



# Associate Parliamentary Limb Loss Group

for the promotion within Parliament and Whitehall of the Prevention of limb loss and the Provision of prosthetic, orthotic, wheelchair and other vital rehabilitation services to all persons suffering limb loss in the UK and Internationally

## All Party Landmines Eradication Group

to monitor developments in the field of landmine and explosive ordnance eradication, to press for progressive clearance of such devices, and to explore means of providing for the surviving victims of their devastation

### Minutes of the Meeting held at 4PM on Wednesday 5<sup>th</sup> December 2007 in Committee Room 18 at the House of Commons London SW1A 0AA

#### PRESENT

**MEMBERS:** Frank Cook MP (in the Chair); Baroness Wilkins; Mark Hunter MP; Susan Kramer MP and Norman Lamb MP.

**ASSOCIATES:** Steve McNeice; Sam Gallop; Robin Luff; Paul Charlton; Sarah Hodge; Rebecca Beltran; Penny Penton; Denis May; Jenny Rogers; Glyn Heath; Bob Watts; Philip Garvin; Mary Jane Cole and Charlotte Imbert.

#### 22. MINUTES of Meeting held on 5<sup>th</sup> December 2007

The Minutes of the previous meeting held on 5<sup>th</sup> December were **AGREED** and matters arising considered.

#### 23. JOINT CONFERENCE of APLLG with APDG on 9<sup>th</sup> November '07

**NOTED** with appreciation that an influential Joint Conference with the All Party Parliamentary Group for Diabetes, opened by Justine Greening MP, was held at the Roehampton Rehabilitation Services Centre (*see Appendix A*).

#### 24. ALL PARTY PARLIAMENTARY GROUP FOR CHILDREN

**NOTED** that it was intended to hold a Joint Conference with the All Party Parliamentary Group for Children, at the Harold Wood Rehabilitation Services Centre, in Essex.

#### 25. ALL PARTY PARLIAMENTARY DISABILITY GROUP

**NOTED** that it was hoped to hold a Joint Conference with the All Party Parliamentary Disability Group, at the West Midlands Rehabilitation Services Centre in Birmingham, to demonstrate the human rights benefits and the economic benefits of rehabilitation.

## 26. WHEELCHAIR SERVICES

NOTED that following the widespread support for the following joint EARLY DAY MOTION 25 the requested meeting with the Parliamentary Under-Secretary of State (Care Services) had been deferred three times and that a further date was being sought.

### EARLY DAY MOTION 25

Tabled by Dr Roger Berry (Labour MP for Kingswood)

Seconded by Justine Greening (Conservative MP for Putney)

Seconded by Susan Kramer (Liberal Democrat MP for Richmond Park)

This House notes the concerns of the Associate Parliamentary Limb Loss Group and of the All-Party Parliamentary Disability Group about the unmet mobility needs of people of all ages; is concerned that this leads to significant loss of independence and increased costs of care; recognises the model examples provided by charities such as MOTABILITY and WHIZZ-KIDZ; and therefore urges the Government, in collaboration with the emPOWER Charities consortium, to encourage and support greater provision of powered wheelchair services, in collaboration with, and additional to, services at present provided by the NHS.

## 27. CENTRE FOR EVIDENCE BASED PURCHASING

NOTED that

- The Interfaces Project had been completed and developments were being pursued
- The Batteries Project was progressing
- The Centre had not approved proposals for Orthotic, Footwear and Whole-Life Costing projects, and alternative sources of funding would be sought.

## 28. EUROPE LIMB LOSS DAY

NOTED that consultations to secure a Europe Limb Loss Day continued.

## 29. LINKED GROUPS UNITED KINGDOM

NOTED progress with the establishment of linked Groups, in Scotland, Wales, and Northern Ireland.

## 30. LINKED GROUPS INTERNATIONAL

NOTED established links with SAFOD (South African Federation of the Disabled).

## 31. BRITISH ORGANISATION OF NGO'S DEVELOPMENT (BOND)

NOTED that a report of the valuable work of BOND would be circulated with the Minutes (*see Appendix B*) and that further enquiries to Charlotte Imbert at BOND would be welcomed.

## 32. LANDMINE ACTION

Arising from appreciation of endeavours of the NGOs associated with the All Party Landmines Eradication Group (*see Appendix C*), and from insights into the sustained parliamentary endeavours over many years, it was AGREED that full support must continue to be given to the concluding of a legally binding instrument of international humanitarian law to prohibit cluster munitions. The interest of the International Society for Prosthetics and Orthotics was welcomed.

## 33. PORT-ER (Prosthetics, Orthotics & Rehabilitation Technology - Education & Research)

NOTED that PORT-ER was sponsoring Clinical Specialists including:

- A collaborative project with Nottingham University Hospital, Jimma University in ETHIOPIA, a German charity "Menschen fur Menschen" and the International Committee of the Red Cross

- Specialist Prosthetics and Orthotic Services and Rehabilitation in Diabetes and other Neuropathic disabilities in TANZANIA.

#### 34. ANANDWAN

Warm congratulations were expressed to Penny Penton and her colleagues for their voluntary creation and sustenance of the Anandwan project (*see Appendix D*) illustrating how past and present allied health professionals in the NHS were serving overseas in addition to all their other commitments.

#### 35. RESPONSE INTERNATIONAL

On behalf of RESPONSE INTERNATIONAL, Philip Garvin described the challenge of persuading donors to meet the total budget for a successful and sustained rehabilitation programme. Essential elements were: a Victim Survey compatible with existing Mine Action data programmes; and a Human Rights element, preferably via a dedicated Human Rights Officer.

To proceed with rigour required a layered approach rather than a grossing up estimate of the total need. First should be a household survey, preferably using the victim component from a Mine Action database (hospital patient records often do not register sufficient detail); Secondly, informed of the victim numbers, scene of incident, location of victims, we can plan the preventive measure of Mine Risk Education, as well as the provision and location of Physio, prosthetic production, fitting and maintenance workshops etc. in an informed and cost effective way.

Limbless Rehabilitation faced acute competition from other causes. As well as Human Rights, RI presented the economic case for The Cost of Disability - The Cost of Doing Nothing; asking the question “How much is your country losing in GDP because of disability?” Failure to rehabilitate the disabled of a poor community heavily compromised resources provided for reconstruction and development works.

Disability needed to be “**Mainstreamed**” because

- At the United Nations Millennium Summit, eight Millennium Development Goals (MDGs) were agreed upon and 190 countries signed up to them
- None of these specifically address disability, although eradicating poverty is one of them
- Disability should be mainstreamed - this means including it in all policy recommendations covering a wide spectrum of social and economic concerns
- Disability should rank alongside the major world issues of poverty, gender, children and HIV/AIDS and attract the same level of UN funding
- Until this happens, poverty will never be beaten

#### 36. POWER

**NOTED** that since 1995 POWER had restored over 8,000 people to mobility in LAOS, having developed a nationwide rehabilitation service in partnership with the Lao Ministry of Public Health, and continued to deliver P&O services to some 1,500 people per year. POWER undertook a full census on disability in 1996 in order to plan the programme delivery accurately. A recent Government census shows currently some 27,000 arm/leg impairments out of a total of 70,000 in the country - there could well be many more as disabled people do not tend to come forward, typical of poor countries where disability is regarded as shameful. Laos is currently POWER’s sole “mobility” project, as a funding/strategic partner now, as the service is indigenised with minimal

expatriate input. Lao people having been trained to deliver the service to internationally recognised (ISPO) standards. Work in our other programme countries focuses more on disability rights and awareness together with basic needs (vocational training and micro-enterprise) as the funding situation for P&O is so desperately poor internationally. There is a critical need to develop a quality provision in MOZAMBIQUE but donors are not keen. The same applies to ZAMBIA. Donors tend to regard P&O projects as expensive and APLLG has a crucial role to play in ensuring that mobility has the highest priority in any discussion of human rights.

### **37. CORNEL ROMANIAN REHABILITATION CENTRE TRUST**

**NOTED** the achievements and outreach in ROMANIA of the Cornel Trust despite severe challenges and shortages (*see Appendix E*).

### **38. MINES ADVISORY GROUP (MAG)**

**NOTED** with appreciation that MAG was operational in Angola, Cambodia, Congo, Iraq, Laos, Lebanon, Sri Lanka, Sudan and Vietnam. MAG helped provide solutions in mine clearance, mine risk education and explosive ordnance disposal. They used a variety of methods to remove poverty and economic devastation including metal detecting, minefield marking, sniffer dogs, large machinery etc. Their vision working with local partners to rebuild communities was a world where people could build peaceful and prosperous futures free from the impact of the remnants of conflict.

### **39. WORLD FEDERATION OF OCCUPATIONAL THERAPY (WFOT)**

**NOTED** the emerging role of the WFOT in Disaster Preparedness and Response, and the importance of Occupational Therapy. Key aims included the development of long term strategies, the building of longer term national capacities and the development of sustainable local service provision (*see Appendix F*).

### **40. UNITED NATIONS CONVENTION ON RIGHTS OF PERSONS WITH DISABILITIES**

**NOTED** that the Government would continue to be pressed to ratify the United Nations Convention as soon as possible.

***NOTE: On the day following the meeting APLLG heard from the Minister for Disabled People that it is intention to ratify the Convention during or by the end of the coming year.***

### **41. DEPARTMENT FOR INTERNATIONAL DEVELOPMENT & FOREIGN & COMMONWEALTH OFFICE**

**AGREED** that meetings to convey funding needs and collaboratively to seek solutions should be sought with these key Departments. Possibilities of PQs and an EDM would be explored.

### **42. ANNUAL GENERAL MEETING**

The next Meeting, which is the Annual General Meeting, is planned to take place on Wednesday 23<sup>rd</sup> April 2008 at 3PM-5PM in Committee Room 7 at the House of Commons. Confirmations and invitations will be sent out in due course.

There being no further business the meeting then terminated.

**-- END --**

# Associate Parliamentary Limb Loss Group

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## All Party Parliamentary Group for Diabetes

To study the condition of diabetes and its clinical and legal complexities

*Baroness Masham, Lord McColl, Danny Alexander MP, Paul Clark MP, Mark Hunter MP, Justine Greening MP, David Marshall MP, Doug Naysmith MP, Adrian Sanders MP, Helen Southworth MP and Angela Watkinson MP*

welcome your joining in promoting the

### COMMISSIONING

of *Optimum Health and Wellbeing* to

## PREVENT LIMB LOSS in DIABETES

Friday 9 November 2007

10.00 am to 3.30 pm

Queen Mary's Hospital, Roehampton Lane, London SW15 5PR

The Buffet Lunch and Conversazione and Exhibition will further enhance your opportunities to exchange and influence ideas about developments and innovations.

*“Diabetes is a world wide epidemic, with over 2 million people with diabetes in this country alone. When faced with such a challenge, success will only be possible with cooperation between all the stakeholders; politicians, doctors, specialists, pharmaceutical companies and diabetics themselves” Adrian Sanders MP*

*“In the United Kingdom every week 100 people with Diabetes have an amputation. Can we reduce that figure?” Justine Greening MP*

You will collaborate with representatives from the Department of Health, the Healthcare Commission, the National Diabetes Team, the Society of Chiropractors and Podiatrists, Diabetes UK, Age Concern and Specialised Commissioning.

You will be helping to promote and stimulate and safeguard the Commissioning through Allied Health Professionals of optimum person-centred health outcomes; service quality based on a strong evidence stream; patient choice and access to the full range of services from designated providers; exit and entry of providers to maintain safe and high quality services: contestability and value for money; clinical data bases to monitor clinical outcomes and performance against standards; collaboration with GP practices to maintain and strengthen integrated care pathways; and career development and training programmes for the expertises required.



BOND (British Overseas NGOs for Development) is the UK's broadest network of voluntary organisations working in international development. Founded in June 1993, BOND aims to improve the UK's contribution to international development by promoting the exchange of experience, ideas and information.

BOND is responsible for encouraging its member organisations to become involved in campaigning and advocacy; it has also taken on the responsibility of encouraging all the organisations that were once part of **MAKEPOVERTYHISTORY** to continue campaigning on economic justice issues.

European Union policies have a huge impact on developing countries. BOND supports its members to understand and influence the EU through capacity-building, information-sharing and facilitating policy and campaigns activities.

As a Network, it may be more effective to work in groups rather than as the membership as a whole entity. The BOND Groups Programme actively encourages members to work together on particular issues.

BOND Groups benefit the wider BOND Network through the development of expertise in the sector, by garnering momentum and action for collective advocacy work, and by providing another space for continuing training and development. Groups may also act as a source of advice and capacity building in their specialist area for others in the network.

BOND produces a monthly UK Funding News Update. This has information on funding for *UK-based* organisations working in international development. If you would like to be added to the e-list please email [information@bond.org.uk](mailto:information@bond.org.uk).

If a BOND member, it is possible to join BOND's [Funding Working Group](#), which provides a forum for BOND members to share information on UK donors. It meets three times a year and also liaises with the [EC Funding Working Group](#) on EC funding issues.

# landmine action

## Impact at the time of use

Cluster munitions kill and injure civilians at the time of use because they indiscriminately scatter explosives over a wide area. When cluster munitions are used in or near areas of civilian population these attacks are very likely to be in breach of the Additional Protocol I to the Geneva Conventions.

## Long term impact

The large number of submunitions in each container, and the failure rate of these submunitions, mean that cluster munitions leave huge quantities of lethal contamination after attacks. It is because of this contamination that they are often compared with landmines.

This contamination kills and injures people trying to rebuild their lives after conflict. It can stop people from being able to use their land and the contamination will remain for decades.

For example, thirty years after the bombing stopped, hundreds of civilians in Vietnam are still killed and injured every year by unexploded submunitions.

Cluster munitions killed and injured more than 200 civilians in southern Lebanon in the few months since the ceasefire, also blocking agriculture, housing, schools and water sources. The United Nation's most senior official for humanitarian affairs, Jan Egeland, described the effect of these weapons in Lebanon as:

*"...shocking and to me completely immoral..."*

The small size and curious shapes of submunitions make them particularly appealing to children and in many countries they make up the majority of casualties caused by this contamination.

## The UK: one of the worst offenders

Despite this background, the UK has been one of the world's largest users of cluster munitions.

- The UK dropped some 78,000 submunitions during the air campaign in Kosovo.
- The UK used over 100,000 submunitions during the invasion of Iraq.
- Government officials have often said that cluster munitions are needed for certain very specific situations - but these situations have not been clearly defined and investigations have shown that the UK used them in large numbers and against all sorts of targets - including in residential areas.
- The UK Government has done no analysis of the civilian harm resulting from cluster munitions.
- The UK's ground launched cluster munitions are supposed to self-destruct. However, these same munitions were used extensively by Israel in Lebanon and still produced large quantities of unexploded ordnance contamination. Even these supposedly modern munitions cause the same problems as the cluster munitions that came before.

## UK position:

On the 20<sup>th</sup> March 2007 the UK Government announced that it was banning the use of “dumb” cluster munitions with immediate effect. The UK have up to this point stockpiled the following cluster munitions:

- MLRS with M26 surface rockets each containing 644 M77 submunitions
- RBL755 aerial bombs with 147 submunitions
- CRV-7 helicopter launched cluster munitions containing 9 submunitions
- L20A1 extended range bomblet shell containing 49 M85 submunitions

This announcement means that the UK has withdraw the M26 rocket and the RBL755 from service. Of the cluster munitions that they still have it is the M85 submunitions used in the L20A1 shell that are of outstanding concern. The UK used 2,100 L20A1 shells, containing 102,900 submunitions in Iraq in 2003, which caused dozens of civilian casualties.

Although these submunitions are fitted with self-destruct mechanisms, they are still indiscriminate within a wide area when used near civilian populations, and as was witnessed recently in Lebanon, they still create large quantities of post-conflict contamination because the self-destruct mechanisms don't work.

In his statement announcing this policy Des Browne stated that:

*“the types of cluster munitions that we intend to retain are legitimate weapons with significant military value which, as a result of mitigating features, is not outweighed by humanitarian factors”*

In relation to this statement it could be noted:

- That until the end of last year, the Government asserted that all of its cluster munitions were legitimate weapons - so this claim is subject to change.
- The UK has produced no substantive evidence that these or any other of its cluster munitions are of “significant military value” - all they offer is vague hypothetical claims.
- The UK has not assessed the performance of these “mitigating features” in actual combat operations.
- The UK has not undertaken any evidence-based assessment of the “humanitarian factors” associated with the use of these weapons either by itself or by others.

Given these considerations it seems that UK policy is still being made without a base in evidence and without sufficient consideration of the risks presented to civilians.

## Self destruct mechanisms:

Israeli Military Industries, who manufacture the M85 submunitions, state the following on their website:

*‘the valuable and unique IMI Self Destruct Dual Purpose (Anti-Personnel and Anti-Armour) M85 bomblet ensures that no hazardous duds are encountered by advancing friendly forces. .. the IMI safety mechanism prevents the inadvertent arming of duds by manual means.’*

However it is proven that the presence of a self destruct mechanism does not go far enough in reducing the humanitarian consequences. Last year the Norwegian Defence Research Establishment conducted tests that concluded that the reliability rate of the self destruct mechanism on the M85 bomblet, when looked at in isolation, is only 74% - meaning that 1 in 4 of

the self destruct mechanisms fail to function. Technical solutions, such as self destruct mechanisms will only be required to function if the bomblet has armed, but failed to explode on impact.

The results from the Norwegian Defence Research Establishment are further backed up by evidence from the field. Large numbers of unexploded M85 submunitions have been found in Lebanon after use during the conflict last year.

A source at the UN Mine Action Coordination Centre in South Lebanon stated that:

*We can categorically state that we are finding large numbers of unexploded submunitions that have failed to detonate as designed and failed to self destruct afterwards. In effect these submunitions have failed twice. These M85 submunitions are even more dangerous than other types because their self destruct mechanism makes them more problematic to deal with and where ever possible they are destroyed in situ.*

### **UK statements on failure rates:**

Although the UK have made these claims about the M85 having mitigating factors, they do not seem to be able to back this up with concrete evidence. Over the last 4 years there has been varying statements regarding the failure rates of the M85:

- In June 2003 in response to a parliamentary question about failure rates Adam Ingram (the Minister of State for Armed Forces) state that it has a proven maximum failure rate of 2%
- In March 2005 the UK Government stated in a CCW working paper that the M85 failure rate with the self destruct mechanism is less than 1%
- In November 2006 again in response to a parliamentary question on failure rates Adam Ingram stated that the M85 has a 95% success rate

In addition to this, they appear to avoid questions on the failure rate of the self destruct mechanism itself. On the 19 and 20<sup>th</sup> April PQs were asked regarding tests have been undertaken not just on the failure rate of the M85 and in addition the failure rate of the self destruct mechanism. The response from Adam Ingram disregarded the self destruct mechanism and stated that average bomblet failure rate is approximately 2%.

Beyond these arguments and the specific numbers:

- The tests used to evaluate submunitions performance are undertaken only in ideal conditions and do not attempt to replicate actual combat conditions with respect to weather, ground conditions or obstructions such as buildings or trees.
- The UK has made no efforts to assess the actual performance of these munitions in combat despite saying that it would have to do so in order to get an accurate understanding of reliability (parliamentary statement by Adam Ingram, 16<sup>th</sup> June 2003)

If we took this approach to a scientist or a public health professional and asked: “does this look like a robust effort to assess the likely risk to civilians caused by these munitions?” the answer would be NO.

### **CCW**

On the 13 November 2007 The Convention on Conventional Weapons (CCW) agreed the following:

*The meeting of the High Contracting Parties to the CCW decides that the GGE will negotiate a proposal to address urgently the humanitarian impact of cluster munitions, while striking a balance between military and humanitarian considerations*

*The GGE should make every effort to negotiate this proposal as rapidly as possible and report on the progress made to the next meeting of the High Contracting Parties in November 2008*

*The work of the GGE will be supported by military and technical experts. The GGE will meet in 2008 not less than 3 times for a total of up to 7 weeks.*

*January 14-18*

*July 7-31*

*September 1-5*

*November 3-7*

### **A weaker mandate?**

A number of states, notably Russia but also Belarus, China and Cuba, were very much opposed to establishing a negotiating mandate.

In addition several states, Brazil, Pakistan, India, South Korea and the US, also indicated that they would not be able to support a negotiating mandate if it was explicitly aimed at establishing a prohibition, or if it had a deadline for the conclusion of negotiating the instrument.

As a result the mandate established is significantly weaker than the Oslo Declaration. The CCW mandate does not specify that the negotiations should lead to a new legally binding instrument, that it should include any kind of prohibition or outline a timeline for the conclusion of the negotiations.

In establishing this mandate the CCW rejected a strong proposal from the EU, using Oslo Process language, that called for the forum to negotiate a legally binding instrument in 2008 prohibiting cluster munitions that cause unacceptable harm to civilians.

A number of states within the forum, not only core Oslo process states, expressed concern about the CCW's mandate, with Canada stating that the CCW could be *wasting a great deal of time reaching agreement on how to interpret the mandate, which would belie addressing cluster munitions urgently.*

After the conference the ICRC stated that it regrets that the mandate does not contain a strong commitment to a legally binding instrument.

The mandate also falls short of the UN Secretary General Ban Ki-moon call at the start of the conference for States to *address the horrendous humanitarian, human rights and development effects of cluster munitions by concluding a legally binding instrument of international humanitarian law.*

Steve Goose of Human Rights Watch stated *After this week's debacle, it's clear the CCW is only for the 'aim low, go slow' nations, that want little or nothing done to affect their ability to use, produce, trade and stockpile all types of cluster munitions. There's no chance a clusters ban will emerge from the CCW, but the good news is that Oslo is racing toward a treaty that will save many lives.*

# ANANDWAN

November 2007 by Penny Penton

**Introduction:** During 2004 and 2005 I went on 3 visits to work with a surgical team performing tendon transfers to correct hand deformities caused by leprosy. The village in central India is founded for the care of those with leprosy, and now has a more open door policy providing a home and employment for people with a wide range of disabilities. The need for provision of orthotics and prosthetics was clearly evident and this was discussed with patients and medical staff. Following some research and help from various pre-retirement colleagues back home, various ideas were considered. Following the second surgical camp two of us therapists stayed on to see a rep from Otto Bock in the community and in December 2004 a proposal was produced by them for the design of a building which the community could provide, and a schedule of equipment for which us 2 OTs and 1 PT would raise funds. Having retired from employment it fell to me to co-ordinate. A short course at the Directory for Social Change indicated that channelling the money through an established charity with relevant aims was the most efficient way forward and another Occupational Therapist introduced me to Sam Gallop and the Limbless Association at the beginning of 2005.

**Fundraising:** We raised funds mainly through small donations from friends and contacts with which we were already involved, a number of talks, two concerts, meals including an amazing pudding party and even a murder mystery evening at a school. We produced a DVD and relevant literature to send to larger organisations where personal contacts would allow. The all important banking and gift aid was organised by the Limbless Association. We managed to raise the down payment and following 4 instalments agreed with Otto Bock in a Memo of Understanding, within the year. The expenses have been borne by the 3 therapists involved.

**Launch:** In February this year the unit was ready for opening. The building consists of a treatment area, fitting room, adjoining workshop, and storeroom. The outside area now has a slope and steps with adjustable rails and huge shady tree where most of the action takes place.



**Now:** We have just returned from seeing the place fully functioning. It is staffed by a prosthetist, Nikita Saxena, the key to the future, who is exceptional, bright, enthusiastic and committed, managing staff, patients, administration and planning for the future, helped by the superintendent doctor, 2 technicians who have spent time training with Otto Bock, a part time tailor, and a night watchman. A total of 10 limbs were supplied up to the end of August; 8 below knee, 1 above, 1 below elbow and 19 callipers. It is now possible to apply for government accreditation allowing patients to gain grants for appliances. In the first diagnostic clinic for Chandrapur district which has just taken place last week, 25 patients were seen and will be supplied with a variety of orthotics and prosthetics.

Provision of a service for those in Anandwan suffering from a variety of mobility problems including leprosy are now being addressed. And it is now possible to see those with new limbs walking in the local market. They have the opportunity to consider improvements in their life styles and new opportunities for employment. The plans to become a regional service are already under way and over-the-counter appliances as well as cobbler's services will be available. They also plan to construct a special early intervention centre to help children suffering with cerebral palsy and other problems who are now asking for help.

**The Future:** The involvement of Bernard O'Keefe and Amit Mukerji from Otto Bock and their generosity with training and advice have been vital and will ensure that future standards of service remain high while also being realistic. The links with Kate Meryl and me will continue both by email and through the annual surgical trips. We have promised £5,000 next year to help them fund staff and any new equipment and materials need for the coming year. They are also supported by friends in India and look forward to becoming financially independent.

This project will provide the attraction of a unique service of good technical quality for a deprived rural region, a long hoped for ambition of this community and part of their vision for the future.



# THE CORNEL ROMANIAN REHABILITATION CENTRE TRUST

We are a small group of Prosthetic & Orthotic practitioners who have been working in Romania since May 2000 on a humanitarian basis, basically working out of suitcases and borrowed rooms.

There is virtually no local provision of any sort for the supply of Prostheses or Orthoses for the disabled people in this region and we are trying to improve the desperate situation for these unfortunate children and adults. We have supplied over 100 patients with devices over the years but there are literally thousands of people whose lives we could transform if we were able to

bring our plans to fruition.

This is the building we are hoping to refurbish and convert to a combined Rehabilitation Centre and Training Establishment. The building is situated in the town of Cumpăna, near Constanța on the Black Sea Coast in South-East Romania.



We are being actively encouraged to proceed with the project by the local authorities and they are offering us what assistance they can and have given us the land and the derelict building on a 49 year rent free lease. The estimated building and refurbishment costs are around £160,000 and it will cost another £30,000 to equip the centre with the required machinery and equipment. A further £40,000 will be required for operating costs in the first year until sufficient income is generated from the Romanian Insurance House to pay for the Prostheses and Orthoses supplied.

Local staff will be trained to enable the centre to eventually become self-sufficient and continue to serve the needs of the local people and act as a training centre. Until such time as the project is completed we will provide a limited clinical service in this area on a visiting basis to continue the rehabilitation work we have been doing for the last 7 years.





## World Federation of Occupational Therapists Occupational Therapy in Disaster Preparedness and Response

Disasters are occurring more and more regularly around the world. Occupational therapists have a role in this emerging field of policy and practice.

Occupational therapy is a profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate successfully in the activities of everyday life that have meaning and purpose to them within their cultural context. Occupational therapists (OTs) achieve this outcome by enabling people to do things that will enhance their ability to live meaningful lives or by modifying the environment to better support participation.

In response to the major tsunami which hit many coastal areas in the Asia Pacific region in December, 2004, the World Federation formed a project team to address the concerns raised by occupational therapists around the world.

The World Federation of Occupational Therapists undertook a situational analysis of the Tsunami affected region in the Asia-Pacific region in March 2005. In response to the findings WFOT embarked upon a major disaster preparedness and response (DP&R) project, which has resulted in the raised awareness and capacity building of occupational therapists to respond to disaster situations in four countries affected by the Asian Tsunami. It has also stimulated the development of a plan of action and task force in the USA, and relevant activities in the United Kingdom and other countries. It is intended that the next phase of this project will be the development of an educational module for use within occupational therapy education programmes.

WFOT feel the major task in disaster preparedness and response management for occupational therapists (and others working in health care) lies in long term strategies in collaboration with key stakeholders. The potential benefits of the involvement of occupational therapists in disaster preparedness and response management are numerous and are largely related to building longer term national capacity and self-reliance in disaster affected countries, and beyond. They include:

- Disaster affected communities and people being better served by better equipped local health professionals in their ongoing efforts to rebuild their lives and livelihoods, contributing to outcomes that can be sustained by local service providers and systems as donor programs wind down.
- Local health professionals (occupational therapists and others as involved in this project) engaging with disaster and reconstruction policy, planning and coordination mechanisms, contributing pertinent expertise to the current response effort while laying the foundation for more cohesive involvement and response efforts in the event of future disasters.
- Local occupational therapists and others more effectively able to participate in and progress wider community, government and international objectives for enabling 'access for all' to

community based rehabilitation and health care services, contributing to the achievement of national, regional (eg. ESCAP) and UN goals (eg. WHO, UNICEF, Human Rights and Millennium Development Goals).

- Stronger networking and coordination between local health professionals, government services and projects, and national and international NGO programs, potentially providing for a more integrated, holistic and yet rationalised and self-reliant service framework.
- At a more practical level, benefits include: better quality, ongoing care and support for individuals and their families, particularly those with psycho-social trauma and physical injuries who will benefit from occupational and community based rehabilitation and support programs; stronger referral and follow-up systems between community care, hospital and rehab centre programs; and more disability and age friendly accessibility in private and public buildings/spaces.
- Relationships between donors and occupational therapy organisations (including WFOT and national associations) established that lay the foundation for ongoing partnerships for mutual benefit and the benefit of communities into the future.

Practitioners should be equally responsive to psychological and psychiatric conditions as they are to physical disorders. A special focus is needed on the early detection of severe psychological distress and psychiatric phenomena. Occupational therapists' education prepares them to be a major contributor to this refocusing of attention.

For vulnerable groups such as children, women and the elderly as well as individuals with previous disabilities and newly acquired conditions, meaningful occupation in daily personal and community activities can have therapeutic outcomes during disaster recovery. In all approaches to DP&R, gender roles must be sensitively addressed and strategies developed to enhance equality in opportunity and resource allocations.

Occupational therapists should be involved in all stages of planning and preparation at local district and national level for disaster management. Specific roles **post-disaster** may include, but are not limited to, the following:

- ❖ Ensuring accessible environments post disaster at all stages of recovery (e.g. in displaced persons camps) and reconstruction (in rebuilding homes and community facilities).
- ❖ Organization of daily routines in displaced persons camps and surviving communities to include persons with disabilities, women, elderly and children.
- ❖ Liaison with and encouragement of community leaders and others to reorganize community supports and routines.
- ❖ Use of everyday occupations including play and sports to facilitate recovery.
- ❖ Assessment of mental health status of survivors for depression and suicidal tendencies, with subsequent counselling and occupation-based activities.
- ❖ Training of volunteers to carry out 'quick mental health assessment' and counselling, thus providing more immediate services for greater numbers.

Disaster response and preparedness is an emerging field of policy and practice for occupational therapy. WFOT encourages collaboration and experience sharing in this emerging field, so that we can continue to develop our capacities to appropriately address the needs of people and communities affected by disaster.

**Kit Sinclair, Ph D**  
**President**  
**World Federation of Occupational Therapists**