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At a rehabilitation centre in Battambang, Cambodia, children with different physical impairments learn to walk. The girl in front on the left is wearing an orthosis.

Chapter 5
Child-focused Victim Assistance

Section 5.3
Rehabilitation

Explanatory Note

THIS document is one of **eight** PDF documents that comprise the Guidance on Child-focused Victim Assistance. All are available in PDF at <http://www.unicef.org/publications/>. The full document is also available.

The first PDF contains the Acknowledgements, Foreword, Acronyms and Chapters 1 through 4:

Chapter 1. Introduction: The Need for Child-focused Victim Assistance Guidance
Chapter 2. Mine Action, UNICEF and Guidance on Child Victim Assistance
Chapter 3. Victim Assistance: Stakeholders and International Standards
Chapter 4. Principles, Coordination and Cross-cutting Aspects of Victim Assistance

This stand-alone document on ***Rehabilitation*** is one of the six technical components of Child-focused Victim Assistance Guidance. Together, they comprise Chapter 5 Child-focused Victim Assistance. The other five parts (each of them in a PDF document) of Chapter 5 are:

Section 5.1 Data collection and analysis
Section 5.2 Emergency and continuing medical care
Section 5.4 Psychological and psychosocial support
Section 5.5 Social and economic inclusion
Section 5.6 Laws and policies

The eighth and final PDF document, Chapter 6, contains resources and references that users may find helpful.

BETWEEN 1999 and 2012, 88,331 people living in some 60 countries are known to have been killed or injured by landmines or explosive remnants of war (ERW). Of these, at least 15,868 were under the age of 18 at the time of the accident. Although progress has been made in reducing the threat of unexploded ordnance worldwide, some 1,000 children – 90 per cent of them boys or young male adolescents[1] – are still killed or injured annually.

Cluster munition remnants and improvised explosive devices (IEDs) are particularly deadly for children. Blast and fragmentation injuries often cause long-lasting impairments including limb amputations, loss of eyesight and hearing, severe injuries to genitals, internal organs, face and chest, brain damage and spinal cord damage.

These physical injuries are aggravated by the psychosocial, socio-economic and protection consequences of the traumatic event of a blast accident as the survivors confront lifelong difficulties accessing education, livelihood opportunities and, like many vulnerable children with disabilities, are subject to violence, abuse and exploitation.

This Guidance was developed in response to requests for support in developing child-focused victim assistance programming. It provides support for:

- Developing new policies and programmes (or adapting existing ones) that assist child mine/ERW victims that are age- and gender-appropriate and promote the rights of children and young people[2] with disabilities.
- Promoting access for children directly and indirectly affected by landmines and ERW to comprehensive support in emergency situations, directly or through their families, communities and service providers.
- Designing programming for mine/ERW injured children that is mainstreamed into wider disability, economic and social development, and poverty reduction efforts.
- Supporting stakeholders to meet the needs and enhance the quality of life of children and their families affected by landmines and ERW by advocating for and facilitating access to affordable health care, rehabilitation, psychosocial support, social and economic inclusion (education, livelihood support and social assistance, etc.).
- Encouraging stakeholders to facilitate the empowerment and participation of children affected by armed conflict and of children with disabilities.

This Guidance will be useful to Governmental and non-governmental entities and civil society organizations that provide services or influence policy and budgeting related to survivors and victims of landmines/ERW and persons with disabilities; UNICEF and other UN programme and policy staff at all levels; children and people with disabilities and their families and other care givers; Mine Action actors; Governmental and non-governmental entities and international organizations, including UN actors, providing services for survivors and victims of landmines/ERW and persons with disabilities; and researchers and academics.

Acronyms

AIDS	acquired immune deficiency syndrome
APMBC	Anti-Personnel Mine Ban Convention
C4D	communication for development
CBR	community-based rehabilitation
CCM	Convention on Cluster Munitions
CCW	Convention on Certain Conventional Weapons
CDC	Centers for Disease Control and Prevention (United States)
CMC	Cluster Munition Coalition
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DFID	Department for International Development, Government of the United Kingdom of Great Britain and Northern Ireland
DPO	disabled people's organization
ERW	explosive remnants of war
GA	General Assembly (of the UN)
GICHD	Geneva International Centre for Humanitarian Demining
GMAP	Gender Mine Action Programme (A Swiss NGO)
HI	Handicap International
HIV	human immunodeficiency virus
ICBL	International Campaign to Ban Landmines
IDP	internally displaced persons
IED	improvised explosive device
IMAS	International Mine Action Standards
IMSMA	Information Management System for Mine Action
ISPO	International Society for Prosthetics and Orthotics
ISU	Implementation Support Unit (of the APMBC)
MA	mine action
MRE	mine risk education
NGO	non-governmental organization
NSA	non-state actor
PDR	People's Democratic Republic (as in Lao PDR)
PFA	psychological first aid
P&O	prosthetics and orthotics
UN	United Nations
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNMAS	United Nations Mine Action Service
UXO	unexploded ordnance
VA	victim assistance
WASH	water and sanitation and hygiene
WHO	World Health Organization

Boxes

Figures

5.3 Rehabilitation

Introduction

REHABILITATION is a set of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environment. Although the concept of rehabilitation is broad, not everything to do with disability can be included in the term. In line with the CRPD, the term *rehabilitation* is preferred to the term *physical rehabilitation* as it is more comprehensive and less medically oriented.

Rehabilitation targets improvements in individual functioning – for example by improving a person's ability to eat and drink independently. Rehabilitation also includes making changes to the individual's environment, for example, by installing a handrail. Barrier removal initiatives at societal level, such as fitting a ramp to a public building, are commonly not considered rehabilitation. A key aspect of rehabilitation is the psychosocial dimension. For example, getting a prosthesis, trying it out and learning to live with it in the longer term, or learning to live without or partial eye-sight or hearing, involves complicated psychological mechanisms, which need to be acknowledged, supported and dealt with, from the beginning onwards. (This aspect is addressed in Section 5.4, "Psychological and Psychosocial Support".)

Rehabilitation services range from the basic to the specialized and are provided in many different locations, e.g. hospitals, prosthetic workshops, homes and community environments – at times by mobile units in order to reach remote areas. Rehabilitation is initiated by the health sector but requires collaboration among all sectors, particularly Social Protection.

One core task of the specialized services is to produce assistive devices. An assistive device is a device that has been designed, made or adapted to assist a person with an impairment to perform a particular task. Many people with disabilities benefit from the use of one or more assistive devices. Common types of assistive devices include mobility devices (e.g. crutches, prostheses, wheelchairs and tricycles), visual devices (e.g. glasses, white canes) and hearing devices/aids. To ensure that assistive devices are used effectively, important aspects of their provision include user education, follow-up, repair, replacement, access to appropriate therapy and environmental adaptations in the home and community.

Between 5 per cent and 15 per cent of persons living in low- and middle-income countries who require assistive devices and technologies have access to them. Less than 3 per cent of the hearing aids needs are met in developing countries. Mobility devices are of particular importance for landmine and explosive remnants of war (ERW) survivors and other amputees. Children's artificial limbs need to be replaced every 6-12 months due to their growing body and bones. A ten-year old child with a lower limb amputation, for example, is likely to need 25 prostheses in the course of his or her life. Appropriate child wheelchairs also need to be adapted often as children grow.

For cultural reasons, in some countries, girls and women may not be able to access medical or rehabilitation services if only male practitioners are available. Or, they may not be able to travel to available services without a male escort.

"I got a new prosthesis and I got rid of my crutches. I am ready to live a new life. I can go to the hospital by myself.... I can walk five to seven kilometers.... It is an amazing feeling when someone who has lost a leg—who was not even sure that he would still live, who did not see any light in the tunnel—gets a prosthesis and starts a life as a person and starts thinking about the future."
— A landmine survivor

Sperber Richie, Beth, et al (2002), *Paths to Recovery: Coordinated and Comprehensive Care for Landmine Survivors*

Goal

Landmine/ERW survivors including children have access to rehabilitation services which contribute to their overall well-being, inclusion and participation; they have access to appropriate assistive devices of good quality, which enable them to participate in life at home, school, work (when age-appropriate) and in the community.

The role of rehabilitation in child-focused victim assistance

The role of rehabilitation in child-focused victim assistance is to promote child-friendly rehabilitation services and to ensure that institution-based rehabilitation is complemented by community-based rehabilitation.

Two years after the end of the civil war in Sri Lanka, a war-injured boy receives prosthetic care in the Meththa Foundation Physical Rehabilitation Centre, Mannar, Sri Lanka.

The right to maximum independence

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:

(a) Begin at the earliest possible stage, and are based on the multidisciplinary assessment of individual needs and strengths;

(b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.

3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Article 26, Convention on the Rights of Persons with Disabilities

Key concepts

Rehabilitation

There are three goals in rehabilitation: healing, improving functioning and inclusion in the community of both the injured person and his/her family. This section focuses on the second aspect, improving functioning, to encourage functional independence. For a child who lost a lower limb, this requires a prosthesis that fits well. Prosthetic and orthotic (P&O) services should start early after amputation with tight wrapping of the stump and regular exercise through physiotherapy to ensure optimal results. After receiving the prosthesis, the girl or boy needs to learn how to walk through gait training so that she or he can move around freely without having to use crutches. Children with spinal injuries may have to learn how to use a wheelchair. Children who have received injuries to the digestive system, the hands or the face may have difficulties maintaining their nutrition wellbeing. All survivors, irrespective of their specific injuries, will need to re-learn how to do daily activities like washing, dressing, using the toilet, eating independently to the extent possible. All this requires occupational therapy. Children and young adults with amputations can greatly enhance mobility by learning how to ride a bicycle or a tricycle to cover longer distances. Rehabilitation should also include speech therapy to address communication disorders.

Parents should be educated on the benefits of various rehabilitation services. For low-income families the rights and needs of persons with disabilities are often not considered a priority. Family members must learn how best to support a person with limb loss or other types of impairments. This training can be provided by community-based rehabilitation (CBR) workers who might also assist in maintaining the assistive devices when it is time to seek modifications or a replacement – or to apply low-cost and low-tech solutions for adaptations at home, for example to adapt a toilet so that it can be easily used by child survivors. See Box 12 for several types of assistive devices that should be considered for a child survivor.

Box 12: Assistive Technology Devices for Children with Disabilities

Category	Examples of products
Mobility	▪ Walking stick, crutch, walking frame, manual and powered wheelchair, tricycle ▪ Artificial leg or hand, caliper, hand splint, club foot brace ▪ Corner chair, special seat, standing frame ▪ Adapted cutlery and cooking utensils, dressing stick, shower seat, toilet seat, toilet frame, feeding robot
Vision	▪ Eyeglasses, magnifier, magnifying software for computer ▪ White cane, GPS-based navigation device ▪ Braille systems for reading and writing, screen reader for computer, talking book player, audio recorder and player ▪ Braille chess, balls that emit sound
Hearing	▪ Headphone, hearing aid ▪ Amplified telephone, hearing loop
Communication	▪ Communication cards with texts, communication board with letters, symbols or pictures ▪ Electronic communication device with recorded or synthetic speech
Cognition	▪ Task lists, picture schedule and calendar, picture-based instructions ▪ Timer, manual or automatic reminder, smartphone with adapted task lists, schedules, calendars and audio recorder ▪ Adapted toys and games

Source: UNICEF. The State of the World's Children 2013. Children with Disabilities. New York 2013. <http://www.unicef.org/sowc2013/report.html>

Institutional and community-based care

Rehabilitation services can be provided in a variety of settings. Most common are institutional settings such as hospitals or separate rehabilitation clinics. Basic services can be provided by trained Community-based Rehabilitation (CBR)-staff at the community level, such as when CBR workers train family and community members to improve care or to initiate simple improvements at home. CBR workers can also link children with broader mainstream services available for children and communities more generally. At the institutional level, many facilities are run by governments with International Committee of the Red Cross or NGO-support or as non-profit or private enterprises. Not all services follow standards as defined by the International Society for Prosthetics and Orthotics (ISPO) and the World Health Organization (WHO) and many do not have staff trained to ISPO/WHO norms. Sub-standard devices that cause medical complications often lead disappointed users, including children and adolescents, to abandon the prosthesis and lose out on the potential benefits good rehabilitation services can provide at an affordable cost.

Mobility device service providers often find it difficult to recruit local and well trained physiotherapists, occupational therapists and social workers or persons trained in providing psychosocial care. Few service providers provide outreach work to the communities or actively link to CBR networks where they exist. Self-help groups at the community level can provide basic services to their members and beyond and are often promoted by CBR-workers. Many of these groups also demand access to adequate care and services from the government.

Countries with high numbers of military casualties tend to have their own rehabilitation services for injured soldiers and war veterans with disabilities. These services should be opened for all citizens instead of developing and maintaining a parallel civilian rehabilitation sector.

Highest attainable standards

High quality artificial limbs can be produced using an appropriate technology at a fairly low cost but even this cost is often too high for low-income families. Assistance to victims of conflict (and for other persons with disabilities) is free in many countries – at least officially – but someone in the end has to pay the bill for running mobility device services. While some specialists in the field may advocate for or promote the use of locally available (and sometimes lower quality) materials, this should be accepted only if these materials meet the minimum standards stipulated by the ISPO. Article 25 of the CRPD clearly calls for achieving the highest attainable standards.

Box 13: Community-based Rehabilitation in Iran (Islamic Republic of)

The CBR programme in the Islamic Republic of Iran encourages village health workers and CBR personnel to identify people with disabilities early and refer them to the primary health-care services in the community. Following referral, a mobile team of rehabilitation personnel visit the home to provide home-based rehabilitation. If specialized interventions are required, referral is made to a tertiary-level care centre, usually in the provincial headquarters or capital city. Following rehabilitation at a specialized centre, people are referred back to the primary health-care services, which work with the CBR programme to ensure that rehabilitation activities are continued, if necessary. The mobile team provides follow-up to monitor progress and provide further assistance when required.

Source: WHO/UNESCO/ILO/IDDC (2010), CBR Guidelines, 'Health component', p. 52

Desirable outcomes

- Child survivors receive individual assessments and jointly with their caregivers are involved in the development of rehabilitation plans outlining the services they will receive. Where they exist, individual assessments should be undertaken as a component of social work/case management systems.
- People with disabilities and their family members understand the role and purpose of rehabilitation and receive accurate information about the services available.
- Specialized rehabilitation services are available with affordable transport to access these services; decentralized maintenance and repair workshops for prostheses , orthoses , wheelchairs and assistive devices are available; children and their care givers are trained in care and maintenance of assistive devices at home.
- Basic rehabilitation services are available at the community-level; community-based rehabilitation (CBR) personnel receive appropriate training, education and support to enable them to undertake rehabilitation activities with children.
- Special efforts are made to reach those in need of rehabilitation services in hard-to-reach locations. Mobile rehabilitation teams deployed if no local services available.
- Special efforts are made to reach women and girls in need of rehabilitation services.
- Care givers, families and children themselves have access to information, knowledge and support to strengthen the psychosocial resilience and recovery of child survivors and victims.
- Rehabilitation workers are adequately trained in psychosocial care tailored to meet the needs of children and adolescents.

Suggested activities

Promote specialized rehabilitation and production of assistive devices according to international standards and best practice

- ✓ Support the Government body responsible for addressing the needs of persons with disabilities – often the Ministry of Health and the Ministry of Social Affairs or Social Welfare – to develop a comprehensive rehabilitation strategy and action plan. Develop this plan jointly with rehabilitation providers, Disabled People's Organizations and people with disabilities and agree on the appropriate P&O technology, address the training needs of rehabilitation staff *(not forgetting the need to have female professionals)* and advocate for a specific national budget line. Update the existing strategy and plan if necessary.
- ✓ Support rehabilitation services for civilians living in areas not under government control in cases of armed conflict, where possible.
- ✓ Educate parents, teachers, social workers, local leaders and decision making persons of any rank including medical and protection staff about the potential that results from good rehabilitation.
- ✓ Provide child-friendly rehabilitation, including occupational and speech therapy, services to the highest attainable levels.
- ✓ Respect privacy especially for girls and female caregivers in sex-segregated areas.
- ✓ Provide and equip areas designated as child-friendly spaces.
- ✓ Undertake mapping of rehabilitation services available for children and strengthen referral mechanisms to these.
- ✓ Train rehabilitation workers in psychosocial support and referral to other services as required, including in interpersonal skills that stress respect for all clients and understanding signs of distress caused by the

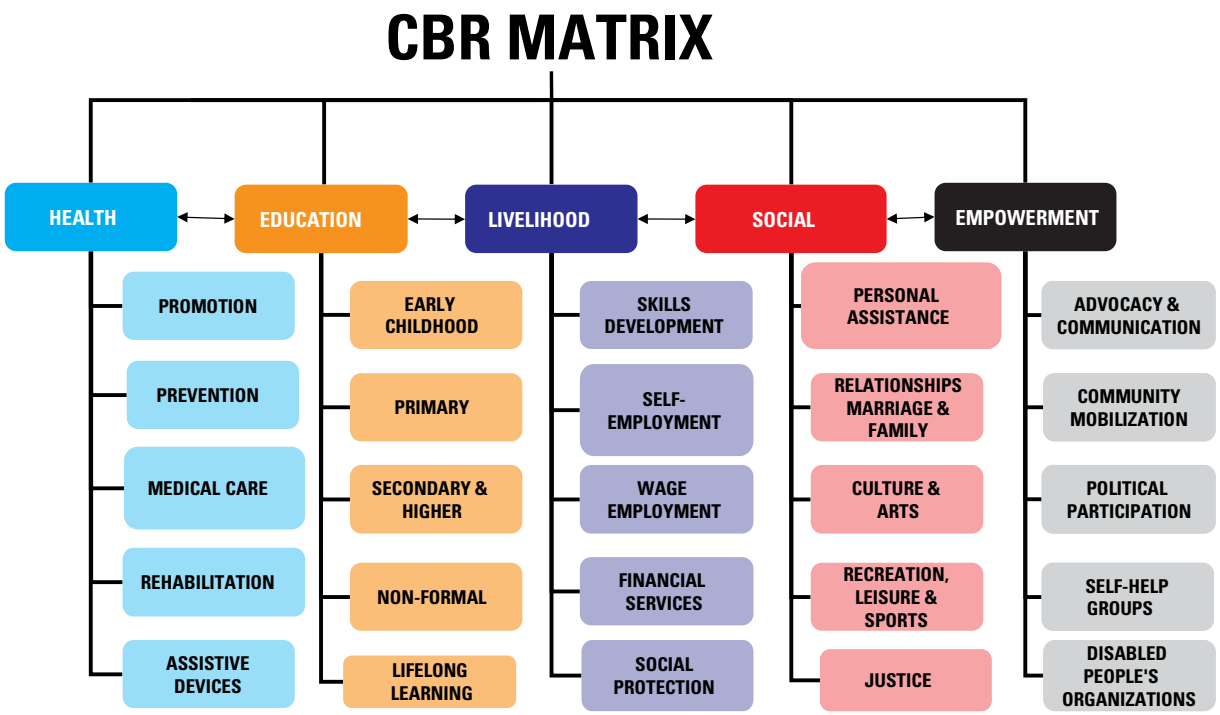
traumatic event of a mine/ERW explosion and listening for those signs. Workers should understand that their clients are not 'patients' who are sick. Training should be age-appropriate and tailored to meet the needs of each age group with traumatic injuries.

- ✓ Promote a team approach comprising the client (including the child if feasible), caregivers, family, P&O professionals, physiotherapists, occupational therapists, (psycho) social workers and others.
- ✓ Promote community outreach to identify and follow up on clients. Too often people who get a prosthetic limb stop using it because of pain or other trouble.
- ✓ Promote psychosocial care as an integral part of rehabilitation, e.g. by promoting peer-to-peer support at both the institutional and the community level. Involve family members and other caregivers.
- ✓ Promote sport and leisure activities at the rehabilitation facility as well as back in the home community. Include persons without disabilities.
- ✓ Ensure referrals as needed, for example, to medical care (for corrective surgery if needed), physiotherapy prior to fitting, the provision of assistive devices, to (continued) psychosocial care, nutritional support when required, and so forth. Address specific needs of persons with spinal cord injuries, digestive system injuries, those in need of hearing aids and other special needs.
- ✓ Ensure accessible, timely and affordable maintenance, repair and replacement of prostheses, orthoses and assistive devices.
- ✓ Monitor and evaluate the effectiveness, quality and acceptance of mobility device service providers by their clients.

Promote access to mobility device services

- ✓ Locate mobility device service providers as close as possible to where survivors/child survivors live.
- ✓ Ensure effective referral for children to child-friendly rehabilitation services.
- ✓ Ensure that providers are following appropriate service provision standards.
- ✓ Provide for free or affordable transport to mobility device service providers including physiotherapy.
- ✓ Provide acceptable accommodation for clients staying overnight and for longer rehabilitation periods.
- ✓ Support mothers seeking mobility devices services for themselves or one of their children for child care for their other children both in their communities and/or at the rehabilitation facility.
- ✓ Ensure that protocols are in place to prevent the separation of children from their families when children or their care givers receive specialized rehabilitation services.

Figure 1: Model for Integrated Community-based Rehabilitation Approach



Source: WHO/UNESCO/ILO/IDDC (2010), CBR Guidelines

Promote community-based rehabilitation

- ✓ Train community-based rehabilitation workers who can support landmine/ERW survivors when returning to their families and to their community after discharge from hospital. CBR workers may assist with adequate wrapping and with exercises to strengthen the body prior to fitting a prosthesis, identify and refer children in need of nutritional support. CBR workers may provide important support during periods of transition, such as when a child starts school or an adolescent starts work.
- ✓ Ensure that children with disabilities and their family members are involved when developing an individual rehabilitation plan. (Case management approach, see Section 5.5 on "Social and Economic Inclusion".)
- ✓ Ensure close links to specialized care to allow optimal medical care, especially for children as they may require repeat surgeries and regular replacements of P&O devices and other follow-up.

Box 14: Being Able to Work Again – Nepal

Community Based Rehabilitation Biratnagar (CBRB) is a nongovernmental organization that has been working in the eastern region of Nepal since 1990. Currently it is working in 41 villages of the Morang District and in Biratnagar Submunicipality, providing rehabilitation services to more than 3,000 children and adults with disabilities.

In 1997, CBRB started a small orthopaedic workshop to carry out minor repairs of assistive devices, as many people with disabilities had to travel to the capital or neighbouring India for repairs. Over time, CBRB worked towards establishing a fully equipped orthopaedic workshop. Working in partnership with Handicap International (Nepal), they developed a comprehensive service that included the fabrication, provision and repair of assistive devices.

CBRB provides quality orthoses (e.g. callipers, braces, splints), prostheses (e.g. artificial legs and hands) and mobility devices (e.g. crutches, tricycles, wheelchairs) to people living with disabilities in 16 districts of eastern Nepal. CBR personnel, therapists and workshop technicians work hand-in-hand to enhance the quality of life of people with disabilities.

Chandeswar has benefited from the orthopaedic workshop. He is a rickshaw-puller who suffered an injury and had his left leg amputated. He lost his income because he was no longer able to work as a rickshaw-puller and he lost his savings because he needed to pay for his medical care. Chandeswar was identified by the CBRB team working in his village, who fitted him with a below-knee prosthesis and provided rehabilitation to ensure he was able to walk well with his artificial leg and learn how to pedal his rickshaw again. Once again, Chandeswar is pedalling his rickshaw around the busy streets of Biratnagar and making a reasonable living.

Seeing the benefit to people like Chandeswar, the President of CBRB says: "We were carrying out CBR for many years but since we started providing quality assistive devices, we have become more effective, our credibility has gone up and now we have a great acceptance in the community".

Source: WHO/UNESCO/ILO/IDDC (2010), CBR Guidelines, Health Component, p. 58

Technical Resources

Documents are listed in ***inverse chronological order***, starting with the most recent ones.

Rehabilitation

Handicap International (2013), *Victim Assistance Factsheets,* Lyon; here Factsheet 2 *Rehabilitation,* <http://www.hiproweb.org/fileadmin/cdroms/VictimAssistance/Fact_Sheets/HI-FactSheets-HD.pdf>

International Committee of the Red Cross [ICRC] (2013), *Physical Rehabilitation Programme, Annual Report,* Geneva 2013 [and earlier years, see also regular *Mid-term Reports.* See info on "Services for mine/ERW survivors", p. 13] <http://www.icrc.org/eng/resources/documents/publication/p4160.htm>

ICRC Special Fund for the Disabled (SFD) (2013), *Annual Report 2013,* Geneva [and earlier years, see also regular *Mid-term Reports*] <http://www.icrc.org/Web/doc/sitesfd0.nsf/htmlall/6HWVXE/$FILE/SFD_AnnualReport2014_LR%5B1%5D.pdf?OpenElement>

WHO/UNESCO/ILO/IDDC (2010), *Health Component* [and other Components], *Community-Based Rehabilitation: CBR Guidelines,* Geneva, <http://www.who.int/disabilities/cbr/guidelines/en/>

Werner, David (2009), *Disabled Village Children: A guide for community health workers, rehabilitation workers and families,* 2nd Edition. Hesperian, Palo Alto, <http://hesperian.org/wp-content/uploads/pdf/en_dvc_2009/en_dvc_2009_fm.pdf>

WHO (2008), *Guidelines on the provision of manual wheelchairs in less-resourced settings,* Geneva, <http://www.ncbi.nlm.nih.gov/books/NBK143778/pdf/TOC.pdf>

Prosthetics and Orthotics Programme Guide, Implementing P&O Services in Low-Income Settings (2006), A guide for planners and providers of services for persons in need of orthopaedic devices, …, Endorsed by The International Society for Prosthetics and Orthotics [ISPO], … Geneva, <http://www.ispoint.org/sites/default/files/img/programme_guide_final_version.pdf>

Prosthetics and Orthotics Project Guide: Supporting P&O Services in Low-Income Settings (2006), Endorsed by ISPO, Geneva, <http://www.usispo.org/assets/pdf/Project_Guide_Final_Version.pdf>

Hobbs, Liz, McDonough, Susan and O'Callaghan, Ann (2002), *Life after injury, A rehabilitation manual for the injured and their helpers,* Third World Network, Penang, <http://www.twnside.org.sg/title/injury.htm>

Endnotes

1 A "child" is defined in the Convention on the Rights of the Child as a person younger than 18 years of age. "Adolescents" are generally defined to be between 10 and 18 years old. Some definitions of "young people" go up to 24 years.

2 "A system providing proper fit and alignment based on sound biomechanical principles [that] suits the needs of the individual and can be sustained by the country at the most economical and affordable price." Day, H.J.B., J. Hughes & N. Jacobs (eds.), *Report of ISPO Consensus Conference on Appropriate Orthopaedic Technology for Developing Countries*, ISPO, Phnom Penh, Cambodia, 5-10 June 1995, ISPO/USAID/WHO, Brussels 1996.

3 Prosthesis - 'an artificial device that is used to replace a part of the body that is missing, such as an arm, leg, or joint'.

4 Orthosis - 'An external orthopaedic appliance, for example, a brace or splint that prevents or assists movement of the spine or the limbs.'