated due to societal concepts and negative ideas towards persons with disabilities. With these challenges, we have come out with a movement of solidarity so as to be able to sensitize, educate and encourage other women to get married to persons with disabilities.
This will help the society to know much about disability.
We also carry out the following activities:

1. Njangee: This is a support fund, which members contribute in support to each other
2. Saving and loan scheme
3. Sharing of life testimonies about persons with disabilities

Our goal is to network with other women's associations nationally and internationally. This will help us to eliminate the mystery surrounding persons with disabilities.

NB: We therefore recommend that the government should include us in the social program, support and promote our projects. Also international bodies can also help us in the networking process because in our own will not be able to reach out to other organizations which are interested in the promotion of activities carried out by people with disabilities and their wives and daughters.

C.6 KEY CONCEPTS

C.6.1 THE ROLE OF NGO'S IN REHABILITATION OF PEOPLE WITH DISABILITIES IN CAMEROON

Nungu Magdalene Manyi

Do you know that the World Disability Report published by DPI (Disabled Persons International) in 1999 states that 10% of every population is made up of persons with disabilities and that there are about 650 million people with disabilities in the world? Approximately 60 million of this population is found in Africa alone. This implies that Cameroon with a population of 16 million has approximately 1.6 million people with disabilities.

I will like to describe the category of people I will talk about. These are people with either physical, sensory, or psychological impairment. You would bear with me that these people group are a major minority group and most of them are living in abject poverty, isolated, most unemployed, least educated, therefore there are high rates of illiteracy. These people therefore are high victims of all kinds of abuse and violence

leading to dependency, low self-esteem, low social recognition, and most are excluded from mainstream societal activities. Our group, CEFED, has carried out research in four villages in Bafut, Mezam central, Batibo and Santa, and found 300 persons to come out with these findings.

What then is the role of the NGOs in this kind of background in rehabilitating persons with disabilities? Before I continue, I will like to give a short definition of what I mean here by "rehabilitation of disabled person". Permit me to borrow the definition of the rehabilitation act passed in Thailand called " The Rehabilitation of Disabled Persons ACT A.D. 1991 (B.E. 2534)". This act defines the rehabilitation of disabled persons as "the improvement of potentials and capacities of disabled persons through medical, educational, social methods and vocational training in order to provide them the opportunity to work or live their lives equal to that of the non disabled".

From the above exposition, NGOs can play the following role in rehabilitating persons with disabilities in Cameroon.

1. **Public education and awareness-raising programs to promote positive perceptions on the potentials of disabled persons in the society.** For example, it could be through the radio, outreach program in villages, churches, meetings, cultural groups, take appointments with Fons and talk to the people. We explain the fact that the disabled person is as normal as any other person and needs his own rights. Families should take care of the children with disabilities. Families should change their attitude towards people with disabilities. A young girl, Sandra, is an example of what sometimes happens to children. Because she had cerebral palsy, she was abandoned as a baby at the riverside to return to the spirit world. However, she was found and taken to the grandmother who kept her alone, sitting in a room with fowls. She was not kept clean, and had to eat from the ground. When found, she was taken to CEFED Centre, she was cleaned and she started learning how to communicate with sign language.
2. **There is need for NGOs to set up career-oriented education of disabled persons and this should be done with the consent of the persons with disabilities.** For example, Emelda is a young woman who is 23 years old and who is also deaf and mute. Her family did not support her, but she chose to learn how to sew and after two years, she graduated and now runs her own small business and is ready to empower others. To often, people with disabilities are just given employment training and their own gifts and talents are not considered.
3. **The NGOs should increase the range of projects available from inferior projects to more profitable projects that increase income security and create gainful employment for the benefit of persons with disabilities and for their families.** Income gained from "kios boxes" and "cigarette boxes" cannot satisfy the family. They should be long-term programs/projects that include income security and good/permanent jobs and create gainful employment for persons with disabilities. People with disabilities can be teachers, engineers, health professionals, accountants, and a wide variety of other professions.
4. **NGO's can press for legislative provision to promote and protect the human rights of persons with disabilities**.
5. **NGO's should establish accessible well-equipped resource centres and clinics that will provide information on issues affecting persons with disabilities.**
6. **NGOs should create an environment for the effective provision of services and resources to person with disabilities in order to positively change their status, level, extend of participation in mainstream development, and achieve increased equal opportunities.** E.g. community rehabilitation programs, special education training schools (Integrated approach), empowerment centres for life skills.
7. **Create leadership opportunities for persons with disabilities in their communities**.
8. **Avoid words that will devalue the person with disability.** NGO's can lead the way in ensuring that the language that is used does not perpetuate stigma.
9. **Carry out a health scheme program to either correct or alleviate disabilities.**
10. **Promote the integration of people with disabilities into the labour market i.e. mainstreaming**
11. **Promote International Corporation.**

To conclude, NGOs have a real vital role in promoting disabled persons to live to their highest level of living, to participate in mainstream development, and to achieve increased equal opportunities.

C.6.2 BEST PRACTICE AND EVIDENCE BASED PRACTICE IN REHABILITATION SETTINGS

Prof. Lynn Cockburn (Occupational Therapist)
University of Toronto, Canada

Objectives for this presentation

- Define "evidence based practice" and "best practice"
- Provide key points on evidence based practice
- Stimulate discussion on how these concepts apply to rehabilitation settings in the NWP

Evidence Based Practice

- Integrating research evidence into the clinical reasoning process to be able to explain the rationale for your practice and to predict probable outcomes
- Explain to clients in words they understand
- Integrates individual clinical expertise with best available external clinical evidence for systematic research

Consider…

- Is what I am doing effective? How do I know that it is or isn't?
- Be open to change when evidence suggests more effective approaches
- How your own beliefs and environment influence your practice
- Continually ask yourself to really listen to your clients so that you can help them
- Advocating for clients
- Continually evaluate practice to ensure that you are truly assisting clients to participate and be included in society

Difficulties in putting into practice

- Have to have access to information
- Know how to access, evaluate and interpret relevant research and other evidence
- Have to have the capacity to collect information to support intervention recommendations
- Need to communicate outcomes to clients and carers so they can make informed decisions about whether to participate

Steps to Evidence Based Practice

- Problem: state as answerable questions
- Track down the best evidence to answer your questions.
- Critically assess the evidence. Is it appropriate to your setting? Is it useful information?
- Implement the most valid and applicable findings.
- Evaluate your performance and continue.

Gather evidence

- Read – search "the literature"
- Talk to colleagues and share resources
- Attend conferences and workshops
- Talk to clients/patients and their carers
- Join associations
- Systematically observe and collect information from your own practice

Evaluate the evidence

- Current and effective
- Probably won't answer your question – BUT don't be discouraged! Think about what it contributes to your understanding of issue.

- The goal is to find the best possible answer by sifting through the evidence

Assessing a study

- When was the study done?
- How many participants?
- Difficult for rehabilitation studies to have large numbers of clients
- Is the study group similar to your clients?
- Diagnosis, condition, sex, age, culture and so on
- Where there outside influences on the study?
- Would the results be similar if the study was conducted again?

Examples of evidence

- Zonta and colleagues (2003) in Brazil - AIDS patients
  - 79% were considered functionally independent; 14% partially dependent; 7% dependent
  - For most of them, independence requires effort and their quality of life is reduced
  - Mild or moderate disability levels were common
  - 21% of the patients required management by a rehabilitation team
  - It is important to focus attention on the quality of life of patients with AIDS

Examples of evidence

- The studies that have been done through CBC Health Board to document eye health problems and the need for programs for people with low vision or blindness + combined with information about how to assess and treat
- Has led to new and effective programs

"Best Practice"

- Built on evidence based practice
- Uses ALL available information to SYSTEMATICALLY develop assessment and intervention practices
- Continually updated and changed

Questions to think about…

- How do these concepts assist in the development of rehabilitation services in NWP and in Cameroon?
- What are some steps that could be taken to include more evidence and best practice into rehabilitation work?
- Are there some other concepts that we can use to complement evidence and best practice?

C.7 COMMUNITY BASED REHABILITATION

C.7.1 OCCUPATIONAL THERAPY: RELEVANCE & APPLICATION WITHIN CBR

Helen Collinge, Project Director/Occupational Therapist
PCRS Kumba

COMMUNITY BASED REHABILITATION

"CBR is a strategy within community development for rehabilitation, equalisation of opportunities & social inclusion for all children & adults with disabilities. CBR is implemented thro' the combined efforts of PWD's, their families & communities & the appropriate health, education, vocational & social services. The major objective is to ensure that PWD's are empowered to maximise their physical & mental abilities, have access to regular services & opportunities & become active, contributing members of their communities & societies" (ILO, 2002)

CBR: Core Ingredients & Inherent Values

- Community based

- Providing rehabilitation
- Culturally compatible
- Using local resources
- Empowerment
- Enablement
- Social Justice
- Importance of active & meaningful lifestyles
- Respect for cultural differences

OCCUPATIONAL THERAPY
- OT is a health care profession based on the knowledge that purposeful activity can promote health and *well-being in all aspects of daily life*.
- The primary goal is to enable people to participate in activities of every day life.
- The aims are to promote, develop, restore & maintain abilities needed to cope with daily activities to prevent dysfunction.
- Treatment is designed to facilitate maximum use of function to meet demands of the person's working, social, personal and domestic environment.
- The essential feature of OT is the active involvement of the person in the therapeutic process.

OT: Core Ingredients & Inherent Values
- Use of occupation & occupational performance to optimise human activity: maintaining & enhancing health, wellness & productivity,
- Holistic: physical, psychological, social, environmental, educational factors
- Client-centred
- Context driven

Occupation
- SELF CARE: bathing, dressing, toileting, grooming, shaving
- PRODUCTIVITY: cooking, cleaning, washing, sweeping, schooling, working, farming
- LEISURE: going to church, reading, listening to music, visiting friends/family

Ndiko Patrick
- Mobility & Orientation
- Self Care ADL
- Productivity ADL
- Leisure ADL

Elizabeth
- Mobility
- Self Care ADL
- Productivity ADL
- Leisure ADL

Philip
- Self Care ADL
- Productivity ADL
- Leisure ADL

Divine
- Mobility
- Self Care ADL
- Productivity ADL
- Leisure ADL

Current Roles of OT's in CBR
- *Transfer of basic rehabilitation skills* to community members, *creation of positive attitudes* & *limitation of burden (training, education, supervision)*
- *Provision of therapy* when needed in *preparation for participation* (basic rehab exercise; assistive technology, wheelchairs, aids & skills to interact, self-esteem building, teach basic skills for advocacy)
- Current Roles of OT's in CBR
- *Provision of first line referral services & guidance* to help people find their way into the system & become their own advocates (bridge the gap between community & institution)
- *Facilitation of programme implementation*, *establish program development* at both government & community levels

- *Promotion & facilitation of effective & efficient collaboration* among the many sectors that contribute to CBR e.g integrate services in PHC
- *(Fransen, 2005)*

Conclusion
- OT's core philosophy & focus on enablement, combined with its attention to process rather than just outcome, has significant potential in leading the implementation of CBR in all countries.

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C.7.2 USING & WORKING WITH CBR VOLUNTEERS: LESSONS FROM THE FIELD

Nku Bende, Rehabilitation Worker
PCRS Kumba

BACKGROUND
- CBR philosophy encourages use of volunteers in the field. However, uncertain how this would work in Cameroon, unsure how to start
- 2005, asked by CHC to assist at International Day for Sick. Saw many disabled in need of rehabilitation
- Asked CHC if we could teach them to do more rehab/referral activities in addition to prayer
- CHC agreed, became 1st trial of PCRS CBR volunteers

Volunteer & Rehabilitation Worker Orientation &Mobility Training (RW & OM)
Volunteer Training
- May 2005 included CHC volunteers in O&M
- Volunteers began training blind in their communities and gave very positive feedback
- More people asked to learn/become volunteers
- Developed 1 week 'CBR & Identification of Disabilities Training': RW's & Director
- Ran 2 of these trainings: Aug 2005, Feb 2006
- Trained 75 volunteers, including CHC, CDD's, church volunteers, pastors, MINAS

CBR Training
- CBR
- Disability, Impairment, Handicap
- Rehabilitation
- House-to-House surveys
- Primary Health Care
- Identification & testing for disabilities (blind, low vision, deafness, physical handicap, epilepsy, mental handicap, multiple handicap)
- Nutrition
- Recording & referral procedures

Volunteer Training 2006
Volunteers Role
- House-to-house surveys within own quarter/ village using survey form and E chart, to identify clients
- Record list of potential clients
- Report clients to RW during visits
- Introduce RW to clients
- Engage family in referral/rehabilitation plan
- Assist in referral/rehabilitation plan
- Follow-up clients & feedback to RW

Who May Be a Volunteer?
- People from church groups: CMF, CYF, CWF
- Mectizan Distributors
- Community Health Workers
- Pastors
- School teachers
- Anyone interested in helping disabled persons!

Motivation of Volunteers

- Small per diem during training
- Certificate, announced & blessed in church
- Letter to church/village head to inform
- PCRS Volunteer Identity card
- Respected by community/clients ('Dr')
- Seen as advisors for other problems within the community
- Visited by staff/taken out in project vehicle
- Further training/employment opportunities
- Letter of recommendation when needed
- Occasional allowance for specific work

Lessons Learnt

- Volunteers very useful tool in community
- Increase Number of cases identified, provide publicity, educate in PHC
- Encourage community/church to identify own volunteers
- Explain role clearly to volunteers & community
- Provide volunteers with necessary tools
- Visit them monthly
- Arrange occasional volunteer meetings
- Many trained but not all work, but accept this, still increases no people aware of services

C.8 PSYCHOSOCIAL ISSUES

C.8.1 PSYCHOSOCIAL EDUCATION ON STRESS

Nkwentisama Albertine
(Acting Program Directress CRAT Bamenda)

INTRODUCTION

All people experience stress. Some suffer more then others from its effects. For example one person may be strongly affected while others are little affected by the same kind of stress.

DEFINITION OF STRESS

STRESS is a physical and psychological disorder caused by experiencing a situation, which one finds it difficult in coping with. The causes of stress can be prevented or reduced, which will improve mental and physical health. Alternatively people can learn ways of coping with stress.

WHAT ARE SOME OF THE CAUSES OF STRESS

- Experiencing a situation that one finds it difficult to cope with.
  Displacement/uprooted. Can be as a result of war, domestic violent/family problems or religious problems and can cause a considerable distress among the people. From statistics, these situations have caused severe mental consequences and permanent scars in the mind.
- Bereavement, destruction of personal belongings and sudden disruption of social structure can lead to severe psychological disturbances'.
- Prolong illness, poverty, unemployment, inability to fulfill your desire, sexual assaults isolation, threats etc are some of the causes of stress.

Finding out the causes of stress is the first step in managing it. It is good for you to ask yourself, the events you have faced before or recent, what is the present situation and what is the future plan. If you know what is the cause of stress, it will help you cope better. This will equally help you prevent the development of minor mental health problems. Such minor mental health problems include:

Mental disorders	loss of concentration
Behavioural changes	depression
Aggressive- violent	low level of tolerance

Irritation Restlessness
Forgetfulness Anxiety Drug abuse
Physical disorder, high blood pressure, headache, insomnia, hormone disturbance, premature birth and libido(loss of sexual desire).

PREVENTIVE METHOD OF STRESS

This section provides you with some `psychological first aid' advice in how people can reduce their stress:

The first dose is to face your problem, and talk about the problem with someone you trust e.g. close friends, family members, pastor, or counsellors (CRAT) etc.

Ask for helps and support

- Prayer. Prayer is the master's key. When you pray belief that God can open a way where there seem to be no way. Belief that God has a plan for you
- Think positively
- In moment of stress, avoid noise
- Keep yourself occupied

Recreational activities such as: listening to quiet music going for a stroll reading, playing, singing, Making love (if you are marry)

The most essential tool is relaxation. For it to be effective, it is helpful to observe a few preliminary conditions:

a) Place. A quiet, well ventilated place free of disturbances
b) Time: Morning or evening- twice a day for ten minutes before taking meals.
c) Clothing: loose cotton clothes are the best.

Regular practice will help to create a healthy peaceful life.

BREATHING EXERCISE

When we are disturbed mentally our breathing becomes shallow and irregular. This in turn will cause changes in our physical body. By learning to make our breathing deep and regular, we can oppose these physical and psychological changes. Thereby produce a state of mental and bodily peace. To achieve this, assume any posture that is comfortable. (e.g. sitting in a chair, lying on a bed) and in a relaxed tranquil state, observe yourself breathing in and breathing out for few minutes. Often we will notice that our chest is being used predominantly for breathing. But for this exercise to be effective, slowly and gradually learn to shift your breathing to the abdomen so that most of the breathing is done by the movement of the abdomen muscles.

PROGRESSIVE MUSCULAR RELAXATION (MINDFUL BODY AWARENESS)

During stress the muscle are continuously in a state of contraction, physical and psychological symptoms will appear in the body, for example, tension, headaches, backache, neck pain, joint pain, weakness and tiredness. Further, there may occur psychological fear, tension, tightness, being easily startled, over reactivity and irritability. These mental states can produce chronic contraction or tension of muscles leading to the above physical symptoms. By practising the following exercise you can obtain release from these painful physical and psychological complaints by creating a state of relaxation, calmness and peace.

How to do this: lie down flat, facing up, on a mat or bed. Spread out your legs and let your hands lie by your side. Close your eyes and observe your breathing in and out slowly, without hurry, and deeply as described above.

Relax all part of your body while in this posture until you feel satisfied. Do not get up suddenly, but slowly move your body a little and become aware of the body before getting up. After the exercise try to appreciate the difference between the tensed and relaxed state. After this exercise, you can get a good dose of sleep.

These preventive measures are applicable not only to an individual but also to groups, and in communities. Do not take alcohol when you are stress up nor to smoke.

C.8.2 THE ROLE OF SOCIAL WORKER IN THE REHABILITATION AND INTEGRATION OF PEOPLE WITH DISABILITIES

Fambombi Dickson, Social Worker
Mbingo Baptist Hospital, Cameroon Baptist Convention

INTRODUCTION

Whether in developed or developing countries, social workers share values and commitments to human advancement that transcend the differences of their geo-political and workaday settings. This affirms the fundamental values of social work that include belief in the worth and dignity of each individual person and faith in the capacity of people every where to work individually and collectively for their own good and the health and well-being of others.

The social work profession propagates social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social systems, social work intervenes at the points where people interact with their environments. It addresses barriers, inequalities and injustice that exist in society.

It responds to crises and emergencies as well as everyday personal and social problems.

It utilizes variety of skills, techniques, and activities consistent with its holistic focus on social issues and related services.

A social worker helps to assess and alleviate problems related to personal, family, or social situations. They constitute a vital part of the rehabilitation multidisciplinary team, and help provide support for the patient and family, coordinate discharge planning and assist with financial problems and family conflicts.

Certainly, many of our brothers and sisters within this group can not afford effective health care/management. They need assistance from either a relation or external person/body/Government. We assess some of these cases within the hospital, (in cases of trauma, or sudden disability) appeal to their relatives and other benevolent persons for assistance. It is often not easy to have a sponsor.
Some times families run away or are scared because of some sudden disabilities. In such cases we proceed with counseling for individuals or the entire family. Losing parts of your body like the arm or leg through amputation due to ulcer (especially diabetic ulcer) and accident is hard to accept. Yet these parts need to be removed for survival. The social worker takes time to counsel both with patient and family for acceptance and subsequent living.

DEMYSTIFICATION OF DISABILITIES

Many traditions paint bad images about various disabilities. This makes acceptance of conditions very difficult to both the victims and relatives. Many victims of circumstances are innocently labeled, thus the need to counsel with both family and community.

For instance, having epilepsy does not guarantee that you stole or was bewitched for adultery. Being a deaf or dumb does not implicitly means that your parents saw masquerade. Losing your leg from an accident does not mean that your ancestors or a friend has cursed you. Having leprosy does not mean that you sinned and God has cursed you or that you ate chimpanzee.

We might not have definite scientific explanations to some of these problems. But this does not call for labeling and prejudicing others. The above casual conclusions con not be adequately proven.

INTEGRATION AND PARTICIPATION

One of rehabilitation needs is related to stigma which renders victims helpless and rejected. Appreciation to those victims who participate in various domains. Still, many need to be capacitated for them to be participatory. When they participate, they gain control over life and feel useful again. Effective rehabilitation and integration facilitates participation.

We counsel both with persons concerned and their immediate families to combat stigma and instill recognition/acceptance. This is achieved when those with disabilities take responsibility over their family issues and contribute to the development of their communities.

SOCIAL SUPPORT AS A VEHICLE OF CHANGE

Those with disabilities have to be impacted with proactive and goal oriented spirit to enhance self development. Certainly there aren't enough workers to take care of all daily problems of this category of people. Thus, if they have group periodical meetings, it will be more beneficiary to them.

Support group meetings give them a forum to identify common problems, experiences, goals and strategies. We help clients- individuals, groups or communities – to achieve self-fulfillment and maximum potential within the limits of the respective rights of others. This service is based on helping the clients to understand and use the professional relationship, in furthering clients legitimate desires and interest.

PERSONAL GOAL AND SELF ACTUALIZATION
Carl Roger, a Psychologist believes that all individuals possess what is called Self actualization. The Social worker creates an atmosphere in which clients can experience personal growth. In this respect clients will be oriented towards gaining contact with their true feelings and values, which increases self autonomy and personal growth.

WORKING IN SOLIDARITY
Social workers have an obligation to challenge social conditions that contribute to social exclusion, stigmatization or subjugation and to work towards an inclusive society. This pre-necessitates the HOLISTIC regards of people with disabilities. Thus social workers uphold and defend each person's physical, psychological, emotional and spiritual integrity and well-being

INDEPENDENT LIVING
We provide comprehensive services to people with disabilities to enhance their ability to live independently, function in their homes and with their families and to participate in their communities.

SOME AREAS OF INTERVENTION

- Advocate for the rights of persons with disabling conditions to develop, maintain and enhance independent living.
- Confront and deal with fears, attitudes and prejudices towards people with disabilities
- Facilitating support groups
- Individual counseling
- Advocacy and client outreach.

The CBC Health Board **Social Workers** Operate on this Biblical Background Pro. 31 8-9 *"Speak up for those who cannot speak for themselves, for the rights of those who are destitute. Speak up and judge fairly; defend the rights of the poor and needy"*

C.9 PROMOTING HEALTH

C.9.1 PROMOTING HEALTH AND SOCIAL PARTICIPATION: AN INTRODUCTION TO DISABILITY RELATED POLICIES IN THE NORTH WEST PROVINCE

Goli Hashemi, Graduate Student (Occupational Therapy),
London School of Hygiene and Tropical Medicine

1. Outline

Review of background information
Overview of policies
Current situation in the NWP of Cameroon
Challenges
Recommendations
Discussions

2. Background Information

- According to WHO an estimated 10% of the world population experience some from of disability or impairment.

- 80% live in low income countries, are poor and have very limited if any access to basic services including rehabilitation.
- In the NWP:
    - Total population is 1.7 million
    - ? Population of people with disabilities 170’000 ?

3. Overview of policies

The United Nations. The Standard Rules on the Equalization of Opportunities for Persons with Disabilities

The case in Cameroon: Law No. 83-013: related to the protection of the disabled person and its Decree of Application No. 90-1516

4. Key Aspects of Law 83/015 and its Decree of application No: 90-1516

Education and educational assistance
Vocational Training
Socio-economic integration and installation
Reserved and protected employment
Recreative and sporting activities
Social Aid: individual and collective
Preferential measures: Accessibility and Fee exemptions
Prevention and early detection of a disability

5. The Disability Card

- A document that proves that an individual has at least a 50% level of disability
- Available via the Ministry of Social Affairs
- Recognized across the country
- Meant to provide individuals possessing this card with many advantages

6& 7. In the North West Province

- Education and Educational assistance:
    - Schools for children with special needs (visually or hearing impaired) are all private
- Vocational Training
    - Examples are in SAJOCAH and Mbingo Baptist Hospital
    - No government funded program available
- Rehabilitation Programs/facilities
    - PT department at the Provincial Hospital (public)
    - SAJOCAH, Mbingo/Banso Baptist Hospitals, and other smaller NGOs provide rehabilitation services
- Number of professionals
    - Physiotherapists (2 at the provincial hospital and others are at SAJOCAH and Mbingo BH)
    - Assisted by aides and assistants

8 & 9. Challenges

- Very limited if any government led programs for those living with a disability
    - The disability card only accepted by the government led programs
    - Disability card can only be obtained from government doctors/institutions
    - Only people who have the disability card can take advantage of its benefits
- Lack of awareness
    - The extent of disability within the province
    - Awareness regarding the needs of people living with a disability
    - The rights of people with disabilities
    - Poor awareness of the use and process involved in obtaining a disability card by rehabilitation workers and others
- Difficulties in implementing the laws
    - Not only the responsibility of the Ministry of Social Affairs
    - Lack of monitoring
    - Limited resources
- Very limited number of trained personnel, within health care and educational settings

- Limited history of collaboration and lack of professional development

Recommendations

- Collaboration- Multisectoral collaboration and establishment of stronger networks both within and between government and Non-Government Organizations
- Awareness raising- educating all at every level regarding the needs of people with disabilities and their rights
- Improved collaboration between service providers to develop a stronger body of trained professionals who work with this population
- Developing one strong and reputable organization to represent those living and affected by disabilities and smaller organizations
- A situational analysis

Why?

- Disability continues to increase
  - Road traffic accident
  - Infectious diseases not yet eliminated
  - Increase in non-communicable diseases
  - Medical advancement
- Not only effects the individual but also their family and caregivers
- People with disabilities can offer a lot to the socio-economic life of a community

C.9.2 HEALTHY GESTATION TO AVOID DISABILITY IN CHILDREN

N'tangri Rolly Ontangs

There are so many factors that bring about disability in children. These range from genetic or chromosomal factors to environmental factors both prenatal and postnatal.

This paper will not delve into genetic or chromosomal factors i.e. factors involving defective formation of the genetic material itself (deformation of the chromosomal configuration:"Karyotype") over which we have little or no control. In passing however, suffice it to say factors of that nature involve **spontaneous mutation of genes** and/or chromosomes, **genetic incompatibility** between parents; **gene disposition** to a certain disorder; **chromosomal dysgenesis** i.e. failure if chromosomes to develop properly during the formation of spermatocyte or conception or development resulting in abnormal chromosomal make-up, translocation (i.e. mismatched chromosome pairs or portion of a chromosome in the fertilized ovum); and **structural abnormalities** such as partial/complete deletion.

The focus of this paper however is on risk factors during the gestation period that should an expectant mother indulge in, will affect the unborn baby thus bringing about disability in such children. Such factors include:

a) Maternal Anxiety and Stress: This is a mother's emotional state that makes her pump **adrenalin** into the blood system. Given that the foetus and the mother are mutually linked, when the mother experiences such an emotional state, the foetus will experience a similar physiogical state. This results in the delivery of an irritable hyperactive infant that is usually precocious and weighs less than the average. Such an infant sleeps and feeds poorly at birth.

Prolonged stress in the pregnant women can affect prenatal development in three principal ways: Firstly, she secrets hormones that reduce the flow of oxygen to the foetus while increasing its heart rate and activity level. Given that the foetus depends on the richness of oxygen in the mother's blood to maintain the oxygen balance vital to its own system, it goes without saying that prolonged deficit in the oxygen level brings about a deleterious effect in the form of severe mental retardation in the child. Secondly, stress weakens a pregnant woman's immune system rendering her more vulnerable to illnesses, which can damage foetal development. Thirdly, out of stress, a pregnant woman can behave unchristianly by either smoking, taking alcohol, having insomnia, failing to take exercises, to rest and to feed properly conditions that affect the unborn baby negatively.

b) Maternal Nutrition and Diet: Studies have shown a high correlation between the nutritional state of the mother and the health of the foetus. Hence severe maternal malnutrition and undernourishment increase the risk of birth complications and neurological deficits. Knobloch and Pasamanich (1966) for example report that a Baltimore Study showed that stillbirths and major deformities are highly related to the mother's

prenatal diet. What is more, limited intake of **folic acid** by the mother makes the child vulnerable to **Spina Bifida.** A shortage of Vitamin B would affect the child's mental ability just as maternal malnutrition in the early stages of foetal growth is decisive in the production of certain physical abnormalities in the baby (Warkany (1947). There is overwhelming evidence that **the nutritional level of both male and female prior to procreation and that of the female during gestation** is the most critical single variable affecting the production of genetically and physically sound children. **Hence malnutrition and the accompanying absence of essential vitamins and minerals constitute the greatest single determinant of defects in children.**

c) Maternal Age and Parity: Complications occur at birth depending on whether the mother is a teenager, an old woman or a woman who has had multiple births. For example, children of teenage mothers have empirically been proven to have academic and behavioural problems in school while mothers from 30 years old have been known to give birth to children with congenital **hydrocephalus**, **microcephalus**, **mental retardation, Down syndrome**, and a variety of congenital deviations. Down syndrome is the best-known incidence in man because the dependence of this syndrome on maternal age, independent of parity, is very clear. **Every increase of 5 years after the age of 25 more than doubles the probability that a child suffering from Down syndrome will be born.**

d) Maternal Diseases: The foetus is largely defenceless against infections because its immune system matures relatively late in the prenatal period. The few diseases that have not been screened out by the placenta affect the foetus especially bacterial and viral infections such as rubella (German measles), cholera, mumps, influenza, gonorrhea, syphilis, small pox, diabetes etc. Rhodes (1961) for instance, reported substantial increase in malformation of children born after their mothers contacted influenza. While some of these diseases like rubella and syphilis are transmitted directly through the placenta, others affect the children perinatally when the foetus is infected by the virus in the lining of the birth canal. Rubella for instance has serious effects on those parts undergoing a critical phase of foetal development when it affects the mother. Such parts include the eyes, the ears, other sense organs and the heart. **In fact there is glaring evidence that maternal diseases are second to maternal dieting in the classification of risk factors that bring about the birth of unhealthy children**.

e) Environmental Hazards: The industrialization of the world has exposed man to toxins in the food he eats, the water he drinks and the air he breathes. This means that industrial waste chemicals are the most common environmental hazards. Though they may appear minute, we should not forget that minute things can have serious consequences on pregnant women and their yet-to-be born children. Environmental hazards include:

- Mercury: which is related to retarded growth, mental retardation and cerebral palsy
- X-rays associated with retarded growth, leukemia (blood cancer) and mental retardation.
- Polychorinated Biphenyles (pcBs), which result in verbal and memory impairment.

Pregnant women should therefore try to know the sources of these hazards and keep away from them especially by washing thoroughly what they eat and by not exposing themselves to toxins emanating from household equipment.

f. Teratogenes: The best-known teratogenes in man are **viruses, radiations and drugs.** For it to be effective, a teratogenic agent must affect some specific metabolic process in the developing embryo and usually causes malformation only if exposure occurs at the time when the embryo is sensitive to its effect. **Thalidomide** for example taken during early pregnancy brings about stillbirth or a child born with very small-deformed useless arms and hands. **Quinine** taken during pregnancy causes congenital deafness in children while **heavy sedation** of the mother can cause asphyxiation of the foetus. A pregnant woman spraying her kitchen regularly with insecticides does not see it as "taking any drug". However, the following should be noted about the effect of teratogenes on the unborn child

- The genotype of the person e.g. thalidomide affects off-springs of humans but not those of rats, just like not all women who took it produced deformed children
- The effect of the teratogene depends on the period of child development Teratogene damage is selective in the sense that it affects a specific aspect of prenatal development.
- Teratogenic impact changes over the course of prenatal development.
- Damage from teratogenes is not always evident at birth but must appear later on in life.
- One teratogene may result in a variety of deviations and vice versa. Alcohol intake brings about Foetal Alcoholic Syndrome (FAS) children with cognitive deficits, Aspirin brings about deficit in intelligence, Coffee brings about decreased muscle tone and Nicotine brings about facial deformities.

In conclusion, it is clear that if pregnant women could take care during the gestation period, the number of

disable children we have amongst us can be reduced. A look at all of the above factors and their prevalence however as well as other factors responsible for disability in children, make us wonder aloud how non-disabled children really come to be.

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C.10 LEARNING FROM EXPERIENCE

C.10.1 HANSEN'S DISEASE: THE MBINGO EXPERIENCE

Pat Lenz, Mbingo Baptist Hospital

Mbingo Baptist Hospital was established to care for people with Hansen's Disease, which many still call "Leprosy". In those early days HD (Hansen's Disease) was thought to be very contagious, patients were isolated from healthy people. That is part of the reason the hospital is not in a town

Physiotherapy also began at Mbingo because off HD. The first thing I leaned about was a group of special procedures called "tendon transfers". The surgeon would disconnect one end of a muscle at the end- called a "tendon"-and attach it to a different place. Physiotherapy was needed to re-train patient how to use that muscle for a new function.

But I am getting ahead of myself. For those who are not as familiar with HD, let me go back and start at the beginning.

For over 100 years it has been known that the germ called Micohacterium Leprea is the cause of HD. The disease is, in fact, not easily spread, so isolation of patience is not necessary. The best news is that HD can be cured! Beginning about 60 years ago, Dapsone helped stop the bacteria from growing. Over 20 years ago, another new drug came into use that actually kills the bacteria. But what is HD, exactly? HD is a disease of skin and nerves.

1. SKIN - Lesions or patches of varying sizes may appear on the patient's skin. Their appearance also varies with the patient's resistance level. Virtually all disappear with treatment.
2. NERVE'S - The worst part about HD is its effect on nerves. This is called a secondary effect, however, because only 25% or less of patients have problems.
    a. HD can damage sensory nerves, leaving the area without feeling. The most important factor is if protective sensation is lost: that is, the amount of feeling is no longer adequate to protect the patient from damage to his tissue. An example is: he held his cup too long and got a burn because the nerves in his hand didn't tell him it was too hot
    b. HD can also damage motor nerves, resulting in weakness or paralysis. There are very specific locations where this happens- in places where nerves are near the surface and therefore cooler.

    i. The Ulnar nerve, where it passes behind the elbow, is the most common nerve to be affected. The result can be varying degrees of weakness, especially of the little and ring fingers, called "claw hand". This makes it difficult to hold large or flat things, like a cup or a carton.
    ii. The Median nerve is sometimes affected where it crosses the wrist. The result is called "ape hand" or "flat hand". The rest of the fingers are clawed, and the thumb does not

oppose the fingers. This makes it difficult to grasp things, and a side pinch is often used for holding.

iii. The third nerve affected in the upper extremity is the Radial nerve. The wrist and fingers drop. Fortunately this one is not often affected here in Cameroon. But when it is, the other two are also affected, and the arm is almost useless.

iv. The another nerve is the peroneal, which when damaged results in drop foot. The patient cannot walk on his heels, and the toe may drag on the ground.

v. There is one more common nerve I want to mention: parts of the facial nerves are also involved occasionally, and can result in sagging eyelids and twisted mouth. This also puts the eye at risk, and occasionally sight is lost.

c. HD also damages autonomic nerves, which disturbs sweat and oil glad function. That can leave lands or feet dry, and prone to cracking.

So, in what way has Physiotherapy helped patients with these problems? We have worked hand-in-hand with the "Leprosy Inspector", sometimes sharing duties in different ways. Important activities include:

1. Soak, oil and trim - When hands and feet are dry because of nerve damage, they are soaked in clean water for 20-+ minutes, at least once daily. Oil is immediately applied, to keep in the moisture. Sometimes trimming of accumulated callous is needed. "Soak your foot..."

2. Exercise - hands or feet with weakness of one or more muscles do not function in balance, so some movements are not done. Then those joints can get stiff', so regular exercise is needed. Examples: "make table" and stretch thumb web.
3. Ulcer care - if an ulcer develops on the bottom of the foot, due to loss of protective sensation. soaks and dressings, and sometimes a plaster cast are used to promote healing.
4. Re-education before and after tendon transfer - now we come back to this. Certain of the strong muscles can be used to power those whose nerves are damaged by HD. Most of the original function is restored. Example: Extensor/Flexor 4 Tails.
5. Adaptive devices: especially to protect insensitive hands, adaptive device may be used. Examples: pot-holders for hot things, other padding for sharp things. [2 pix] Insensitive feet may also need special shoes to reduce the risk of ulcers.
6. Vocational Retraining - if the patient can't (safely) carry out his previous occupation, he can be retrained in a safer activity. We started with cane baskets and embroidery. Now so many other things are available as well, either on the compound, in the village [taught by CRS workers], or by arrangement out side- including tailoring, farming/rabbits/chicken, bee-keeping, welding, shoemaking/mending.
7. Health Education (i.e. self-care) - especially when a patient has sensory loss, it is very important that he should learn how to prevent injuries to insensitive parts. He needs to be trained how to watch out for danger and avoid it, rather than waiting for accidents to happen. One good example is the bush lamp handle – never let it stand upright. Support groups Can help patients encourage one another to take good care of themselves.

The first piece of good news was that HD can be cured. The second piece of good news is that deformity can be prevented! Start with early case detection; add regular adequate treatment; and finally throw in good self- care practices for those who do get nerve damage. Instead of deformity being present in 25% of patients (which is what the average used to be), it may be10%, or 5 or virtually nothing!

I used to think that tendon transfer was the most significant procedure we had for our disabled patients. Dr. Fluth told of one patient- a young man who had a claw hand. He was treated and sent home with his discharge certificate. His mother instead looked at his hand and said, "You are not well."

He came back and had the tendon transfer. Then his mother smiled, "Now you are well." In fact deformity such as that was the biggest reason for stigmatization, which may be worse in HD than any other disease to date. That is another very important part of the whole disability picture, but we don't have time to go into it now. Since disability plays such a significant role in HD, I now believe that teaching patients self-care can contribute far more to his welfare than any drug or operation.

Soon physiotherapy may be out of a Job, as far as HD is concerned. But the knowledge we have gained will continue to be used. Patients with Diabetes are now coming with the same kind of nerve damage problems. Ulcer care and prevention of injury principles we've used with HD will also help the person with diabetes. And who knows what we will see as HIV/AIDS patients continue to live longer and longer

There is still much work to do, but we thank God we have been able to help with the rehabilitation of many patients through the years.

C.10.2 PRESBYTERIAN COMMUNITY REHABILITATION SERVICES KUMBA

Shu Winifred, Rehabilitation Worker
PCRS Kumba

- A Community Based Rehabilitation project in partnership within the Presbyterian Church in Cameroon & Christoffel Blinden Mission International.
- Based in Kumba in the SW Province, covering Meme Division.
- Started in 2003.
- Working with all disability groups, all ages.
- Mediators for Liliane Funds
- Identification
- House-to-house surveys
- Outreach Clinics
- School/Community screening
- Referrals
- Mobility & orientation
- Small business loans
- Groups for blind (ANAC)
- Vocational training
- Refraction

Identification of Cataract
Deaf/Hearing Impairment
- Identification
- Referral
- Integrated education
- Special education
- Vocational training

In future:
- Home/family communication

programmes
- Prevention

Physical Disabilities
- Identification
- Referral
- Aids & appliances
- Home training/rehab programmes
- Mothers Groups
- Vocational training
- Small scale loans

Multiple Disabilities
- Identification
- Referral
- Aids & appliances

- Home training/rehab programmes
- Mothers' Groups
- Vocational training
- Small scale loans

Epilepsy
- Identification
- Referrals
- Counselling
- Education
- Vocational training
- Small scale loans

Referral Centres
Collaboration/Networking
- PRC KUMBA: Training, advice
- MINAS: link worker, school admission, welfare support, formation of disability groups
- MINSANTE: Eye Unit Kumba District Hospital, DMO's - Mectizan distribution
- CHURCHES/GROUPS: Fund-raising, volunteers, publicity, identification
- SIGHT SAVERS INTERNATIONAL: project planning, training
- STUDENTS: ENAS, Community Development, University of Toronto

C.10.3 THE IMPORTANCE OF DOCUMENTATION IN REHABILITATION PROGRAMS

Yuh Somon, Supervisor
Community Based Rehabilitation, Mbingo

WHAT IS DOCUMENTATION? : A document refers to printed material or writing (information) as record or evidence of something. As a verb is to put forward evidence in support of something, so is documentation the process of putting together or forward printed materials or writing as evidence of something. Thus it is record keeping. To this effect and applicable to the above topic it is the keeping of records and activities about people with disabilities and rehabilitation. God taught us the most important documentation being the Holy Bible. It is the word of God that he spoke and His chosen people documented it in its perfect form for the purpose of our salvation.

CHARACTERISTICS OF DOCUMENTS: - Accurate, timely, genuine, precise, eligible/readable and Understandable, purposeful, informative & educative.

FORMS OF DOCUMENTS AND PRESENTATION
A document could have information presented in many ways and forms. In each case the above characteristics are always the controlling factors as well as according to the specification of the ultimate user(s)
- Graphical/charts
- Diagrammatic
- Statistical
- Tabular
- Narrative

IMPORTANCE OF DOCUMENTATION
For planning, monitoring and assessment/evaluation.
Accountability/Reporting.
References and learning.
PRESERVATION: - Electronic - Printed.
Thanks for your kind attention

C.10.4 SPINE DISABILITY AND REHABILITATION

Dr. Nana Christopher, Orthopaedic Surgeon
Mbingo Baptist Hospital

Dr. Nana presented an excellent presentation, primarily in pidgin. This is a summary of his remarks, and just skims the surface of what he said.

Dr. Nana began by saying since the audience was quite varied in their backgrounds he was going to present a basic talk about spinal cord injury and the importance of rehabilitation when someone experiences a spinal cord injury. He described a spinal cord injury as an injury to the cord that goes from the brain down a person's back within the vertebra (the spine bones). The aim when someone has a spinal cord injury is to make the best use of what is left.

He stated that in the Western world many spinal cord injuries are caused by motor vehicle accidents and sports, including what is called "extreme sports". In Cameroon, the causes of spinal cord injuries are motor vehicle accidents, falls from trees (harvesting), and infections, such as TB of the spine. There are more men than women with spinal cord injuries.

Paraplegia – means 2 limbs affected (the legs)
Quadraplegia – means all 4 limbs are affected (arms and legs)

Dr. Nana wanted the audience to be aware that there are many types of spinal cord injuries, and each person has a unique injury. There are both complete and incomplete spinal cord injuries. Those that are complete, means that the spinal cord has been completely severed and there will be no function below the level of the cut. In those that are incomplete there can be some remaining sensation or motor ability. He demonstrated how it is in the body.

For rehabilitation to be maximized, there needs to be both individualized and multidisciplinary treatment. Dr. Nana emphasized that there needs to be holistic treatment, an holistic approach is very important to ensure that the person receives the best treatment possible. He stated that the team needs to consider the level of the injury, how complete it is, other medical or health conditions, and other factors about the person, such as their social situation, marriage, children, age and so on. The question that the team should always be asking is "What is the most that can be done for this person?" to optimize the person's abilities.

Dr. Nana stated that unfortunately due to the conditions in this area, most people who have quadriplegia don't survive long. There are many variations around the world in terms of the kinds of equipment and rehabilitation methods that people have available when they have a spinal cord injury. His interest is very much in what can be done in the Cameroonian context, since much of the new technology is not available. We need to be looking at better wheelchairs, access and other issues. He emphasized the need to enable people to get going as much as possible, that they should not be left in the house with nothing to do.

Dr. Nana talked about treatment immediately following the injury. It is important to have treatment within 6 hours of injury so the patient should be brought in as soon as is possible, but stabilised. If it is longer than six hours, things can still be done but the time factor is not as important. He encouraged everyone in the audience to learn more about spinal cord injury.

The session ended with several questions which were ably answered by the experienced doctor. If it was not for shortage of time, the audience would have kept asking questions and receiving good answers for quite a long time.

D SUMMARY AND PLENARY SESSION

During the final part of the conference, participants were asked to work in groups of 4 people. Each group began by introducing themselves to each other, then choosing a recorder and a reporter.

The groups were asked to address the following topics:

1. What are the benefits, strengths or other good aspects of this work that you have heard about in the past two days?
2. What are the needs, challenges, problems, issues that you are now thinking of?
3. Given your discussion from #1 and #2, what actions do you think should be taken after this conference? Participants were asked to focus on actions that could be taken by themselves and their organizations, not to state actions that "the government" should take.
    a. What actions do you think the people in this room can take from here?
    b. Secondly, participants were asked to record a personal action that they each committed to carrying out. Research has shown that when people write down their commitment to action at the time of a workshop or conference, they are more likely to carry it out. This personal commitment to action was not shared with the working groups or the large group. Participants were encouraged to keep it so they could remember it if another conference is held in the future.
4. What is the main message that comes out of this conference? Participants were asked to identify one or two statements only. These are included at the beginning of these proceedings.

The following are the responses that were submitted by each group to these questions. Please note that they have not been edited, and are included here as they were submitted by each group (only spelling errors have been changed).

D.1 PARTICIPANTS' REMARKS AND EVALUATION

The idea to network many NGOs working with people with disabilities. Community based rehabilitation rather than institutional based. General concern for the disabled by participants.

Godlove said he has been able to meet new and old friends. He adds that he has learned a lot from the lectures, rehabilitation and information keeping; difficulties faced by disabled women in regards to marriage. He still says he has learned about the importance attached to disables by the international personalities here present. Jesse said what interests him from the presentation is that disability isn't inability. Another point that a disabled with a card you don't pay a train.

Learnt about healthy gestations to avoid disability. Learned about other groups are around. Hearing the statistics tells us more about the reality of the situation and also shows us the necessity of keeping documents plus statistics. Met with different presenters from all different areas plus specialties.

That the disabled getting married to abled people. Another point is that disabled persons should not be left alone, not looked inferior and they should fight, advocate so that they should be heard by NGOs and government in particular. Mother's group is very good for disabled children (P.H). it helps parents of disabled to come and learn, and to assist their children back at home. We have seen the work of mothers from groups how to take care of their disabled children. We have heard about women who are married to disabled men and how the help in taking care of one another.

We have come to realize the social needs of disabled persons. The need for networking. The use of certain words, like handicap, stigmatizes the persons. We should use terms like persons who are disabled, etc. Documentation is very vital for research purpose and future planning.

The contribution of the womb environment to disability. The need to empathize with the disabled. New terminology used in disability. Various service providers available to the disabled and the need to work as a team between provider – provider and receiver – provider.

This was the first conference of its kind; bringing people with disabilities together with those taking care of them to talk and listen to each other. Learned about the great need for networking and collaboration in the areas of disability and

rehabilitation. We have learned how to live with people having disabilities and they in their turn living with normal people. How an individual can cope with his/her disability, i.e. Disability is not inability.

A lot of people interested in care of those living with a disability. Variety of topics – touched on a lot of sensitive areas. Freedom to express opinions especially among those with a disability. Participants from all over and at different levels. Time management / organization. Presentations were good. Also because of audio /visuals – the slides were good.

Lesson on disease seen as epilepsy, paraplegia etc. Lesson on documentation since it is very important for picture information i.e. for good documentation. The work of physiotherapy to the disability after treatment so see that the client goes to the society and be able to do one thing or the other. Lesson on the spinal cord was also interesting because we learnt that if we have a patient with spinal injury we rush him/her to the hospital but we should not pressurized the health care professional to hurrily work on the patient.

A discovery about the existence of many NGO for disability in Bamenda and Cameroon as a whole. We appreciate the coordinators for this programme that has gave us a long way to enrich us. Sharing of experience with others from all works of life.

Role of physiotherapists in Hansen's rehabilitation. Types of disabilities and their consequences. Many disables have accepted their conditions and are living and interacting socially in their communication. Perspective and challenges of disabilities and rehabilitation. The psychosocial aspects of disability and the role of N.G.Os.

We have learned how to handle people with disabilities. The collective involvement of all state holders (PWD) families, community, NGO, Government in the rehabilitation of the disabled. Clarification of the concepts of disability and rehabilitation and the role of N.G.O in the rehabilitation.

The encouragement given to the disabled and equally to the people around them such as family members, friends and others that takes away the load of stigma, and isolation amongst the disabled. Some women admit and accept the condition of their disabled husbands and vice versa and this creates a good relationship among homes and even amongst peers. Some disabled have used their experience to encourage others to live happily with their conditions, especially in craft and other income related issues; and also in marriage related issues.

Awareness of HIV/Disability. How to keep records. How the disabled can care for themselves. The human rights of people with disability.

General organization. Choice of the different ideas. We have learnt how to deal with disable persons, rehabilitation programs in their communities. For example orientation and mobility. Calmness and orderly during the presentations. Good exchange of ideas and experiences. Participants came from all over the country and even abroad. We have had good interaction.

Happy to hear about cooperation and networking in the conference more especially how the disabled can join together and be as one. New ideas have been achieved. The conference has created a forum where the disabled are recognized and have come to know each other, especially associating with knew each other, especially associating with the international bodies. The lesson on documentation and rehabilitation has run a long way to enlightened us how we can keep infos and what to do so as to be noted or included in country's statistics. In the conference we have known some NGOs that we can pass through to be more associated.

Great awareness has been created in the minds of those who are not disabled in order to demystify the knowledge and stigma placed on the disabled. This has taught the able individuals to sit with cope and live with the disabled. Much work is being done by individuals, NGO's, religious bodies, foreign bodies which has gone a longer way to foster issues concerning rehabilitation. Lessons on specialized health impacts related to handicap situation.

D.2 THE NEEDS, CHALLENGES, PROBLEMS AND ISSUES IN ANTICIPATION

Stigmatization, Insufficient funds to run projects, Insufficient didactic materials for Institutions taking care, Inaccessibility to higher Institutions of learning to disables and caregivers, Inaccessibility to Information, Egoistic nature of some heads of Institutions caring for disables in materials information, satisfaction. Inadequate training to staff, Inaccessibility.

To accept the situation and face it. Problem of selecting vocational priority for yourself

Appeal to government about the rights of PWD's and the protection of their children as is stated in law. To identify all the people who have not yet been identified / reached the services (4.000 registered but 85.000 anticipated). Seeing how

the government can help support with financial help to the disabilities groups. To ensure that NGO'S plus G.O's involve PWD's in project planning plus implementation, not just assume that the NGO's know what PWD'S needs are.

Resources are limited, thus rehabilitation difficult to expand. Disabled are stigmatized and deprived of their right in the society. Also some PWD's are shy of their situation making them not productive. Lack of documentation and awareness. Government is not able to take care of a disabled. Not much interested by government.

No clear policy to protect the disabled's rights. Lack of awareness by the public of help available for these groups of persons. Poor funding of disability programs. Shortage of rehabilitation personnel i.e. Physical therapists etc.

The problem of knowing the truly disabled. Meeting the real needs of the disabled. Government nonchalant attitude towards the disabled.

Lack of genuine statistics on disabilities in the N.W.P . Thus difficult to establish the magnitude of the disables

Lack of coordination between the government and NGOs and within the NGOS to minimize duplication. Little promotion of abilities and works of people living with disabilities. Ignorance at different levels within the public and government related to disabilities. Lack of consistency in practice / documentation.

Exploitation, negligent, ignorance, stigmatization, lack of coordination between the government and private sector.

Lack of accurate information / coordination. Lack of networking / communication. Lack of services / personnel. Poor road network which makes movement difficult. Cultures / belief hindrances in some communities.

Unable to identify the felt needs of the destitute. Difficulties in wiping off the traditional beliefs towards disability. Time too small for the speakers to exhaust what they have planned. Government unable to put disability laws into practice eg creating path ways for them. Lack of information, shortage of trained rehabilitation personnel.

Policies on people with disabilities are not only inadequate but are not implemented. No coordination, collaboration and networking amongst the stakeholders in rehabilitation. Lack of documentation. Inadequate professional in the field of rehabilitation no social, physical therapy, occupational therapy.

Most disabled don't know what to do to live useful lives .e.g. There are very few institutions to train them. Medical care is also very difficult to have since most disabled are poor primarily due to their conditions. The equipments used for rehabilitation are very expensive in most cases and this makes it difficult. Coordination (flow of Information), stigmatization, dissemination in educational institutions, collection of data etc.

Lack of Transport, no housing

The problem of accommodation for those who are not living in Bamenda. The splitting of sessions. Not all the participants have gained from all the topics.

We have problems in organizing people with disabilities. The community looking at people with disabilities as curse from God or ancestor. The disables themselves do not want to fight for their rights. There is lack of flow of information amongst associations dealing with disabilities and the powers that be. Lack of security both at home and out of home. Lack of financial support to the rehabilitation.

Mentality of the disabled due to the natural stigma. Inaccessibility to areas where disabled are due to bad roads. False NGO that collect money for self interests. Exploitation of disabled by false NGO. Visually impaired students find it difficult to study in higher institutions due to lack of didactic material and lots of discrimination. Lack of employment into government and private institutions.

D.3 PROPOSED SOLUTIONS:

Given your discussion from #1 and #2, what actions do you think should be taken after this conference? Participants were asked to focus on actions that could be taken by themselves and their organizations, not to state actions that "the government" should take.

Markets for finish products – The big institutions that are capable of advertising and producing in larger quantities can take from the individual disabled producer and sell them give the money to them, there by encouraging and promoting them. Have a coordinator involve of NGO / Association working with disabled persons.

Try to develop disability groups through our own income generating activities. Try to help ourselves. Form networks to have information, assistance, and experiences within different disability groups. Business skills training for PWDs to improve their situation. For all groups and associations to consider how they can implement community element, especially in identification of PWDs. Work which is office / institution orientated will not work.

People should volunteer to do sensitization on people with disabilities. Rural areas to come together and do something for themselves. Encourage disabled people to exploit their skills to do interesting things which can raise their self-esteem.

Training of rehabilitation personnel, locally. Sensitization of Business places, churches, buildings, etc for access facilities for disables.

CBR services should be contained and extended to other places not yet reached. Bottom-up approaches in helping the disabled. Sensitize the church on the needs of the disabled. Keep reminding government on the needs of the disabled.

A regional structure for coordination and networking on disabilities and rehabilitation. Creating awareness in our communities on the importance and availability of community based rehabilitation centers.

Education at all levels (professional, Public, People with disabilities service providers). Establishing networks with regular meetings. Continue to support current provision of basic services.

There should be collaboration amongst people. Social concerned and understanding amongst people. There shouldn't be discrimination.

Continuation of meetings like this either bi-annually or annually.

Good collaboration between NGOs in the field to avoid duplication of statistics. The role of the family should be taken into consideration in rehabilitation. NGOs do not pay well. Sister institutions should inform others when organizing trainings. We should use local materials for didactic purposes. Sensitization should be made through media / TV, njangi groups, family level etc.

Rehabilitation resource center should be created. Form an association for the rehabilitation of disabled. Networking with all the organizations working in the rehabilitation of disables.

Use our personal initiative to change and make better our relationship with the disabled to build a healthy relationship and avoid stigmatization to encourage education, and other social issues. Organize seminars to educate both the disabled and the able to establish a healthy environment and for the encouragement and reassurance of the disabled.

Work hard in fundraising. Accept our conditions. Advocacy in families / communities. Education. Support those already working with craft. Support business for economic empowerment.

If all NGOs work together, rehabilitation work would make easier in the NWP. Training of disables. Encourage them to form peer groups and continue to train others on vocations. Identify the different types of disabilities before rehabilitation programs

We have to carryout sensitization on disability awareness and reinforce the already existing associations for people with disability. We can also network all these associations to come out with a list of all the members in order to see those registered in more than one group and call them up to make a choice amongst the two in many association.

Identify and report any false NGO and report to the legal authorities. Setting up an overall committee for the follow-up of the activities of the different NGOs in question who are exploiting the rights of the disabled. Creation of a multipurpose center (trade education, artisanal, recreation, sports) to bring together the different capabilities of the disabled.

D.4 A SUMMARY OF THE RESPONSES OF 60 COMPLETE EVALUATIONS OF THE CONFERENCE

Please list three things you enjoyed MOST about this conference.

- Wide open range of presentations & topics
- The way the conference was well organized & kept to time
- People were respectful of each other and listened well
- Questions were answered
- PWD[s] participating

Please list three things you enjoyed LEAST about this conference.

- The space – not easy to hear, not accessible
- Presentations were too short
- Lack of media coverage

Is there anything about the conference you would like to see changed for future conferences?

- Provide hand-outs at time of presentation

- Some speakers were not up to par
- Presentations need to be in Pidgin so that those who don't speak English can understand

Is there anything about the conference you would like to see remain the same for future conferences?

Several suggestions were made.

What Topics would you like to see addressed at future conferences?
Several suggestions were made.

Do you feel this conference has been beneficial? Why or why not? – (all said yes)
- Sharing of experiences & Networking
- Very useful knowledge
- Has provided ideas & hope to participants

Please provide any additional comments about the conference or the speakers below or on the back of this sheet:
- Should be an annual event
- Need for an Network or Association related to Disability and Rehabilitation organizations

THANK YOU – Please return this for to the "Evaluation Envelope"

E APPENDIX

REGISTRATION LIST

Many organizations were represented at the conference. Unfortunately, we are not able to include a detail presentation on the activities of each of these organizations. This may come up subsequently.

No	NAME	Address
1	Agwe Clifford	
2	Akong John	PROMHANDICAM
3	Alfred Nkwenti	Mbingo Baptist Hospital
4	Ambanibe Jerome Akeneck	ASODI Orphans
5	Ambo Gaby	CRAT
6	Andrew Smith	University of Toronto
7	Asongwe Bertille	Pah Teh Foundation for Disadvantaged Children (PAFDIC)
8	Ayeah Eugene	
9	Berinyuy Gladys	
10	Besong Shakespeare	Presbyterian Community Rehabilitaiton Services
11	Bisong Michael	PCRS Kumba
12	Chia Milton Kukwa	
13	Cynthia Killa Fokwang	None
14	Dan Takusi	
15	Dickson Fambombi	Mbingo Leprosy Hospital
16	Difang Bruno	St. Louis Institute
17	Dr. Awasom	General Hospital
18	Dr. Nana Christopher	Mbingo Baptist Hospital
19	Emily Kere	Planning committee
20	Emmanuel Ngang	Nku'mu Fed Fed
21	Esung Eliza	Presbyterian Community Rehabilitaiton Services
22	Ezekiel Benuh	Planning committee, CBC Services for People with Disabilities
23	Florence Asanji	SAJOCAH

24	Fokwang John K	None
25	Fopoussi Anatole	Provincial Hospital B'da
26	Francis Fokwang	Planning committee
27	Ful Promise A.	University of Buea
28	Gavin Park	Toronto
29	Godlove Che	
30	Goli Hashemi	Planning committee
31	Grace	CRS Worker Mbingo
32	Helen Bih	Wives-Daughters of Persons with Disabilities Solidarity Movement
33	Helen Collinge	Presbyterian Community Rehabilitation Services
34	Humphrey Akwar	University of Buea
35	James Tangang	
36	Kain Gideon	Mbingo Community Based Rehabilitation
37	Kenmeugwe Nziali	PROMHANDICAM
38	Kenneth Nshiom	Mbingo Baptist Hospital
39	Kpengue Honore	SILH
40	Kukwa Amos Fointama	Mbingo Baptist Hospital
41	Kunna Galabe Henry	
42	Kyeng Mirabelle	St. Louis Institute
43	Levy Ndeme	Presbyterian Community Rehabilitation Services
44	Limen Forence	Christian Fraternity
45	Lydianne Manka	Flashstar Décor Ntarikon
46	Lynn Cockburn	Planning committee
47	Maguegou Josianne Claire	St. Louis Institute
48	Mbakwa Thomas	Divisional Del. Soc. Affairs
49	Melisa Scheurter	University of Toronto
50	Milvi Tiislar	University of Toronto
51	Mr. N'tangri Rolly	BUST
52	Muguoh Christopher N.	Special Need Entrepreneur Group (SNEG)
53	Ncham Johnson Ngeh	
54	Nche Che Ambroise	
55	Ndangam Helen	Solidarity Out Reach
56	Ndifon Emmanuel	CBC Integrated School For the Blind
57	Nding Helen	Presbyterian Community Rehabilitaiton Services
58	Nforbisi Martin Che	
59	Ngah Richard	St. Louis Institute
60	Ngang Judith	
61	Ngasoh Joseph	
62	Ngong Peter	
63	Nicholas Mukong	Chief of Adm. & Gen. Affairs
64	Nih Ngoh Standley	HSUVI
65	Nimbo Christain	
66	Njankenji Jubsia	Military Nursing School
67	Njua Martina	
68	Nku Bende	Presbyterian Community Rehabilitation Services
69	Nkwain Jesse	
70	Nkwentisama Albertine	CRAT
71	Ntaimah Peter	University of Yaounde
72	Ntalabe Joseph Ndem	Ministry of Health
73	Nungu Magdalene	Centre for the Empowerment of Females with Disabilities
74	Nyincho Samuel	Hope Social Union & ANAC
75	Oumpa Zimiri A.	SILH
76	Pat Lenz	Mbingo Baptist Hospital
77	Peter Mue	Planning committee
78	Popela Fokum Joseph	
79	Raphael Che	
80	Shu Winifred	Presbyterian Community Rehabilitation Services
81	Sr. Cecilia	SAJOCAH
82	Tah Jafferson K.	Mbingo Community Based Rehabilitation
83	Taju Tanko Godlove	
84	Tambe Richard	Community link up project for the disabled

85	Tamukum Emmanuel	Hope Social Union for the Visually Impaired (HSUVI)
86	Tamuton Colin Teghen	
87	Tancho Fidel	Hope Social Union
88	Tata John	
89	Timni George	
90	Todam N. Nathalie	St. Louis Institute
91	Tsopfack Pierre	PROMHANDICAM
92	Wanchia John Ngwa	SNEG
93	Wilfred Njegheh	St. Louis Institute
94	Yangsi Federick Bangsi	
95	Yembu Tumenta	Military Nursing School
96	Yerima Tayong	ANAC
97	Yilla Elizabeth	
98	Yuh Simon	Mbingo Community Based Rehabilitation
99	Zanga Stanislas	PROMHANDICAM

ACRONYMS

ADL: Activities of Daily Living
CBR: Community Based Rehabilitation
CMF: Christian Men's Fellowship
CP:Cerebral palsy
CRAT: Human Rights and Community Mental Health Program
CRS: Community Rehabilitation Services
CWF: Christian Women Fellowship
CYF: Christian Youth fellowship
DMO: District Medical Officer
ENAS: National Advanced School of Social Affairs?
ILO: International Labour Organization
MINAS: Ministère des Affaires Sociales (Ministry of Social Affairs)
MINSATE: Ministère de la Santé (Ministry of Public Health)
NGO: Non Governmental Organization
O & M: Orientation and Mobility
OT: Occupational Therapy/Therapist
PCRS: Presbyterian Rehabilitation Services
PHC Primary Health care/Center
PRC: Presbyterian Rehabilitation Center
PT: Physical Therapy/Therapist
PWD: People With Disabilities
Rehab: Rehabilitation
RW: Rehabilitation Worker