16 Rehabilitation Practice, Employment, and Policy for Rural Development for People with Disabilities in West Africa

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Overview

Too often, rehabilitation researchers and professionals may focus on the rehabilitation needs of persons with disabilities in urban areas of the developing world. However, persons with disabilities in rural areas need more attention as this population has more unmet rehabilitation needs. This chapter explores the issues of rehabilitation for individuals with disabilities in rural West Africa. By reading this chapter, you will gain some foundational information on healthcare and rehabilitation needs of persons with disabilities in West Africa, the challenges and barriers that prevent community inclusion, and the implications of these issues to the rehabilitation professionals.

Learning Objectives

Upon completion of this chapter, the reader will be able to:

1. Describe the countries in West Africa.
2. Identify major barriers facing person with disabilities in West Africa.
3. Describe briefly the healthcare delivery system in West Africa.
4. Understand the barriers faced by peopled with disabilities in the West African region.
5. Describe the strategies to increase service delivery to persons with disabilities.
6. Describe the implications for rehabilitation research and practice.

Introduction

The World Health Organization estimates show that about 15% of the world's population is living with at least one form of disability. In addition, 8% of the world's population of people with disabilities live in developing countries. One of the characteristics of developing nations is extensive rural areas with limited educational, health, and other resources. West Africa has vast rural settings. Therefore, most rural villages in West Africa can be regarded as having typical characteristics of such settings with limited availability of resources. Common among the countries of West Africa is that they are classified as developing countries. Chronic poverty is another characteristic of the countries in West Africa. This region has been described as one of the poorest regions of the world, where

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most of the residents live on less than $2 dollars per day. Those mostly affected by this chronic poverty are individuals with disabilities and children (Plan International Inc., 2013). Poverty has been shown to have a common relationship with disabilities and vice versa. Poverty results in lack of opportunities to education, healthcare services, adequate source of livelihood, and much more (WHO, 2010).

The authors of this chapter want to emphasize the limited literature on issues of rural health and rehabilitation services for people with disabilities in West Africa. There is acute lack of data on people with disabilities in rural West Africa and limited literature on disability-related issues even in urban settings. Much research is needed in West Africa to understand the impacts of disabilities and service needs of individuals with disabilities in this part of the world. Limited data or lack of data on disability in West Africa is not peculiar to just this region; the World Report on Disability (WHO, 2011) reported limited or lack of disability-related data in many developing countries.

West Africa: An Overview of the Countries

West Africa is a geographic location within the continent of Africa. The population of West Africa is approximately one third of the sub-Saharan African population. West Africa is a vast region with vast population of rural dwellers. The region consists of the following 16 countries: Benin, Burkina Faso, Cape Verde, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone, Togo, and Mauritania. Before the twentieth century, West Africa suffered abuse and was victim to both slave trade and colonialism. The location of this region of Africa made it a target for invasion by early explorers (Encyclopaedia Britannica, 2016). Table 16.1 is a representation of some vital information on each country of West Africa.

Disability and Service Delivery in West Africa

The concept of disability varies across societies and is central to the status or position afforded by people with disabilities within that society (Eskay, Onu, Igbo, Obiyo & Ugwuanyi, 2012; Mpofu & Harley, 2002). In West Africa, conceptions of disability are largely influenced by long-held religious beliefs, sociocultural beliefs, and traditional practices that define what is considered normal, abnormal, and acceptable (Eskay et al., 2012). Traditional perceptions in West Africa about disability are metaphysical and spiritual in nature. Hence, this society adopts the religious model of disability whereby disability is viewed as the result of influences of a higher power, evil influences, violations of social norms or disobedience to gods, and reincarnation (Avoke, 2002; Rubin & Roessler, 2008). The religious influence on beliefs about disability results in high demand for religious/spiritual form of intervention and treatment. Thus, treatment for many types of disabilities in the informal sector (outside the healthcare system) centers on casting out the evil forces or trying to appease the gods with the aim of obtaining healing for the individual. Disabilities such as psychiatric or intellectual disabilities have high referrals for traditional and religious healers who often perform some form of religious sacrifices, ceremonies, and exorcisms to appease or ward off the evil spirits (Eaton & Agomoh, 2008; Read, Adiibokah, & Nyame, 2009).

Further, traditional treatment for disability also emphasizes the use of herbs, massage, bone setting, body incisions, and other practices for the treatment of physical and mental disabilities (Borokini & Lawal, 2014). The modern view of disability which is based on a blend of medical and functional model of disability (Smart & Smart, 2006) is becoming the norm. Among many healthcare providers in West Africa, individuals with disabilities are considered as sick, lacking ability or the capacity to perform work or engage in social and economic roles within the range considered normal for a human being. Thus, the focus of disability service delivery is to

Table 16.1 Demographic information of countries in West Africa

Country	Country description	Population	% of rural population	Life expectancy at birth	Education and health	Population of PWD
Benin	The Republic of Benin was a French colony from the late nineteenth century until 1960. Benin consisted of several individual kingdoms prior to colonization	10,783,000	56.9%	Male: 60.1 years Female: 62.9 years	Literacy: % total population aged 15 and above, 42.4% Male literacy: 55.2% Female literacy: 30.3% Health: physicians 334 (1 per 23,256 persons); hospital beds 590 (1 per 11,238 persons)	Data not available
Burkina Faso	Burkina Faso was a French colony until 1960 when it gained its independence. The country was previously known as Upper Volta until 1984 when it changed its name to Burkina Faso	18,450,000	70.1%	Male: 52.4 years Female: 56.5 years	Literacy: % total population aged 15 and above, 28.7% Male literacy: 36.7% Female literacy: 21.6% Health: physicians 838 (1 per 20,006 person); hospital beds 6288 (1 per 2500 persons)	Data not available
Cape Verde	A country comprising of a group of islands that lie 385 miles off the west coast of Africa	525,000	34.5%	Male: 68.5 years Female: 73.0 years	Literacy: % total population aged 15 and above, 87.6% Male literacy:92.1% Female literacy: 83.1% Health: physicians 1314 (1 per 385 persons); hospital beds 1076 (1 per 476 persons)	Data not available

(continued)

Table 16.1 (continued)

Country	Country description	Population	% of rural population	Life expectancy at birth	Education and health	Population of PWD
Cote d'Ivoire	This country became a French colony in 1893 and achieved independence in 1960 (Camhaire, Mundt, & Lawler, 2015)	23,327,000	45.8%	Male: 56.9 years; female: 59.2 years	Literacy: % total population aged 15 and above, 43.1% Male literacy: 53.1% Female literacy: 32.5% Health: physicians, 2825 (1 per 7143 persons); hospital beds 10,825 (1 per 1852 persons)	Data not available
Gambia	Gambia is a virtual enclave in the Republic of Senegal. It is one of the smallest countries in Africa	2,023,000	40.4%	Male: 61.8 years Female: 66.5 years	Literacy: % total population aged 15 and above, 55.5% Male literacy: 63.9% Female literacy: 47.6% Health: physicians 156 (1 per 9769 persons); hospital beds 1221 (1 per 1250 person)	Approximately 15% of population
Ghana	Ghana gained independence from Britain in 1957 and was the first sub-Saharan African country to gain independence	27,635,000	46.0%	Male: 63.0 years Female: 67.7 years	Literacy: % total population aged 15 and above, 67.3% Male literacy: 73.2%; Female literacy: 61.2% Health: physicians 2640 (1 per 9124 persons); hospital beds 22,194 (1 per 1111 persons)	Approximately 10% of population

Country	Country description	Population	% of rural population	Life expectancy at birth	Education and health	Population of PWD
Guinea	Guinea was colonized and ruled by France until 1958, when it became independent	10,961,000	62.8%	Male: 57.6 years Female: 60.7 years	Literacy: % total population aged 15 and above, 41.0% Male literacy: 52.0% Female literacy: 30.0% Health: physicians 818 (1 per 12,504 persons); hospital beds 2999 (1 per 3333 persons)	Approximately 15% of population
Guinea-Bissau	Guinea-Bissau was part of the Portuguese Empire for centuries until it gained independence in 1974	1,732,000	50.7%	Male: 47.9 years Female: 51.9 years	Literacy: % total population aged 15 and above, 59.9% Male literacy: 71.8% Female literacy: 48.3% Health: physicians 332 (1 per 5007 persons); hospital beds 16,042 (1 per 104 persons)	Data not available
Liberia	The Republic of Liberia is Africa's oldest republic. The colony was founded in 1816 for the freed American and Caribbean slaves. In 2005, Liberia became the first African country to have a female president	4,200,000	50.3%	Male: 56.0 years Female: 69.0 years	Literacy: % total population aged 15 and above, 47.7% Male literacy: 64.7% Female literacy: 44.0%	Approximately 16% of population

(continued)

Table 16.1 (continued)

Country	Country description	Population	% of rural population	Life expectancy at birth	Education and health	Population of PWD
Mali	Mali is a landlocked country of West Africa. It is one of the largest countries in Africa but with a small population	16,956,000	60.0%	Male: 52.8 years Female: 56.4 years	Literacy: % total population aged 15 and above, 31.1% Male literacy: 43.4% Female literacy: 20.3% Health: physicians 1053 (1 per 10,566); hospital beds 1664 (1 per 6203 persons)	Data not available
Niger	The Republic of Niger is an arid state that is located at the edge of the Sahara desert	18,882,000	81.3%	Male: 53.2 years Female: 55.6 years	Literacy: % total population aged 15 and above, 15.5% Male literacy: 23.3% Female literacy: 8.9% Health: physicians 1029 (1 per 16,673 person); hospital beds 3805 (1 per 3935 persons)	Data not available
Nigeria	Nigeria is the most populous country in Africa. This country was colonized by Britain and got its independence in 1960	181,562,000	52.2%	Male: 51.3 years Female: 53.2 years	Literacy: % total population aged 15 and above, 59.6% Male literacy: 59.6% Female literacy: 49.7% Health: physicians 58,360 (1 per 2698 persons); hospital beds 85,523 (1 per 1609 persons).	Approximately 14% of population
Republic of Senegal	Received independence in 1960 from France. Stable democratic government	14,151,000	56.3%	Male: 58.9 years Female: 63.0 years	Literacy: % of total population aged 15 and over, 57.7% Male literacy: 69.7% Female literacy: 46.6% Health: physicians 253 (1 per 49,975); hospital beds 27,816 (1 per 454 persons)	Approximately 200,00

Country	Country description	Population	% of rural population	Life expectancy at birth	Education and health	Population of PWD
Sierra Leone	Sierra Leone was colonized and ruled by Britain until 1961. The colony was founded by a British organization in 1792 for individuals freed from slavery in America	6,319,000	60.1%	Male: 54.9 years Female: 60.0 years	Literacy: % total population aged 15 and above, 48.1% Male literacy 48.1% Female literacy 37.7% Health: physicians 115 (1 per 50,017 persons); hospital beds 1174 (1 per 5000 persons)	Approximately 450,000
Togo	Togo is a country in West Africa located on a narrow strip of land between Burkina Faso, Benin, and Ghana. It gained its independence in 1960 from France	7,059,000	60.0%	Male: 61.5 years Female: 66.7 years	Literacy: % total population aged 15 and above, 66.5% Male literacy: 78.3% Female literacy: 55.3% Health: physicians 648 (1 per 10,001 persons); hospital beds 4411 (1 per 1429 persons)	Data not available
Mauritania		3,767,000	40.1	Male: 59.7 years Female: 64.2 years	Literacy: % total population aged 15 and above, 58.0% Male literacy: 64.9% Female literacy: 51.2% Health: physicians 445 (1 per 7202 persons); hospital beds 1252 (1 per 2450 persons)	Data not available

Sources: Encyclopaedia Britannica (2016) and World Bank (2016)

provide basic medical, educational, and vocational support and vocational support and training that assist persons with disability to achieve some level of functioning and social integration (Obiakor & Afolayan, 2012). All the West African countries lack functional disability-specific service delivery system especially in the areas of education, employment, and transportation and in other vital participation domains even in the urban cities.

Influence of Colonization and Religion on Service Delivery

Formal disability services in West Africa began as part of a rehabilitation program for African soldiers who acquired disability during combat in World War II (Grischow, 2014). This initiative was based on the social model of disability with an attempt to socially and economically reintegrate these individuals into the workforce. At its inception, only soldiers from the former Gold Coast (now Ghana) were targeted for vocational rehabilitation and placement in urban labor markets or sheltered workshops. Soldiers with temporary or partial disabilities were taught trades in occupations that they could pursue individually or in a sheltered workshop or in government employment, whereas soldiers with permanent disabilities were placed in long-term care or asked to return to their families. By mid-1945, soldiers from other West African countries such as Nigeria, the Gambia, and Sierra Leone, including civilians, were included in the program. However, the program lost its momentum and was abandoned by the colonial government in 1947 (Grischow, 2014). During the late 1950s and early 1960s, the then president of Ghana, Kwame Nkrumah, revived this vocational rehabilitation program and achieved much success that led to extension of the program to the rural areas of the country. The focus of this early rehabilitation program was on basic skills training in the areas of carpentry, metalworking, and farm gardening (Ghana Department of Social Welfare and Community Development [GDSWCD], 1966).

Between the years 1945 and 1970, church missions were the mainspring behind the establishment and maintenance of disability and social programs for children and adults with disabilities in Nigeria (Garuba, 2003). The missionaries were the first to introduce schools for the deaf and the blind across the country (Obiakor & Offor, 2011). Following the Nigerian Civil War (1967–1969) which resulted in a higher incidence rate of disabilities, the federal government of Nigeria increased their attention toward issues of disability. For instance, as an initial effort, the government took over the missionary schools and released a national policy on education emphasizing the need of special education (Garuba, 2003). Over time, the government increased the number of schools, community-based vocational rehabilitation centers, and workshops, for individuals with physical, visual, and hearing disabilities, with a view to assisting them secure sustainable long-term employment (Obiakor & Offor, 2011; Renne, 2013). Currently, colonization has a significant influence in the pattern, availability, and delivery of disability services in West Africa (Obiakor & Afolayan, 2012). For instance, a significant part of the service delivery framework used in both the public sector and private rehabilitation institutions is based on the model used by the missionaries in their vocational centers and mission schools.

Impacts of Nongovernmental Organizations (NGOs) on Service Delivery

There is gross lack of affordable and appropriate disability services for individuals at the state and local levels in Nigeria as well as in the other countries of West Africa (Lang & Upah, 2008). The few disability-related organizations and services for people with disabilities are located in the urban cities. The bulk of disability and rehabilitation services are typically provided by private institutions such as religious organizations and nongovernmental agencies (NGOs). NGOs provide direct support services to people with disabilities to enhance their ability to

achieve economic self-sufficiency and community inclusion. NGOs work with organizations of people with disabilities to facilitate advocacy and human rights activities (Lang & Upah, 2008). In Guinea, Ghana, Sierra Leone, and Liberia, Christian Blind Mission International (CBM) supports work related to disability, including medical services, education, and rehabilitation for people with disabilities (mainly for people with visual disabilities, hearing disabilities, physical disabilities, mental disabilities, or intellectual disabilities) (UNHCR, 2008). During the recent Ebola virus outbreak in some parts of West Africa, missionary groups from various organizations, including Samaritan's Purse and Catholic Relief Services, worked alongside doctors, nurses, and relief workers to eradicate Ebola crisis in Liberia, Guinea, and Sierra Leone (Dianna, 2014). Handicap International helped prevent Ebola by ensuring Sierra Leone citizens are informed and educated about Ebola (Handicapped International, 2016).

Some charitable organizations have also played crucial roles in championing the causes of disabilities, especially for certain types of disabilities (e.g., severe visual impairments). For example, in Sierra Leone, the UK Association for the Blind supports the Milton Margai School for the Blind (Open Charity, 2010; The UK Association for the Blind in Sierra Leone, 2010). In Guinea, Disabled Peoples' International (DPI) has promoted human rights of persons with disabilities through full participation and equalization of opportunity and development (UNHCR, 2008). In Ghana, Action on Disability and Development-Ghana empowers women with disabilities to take part in the decision-making process within both the disability movement and the mainstream women's movement in order to explore and solve issues pertinent to women. Also, the Italian Association Amici di Raoul Follereau (AIFO) supports persons with disabilities and the poor and vulnerable group through community-based rehabilitation (Naami & Hayashi; UNHCR, 2008). For example, in Liberia and Senegal, Handicap International through their efforts in preventing disability and disease, community health services, and provision of psychological support for individuals with disabilities (Handicap International, 2015).

The services provided to people with disabilities in West Africa are desirable as well as commendable; unfortunately, the predominant disability model used in service delivery in some of these NGOs is the tragedy or charity model which espouses that individuals with disabilities are victims of circumstances that:

1. Deserve pity and compassion
2. Incapable of taking care of themselves or managing their own affairs
3. Should be supported with charitable donations to meet their economic and social obligations (Nikora, Karapu, Hickey, & Te Awekotuku, 2004)

Government and Government Policies

Government support in terms of funding and provision of a sociopolitical policy framework that addresses disability issues is very minimal in countries in West Africa (Lang & Upah, 2008; Tinney, Chiodo, Haig & Wiredu, 2007). Medical rehabilitation facilities are scarce and in a parlous state (Eaton & Agomoh, 2008; Tinney et al., 2007), and vocational rehabilitation facilities and special education programs are poorly funded and under-managed (Obiakor & Offor, 2011). Additionally, in both Nigeria and Ghana, the Ministry of Social Welfare, not the Ministry of Health, is a primary government agency responsible for disability issues. Within this framework, the government's approach to disability service provision is guided by the underlying ideological belief that disability issues should be addressed through charity and welfare (Lang &Upah, 2008; Tinney et al., 2007). In 1993, the Nigerians with Disability Decree (1993) was promulgated, but no policies were formulated to enable its implementation.

All the countries in West Africa have either signed or ratified the UN Convention on the Rights of Persons with Disabilities (including the optional protocol) (United Nations, 2016).

Before the existence of the Convention, there is no disability legislation that provides a framework for the delivery of disability services and prohibition of discrimination and ensures equal rights and access to opportunities for persons with disability (Akhidenor, 2007; Eaton & Agomoh, 2006). While many West African countries are in some respect in line with the UN Convention on the Rights of Persons with Disabilities, yet the impacts of the Convention is yet to be noticed in West Africa. Most developmental efforts in this region have been in urban areas, with little, if any, attention to rural areas, where health, both physical and mental, and educational resources for persons with disabilities are unavailable (Children in Crisis, 2013). Yet, the percent of the rural population compared to the urban residents of West African countries is very high (see Table 16.1 for percent for rural population), and resources are barely available in rural areas (World Bank, 2016). Presently, there is no disability infrastructure or support system in public institutions including schools, recreation facilities, and places of work; thus, persons with disability are not well integrated into the society. This is especially the case for the vast majority of Nigerians with disabilities, especially those living in rural areas (Lang & Upah, 2008).

The Ghanaian government legislated disability policy includes the 1992 Constitution, the Persons with Disability Act of 2006, and the Mental Health Act of 2012 (Doku, Wusu-Takyi, & Awakame, 2012). Similar to other West African countries, implementation of these policies has been largely hampered by political, organizational, and structural problems, as well as sociocultural beliefs. Tijm et al. (2011) emphasizes that the realization of disability policy in Ghana will depend on the changes in both the physical and social environments. In Sierra Leone, the government has supported the Milton Margai School for the Blind that was founded in 1956 by Wilhemina Johnson, who had a certificate in special education from the United Kingdom and who herself had visual impairment (Open Charity, 2010; UK Association for the Blind in Sierra Leone, 2010). The 1991 Constitution of Sierra Leone provides protection for the rights of persons with disabilities in such areas as welfare and educational opportunities. The countries of West Africa need to commit to a system-wide implementation of disability legislations including building of accessible public infrastructure to increase the community participation and inclusion of persons with disabilities. It is worth noting that the UN, in its efforts to champion the right and protection of persons with disabilities, has positively influence West African policies related to person with disabilities. The UN Convention on the Right of Persons with Disabilities has set the stage for countries to change discriminatory practices against persons with disabilities (Disabled World, 2016).

Employment and People with Disabilities in West Africa

Persons with disabilities in rural West African areas are hardworking citizens of their various countries. Many of these individuals are not literate due to lack of opportunities and inaccessible educational environment and programs. Despite multifaceted barriers encountered daily by these individuals with disabilities in the rural villages, some of these individuals strive to survive and even contribute to the economy of their communities. These individuals can be seen working in farms, engaging in various productive activities including cobbling, begging for livelihood in the market places, weaving mats, and engaging in other activities in order to provide daily food for themselves and their families. It is noteworthy to emphasize here that the living situations and daily barriers in these rural villages hinder self-actualization, well-being, and quality of life of persons with disabilities in rural West Africa.

The major parts of these barriers are lack of assistive technology such as wheelchairs for community participation of these individuals and limited availability and in most cases none existence of rehabilitation programs to assist with education of children with disabilities. For example, a Sierra Leone study shows that children with disabilities are much less likely to attend school than children without disabilities. The chances of attending school become even slimmer if that person is

a girl with a disability (World Bank, 2009). Without proper skill training and education, people with disabilities in rural West Africa do not have any chance of securing meaningful employment, getting out of poverty, and enjoyment of a better quality of life. Issues related to employment of persons with disabilities in rural areas of West Africa can be managed using the concepts and principles of community-based rehabilitation (CBR). (See section on CBR for more detailed discussion of the CBR concepts.)

Barriers to Service Delivery for People with Disabilities in West Africa

Access to healthcare services is indispensable in meeting health-related human right (World Health Organization, 2008). Despite the obvious importance of health as a right, many citizens of the world, especially those in the developing countries, do not have access to healthcare services. The World Health Organization's (WHO, 2010) report emphasized the healthcare services and health workforce crisis in most of the sub-Saharan Africa. All the countries in West Africa fall under the developing country category; hence, the healthcare system in most of these countries is still developing and is understudied. West African countries face healthcare and service-related crisis due to many factors such as the ones discussed in this chapter. The healthcare and service-related crisis are most pronounced in rural and remote areas or villages. For instance, Awofeso (2010) reported that about 52% of the Nigeria population live in rural villages with limited and in most cases absent of healthcare infrastructures. Many barriers to services to individuals with disabilities exist in all West African countries. Some of these barriers are highlighted as follows:

Belief System and Attitude Toward Disability

Belief system influences attitude of any individual. The beliefs of someone on an issue can result either in positive or negative attitudes toward that same issue. The beliefs of rural West African villagers about disability are influence by prevailing philosophies on the meaning of disability. According to Umeasiegbu, Mpofu, and Johnson (2012), religious and cultural beliefs are important factors toward access to community resources to individuals with disabilities. Traditional values and practices, rituals, norms, and expectations are some of the factors that "pose barriers to community participation" (p. 107) to different areas of village life for persons with disabilities. In most countries in West Africa, there are superstitious beliefs about disability. The superstitious beliefs include that disability is act of God (e.g., punishment for sin committed) or the result of witchcraft or evil spirit or unfinished issue from past life (for some traditional West African religion who believe in reincarnation). "Many such cultural and religious beliefs are associated with stigma and shame for people with disabilities and their families. Culture and religious beliefs can perpetuate myths, stereotypes, and other negative attitudes of the society" (Umeasiegbu et al., 2012, p. 107). Belief and perceptions about disability in West Africa are much diversified, a mixture of positive and negative perceptions and beliefs. According to Wright (1960), some villages in Benin regard children born with disabilities as protected by supernatural power, while in some tribes in Nigeria, reactions to childhood disabilities vary from overprotection to total rejection. Among the Ashanti tribe of central Ghana, it is traditional to preclude men with physical disabilities from performing community leadership such as becoming chiefs. Disability, such as epilepsy, is enough ground to destool a chief from office (Sarpong, 1974). Moreover, some Christian churches in Nigeria still regard PWDs in need of prayer in order to be delivered from evil spirits, which is believed to have caused the disability. Such beliefs are barriers to seeking medical care and rehabilitation. Munyi (2012) stated that the "desire to avoid whatever is associated with disability has affected people's attitudes towards people with disabilities simply because disability is associated with evil. Most of these negative attitudes are mere misconceptions that stem from lack of proper understanding of disabilities and how they affect functioning" (p. 3).

Lack of Policy Implementation

Many countries in Africa have adopted policies and legislation aiming at the promotion of human rights for people with disabilities. These West African countries have disability-related legislations on "paper," but the implementation of such disability legislation is lacking in most of these countries. Some countries within the region such as Sierra Leone have a developing disability legislation. Countries in West Africa have neglected the human rights of individuals with disabilities. Umeasiegbu, Bishop, and Mpofu (2013) stated that "the mere existence of formal recognitions in constitutions…do not necessarily lead or equate to implementation; the rights of persons with disabilities have consistently and continually been inadequately recognized or protected" (UN, 2010). Obviously, the rights of person with disabilities in the West African region have been denied leading to abuse, discrimination, lack of access to built and natural environment, and exclusion from educational and economic participation. One of the reasons for non-implementation of disability-related legislation in this region is the lack of "godfathers" for people with disabilities within the political system of these countries. The governments of these countries are not interested in the welfare of individuals with disability. Unfortunately, this population does not have "voice" nor political power within the government of their respective countries.

Change is gradually coming to this African region. Currently, most countries in West Africa have ratified the United Nations' Convention on the Rights of Persons with Disabilities (CRPD). The signing and ratification of this international convention by these developing countries are applauded. Signatory and ratification of international disability convention should not be the end of the action by these countries. The CRPD is an international convention adopted by the United Nations' General Assembly on December 13, 2006. The goal of the CRPD is "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity" (United Nations, 2006, Article 1., para. 1). The essential principles of the CPRD include (a) respect for inherent and individual autonomy, (a) nondiscrimination, (c) full participation and inclusion in the society, (d) equality of opportunity and accessibility, (e) equality between men and women, and (f) respect for the evolving capacities of children with disabilities and respect for the rights of children with disabilities to preserve their identity (Umeasiegbu et al., 2012; UN, 2006; WHO, 2010).

Chronic Poverty

Chronic poverty is endemic in West Africa. For example, Sierra Leone is regarded as one of the poorest countries in the world despite that the country is rich in natural resources. Disability and poverty are said to go together as both conditions have direct impacts on each other (World Bank, 2009). The presence of a disability in a family compounds poverty status of the family. Disability is generally expensive, and hence, the little resources of the family are spent on food rather than on the needs of the family member with the disability. Social support from the government is mostly absent in countries in West Africa; therefore, the burden for caring for the person with a disability is solely on the family. Most people with disabilities and their families are the poorest of the poor. It is common to see individuals with different types of disabilities on the streets of urban cities begging for money. Many individuals with disabilities do not have access to assistive technology such as wheelchairs, braille materials, and others. The lack of resources to acquire assistive technology and obtain education and other necessities of life prevents general community participation of people with disabilities. Poverty among women and girls with disabilities is worse than among men with disabilities. For example, in Eastern Nigeria, it is traditional for male children to receive inheritance from their fathers. Female children are denied such inheritance. Therefore, women and girls with disabilities are disempowered by this tradition (Umeasiegbu & Harley, 2014).

Strategic Approaches to Enhancing Service Delivery for People with Disabilities

Enhancing service delivery for the rural populations of people with disabilities in West Africa is not impossible, but to achieve these, coordinated efforts by the various country governments are required. This section discusses some of the strategies that may improve the provision of services for individuals with disabilities residing in rural communities. The strategies to accomplish this goal include (a) implementation of country and international disability-related laws, policies, and legislation, (b) awareness creation about disability, (c) establishment of funds to mainstream disability issues into the society, (d) advocacy efforts, and (e) increase resources and infrastructures.

Legislative Implementation and Monitoring

A major barrier to service delivery to individuals with disabilities in West Africa is the lack of implementation of existing legislations and, worse still, the nonexistence of such disability legislations. Any law or legislation is devoid of its power without the implementation of such law. Countries in the West African region need effective implementation of existing disability laws, amendment of laws that are lacking essential components, and enactment of laws where there are no such laws. The governments of various countries in this region need to be held accountable for implementation of legislations. The signatory and ratification of the CRPD by the countries in West Africa are progressing toward human rights recognition of people with disabilities and future improvement in service delivery both to persons with disabilities in the rural, suburban, and urban areas. Effective policy implementation may not happen overnight, but with advocacy, these countries will progress toward societal inclusion of people with disabilities.

The UN's CRPD requires that monitoring of the implementation violation of the CRPD be carried out for each UN member state who ratified the convention. The monitoring is undertaken through reports from the UN member states, organizations of people with disabilities, human right organizations, the UN, and other organizations (UN, 2010). The CRPD implementation and monitoring are still emerging issues which will fully develop overtime. Currently, the criteria for evaluating or assessing a country's implementation are not well understood in terms of the evaluation for developed and developing countries. It is obvious that many developed countries have robust disability legislations and implementation of such legislations and, therefore, different levels of evaluation may be necessary. The story is not the same for many of the West African countries who have very little or nothing in terms of established disability legislation implementation.

Strategic Plan for Action. A vital step toward implementation of disability-related local and international policies is the setting of national agenda by individual West African countries. Umeasiegbu and Harley (2014, p. 127) recommended that for effective societal inclusion of people with disabilities, each country's government needs "to identify strategies for implementation and monitoring of the …CRPD by incorporating it into their developmental efforts at all levels of organizational structure, policy formation, economic priority, cultural and community pursuits, and educational opportunities."

Awareness Creation on Disability

There are many traditionally held beliefs, values, and customs that are detrimental to individuals with disabilities and disability-related development in the West African region. Sometimes myths and stereotypical beliefs about disability are maintained as culture. Some of these cultural practices in fact cause disabilities. For instance, some tribes in Nigeria practice female genital cutting, otherwise known as female circumcision. Female circumcision may lead to sexual-related dysfunctions and psychological problems in women and girls.

Disability awareness is needed both in urban and rural areas. There is need for awareness about the causes of disability, such as that disability may result from medical condition and diseases, wars, accidents, and others. Awareness should also focus on how social conditions or situations can worsen or improve the situation of people with disabilities. The country governments, community leaders/elders, religious leaders, healthcare professionals, teachers, nongovernmental organization, and organizations of people with disabilities need to be involved in this awareness creation campaign. Children with disabilities especially girls in rural areas of West Africa are less likely to go to school as the results of their disabilities and shame by family members. Many families with children with disabilities feel ashamed about the disability status of the family members. One of the ways these families deal with this shame is to hide that family member from the public, including exclusion from participation in school, church, and family social occasions. Creating awareness about the need to seek medical help, school attendance, and employment are crucial to independence and community participation of individuals with disabilities. According to the WHO (2010), awareness raising enables people to recognize opportunities for change. "Raising awareness in families and communities about disability issues and human rights can also help to remove barriers for people with disabilities so they have greater freedom for participation and decision-making" (Empowerment component, p. 4).

Advocacy for Social Justice in Service Delivery

Social injustice against persons with disabilities is common in all the countries of West Africa. Injustice is seen in every facet of life and unfortunately even considered the norm. In order to tackle the multi-faced problems confronting persons with disabilities, access to social justice becomes paramount. Advocacy and social justice systems that redress the injustices and address needs of people with disabilities are urgently needed. People with disabilities need representations in all the ministries (justice, health, education, social affairs, finance, transportation, and others) of their country's government.

The CRPD is an instrument for national and international advocacy and provides background information and instructions on various areas of needs that can be the focus of advocacy efforts. Each country will need the formation of disability advisory council which will focus on immediate issues of injustices and how to remedy unfair situations. The civil society groups and organizations of people with disabilities should be represented on the country's disability advisory council. Local and international NGOs have tremendous roles to play in advancing social justice and service delivery for people with disabilities in West Africa.

Community-Based Rehabilitation

The use of community-based rehabilitation (CBR) as a form of service delivery for PWDs is of particular importance for individuals residing in rural areas within West Africa. CBR is an innovative concept first initiated by the WHO (2010) as a follow-up to the 1978 International Conference on Primary Health Care and the Declaration of Alma-Ata. The Alma-Ata Declaration was the first international advocacy effort on primary healthcare (the *health for all* strategy) by the WHO. CBR involves collaborative efforts from the WHO, United Nations (UN), nongovernmental organizations, and local institutes of PWDs. Initially the CBR "was primarily a service delivery method making optimum use of primary health care and community resources and was aimed at bringing primary health care and rehabilitation services closer to people with disabilities, especially in low-income countries" (WHO, 2010, p. 23).

In recent years, CBR model of service delivery for PWDs has expanded into five interactive and complex components (known as CBR matrix) which includes health, education, livelihood, social, and empowerment. A highly recommended read on CBR is the WHO's (2010) publication entitled *Community-based Rehabilitation: CBR Guidelines.* The WHO's CBR Guidelines emphasize.

Education for People with Disabilities

Education is an important agency for individual and national development. Education is a force for self-reliance, poverty reduction, promotion of quality of life, and sustainable development (Umeasiegbu & Harley, 2014; UNICEF, 2016).

According to Umeasiegbu and Harley (2014, p. 119), "education empowers" people "with disabilities to get involved in their health care needs, be self-advocates, and participate in community development."

International Collaboration Recommendations

Africa is one of the parts of the world that remains grossly unexplored in terms of disability and rehabilitation-related research, practices, and education. West Africa provides unique opportunities for exploration and applications of rehabilitation counseling research, education, and practice. The authors of this chapter see the expansion of rehabilitation counseling profession through global collaboration in West Africa. Discussed in this section are ideas for international collaboration in West African countries. Suggested ideas for collaboration include collaborative advocacy efforts, research, education, and rehabilitation practice exchange program.

Collaborative Advocacy Efforts

One of the important events of the twenty-first century for the disability community is the institution of the Convention on the Rights of Persons with Disabilities (CRPD) by the United Nations (2006). The purpose of the CRPD is to promote and protect the rights of individuals with disabilities and to increase their participation in the society. The CRPD presents the opportunities for rehabilitation counseling profession to be involved in the fostering of global inclusion of people with disabilities. There is need for new objectives toward the development of global rehabilitation intervention that will increase advocacy and social justice for people with disabilities.

The rehabilitation profession can play unique roles in advancing global social justice, equity, and advocacy for persons with disabilities. International advocacy can be achieved in numerous ways including involvement in international organizations such as the WHO, UN, International Labour Organization (ILO), Rehabilitation International, World Bank, and others. These international organizations are involved in global collaborative development efforts with countries, including countries in West Africa. For instance, graduate students in rehabilitation counseling can seek internship opportunities with these international organizations. Internship with such international organizations will provide opportunity to learn about global disability policies and rehabilitation needs of individuals with disabilities in the West African region and hence may increase interest in international advocacy work. Such interns may be assigned by the international organization to work with a country's government on issues of human rights, policy development and implementation, education of children with disabilities, access to healthcare services, employment, or other capacity development efforts.

Collaboration in Research

In 2014, the WHO (2014) released a new document entitled *WHO Global Disability Action Plan 2014–2021: Better Health for all People with Disability.* The WHO action plan includes three objectives: "(1) to remove barriers and improve access to health services and programs; (2) to strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation; and (3) to strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services" (p. 5). The rehabilitation professional has relevant obligation to assist in the fulfillment of these global objectives. Rehabilitation counselor educators especially are dedicated to research that improves the quality of life of persons with disabilities; hence, the WHO action plan creates opportunities for international research by rehabilitation professionals.

Opportunities for original research abound in West Africa especially in the rural villages with a large population of individuals with different types of disabilities. Many dimensions of disability remain unexplored; hence, West Africa is an excellent "laboratory" for disability-related research. Researchers interested in conducting research in West Africa will need to develop partnerships with researchers of African descent and various NGOs and organizations of persons with disabilities who are already doing advocacy and developmental work in those areas and, therefore, have knowledge of the areas. A major challenge for international research is obtaining the needed funding from grant awarding agencies. Funders may have priority areas and interests that may differ from the researchers' interests. Nonetheless, sources for international research may include organizations such as the government of the African country, Fogarty International Center, American Association of University Women, American Psychological Association (international funding and awards), Fulbright Program, Baxter International Foundation, US Department for International Development (USAID), Department for International Development (DFID), and others.

Capacity Building in Rehabilitation

One of the ways to strengthen and improve service delivery in rural West African communities is through capacity building. Capacity building is defined by the WHO (2016, para. 3) as "the development and strengthening of human and institutional resources." Both human and institutional resources are lacking in both urban and rural West African areas. There is acute shortage of healthcare service providers. The available service providers are concentrated in urban areas where hospitals and clinics are mostly located. The few clinics in the rural areas are not adequately equipped for even minimal service provision.

At national levels, many of these countries are poor and do not have the resources and support services to provide assistance for their citizens with disabilities. Developed countries "rely on clinically trained professionals for service delivery in a structured setting, but in developing countries, rehabilitation is mostly by families in unstructured settings" (Umeasiegbu et al., 2013, p. 108., as cited in Mpofu & Harley, 2002). The shortage of healthcare providers in most countries of the developing world is a limitation to service delivery to persons with disabilities. Moreover, most healthcare providers in West Africa practice their profession based on medical model of disability as opposed to social model. Many healthcare providers are not trained in the areas of psychosocial impacts of disability and may not even be familiar with rehabilitation needs of persons with disabilities.

Rehabilitation counselors are knowledgeable on psychosocial implications of disability and hence in a better position to provide international capacity building (training, education, and consultations) to healthcare providers, NGOs, government officials, and persons with disabilities and their families. Bentley, LeBlanc, Bruyère, and MacLachlan (2016) described an international capacity building initiative between Johns Hopkins International Injury Research Unit and Makerere University in Uganda, East Africa, thus:

> The project aims to strengthen trauma, injury, and disability research and educational capacity in Uganda. Aims of the project are to develop a core group of researchers at Makerere University, promote research around key national priorities, establish a national forum, and create a research locus/program…The expected outcome will be a sustainable research enterprise that is for Ugandans by Ugandans with the technical assistance of Johns Hopkins as a partner institution (p. 72).

Rehabilitation Exchange Programs

The partnership between Johns Hopkins International Injury Research Unit and Makerere University, Uganda, is also an example of some form of exchange program in some ways. Exchange programs provide opportunities for rehabilitation professionals, educators, researchers, and students to visit developing countries such as countries in West Africa to provide services such as direct counseling and interventions, research, education and training, and engagement in policy

development and implementation. Rehabilitation educators can participate in exchange program using their sabbatical or other research opportunities.

Summary

Individuals with disabilities in West Africa face multiple challenges due to multiple problems such as lack of implementation of disability-related legislations, poverty, and absence of resources. These challenges are made worse by residing in rural areas of West Africa. These challenges can be ameliorated by strategic plans by the countries of the region and their international allies such as rehabilitation professionals.

Resources

The following websites provide additional information or resources:

1. World Health Organization's Regional Office for Africa: http://www.afro.who.int/index.php
2. United Nations Office for West Africa: http://unowa.unmissions.org/
3. United Nations Convention on the Rights of Persons with Disabilities: https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html
4. World Health Organization's World Report on Disability: http://www.who.int/disabilities/world_report/2011/report/en/
5. World Health Organization's community-based rehabilitation (CBR): http://www.who.int/disabilities/cbr/en/
6. World Bank Disability and Development: http://www.worldbank.org/en/topic/disability/overview

Learning Exercises

1. Identify one nongovernmental organization (NGO) in West Africa, and learn about its work. Compare this NGO with a nonprofit organization in your community. What are the similarities and differences between these organizations?
2. The world is now a "global village" due to increased technology such as the Internet. Watch or listen to international news through organizations such as CNN International and BBC. What have you learnt about our world? In what ways can you make a difference in the lives of the world citizens who have disabilities?
3. Read about the United Nations Convention on the Rights of Persons with Disabilities (CRPD): https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html. What has your country done about the CRPD? How can you apply the principles of the CRPD in your research and practice?

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