Disability and the Global South, 2015
Vol.2, No. 2, 570-589

OPEN ACCESS
ISSN 2050-7364
www.dgsjournal.org

Using Postcolonial Perspectives to Consider Rehabilitation with Children with Disabilities: The Bamenda-Toronto Dialogue

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This article discusses tensions in children's rehabilitation that came to light through a series of 'postcolonial dialogues' amongst Canadian and Cameroonian participants. We defined 'tensions' as conflicts, contrasting ways of seeing things, and/or taken-for-granted ideas that shape issues related to rehabilitation for children with disabilities. These tensions were identified, articulated, and deconstructed through an iterative, multi-phase dialogue among eight individuals who identify as people with disabilities, rehabilitation providers, and/or rehabilitation researchers in Cameroon and Canada. The tensions discussed in this article problematize conceptualizations of disability and of client-centred care, the role of pain as a reinforcement tool in rehabilitation, and assumptions about poverty and religion in the context of rehabilitation practice. We present this synthesis to achieve several aims: (1) to provide multiple ways for rehabilitation providers and others to better understand these particular substantive issues; (2) to model the use of a critical lens as an approach for thinking about rehabilitation that promotes reflective and deliberate practice and that can be applied across contexts; and, (3) to promote dialogue about postcolonial and other critical perspectives on rehabilitation with children and with other groups.

Keywords: children's rehabilitation; Cameroon; Canada; reflective practice; concept formation

Introduction

Although estimates of the prevalence of children with disabilities[1] vary greatly, research generally paints a picture of widespread impairments among children, with far greater burden experienced by children in the Global South (World Health Organization, 2008). Rehabilitation can be a key support for children with disabilities (World Health Organization, 2011), yet rehabilitation research is disproportionately generated in and for the Global North. Furthermore, despite the endorsement of community-based rehabilitation (CBR) by the World

Health Organization and others (International Labour Organization et al. 2004), high-tech, institution-based models of rehabilitation are pervasive in the Global North and often feature prominently in training programmes for health and rehabilitation providers in the Global South (Frenk et al. 2010; World Health Organization, 2011). There is a well-worn path for exporting Eurocentric rehabilitation innovations from north to south; rarely are models and practices born in the south translated into rehabilitation practice in countries of the Global North, like Canada. This gap is profoundly short-sighted given the unique ability of countries in the Global South to better understand and overcome the limits of a Eurocentric worldview. While alternatives to the mainstream stand to benefit all, in a country like Canada the ability to engage multiple worldviews is particularly important given the multicultural nature of Canadian society.

There is a *critical turn* in rehabilitation science in which scholars problematize (question) assumptions underpinning core concepts in an effort to promote more equitable and effective care (Gibson, 2014; Nicholls and Gibson, 2010; Papadimitriou, 2008; Winance, 2006). This shift is an important corrective for a field that has been critiqued for being too steeped in positivism, for being under-theorized, and for focusing too much on a biomedical model of disability (Gibson and Teachman, 2012; Goodley, 2013; Nicholls and Gibson, 2010; Phelan, 2011). By 'critical', we are referring to theoretical perspectives explicitly interested in power, privilege, and wider social-political contexts. Critical approaches seek to make visible assumptions or taken-for-granted 'truths' that shape society, and to invite alternative ways of understanding these phenomena (Kincheloe and McLaren, 2005). Critical approaches are emancipatory in their aims, whereby new ways of seeing give rise to novel and more progressive forms of action.

A particularly important critical lens for rehabilitation is *critical disability studies*, which takes as its object of inquiry the ways in which disability itself is conceptualized (Goodley, 2013). A critical disability studies perspective has been applied to rehabilitation with children with disabilities and their families in various ways. As examples, in Canada, Gibson and Teachman (2012) have investigated how unreflective assumptions about the value of walking over other forms of mobility, underpin rehabilitation programs for children with cerebral palsy. In the UK, Fisher (2007) has drawn on the narratives of parents of disabled babies to critique biomedical constructions of 'normality' towards (re)conceptualized enabling care practices. Although this work signals the potential value a critical lens can bring to children's rehabilitation, to date research and scholarship has been largely limited to high-income settings.

Postcolonialism is another critical theoretical lens, which is an interdisciplinary approach to revealing, analyzing, and responding to the ideological legacies of imperialism. Despite the prefix 'post', most postcolonial scholars understand the field to focus on the existing and ongoing legacies of colonialism that advantage some people at the expense of others. Postcolonial theory identifies and resists ideas of culture as static and fixed, and instead

offers a way of understanding culture as dynamic, fluid and rooted in experiences of colonialism (Ashcroft et al. 2008). Furthermore, this lens is used to illuminate how these forces create spaces of inclusion and exclusion, and value certain ways of knowing over others.

As such, a postcolonial approach holds important insight for the move toward more inclusive societies. In particular, postcolonialism has much to offer *rehabilitation* given the expansion of the field worldwide (World Health Organization, 2011), which is frequently informed by the Eurocentric orientation that commonly underpins rehabilitation models. Eurocentric in our usage, refers to ideologies, concepts and practices that originate(d) in European countries and their colonies, and constitute a dominant and dominating world view. Postcolonial analyses of rehabilitation which question Eurocentric assumptions are scarce. Exceptions include the work of Leshota (2013) who uses a postcolonial approach to argue for the need for improved rehabilitation models; Geiger (2010) who considers expanded notions of rehabilitation in Africa; and, Frank et al. (2008) who describe postcolonial practice in occupational therapy based on their work with an indigenous community in the United States. Postcolonial analysis of rehabilitation *with children* is even scarcer (Hollinsworth, 2013) Hollinsworth (2013) has advocated for the utility of a postcolonial lens when working with children with disabilities in the Australian context. Others have linked postcolonialism and children's rehabilitation in the context of child soldiers (Cahn, 2005).

Our objective in this article is to contribute to this nascent field by presenting a series of tensions in children's rehabilitation that came to light using a postcolonial lens. The tensions were identified through an iterative, multi-phase dialogue among a team of individuals who identify as people with disabilities, rehabilitation activists, rehabilitation providers, and/or rehabilitation researchers in Cameroon and Canada. As a team, we defined 'tensions' as conflicts, contrasting ways of seeing things, assumptions, and other taken-for-granted ideas that shape issues related to rehabilitation for children with disabilities. The purpose of the dialogue, was to surface, articulate and deconstruct tensions within and between Canadian and Cameroonian children's rehabilitation practices. We present the tensions in order to achieve several aims: (1) to provide multiple ways for rehabilitation providers and others to better understand these particular substantive issues; (2) to model the use of a critical lens for thinking about rehabilitation that promotes reflective and deliberate practice and can be applied across contexts; and, (3) to promote dialogue about postcolonial and other critical perspectives on rehabilitation with children and with other groups.

Context and Process

Our multi-phase dialogue was undertaken by the eight co-authors, each based in either Cameroon or Canada, and each of whom (1) was connected with the International Centre for Disability and Rehabilitation (ICDR) based at the University of Toronto, and (2) shared

interest in thinking critically about rehabilitation with children with disabilities. Each team member had previously collaborated with one or both of the co-leads (SAN and LC).

Recognizing that understanding our different contexts makes it possible to view the same issue in different ways, we engaged with the question 'who are we?' throughout the inquiry. We noted our differences and similarities across multiple planes, as well as our evolving insights into how our perspectives shape our understandings of these topics. Three of us (RA, NS, PNM) are Cameroonians from the Bamenda area; five of us (BEG, DC, KB, LC, SAN) are Canadians living in Toronto. However, LC lived in Bamenda during childhood and has collaborated closely with Cameroonian colleagues for the past decade. The dialogues thus are, in part, a structured extension of ongoing interactions between LC and the Cameroonian authors. Our 'northness' and 'southness' is further blurred by the longstanding international engagement (through research, advocacy or clinical practice) of BEG, DC, KB, PNM, SAN. The three Cameroonians are black and the five Canadians are white of primarily Western European descent. Five of us are women and two are men (PNM, NS). One of us has a mobility impairment (RA), one of us is blind (NS), and the other 6 do not identify as having an impairment. All five of the Canadian team members have training as rehabilitation clinicians and researchers, but from different disciplines: occupational therapy (DC, LC), physical therapy (BEG, SAN), and speech-language pathology (KB). One of us works in a rehabilitation international non-governmental organization (PNM), two of us are community activists (RA, NS), 3 of us are based at a university (DC, LC, SAN), and two are jointly based at a university and at a children's rehabilitation hospital (BEG, KB). Two are academic researchers who work from critical perspectives in global health research (SAN) and childhood disability studies (BEG). All of us consider ourselves to be advocates working within our spheres to reduce inequities, particularly as they relate to adults and children with disabilities.

Explicit awareness of these (and other) identities assisted us in using an intersectional approach during the inquiry (Gill, 2007). That is, we attended to how our various identities intersected (within ourselves, and across our team) to create different social realities and, therefore, different ways of understanding tensions inherent in rehabilitation with children with disabilities. From this conceptual starting point, we undertook a structured dialogue whereby we examined the following question: '*What are some of the important tensions related to rehabilitation for/with children with disabilities that come to light when using a postcolonial lens?'* By bringing a reflexive intersectional lens to bear on the process, we also asked ourselves what might be the same or different about us, our socio-cultural contexts, and our worldviews, and how these similarities and differences might shape how we understand particular rehabilitation issues or professional behaviours.

Specifically, our process involved the following steps. We first agreed upon the general plan for the dialogue, including who the team members would be, the core question we would address, the critical conceptual approach we would adopt, and the procedural steps of the

dialogue itself. These procedural steps comprised an iterative series of workshops whereby a subset of the team met for several hours to collaboratively discuss, debate, and deconstruct ideas relating to our core question. The ideas were written into workshop reports by SAN and/or LC, with written comments invited by email from all team members. Each report was then used as the basis for discussion at the next workshop. The first workshop was led by SAN in Toronto and involved LC, DC and KB. The second workshop was led by LC in Yaoundé and involved NS, RA and PNM. The third workshop was led by SAN in Toronto and involved LC, DC and KB. The fourth workshop was held by Skype and involved RA, NS, SAN, LC and PNM. Following the fourth workshop, a draft manuscript was prepared and discussed by all team members in our fifth workshop by Skype, telephone or in writing. Input was then used to finalize the manuscript for peer-review.

The Skype and telephone interactions became more important than originally conceived, since we discovered that our original plan of sharing workshop drafts by email tended to privilege our team members that (1) have easy access to internet and email, (2) have full sight, and (3) have experience reviewing academic reports or manuscript drafts. Conversely, experience with electronic media and academic review tended to privilege the participation of some team members, which was to the disadvantage of the entire team. Therefore, we complemented our original plan with proactive and creative strategies to ensure input to the various written drafts using approaches that work for all team members, including phone, skype and email discussions of manuscript drafts as an alternative or complement to written feedback.

Throughout the dialogic process, we remained committed to the idea that critical perspectives invite a personal connection to theory. Theory is proposed at the general level, but each person makes sense of it in the particular through real-world stories and experiences. Our dialogue unfolded as a back-and-forth process for each of us during which we oscillated between theory and personal ways of knowing as we learned and deepened our understandings. Each of us drew from our own specific locations, experiences, and perspectives, welcoming the assumption that there is not a single objective truth that we sought to uncover. Rather, ours was a process of dialogue through which we honoured our differences as an asset, while simultaneously seeking commonalities. The result was a shared, collective understanding of five shared tensions in our children's rehabilitation work. Importantly we did not seek to resolve or fix these tensions but rather to acknowledge them. Each of these tensions is described in detail below.

Tensions

Tensions regarding 'disability': which perspectives in which contexts?

Engaging a critical perspective creates the opportunity to call into question the seemingly

static nature of concepts. A more dynamic perspective opens up the possibility of multiple simultaneous definitions, each of which privileges particular concerns at the expense of others. In our dialogue, multiple competing definitions of 'disability' surfaced that reflected and shaped local rehabilitation practices. For instance, some rehabilitation approaches for children with disabilities in Cameroon, reflected a biomedical model, wherein disability was understood as an impairment of the biological body that needs to be fixed. Other examples were more in keeping with the social model of disability, in which disability is understood to reside not in a body but in the disabling social and material environment (Oliver, 1983). That is, children may have impairments, but disability is understood as produced by disabling structures in society such as stigmatizing attitudes, inaccessible physical structures, and exclusionary policies like segregated schools. In the Cameroonian context a related rights-based approach to disability also arose, and was discussed in relation to the Convention on the Rights of Persons with Disabilities (United Nations, 2006). The Convention defines people with disabilities as those with 'long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others' (United Nations, 2006). Disability in this latter context is conceptualized as a matter of inequalities that limit individuals' abilities to achieve full citizenship.

Rehabilitation aims and roles with children will shift according to the particular conceptualization of disability. For example, aims of rehabilitation within a medical model may be 'fixing' lower extremity range of motion limitations of a child with cerebral palsy to assist with walking, or helping improve speech intelligibility following cleft-palate surgery. Within the social model, rehabilitation may target, for example, material or social changes to immediate environments such as homes, schools, and communities; or, advocating for policy and programme changes to promote inclusion of children with disabilities in sports and recreation activities. A rights-based approach shares conceptual terrain with the previous two models, but highlights the inherent dignity and equal worth of all people (regardless of ability) as its core commitments. Furthermore, actions within a rights-based approach are linked with legal commitments enshrined in international treaties and ratified by governments. As such, roles for rehabilitation using a human rights-based approach may include ensuring that children with disabilities have access to health services that is equal to their non-disabled peers, and this equity may be achieved through various means including programme service changes at the local level or legal challenges to the state.

Particular tensions were raised by using a postcolonial lens to consider 'disability'. The medical model is a frequent target by disability advocates in Canada and other high-income countries. Medicine and rehabilitation are critiqued for failing to acknowledge the interrelationships between bodily impairments and the socio-cultural mediators of disability. In an effort to globalize activism efforts, it is tempting for advocates from these settings to bring this critique with equal force to disability elsewhere in the world. However, we discussed that the medical model critique might be made possible and appealing because of

the presence of a robust health care system, like the so-called 'universal' health care system in Canada. Meanwhile, advocacy for investment and improvement in the health care system in Cameroon remains a high priority and a crucial aspect of care for children with disabilities. Making quality services available to treat the treatable and prevent the preventable among children remains a crucial target of advocacy in many settings. This insight can be a caution to medical model critics seeking to 'take this message global'; that is, resist rushing too quickly to discount the role of bodily impairments in disablement processes, especially in contexts where improvements to medical services that 'fix' impairments remain an important need for children with disabilities. We note that this dialogue parallels important developments in both rehabilitation and disability studies to acknowledge the multidimensional nature of disablement rather than focusing solely on bodies versus rights (Hammell, 2006; Hughes and Paterson, 1997; Imrie, 2004; Thomas, 2007; Wiart and Darrah, 2002).

This insight led to the further recognition about the heterogeneity of approaches to disability in the Global North. That is, it is tempting to homogenize assumptions about disability in the Global South as looking a particular way, and to also do the same for the Global North. A postcolonial lens encourages analysis that questions binaries, such as the north and south versions of disability criticism (or lack thereof) that implicitly surfaced in our dialogues. Upon further reflection, for instance, we noted that the Nordic models of disability studies may share more conceptual terrain with thinkers in Cameroon than North America (acknowledging that within North America there are a diversity of approaches as well). Nordic disability researchers are more likely to invoke a relational approach wherein no distinction is made between disability and impairment. Instead, disability is seen as emerging from the interaction of impairments with disabling socio-economic contexts (Goodley, 2010:15-18). This perspective creates a space for acknowledging the positive influences of rehabilitation in tandem with efforts to address social change.

Tensions regarding 'client-centred care': an example of North to South rehabilitation export?

A particular tension that surfaced in our dialogues had to do with models of rehabilitation practice, and the pervasively promoted approach in Canada that seeks to give greater voice to children with disabilities and their families, in care decisions. We recognized this approach as a key principle in that which is variously called client, patient, person, and/or family-centred care (Bamm and Rosenbaum, 2008; Fredericks et al. 2012; Institute for Family-Centred Care 2014; Law et al. 2003). This model of care aims to build mutually beneficial partnerships between patients, families and health care professionals in the planning, delivery and evaluation of health care (Institute for Family-Centred Care, 2014). In contemporary Canadian health care, client and family centred care is promoted (Ministry of Health and Long Term Care, 2010) in opposition to a provider-focused paternalistic model of care,

whereby the health care provider is understood to 'know best' and autocratically makes treatment decisions with minimal patient/family consultation.

Team members in all workshops recognized the centrality of a provider-focused model of rehabilitation in Cameroon (and other low-income countries where we had worked) including care provided in a community-based setting. Furthermore, there was a sense among Canadian team members that the family-centred care approach to rehabilitation with children with disabilities is new and *superior* to a provider-focused model. We also noted our collective appetite (i.e. both Canadian and Cameroonian team members) to disseminate this model with Cameroonian rehabilitation providers. However, we also took note of the fact that the physician-centred approach was a model of care that was previously exported from the north to the south, likely with the same sense of moral duty to share that 'better model' at the time. Therefore, for this contemporary example of patient and family-centred care, we considered what might be the kinds of questions (and cautions) that should be asked before endorsing exportation of this practice model? For example, what do the 'exporters' understand about the culture, religion and traditions of the local people, and the roles these play in shaping the clinical interaction? How do assumptions about life in other settings impact programs that 'should' be developed? How could this new approach unintentionally disrupt otherwise well-functioning aspects of the child's and family's context, and the ways in which decisions are made? Thus without deciding that client/family centred care is universally good or bad, we instead raised questions about how models need to be adapted to fit local contexts.

Opening up the inquiry in this way allowed us to consider other relevant questions that had not previously come to the fore, such as: What rehabilitation practice models may exist in Cameroon that could offer insight for Canadian providers? This approach fits recent thinking about 'reverse innovation', which refers to innovative ideas birthed in areas where resources are highly constrained like many poor countries that also hold benefit for the north (Govindarajan and Trimble, 2013; Immelt et al., 2009). While this idea is gaining currency, particularly as it relates to health care (Syed et al. 2012), critics note the colonial assumptions inherent in the phrase *reverse innovation*; that is, that innovation is the natural terrain of thinkers in the Global North, and therefore that any innovation that flows from the South should be viewed as 'reverse'. We, therefore, preferred to discuss 'shared innovation' in which lessons are sought in an equitable, reciprocal, and iterative way between partners in different contexts. For instance, many of the principles underpinning community-based rehabilitation could strengthen rehabilitation programmes in Canada that rely heavily on institution-based models. For example programmes could recognize that a necessary part of rehabilitation work is ensuring access to justice, including awareness of general and disability-specific laws, and learning from community-based disabled people's organizations, legal aid services, and others (World Health Organization et al. 2010).

Deeper reflection also surfaced assumptions about preferred or dominant models of care. We noted that much of what gets labelled as 'client-centred care' in North America is often a

narrow interpretation of its principles and often has limited relation to how the notion was originally conceptualized. Rehabilitation in Canada and elsewhere continues to have highly directive elements, which may be perceived as counter to client and family centred care but which may nevertheless be appropriate in particular situations (LeRoy et al. 2014). For example, an instance of a health care provider leading decision-making, may or may not align with family-centred care depending on whether or not this process is the stated preference of that family. An overly simplistic understanding of the principles of client and family centred care might see this location of decision-making power with the health care provider as the antithesis rather than its authentic realization. Furthermore, superficial commitment to these principles, continues to mask paternalistic practices that structure and limit client choices to favour professional values (Hammell, 2013; Hammell, 2007). We noted that in North American practice, there is a range of understandings about what constitutes 'family', what client or family-centred care might mean, and how to realize this form of care in a clinical setting – understandings that are themselves linked to social location and experience.

Tensions regarding the roles of pain and discipline in rehabilitation with children with disabilities

One of the experiences that originally motivated this inquiry was the moral distress described by Canadian rehabilitation students and therapists who, during clinical experiences in places like Cameroon, witnessed the use of physical discipline (hitting, spanking) of children during rehabilitation sessions, presented by parents and caregivers as an attempt to reinforce desired behaviours. This form of behaviour management was incongruous with their personal and professional values formed within the contemporary Canadian context where striking a child during rehabilitation is (now) unthinkable. Our Cameroonian team members affirmed that although attitudes are gradually changing, corporal punishment with children is sometimes considered necessary in parts of Cameroonian society, including rehabilitation, provided that the intent is in the child's interest and not performed out of malice or anger. Our Cameroonian team members further noted that physical discipline with children, when conducted humanely, is widely recognised as a way to show care and love for a child (see also Archambault, 2009; Busienei, 2012; Hecker et al. 2014). In the rehabilitation context, corporal punishment has been employed to secure rehabilitation outcomes but the effectiveness of this approach has also been challenged. This discussion was difficult for all team members, which created the opportunity for us to reflect, individually and as a team, on the implications of this divide for our thinking about rehabilitation.

First, in trying to understand how such vastly different norms could co-exist among a team that otherwise shared many of the same normative positions, we used a postcolonial approach to explore the historical roots of the scenarios. This exploration led to a discussion about the history of forced labour in Cameroon. Indeed, corporal punishment has become culturally

normalized in many places, including Cameroon, as part of the legacy of colonialism and legitimized oppression (Mbuagbaw et al., 1987; Ngoh, 1996). Little is known about corporal practices in the pre-colonial period, but it is well-established that during the colonial period, corporal punishment became entrenched as part of processes to establish power (Mbuagbaw et al. 1987; Ngoh, 1996). Those with power used beating and other forms of punishment to ensure that class structures were maintained: there was a class of people who made decisions and a class of people who followed those decisions without questioning or else they were punished (Manning, 1998). Some of the decision makers were (or are currently) religious leaders. These and other factors set up a system of 'big men' in society (Lentz, 1998; Schatzberg 1993). Our reflections also link back to definitions of disability and perceptions of physician-centred care, as discussed in previous sections.

A related issue during colonial times was 'fitness to work' and the need for conscripted labour. People (including children) who were not seen as 'fit' for hard physical labour were less valued (in the colonies and in Europe) (Stiker, 1999), and the legacy of these derogatory assumptions about ability continues today. During the transition to national independence in Cameroon (as in other colonies), Cameroonians who had lived within these systems desired power, and the elites who had been trained by colonial masters became conscious of injustices. As elite Cameroonians gained power, many of these power structures were replicated or perpetuated. The hierarchies in today's workplaces can be seen as maintaining these class structures: many people in lower level positions wait to be told what to do because they have been enculturated to not take decisions (Oppong, 2013). Members of our team believe that these dynamics can also play out in hospitals, clinics and rehabilitation settings in Cameroon whereby rehabilitation workers may wait to be told what to do by those who are more senior, and do not believe that they should be directed by the children or the families with whom they work. The postcolonial context brought the illusion of more democracy and shared decision-making but this approach has not been well supported in practice, as exemplified by the Cameroonian saying: 'They sell you the goat, while they keep hold of the rope around the goat's neck'. These reflections do not resolve the tension about the role of discipline within rehabilitation settings, but they offer a wider base of understanding regarding the etiology of these practices. Importantly, our Cameroonian team members emphasized that understanding the historical roots of such beliefs is crucial not for *justifying* these practices, but as a key to *changing* them.

Second, in seeking to understand the place of pain in the rehabilitation context, Canadian team members (all of whom are rehabilitation providers) reflected on how pain and other harms are frequently a component of rehabilitation with children with disabilities. Often, the role of rehabilitation is to reduce pain; however, there are multiple examples whereby rehabilitation interventions are well-known to increase pain but are conducted nonetheless, because they are viewed as being ultimately in a child's interest. Indeed, parents of children with disabilities, motivated by care and love, will go to great lengths to ensure that their children receive painful procedures. Examples include stretching to increase range of motion

among children with contractures; certain forms of behavioural training for children with autism which may be seen as potentially causing psychological harms; and separating children from parents for extended periods of time to receive rehabilitation. In a medical context, immunizations for children with profound fear of needles can cause both physical and psychological harms, as may cancer treatments that save life at considerable physical and psychological costs.

These reflections invoked utilitarian ethical questions about which ends justify which means, and according to whom? In other words, who gets to decide on what rehabilitation 'best practices' and 'good discipline' might be, especially when they produce or involve pain or other potential harms? Locating these questions in the Cameroon/Canada contexts prompts further questions: Are there shared ethical norms related to the use of pain during rehabilitation with children with disabilities that have worldwide applicability? To what extent should certain practices be accepted under a model of cultural relativism, and how should acceptance be decided (Macklin, 1999)? How is it that certain forms of pain infliction in rehabilitation have come to be seen as normal and acceptable (and worth paying for) in the Canadian system, whereas others have not? Are there and/or should there be different expectations for children with disabilities compared to non-disabled children with regards to the use of pain?

While our team did not expect to resolve many of these thorny issues, we did arrive as the insight that there are multiple reasons why a child may experience pain during rehabilitation, and that helping parents to understand pain as a symptom of a child's condition is important. We further agreed that intentionally inflicting additional pain with the aim of discipline or punishment during rehabilitation is counterproductive as other approaches are more likely to be effective, and that rehabilitation providers and caregivers should be educated as to both the limits of this approach and the positive alternatives that are available.

Tensions regarding children's rehabilitation in the wider context of poverty

Multiple threads of our dialogue were linked to how the wider context of oppressive poverty and/or lack of means can shape circumstances for children with disabilities and their families. Importantly, we often took note of how these processes may not be visible, apparent, or easily understandable to others (including rehabilitation providers) who do not share that same experience of poverty. Rehabilitation can involve many costs. In the absence of social safety nets or other external supports (and even with community-based rehabilitation and other social supports), families may have to prioritize basic shared needs (e.g. food, shelter) over the rehabilitation of one family member.

Cameroonian team members emphasized how families expect all children to be able to contribute to the work of running the home and, often, the family business. If a child with a

disability is unable to contribute to the family's needs or is viewed as a drain on limited family resources, keeping the child in the family home may, in itself, be viewed as a sacrifice and a sign of a loving family. Often, families that are 'economically exhausted' will be greatly challenged to cope with the additional demands of a child with a disability, including accessing rehabilitation that demands money and time for travel for institution-based services. Even with community-based rehabilitation, there is the opportunity cost of participating in care, given that the time a family member devotes to rehabilitation could otherwise be spent generating resources. Our Cameroonian team members explained that limited engagement with rehabilitation may appear to be lack of acceptance or a form of disability stigma, but could also be understood as part of the broader struggle faced by parents to keep their families alive. In settings like Cameroon where there is a cost for not only rehabilitation but also basic needs like school and periodic needs such as health care, there is an unending list of potential priorities that parents face in making difficult decisions, especially when they live with few financial resources. Each person and family has competing demands and have to weigh which priorities are most important and attainable, and where rehabilitation might fit in this list.

The idea that children should contribute to family finances differs from Canadian norms where it is uncommon to consider children in terms of their immediate economic value. That is, children are not usually seen as bringing money into a family (during childhood) and, conversely, are assumed to cost a family a great deal. We note that there are exceptions to this generalization in Canada, where one in seven children lives in poverty and this proportion is on the rise (Conference Board of Canada, 2013). However, discourses about childhood in Canada do not typically position children as breadwinners. It is important that rehabilitation providers in resource-rich countries also remember that many families have to make challenging economic decisions. For example parents might take a night shift to be available for rehabilitation appointments during the day; families may not have the finances to purchase assistive devices; or one parent (often the mother) may be forced to stop working to care for a child (National Children's Bureau, 2014).

Despite surface differences, with further reflection we saw a related but more subtle discourse within rehabilitation in Canada (and elsewhere) that links children to economic value. Child development and rehabilitation initiatives are often oriented and articulated as supporting children towards becoming productive adults (Gibson et al. 2015). Rehabilitation in Canada often frames *independence*- physical, financial and emotional- as the naturalized ideal. As such, rehabilitation is designed to build up children who can 'carry their own weight' and, moreover, contribute their 'fair share' to society. Commitment to these ideals of individualism and productivity, align squarely with neoliberal ideology, which is the dominant political economy of our time. Indeed, this societal approach has become so hegemonic as to seem natural. Relating this insight back to rehabilitation invites us to both recognize alignments between current practices and a Eurocentric approach, and also to imagine alternatives.

Tensions regarding the role of faith in children's rehabilitation

Dialogue among the Canadian team members about children with disabilities was built on the assumption that rehabilitation is secular and not linked to religion. Conversely, in the Cameroon discussions, the opposite was equally true; that is, the role of religion as part and parcel of rehabilitation was much more visible. Our team was well into the dialogue process when these competing understandings came to light, which offered us the opportunity to ask: What new ways of thinking does this discovery give rise to?

With further exploration on the Canadian side, we were able to clarify that rehabilitation in Canada may not be as secular as it appears at first glance. We noted that spiritual health is a well-accepted part of wellness models and some rehabilitation models (Egan and Delaat, 1994; Kroeker, 1997; Simo-Algado et al. 2002). We also noted that rehabilitation is often delivered at hospitals with explicit religious affiliations. For instance, leading rehabilitation centres in Toronto include St. John's Rehab Hospital, which was founded by an Anglican religious order; St. Michael's Hospital, which was founded by a Catholic order of nuns; and Mt. Sinai Hospital, which was founded by Jewish community leaders. In Canada, the dominant model of secular rehabilitation now means that it can be difficult to discuss the impact of religion on provider-client interactions, client beliefs, values and priorities, and/or providers' religious motivations to work in the field of rehabilitation. Furthermore, within the context of client and family centred care in Canada, families may choose to involve spiritual care providers in health care decision making.

All team members recognized that patients and rehabilitation providers frequently hold religious worldviews that inform their understandings of rehabilitation and disability. Impairments are sometimes seen as the result of lack of faith regardless of geographic location. Families can be blamed for not having enough faith to heal their child. One of our team members who has a disability shared how frequently he has people pray for his impairment to be reversed, and when these efforts are unsuccessful, he is told that he must be still 'paying for a past sin'.

Examination of the role of religion in children's rehabilitation also required historical reflection. In Cameroon, the dominant religions within rehabilitation (e.g. Catholic, Presbyterian, Baptist) were imported during colonization (Ngoh, 2002). Furthermore, their shared key message was salvation and the idea of bringing people out of evil to a place of goodness. Impairments in this context were seen as resulting from evil deeds, and people with impairments as in need of saving. Central to the message was salvation through compassion as a Christian value; compassion and the care of the 'less privileged' was seen as a way to salvation. In Cameroon (and many other African countries), rehabilitation remains the mandate of religious groups who view assisting people with disabilities as necessary charitable work. These groups provide important rehabilitation services to people who would otherwise go unserved. Religion in both Cameroon and Canada also serves a vital function in

health care by providing comfort and a source of hope to clients and families, and has a history of providing needed volunteer services.

Despite these positive contributions of religion to rehabilitation, there are also downsides for care and delivery. First, locating rehabilitation primarily as religious work, exonerates governments and public health systems from taking responsibility for rehabilitation as part of the health and social policy and programming. Second, a religious approach is aligned with a charity or philanthropic view of disability based on sympathy or pity as opposed to a rights-based model based on inherent dignity and worth. As such, the solutions that arise from this framing can miss or discount responses based on shifting societal perspectives and policies. These solutions can also preclude working in equal partnership with people with disabilities due to them being viewed as recipients of charity. In this way, the charitable approach can promote and perpetuate negative attitudes that are themselves disabling. Our dialogue concluded that religion has an important role to play in rehabilitation, but one that we see as augmentative to public health services, rather than instead of them. Moreover, any approach that construes disabled people as objects of pity, whether religious or secular, perpetuates the social exclusion of disabled people and should be reconsidered in light of the principles of the Convention.

Discussion

In this article, we have brought a critical lens to bear on issues related to rehabilitation for children with disabilities. In particular, we have used a postcolonial approach to draw attention to the historic and ongoing influence of colonial power relations and to help understand links between and across Canada and Cameroon. The ideas presented in this article align with the work of Grech (2009, 2011) and others who advocate for the emerging field of Critical Global Disability Studies that aims, in part, to bring the insights of postcolonialism to disability theory (see also Goodley, 2013; Meekosha, 2011). This emerging field calls into question Eurocentric assumptions that have fuelled much of disability studies, to the detriment of people with disabilities in the Global South whose contexts may be vastly different. Furthermore, this emerging field promotes analysis of 'the lasting disabling impact of colonialism' (Meekosha, 2011: 667). We have applied a similar lens to our inquiry of children's rehabilitation. Through our dialogue we sought to surface, name, and describe tensions that typically go hidden from view in order to spur dialogue and new ways of thinking. Ultimately, we sought to uncover these tensions in order to identify important considerations for people working in rehabilitation practice, education, policy, and/or research, wherever they may be located. In this way, the article is intended to be a provocation for better self-reflection on our roles in rehabilitation with children with disabilities.

In particular, our hope is to use these critical reflections to contribute to the idea of *deliberate, reflective practice* (Wilding and Whiteford, 2009) among rehabilitation providers, regardless of where they are in the world. We would like to invite new habits of mind whereby rehabilitation providers become more comfortable asking critical questions of themselves and of their contexts. We promote the idea that paying attention to context frequently surfaces complexity, which reinforces the idea that there is often not just one right answer or way of seeing an issue or interpreting a principle. We promote this skill-set in critical thinking with the goal of better equipping rehabilitation providers to deliver high-quality services that best meet the needs of children with disabilities and their families.

Within our dialogue, we have experienced these tensions as equally applicable within Toronto and Bamenda; indeed, we view our reflections as relevant for rehabilitation providers beyond these settings as well. The reflections have salience given the culturally diverse nature of many countries, including Canada and the likelihood that patient and provider will come from different backgrounds. However, these tensions are also relevant because we all have been shaped by colonization. For people occupying dominant positions (in relation to e.g., ethnicity, class, dis/ability, sexual orientation) it may be more difficult to see how the history of colonization shapes who is privileged or marginalized. Nevertheless, no person lives outside of history or place and their inherent and inherited norms. Furthermore, the dominant Eurocentric orientation of rehabilitation training in Canada and other high-income countries feature prominently in rehabilitation training programmes in the Global South. Therefore, rehabilitation providers in places like Cameroon may be trained in a paradigm that more closely matches a Canadian context. As such, the lines between North and South are increasingly blurred as we consider the implications of using this critical lens, problematizing the overly simplistic binaries of North/ South or us/them.

Postcolonialism is a field with a long history, many branches of thought, and with extensive literatures that cross fields of inquiry. As such, it is both an illuminating and a daunting field. It is important to note that only one of our team members (LC) has formal training in postcolonial theory. Several of us (SAN, LC, BEG, DC) have a growing interest in these ideas and have pursued self-directed learning in recent years, whereas others (KB, PNM) know of the concept but are otherwise new to the ideas, and still others (RA, NS) are new to the academic notion of postcolonialism but (along with PNM) witness the impacts of colonialism in their day-to-day lives in Cameroon. We make this observation to support the potential transferability of this analytic approach to others who may not view themselves as versed in postcolonial theory. Building *our own* capacity was a core aim of this inquiry that we suggest is transferable to any group who, like us nurtures a team climate that makes it possible and common to admit a lack of understanding or voice disagreement.

Various notes of caution should be raised. Some of us shared the fear that using a critical lens would result in a ‘purely academic’ exercise without practical, real-world outcomes. We noted that each of us came from a practical orientation (e.g., as disability advocates, as

rehabilitation providers who want to do a better job in our work with children) and that training in theory is less common for those outside of academia. This concern, in itself, was a tension that we acknowledged; that is, how can people working on the ground, doing the day-to-day work of rehabilitation practice and education, also engage with social theories to inform their thinking? One strategy we used in this inquiry, and would recommend for others, was to spend time clarifying terms to ensure shared understanding. A large part of this conversation was, where possible, avoiding theoretical terms, but rather trying to write and speak plainly, collectively defining phrases such as 'surfacing tensions' throughout our process. This process was not only important to engage team members who are unfamiliar with these approaches, but has also been instructive for the team members who have more experience with theory. Capacity in critical theoretical analysis was built amongst us all; the structured opportunity to think deeply was valued as a gift. As noted, we see great promise in this approach for contributing to reflexive dialogue between smaller groups such as ours that ultimately contribute to larger global conversations towards improving children's rehabilitation.

Conclusion

This article presented the synthesis of a series of interactive dialogues among a team of Cameroonian and Canadian rehabilitation advocates who used a postcolonial lens to identify and reflect on tensions related to rehabilitation for children with disabilities. The five tensions discussed problematized conceptualizations of disability and of client-centred care, the role of pain as a reinforcement tool in rehabilitation, and assumptions about poverty and religion in the context of rehabilitation practice. A key aim was to model the use of a critical lens for thinking about rehabilitation in the hope that readers may apply this approach in their own contexts as a strategy for enhancing reflective and deliberate practice. A more specific implication arose from our discussion of pain in rehabilitation practice, and the need for capacity building among rehabilitation providers in positive, non-punitive strategies for engaging children. In terms of future research, the process used to inform this dialogue proved highly productive. As such, we hope that others will take inspiration for this participatory, inclusive, and dialogic approach to critical inquiry within diverse, international teams. We view this inquiry as an initial step toward a larger empirical research study that examines models of rehabilitation currently in practice in Africa (and potentially other settings in the Global South) regarding the real-world ways in which they engage with both global and local perspectives to shape rehabilitation practices, and to what effect. We believe such an inquiry could provide both south-south and south-north learnings for the field. Overall, we hope this article helps motivate continued inquiry using postcolonial and other critical perspectives on rehabilitation, especially as it relates to children.

Notes

1. We use the term *people with disabilities* rather than *disabled people* in keeping with current usage of the World Health Organization. We acknowledge that the term is contentious. Disability studies scholars have argued that disability is not a condition of individuals as is implied by the phrase *with disabilities* but rather something experienced as a result of social discrimination and exclusion, producing 'disabled people' (Morris 2001).

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