



Policy paper
(supplement)

Types and modalities of training for physical and functional rehabilitation professionals

Rehabilitation Services Unit
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Foreword

Professional skill-building is an essential component of Handicap International's strategy of supporting capacity-building for local actors and professionals providing care to people with disabilities.

For the past several years, Handicap International has been supporting the emergence and development of rehabilitation-related training pathways as a way to contribute to the creation and viability of quality rehabilitation services, and access to them, in reconstruction and development contexts.

Ensuring the relevance, quality, effectiveness, sustainability, effect and impact of:

- core training;
- upgrade training;
- continuing education;
- post-training, including a continuing education programme;
- training of trainers;
- each of the various training modalities, i.e., classroom, distance learning, etc.

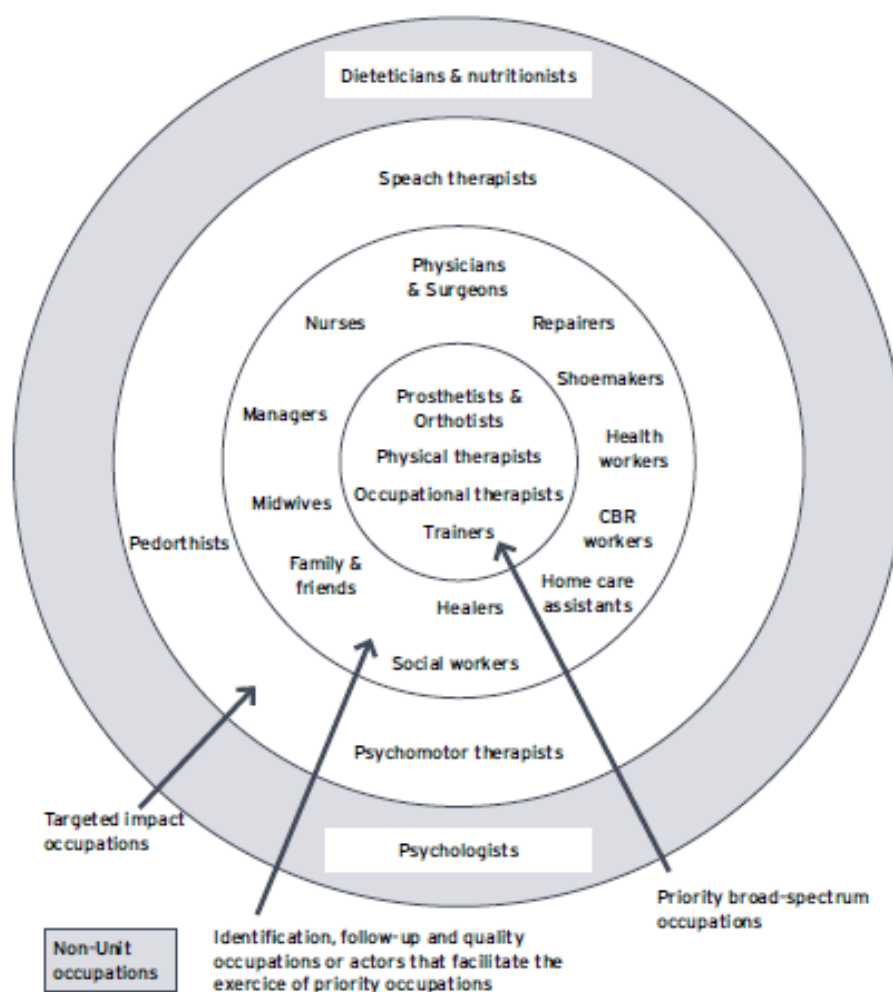
...requires greater attention to team capacity-building.

An external cross-cutting evaluation¹ of Handicap International-sponsored rehabilitation training programmes in five countries, conducted in 2015, allowed an in-depth analysis of Handicap International's training practices and positioning in a variety of intervention contexts. Its recommendations and discussion of lessons learned served as the basis for this supplementary policy paper on training actions for rehabilitation professionals. The evaluation looked only at what Handicap International considers core target occupations (see the diagram on the next page, from the "Physical and Functional Rehabilitation" policy paper²).

¹ Evaluation conducted by STEPS Consulting Social for Handicap International in Burundi, China, Haiti, the DRC, and Rwanda – Available in the [toolbox](#).

² [Physical and Functional Rehabilitation](#) Policy paper - Page 54

Hierarchy of physical and functional rehabilitation-related occupations








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A word of caution

- This booklet is a supplement to the 2013 policy paper on “Physical and Functional Rehabilitation”, which describes Handicap International’s institutional positioning in this domain and the “wide-angle” intervention modalities for training physical and functional rehabilitation professionals. This supplement on the types and modalities of intervention is not, on its own, sufficient.
- This policy paper supplement is intended primarily for an internal Handicap International audience.
- It will focus mainly on training for what are considered priority occupations, that is, the ones that make it possible to meet the broadest range of needs (impact), such as physiotherapy, occupational therapy, and orthopaedic fitting. Training for any other rehabilitation-related occupation must be justified by a situation analysis that validates its relevance; in addition, the “priority” occupations – and a high quality training curriculum for them³ – must already exist.
- Most of the examples come from the 2015 external cross-cutting evaluation and so do not represent all of HI’s current and past training experiences, but they do illustrate the significant ones.
- Although its title indicates that this document focuses on training in the field of rehabilitation, the process can be transferred to another of the association’s areas of activity.

Sidebar legend:

-  : **Caution points**
-  : **Memo - Questions for defining decision criteria**
-  : **Handicap International’s added value**
-  : **Recommendations**
-  : **Examples**

³ According to the [Physical and Functional Rehabilitation](#) policy paper.

Principles and benchmarks

The term “training for rehabilitation professionals” can cover vastly different realities, and so it would be helpful to clarify the possible strategies.

The first part of this policy paper will explain those mechanisms (with few examples) to facilitate a shared understanding.

Later, using findings from the situation analysis confirming (or not):

- the needs in terms of certain types of rehabilitation professionals;
- the interest of the authorities directly concerned by the training; and
- the employability options, among other things;

... the key concepts will be contextualised, in order to guide the decision to intervene and the development of appropriate training strategies.

1. The different types of professional training

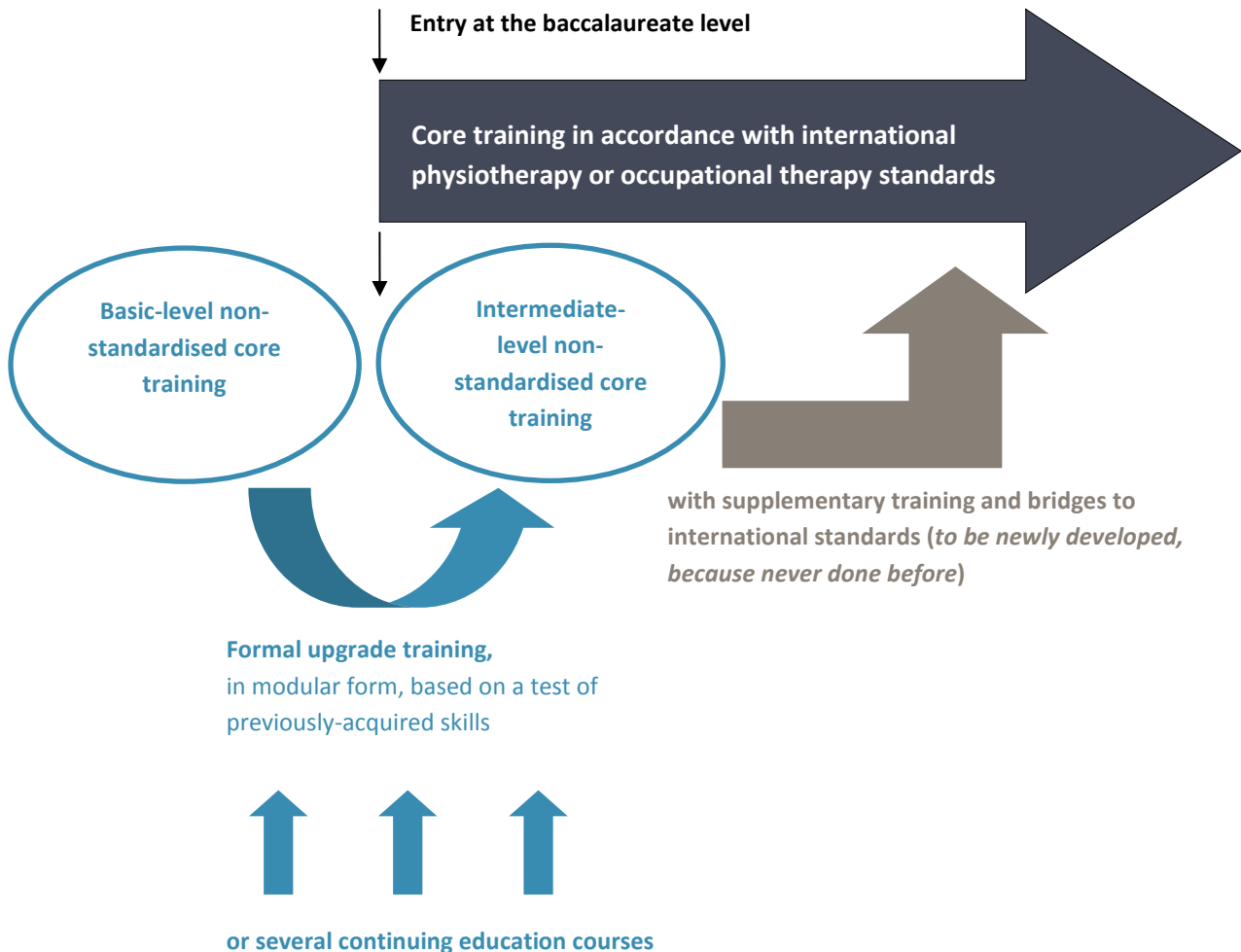
Handicap International’s wealth of experience includes the following types of training:

- Core training; Upgrade training; Continuing education, even post-training including continuing education;
- Training of trainers.

The findings and recommendations from the cross-cutting evaluation of rehabilitation training projects in five countries contributed to a model for realistic, effective, and context-appropriate training that will guide future actions by association actors. An explanation is presented for each type of training.

1.1 What are the different levels of core training in rehabilitation? What are the possible pathways?

Diagram illustrating how the different levels of training for certain rehabilitation-related professions (encountered by HI or possible) should be incorporated into the training pathway⁴



The decision by HI to get involved at the core training level depends on principles relating to the intervention method⁵, including the attempt to implement realistic, context-appropriate solutions.

⁴ Although included in rehabilitation, the orthopaedic fitting occupations have their own training pathways, and will be considered at a later date.

⁵ According to the [Physical and Functional Rehabilitation](#) Policy paper.

a) Initial physiotherapy or occupational therapy training based on international standards in a development context

Validating the relevance of supporting the development of one of these core training courses⁶ requires – in addition to a “market” analysis that includes employability possibilities – making sure that the public authorities and other partners possess the necessary will and capacity. In the “intervention modalities” section, situational elements will guide the questions that should be asked in making an informed decision on whether or not to support a physiotherapist or occupational therapist training programme.

Note that:

- Reference services must have professionals at this level.
- One way to ensure the long-term quality of the services provided is to have supervision by Bachelor’s-level professionals.
- The initial physiotherapy and occupational therapy training is at the Bachelor’s level, and fits well within the BMD (Bachelor’s, Master’s, and Doctorate) system.

In some specific settings such as post-disaster and post-conflict contexts, Handicap International considers the long initial physiotherapy or occupational therapy training required by international standards impossible. Thanks to its historical legitimacy, HI is able to promote intermediate- or basic-level core training, and in that way prioritise a strategy that trains more professionals more quickly with greater coverage of needs⁷. This is clearly reflected in the designation “XX-level non-standardised training”.

b) Intermediate-level non-standardised core training in rehabilitation in a reconstruction context

This type of training should be promoted in contexts where:

- There is a glaring shortage of rehabilitation professionals to address urgent needs that, if not met quickly, will have medium-term consequences (for example, a large number of amputees or paraplegics).
- It is impossible to provide standardised training (for example, ministries are not willing to be involved in or recognise the training at the time the project is launched).

In this training, “the rehabilitation technician must possess some of the skills used by physiotherapists and occupational therapists in hospital, functional rehabilitation centre, and community settings in order to tackle the continuum of care”. As the “Physical and Functional Rehabilitation” policy paper makes clear, such versatility means limited knowledge in a broad range of skills. However, it allows the promotion of a more comprehensive model for meeting people’s needs in settings where training and employing those two categories of professionals may not be possible.

⁶ Handicap International does not favour one specialty over the other.

⁷ According to the [Physical and Functional Rehabilitation](#) - Page 59: “Promote the spread of mid-level, rather than specialist-level, “core target” occupations”.

Non-standardised core training must always be accompanied by national and international advocacy aimed at achieving recognition for acquired knowledge (knowledge, know-how, and soft skills). All of these professionals, having clinical reasoning, are supervised on a regular basis by Bachelor's- and/or Master's-level physiotherapists or occupational therapists.



Recommendations - Take the example of an intermediate-level training course as a reference

The intermediate-level non-standardised core training for rehabilitation technicians, developed in Haiti, should be the reference for all HI programmes⁸: A total of 2,500 hours, with 1,250 hours of theoretical and practical courses at a training institute and 1,250 hours of clinical internship in facilities offering rehabilitation services. Admission requirements: baccaulaureate level, just like the standard international core training for physiotherapy and occupational therapy.

c) Basic-level non-standardised core training in rehabilitation

This type of training should be promoted in contexts where:

- There are basic physical and functional rehabilitation needs.
- The instability of the local team does not justify investment in long training courses.
- There are potential candidates with very different levels of education.
- There is no prospect of long-term services (e.g., refugee camps) or needs (e.g., most fracture-related needs).

In these contexts, training is aimed at basic skills that can be reproduced and replicated onsite to compensate for human resource instability (e.g., refugee teams and national staff).

Professionals at this level have little autonomy, and mainly carry out technical procedures. They therefore work under the supervision of Bachelor's-level physiotherapists or occupational therapists or, if that is not possible, of rehabilitation technicians.

To take an example, this type of training was given in the Dadaab camp in Kenya, as illustrated in the policy paper supplement "Physical and functional rehabilitation in long-standing (long-term) refugee camps"⁹. Level of education was not an eligibility criterion; that choice was made so that refugees who had not had access to schooling beyond the eighth grade would not be excluded from the training. Thus the trainees may have had very different levels of education.

In this type of training, "it is important to be clear with trainees about the fact that the training course does not, at this stage, have any validity outside the camp. However, provide a training certificate detailing the skills acquired."¹⁰

⁸ The competency, training, activity, and validation guidelines are available in the toolbox and are developed based on the desired HI-type capitalisation approach.

⁹ Page 20 of the policy paper supplement [Physical and functional rehabilitation in long-standing \(long-term\) refugee camps](#)

¹⁰ Ibid.



Recommendations - Take the example of a core training course as a reference

The basic-level non-standardised core training for “rehabilitation workers”, adapted from that given in Dadaab (Kenya) – with its modules, clear tree structure, and contents – is the reference for all HI programmes.



Recommendations - Consider the choice of candidates for supporting basic-level core training As these training courses are being implemented, it may be a good idea to provide funding for sending candidates abroad for long Bachelor’s- or Master’s-level training. When they return, their skills will allow them to supervise the basic- and intermediate-level professionals. In addition, these resource people could potentially help put together standardised core training programmes in their country.

Comparison of the scopes of practice, degrees of autonomy, and supervision modalities for each core training level in rehabilitation

PHYSIOTHERAPIST OCCUPATIONAL THERAPIST Bachelor’s level	REHABILITATION TECHNICIAN Intermediate level	REHABILITATION WORKERS Basic level
Essential in reference services	Hospital, functional rehabilitation centre, and community settings	Community-based only
Works on doctor’s order if skills and mechanism exist; otherwise, prescriber	Supervised on a regular basis by the physiotherapist or occupational therapist	Supervised at all times by the rehabilitation technician, physiotherapist or occupational therapist

Data collection centred on the patient, his history, his environment, and his lifestyle

Comprehensive and specific physical and occupational therapy assessment followed by comprehensive and specific care	Autonomy in conducting the functionality-centred comprehensive evaluation, followed by comprehensive care	Application of technical procedures based on instructions from the rehabilitation technician, the physiotherapist, or the occupational therapist
Use of simple or complex comprehensive, analytical, and specific rehabilitation techniques aimed at patient functionality and autonomy	Use of simple comprehensive, analytical rehabilitation techniques aimed at patient functionality and autonomy	Use of simple, elementary rehabilitation techniques

General remarks regarding these three types of training: The more highly structured the health system, the higher the priority the ministries will accord the intermediate and higher levels. The basic level then has a tendency to disappear centrally, but can sometimes persist at the local level, as it has in Rwanda, for example.

d) Formal training for progression from basic to intermediate level

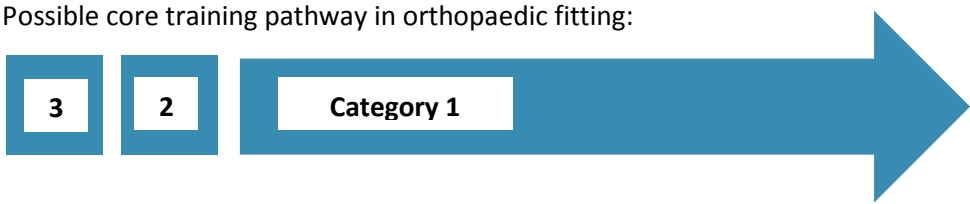
Formal, module-based upgrade training allows progression from the basic- to the intermediate-level non-standardised core training. It also helps equalise the knowledge and technical skill levels in contexts where a series of trainings have been given (often “on-the-job” and sometimes by a number of different actors) with no common curriculum (example: Haiti).

Depending on the length and quality of the core training and the professionals' experience, upgrade training can be tailored (via *à la carte* modules) to each person. It is designed based on a test that evaluates previously-acquired knowledge (knowledge, know-how, and soft skills).

This training is ideally done in existing national training structures (core or continuing education) – or at least with the authorities' consent – to obtain national recognition.

1.2 What are the possible core training levels in orthopaedic fitting?

How specific levels of training in orthopaedic fitting should be incorporated into a training pathway



Personnel categories¹¹

Category	Nomenclature	Normal Minimum Entry	Training
CLINICAL STAFF			
Category I	Prosthetist/orthotist (or equivalent term)	University entry level	4 years formal structured education leading to University degree (or equivalent)
Category II	Orthopaedic Technologist	Usual national requirement for paramedical education	3 years formal structured education – lower than degree level
Category II (lower limb prosthetics)	Lower limb prosthetics technologist	Usual national requirement for paramedical education	1 year formal structured education plus clinical experience in only lower limb prosthetics to Category II level
Category II (lower limb orthotics)	Lower limb orthotics Technologist	Usual national requirement for paramedical education	1 year formal structured education plus clinical experience in only lower limb orthotics to Category II level
Category II (upper limb prosthetics/orthotics and spinal orthotics)	Upper limb prosthetics/orthotics and spinal orthotics technologist	Usual national requirement for paramedical education	1 year formal structured education plus clinical experience in only upper limb prosthetics/orthotics and spinal orthotics to Category II level
TECHNICAL STAFF			
Category III (not a service provider)	Technician (bench worker or equivalent term)	Usual national requirement for technician training	2 years formal structured or 4 years on-the-job or in-house training

These categories are used to award degrees¹² or qualification certificates recognised by professional bodies like the ISPO (International Society for Prosthetics and Orthotics). They give the skills for a specific occupation. There is a direct link between the instruction and the needs addressed by the actual performance of the task or occupation. This is the framework within which ISPO certificates are awarded.

The following must be considered for all trainings:

- The socioeconomic level of the context;
- The existing or requisite distribution of services¹³ and the required type of prostheses and orthoses with the choice of technology (namely, one national centre, two provincial centres, and ten district centres).
- The number of staff people needed by the services, according to the following criteria:
 - The average number of people that can be fit by each orthotist/prosthetist (for Category I and II professionals, this is 500/year).
 - The orthotist/prosthetist - orthopaedic technologist - bench worker ratio (for example, for each Category II professional, two to three Category III bench workers are needed).

¹¹ WHO/ISPO. [Guidelines for training personnel in developing countries for prosthetics and orthotics services](#), 2005, p. 9.

¹² Category I corresponds to the Master's level and fits well into the BMD (Bachelor's, Master's and Doctorate) system.

¹³ One national centre, two provincial centres, and ten district centres.

a) Core training - Category I

This type of training should be promoted for key positions like:

- Managers of national reference centres, which have to produce a full range of high quality orthopaedic devices.
- Orthopaedic workshop heads.

This type of training is rarely relevant locally, because it concerns a limited number of professionals. Hence it is often done abroad, at internationally-recognised schools (see the chapter on [intervention modalities](#)).



Example - Rwanda

In Rwanda, Category I training was relevant in the local context; the internationally-recognised training course set up in Rwanda awards a degree that is recognised nationally.

b) Core training - Category II in a reconstruction context

“The Category II professional is a compromise to replace the Category I professional if not available or affordable in low income countries.”¹⁴

Handicap International promotes this level of training. The training can either be the same for orthotists and prosthetists (P&O technicians), or be specialised (orthotist or prosthetist).



Example - Haiti

In Haiti, Category II training was set up for orthopaedic technologists.

c) Core training - bench worker

Even bench worker training requires a standardised curriculum to ensure uniformity at each level of training and thus facilitate the inclusion of such workers in the line ministries' salary grids.

¹⁴ WHO/ISPO. [Guidelines for training personnel in developing countries for prosthetics and orthotics services](#), 2005.

**Comparison of the different scopes of practice, degrees of autonomy,
and supervision modalities for each core training level**

Prosthetists and orthotists Category I	Orthopaedic technologists Category II	Bench workers Category III
Essential in reference services and training institutes. Responsible for managing the orthopaedic workshop and for quality assurance (complex orders, production quality control)	May be responsible for managing orthopaedic workshops and quality assurance (if there are no Category I personnel), as well as provincial and district-level institutes	
Responsible for providing direct service to the user/patient in all practical P&O areas and for all related rehabilitation issues	Provides quality services, preferably under the supervision of Category I personnel for difficult cases	Assists Category I and II personnel: fabricates and assembles prostheses and orthoses and participates in their maintenance

1.3 What is meant by continuing education?

Continuing education¹⁵ is a learning process that enables an individual to improve upon his core training in order to deal with technological and other changes. It therefore concerns rehabilitation professionals who are either actively working or just starting out (looking for work).

It allows the trainee to acquire additional knowledge¹⁶ or perfect certain areas of knowledge, and can in theory be immediately transferred to the work setting to improve practices.

In its long years of experience, Handicap International has developed and implemented continuing education courses either as an extension of its support for a core training course or with no upstream contribution in the training process. In the latter case, Handicap International sought in-depth information about the knowledge targeted and acquired in the core professional training programme, so that it could reference that knowledge in its continuing education courses.

If a number continuing education courses are being considered for the same group of professionals, it is essential to link them or – put another way – to have a truly coherent continuing education plan, rather than taking a scattershot approach.

¹⁵ Also called “lifelong learning” or “further education” in some countries.

¹⁶ Knowledge, know-how, and soft skills.

Getting real impact from changing practices in the field requires carefully creating the conditions for:

- The involvement of each participant in the continuing education courses:
 - Before the training:
 - The professional should submit a reasoned request for the training, describing his expectations and the identified needs in his work setting (service, etc.). The professional should have a plan for how he intends to transfer the new capacities acquired from the training to his work setting. The professional should spend time preparing for the training topic (reviewing knowledge and know-how and looking for real-life situations to present).After the training: Information must be disseminated to members of their work team. Knowledge should be transferred immediately to the work setting, followed by an evaluation based on criteria defined beforehand with the trainers.
- Involvement by the head of the service and the candidate in identifying the continuing education needs and facilitating dissemination of the training to his team, as well as in helping them change their practices.

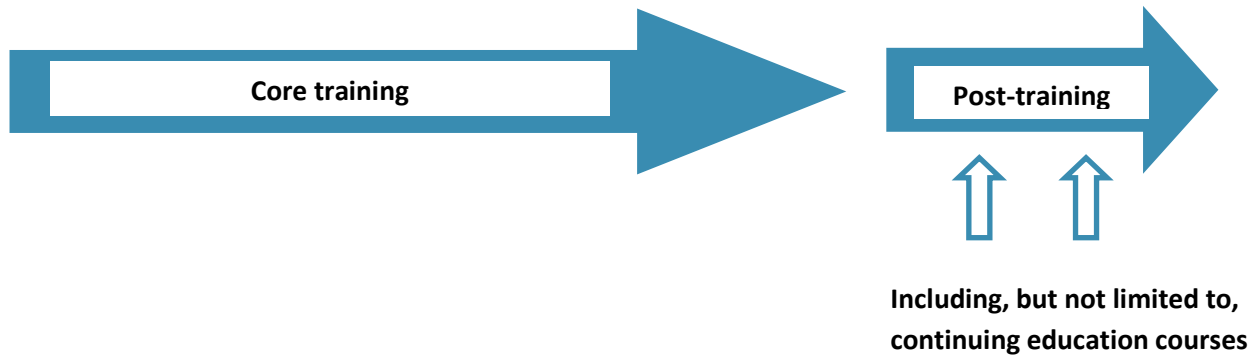
Handicap International will keep track of the continuing education courses given to rehabilitation professionals, to contribute to their recognition or even the possibility of future credit for work experience¹⁷ to make bridging easier.

On the other hand, because organising continuing education courses is one of the roles of professional organisations, Handicap International will prioritise capacity-building for the latter on this point. Continuing education may or may not be included in post-training, as discussed in the next section.

¹⁷ In France, this is known as VAE, or Validation of Acquired Experience. “This right is based on recommendations regarding lifelong learning, the ability to compare qualifications between countries, and mobility. **The “educational” value of work** is affirmed. **Experience** is recognised as a **source of professional competencies**”. Excerpts from the legislative framework for the VAE.

1.4 What does post-training for a core training programme cover? How is it useful?

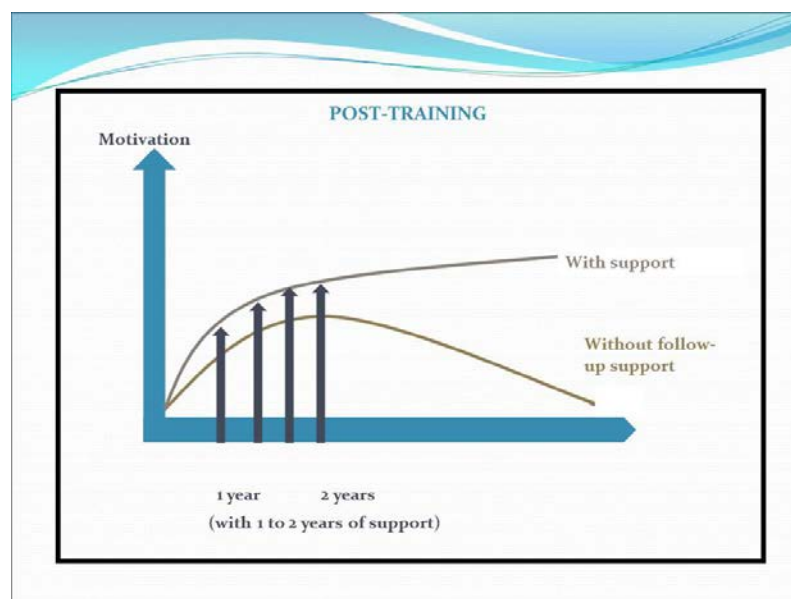
a) Overview



Contrary to what many think, post-training is not limited to continuing education, but goes much further, including the following:

- Support for carrying out individual and collective professional development plans, which are in principle developed during the core training¹⁸;
- Follow-up support for young professionals working in the services;
- The creation and energisation of professional networks, with formation of an association representing the new occupation;
- And lastly, the organisation of continuing education courses.

Based on an evaluation of several non-Handicap International post-training programmes, the graph below shows post-training's impact on new professionals, in particular in the context of creating a new profession.



¹⁸ Example of a group project in Haiti in the post-training context: A professional development plan aimed at raising awareness about the complications of vascular accidents (stroke) and the value of rehabilitation amongst the population in six areas of Port-au-Prince and in the provinces.

Without post-training support, motivation declines and becomes weak; yet “qualitative aspects of the HR crisis include [...] extreme demotivation of health personnel”¹⁹. Hence a lack of post-training support can negatively impact access to services²⁰, the quality of services (including the quality of soft/interpersonal skills), the quality of the service development plan, etc.



Recommendations – Make post-training routine

For all core training, no matter what the level, experience has shown the importance of post-training for unrivalled outcomes and impact. It is therefore recommended that post-training be considered a standard component that needs to be taken into account when supporting implementation of a core training programme.

b) How are networks useful in post-training?

Networks help counter the tendency of professionals to compartmentalise and specialise based on their specific interests and their position in a specific service. It enables them to cultivate and mobilise resources for finding appropriate solutions to situations they encounter.

Networks develop soft skill-related qualities: cooperation, friendliness, recognition of one’s interdependence on other professionals, respect for what each person has to say, benevolence, curiosity, perseverance, rigour, creativity, flexibility, visibility, etc.

The network helps (especially new) professionals strengthen their identity, learn from one another, improve their skills via group discussions regarding practices, and engage in group activities aimed at promoting and raising awareness of rehabilitation.

As a first step, Handicap International and its partners facilitate the development of such networks. Once a new professional organisation has been formed, it can take over – because that is, in fact, one of its main roles. Handicap International then prioritises strengthening the new organisation’s capacities in that area.

¹⁹ According to the Good Health for All call for proposals: Engaging civil society organisations to support national health workforce policies, strategies, capacity building and skills transfer, European Commission, 2009, page 3.

²⁰ Primarily on the determining factor: The existence of trained, motivated professionals: [Access to services for persons with disabilities](#), Handicap International, 2010, page 23.

1.5 Why is training of trainers important?

“The priority “core target” occupations include not just physical therapists, occupational therapists and Prosthetic & Orthotic fitting occupations, but also trainers, who are essential to creating rehabilitation practitioners, replacing them and maintaining and improving their skill level.”²¹

One of the key elements of a training programme is having a trainer who comes from the intervention context and a rehabilitation occupation, because it ensures:

- That the contents of the training programme (theoretical courses, practical simulation exercises, and internships) will be contextualised.
- Access to training for staff from centres in remote or isolated areas, or places that are “off-limits” to expatriate trainers (in China, for example).
- Potential duplication of trainings, for sustainability of skilled human resources in the services.

The objectives of Training of Trainers courses for local professionals are:

- To take ownership of androgogical capacities²², including the facilitation skills needed to participate in theoretical courses, practical simulation exercises, internships, and support for development of individual professional development plans.
- To be able to design and conduct core training and continuing education activities.
- To be able to design and lead a post-training programme, which involves:
 - Supporting the implementation of individual and collective professional development plans, in principle worked out during the core training;
 - Providing follow-up support for young professionals in the services;
 - Creating and energising professional networks and supporting the creation of an association representing the new profession;
 - And lastly, organising continuing education courses.

Handicap International has a lot of direct experience in setting up Training of Trainer courses as a way to duplicate trainings.



Examples

2013 - 2015 project: Training of Trainers for core training of rehabilitation technicians in Haiti;

2014 - 2016 project: Training the trainers from the national research and rehabilitation centre (Beijing) to familiarise rehabilitation centre physiotherapists with home-based care (family support and training/follow-up support for community health workers);

2003 - 2015 project: Training senior rehabilitation professionals working in the Tibet regional rehabilitation centre;

2014 - 2016 project: Training senior rehabilitation professionals working in the Yunnan regional rehabilitation centre.

²¹ According to the [Physical and Functional Rehabilitation](#) policy paper.

²² Androgogy concerns an adult audience; the equivalent for children is pedagogy.

1.6 A brief summary

- What differentiates intermediate-level and basic-level training is both the entry requirements – level of education, among other things – and the number of hours.
- For all core training courses, no matter what the level, experience has shown the importance of post-training to achieving better outcomes and impact. It is therefore recommended that post-training be considered a standard component that needs to be taken into account when supporting implementation of a core training programme.
- Since one of the roles of professional organisations is arranging continuing education,, building their capacities in this area is a Handicap International priority.
- Training of Trainers should be considered an essential component of training programmes, as a tool for transferring both the ability and responsibility to ensure their continuity.
- Internship mentors should be trained as trainers for theoretical and practical courses. The quality of professional training depends on them, too.

2. Why be involved in training actions?

2.1 The main challenges

The major long-term challenge is to develop and maintain, over the long term, the motivation and capacities of human resources in the rehabilitation field. The aim is to help address the needs of people with disabilities, whatever their socioeconomic status.

The short- and medium-term challenge is to quickly improve access to and the quality of rehabilitation services for beneficiaries in different intervention contexts (emergency, reconstruction, or development). “It became clear during these experiences how effective training rehabilitation professionals is for Handicap International projects.”²³

It is essential, however, to take **the challenges of the Relief-Rehabilitation-Development contiguum** into account by adapting to the constraints of each situation in accordance with the “operational differentiation” principle.

²³ From the cross-cutting external evaluation of Handicap International’s rehabilitation training mechanisms. Evaluation conducted in 2016 by STEPS Consulting Social for Handicap International in Burundi, China, Haiti, the DRC, and Rwanda – See the summary of this evaluation in the [toolbox](#).

Based on elements of situation analysis, the second part of this policy paper will describe some of the specific challenges, as well as Handicap International’s added value, as a function of the contextualised, realistic trainings that were implemented.

2.2 Intervention principles and approaches to consider

The major physical and functional rehabilitation-specific principles and recommendations for Handicap International, as presented in the “Physical and Functional Rehabilitation” policy paper, need to be considered in the design, implementation, monitoring, and evaluation of all training courses.

The approaches to which Handicap International refers: Approaches like the Disability Creation Process (DCP) model for understanding disability, Community-Based Rehabilitation (CBR), inclusive development, and access to services should be incorporated into the contents of all training courses.

Cross-cutting approaches (gender, intersectoral, partnership, inclusive development, and access to services): Beneficiary-related principles concerning the most fragile and at-risk individuals, as well as victims of discrimination and exclusion – in particular with regard to questions of gender, childhood, and old age – should be taught during the trainings.²⁴

Gender should get special attention via access to training and employment for women. In addition to the goal of helping to get women’s work recognised, training women in the field of rehabilitation and recruiting them to work in rehabilitation services is important for the women who utilise those services. Some women feel uncomfortable being treated by men. Some may even forego an orthopaedic device²⁵ entirely. “Also, special initiatives and advocacy may be needed so that women can meet entry requirements of professional courses and enjoy opportunities for employment equal to those of men.”²⁶



Example - Afghanistan

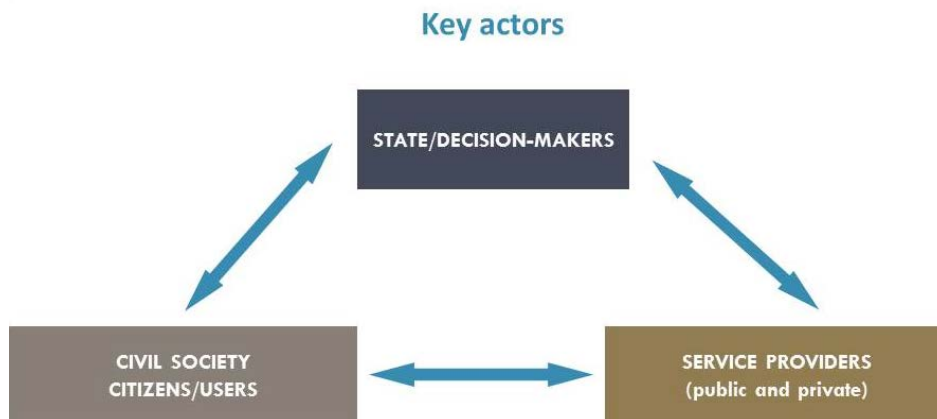
The funding proposal stipulates the prerequisites in the ongoing training project.

²⁴ According to the [Physical and Functional Rehabilitation](#) policy paper.

²⁵ From [Prosthetics and Orthotics: Programme Guide. Implementing P&O Services in Low-Income Settings: A guide for planners and providers of services for persons in need of orthopaedic devices](#). A collaborative effort of 35 organizations and agencies, Endorsed by The International Society for Prosthetics and Orthotics. 2006

²⁶ Ibid.

Partnership approach: Designing a training programme requires taking all of the key actors below into account and trying to create partnerships, depending on the context:



With the **government/decision-makers**:

- As described in the rehabilitation policy paper, ministry involvement is essential: more specifically, the Ministry of Health first and foremost, then the Ministry of Social Affairs²⁷, the Ministry of Education and/or Higher Education²⁸, the Ministry of Labour, and the Ministry of Finances. This is done in an effort to work with them, depending on their scope of responsibility, on the situation analysis, constructing the training programme, designing the curriculum, recruiting the trainers, etc. This makes it easier to get recognition for trainings and create positions – in the public services, in particular²⁹.

With **the services** (regular and specific) and training providers in the country in question:

- Identify and formalise a partnership with training organisations, strengthening them, if necessary.
- Include services in needs identification and internships, formalising their participation via a partnership agreement.
- Include future employers in management of the training (especially with grants) by asking for their help, for example, with recruitment and in defraying the training costs.

With **international training providers**:

- Identify partners (university-based and others), especially when Handicap International considers the training too much to handle by itself, and also when the goal is to promote the establishment of a standardised core training programme.

With **users** and, more generally, with **civil society** in the country concerned by HI's intervention:

- Being aware of the demand and need for rehabilitation will help determine the type and level of training needed.

²⁷ Rehabilitation services sometimes fall under the auspices of the Ministry of Health and the Ministry of Social Affairs.

²⁸ For example, in Rwanda.


²⁹ For example, in Rwanda and Afghanistan.

- Promoting rehabilitation care and occupations to the population.
- Strengthening the professional organisations' ability to promote newly-created professions and get a continuing education programme and professional network up and running, because those responsibilities will ultimately fall to them.
- Depending on the context, it is sometimes a good idea to join civil society advocacy efforts aimed at creating professional rehabilitation positions and, more broadly, a National Rehabilitation Plan.

At the **international** level:

- It is important to mobilise “South” networks, when they exist, as they are directly concerned and can mobilise efficiently around changing practices in complex contexts (for example, the African Federation of Orthopaedic Technicians, or FATO, mobilisation around sustainability issues in African countries having no national rehabilitation plan)³⁰.

Person-centred approach to care: The professional's attitudes will be decisive in ensuring true co-construction and collaboration with the person receiving care. A person-centred approach³¹, coupled with a personalised approach, is essential, and trainees must take ownership of these throughout the training. The tips below³² show some of the key elements.



Do	Don't
Take time to observe the person in his environment and the environment itself	Rush to judge the situation you find or stop at first impressions
Do “with” the person Let the person make his own choices	Do “for” the person Do the work for the person without involving him Impose your own choice on the person you are coaching
Act as a facilitator; respect and educate	Act as an authority or give orders
Rely on the person's capacities and those of the environment	Focus on and see only the person's incapacities or those due to the environment
Believe that all systems have solutions to their problems Listen, understand, and tailor your responses to the person and how he sees the situation; educate	Think of yourself as an “expert” or saviour and decide on the solutions to the person's problems Offer pre-identified, stereotypical, or catalogued solutions
Be realistic (without being negative)	Make promises that you can't deliver on

³⁰ According to the [Physical and Functional Rehabilitation](#) policy paper - page 50

³¹ Presented in SkillWeb:

[http://www.hiproweb.org/fr/accueil/secteurs-dactivites/readaptation/reeducation/docs/liste.html?tx_hidrtdocs_pi1\[uidDoc\]=1036&cHash=d4e5db988e](http://www.hiproweb.org/fr/accueil/secteurs-dactivites/readaptation/reeducation/docs/liste.html?tx_hidrtdocs_pi1[uidDoc]=1036&cHash=d4e5db988e)

³² Edgar H. Schein, “[Process Consultation Revisited Building the Helping Relationship](#)”

Center for Rehabilitation and Recovery, “[Person-centered approaches](#)”

Handicap International training modules from Morocco and Madagascar, 2010-2011.

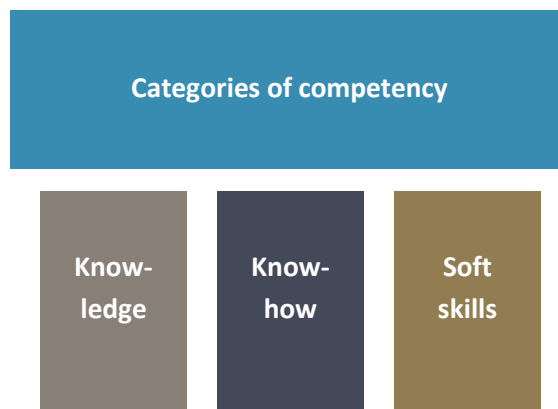
3. The main conditions facilitating effective training

Designing a training programme means devising a curriculum; this in turn requires writing several guidelines:

- Competency guidelines
- Training guidelines
- Activity guidelines
- Validation guidelines

What does each of these guidelines cover?

- **Competency guidelines:** “The ultimate goal of a training action is to help build and develop skills useful to future practice. The expected competencies are described in competency guidelines created prior to the training action”³³. Those competencies are divided into the following categories: knowledge, technical skills (know-how), and interpersonal skills/attitudes/values (soft skills).



Note that changing how students think about people with disabilities and the causes of disease is another goal.

“Effective training action requires ownership of these guidelines not just by the managers and trainers, but by the learners themselves, so that they know where they are in their training”³⁴.

- **Training guidelines:** These guidelines describe the modular structure with learning objectives (acquisitions) and professionalisation objectives (competencies)³⁵.
- **Activity guidelines:** These guidelines describe all of the activities. There is a link between the activity guidelines and the competency guidelines. The proposed activities must be coherent with the modules, the learning objectives, and the course syllabus. They are designed to correspond to the competencies expected in professional situations.

³³ From the « Référentiel qualité de dispositifs de formations professionnelles » - see the [toolbox](#).

³⁴ Ibid.

³⁵ According to the document on modelling: Constituants d'un curriculum de formation professionnelle : modélisation, available in the [toolbox](#).

- **Validation guidelines:** “These guidelines describe the nature of the testing and the evaluation modalities and criteria. The tests should be coherent with the learning objectives and designed in relation to the competencies expected in professional situations”. The choice of evaluation modalities must also be consistent with the choice of teaching methods.
“Ownership of the validation guidelines is as essential for the managers and trainers as it is for the learners”.
The choice of andragogical methods³⁶ (principles of participatory, inclusive, and collaborative facilitation techniques with practical field application³⁷) must be appropriate to the type of training and thus the audience and the profession.

Designing a professional training course means choosing a training institute and internships sites, (which trainees will alternate between):

- With a dynamic, well-defined framework for support/supervision.
- With articulation between the two training sites: that is, with internship objectives, an internship evaluation grid, and time set aside for group discussion on the internships each time the students return to the training institute. That discussion should be appropriately formalised and evaluated.

Generally, 60% of the training is done at the training institute and 40% at the internship site.



Recommendations - Develop the students’ self-assessment and learning skills

- For each internship, encourage the students to have shared objectives and, at the same, to develop their own personal professionalisation objectives, negotiating these with each student. This practice will contribute significantly to students’ self-assessment ability and professionalisation. Also take an interest in the learners’ learning process and if necessary help them improve it: “How does he learn? How can he better assimilate the knowledge?”



Caution points

- As with knowledge and know-how, explicitly state the soft skills required for each competency in the guidelines and think about evaluating them.
- Use a variety of andragogical methods for theoretical teaching, and limit the use of slides.

³⁶ Androgogy concerns an adult audience; the equivalent for children is pedagogy.

³⁷ See Skillweb, [Tools for trainers](#) section.

Intervention modalities: Improving Handicap International's training strategy

The major challenges have already been discussed in the foreword and the previous chapter; the specific challenges will be discussed as each of the situations in this second part is presented.

Reminder of the major challenges:

- To be able to address the rehabilitation needs of people with disabilities. To sustain the motivation and capacities of human resources working in rehabilitation.

Objectives: To define relevant, coherent types of training and then the most effective modalities.

After becoming thoroughly familiar with the occupations in question³⁸:

- Conduct an in-depth situation analysis³⁹ of, among other things, the demand expressed by the community, the professional competency needs observed, the key (or potentially key) resource people in professional training, and the market analysis
- Develop appropriate training responses based on the details given previously on what the different types of training cover:
 - Core training at the basic and intermediate levels, and to international standards.
 - Upgrade training to help professionals move from one level to another;
 - Continuing education;
 - Post-training⁴⁰, including a continuing education mechanism;
 - Training of Trainers.
- Decide which actors to partner with, jointly establishing the terms of a quality partnership
- Then choose the training modalities appropriate to the context, namely:
 - Onsite;
 - Distance learning – for example, “blended learning”;
 - Training abroad, with training grants, etc.

If there are no local training programmes for the occupations in question, recourse to these specific modalities is justified.

³⁸ According to the [Physical and Functional Rehabilitation](#) policy paper.

³⁹ Ideally, this is done in collaboration with an institutional partner.

⁴⁰ See Section 1.4, “What does post-training for a core training programme cover? How is it useful?, regarding the meaning of post-training and the forms it takes: the individual and collective professional development plan, the network and creation of an organisation for rehabilitation professionals, and continuing education. Also see Part 3, “Post-training as a follow-up to a core training programme”.



Cross-cutting caution points prior to any training

The situation analysis for evaluating the relevance of setting up a training programme for rehabilitation professionals should be given enough time and, if possible, be done in collaboration with key stakeholders.

The preparation time for setting up a training locally should be sufficient (three to eight months) for developing the mechanism and the curriculum with the identified partners (national and/or international), recruiting – and perhaps training – the trainers, identifying internships, and preparing the courses.

As a reference:

- Initial physiotherapy and occupational therapy training based on international standards: at least eight months;
- Intermediate-level core training: at least six months.

1. Core Bachelor's- or Master's-level training

Based on international standards:

- Bachelor's level: for physiotherapy, occupational therapy, speech therapy, and Category II prosthetics/orthotics technologists
- Master's level: for Category I prosthetists/orthotists.

1.1 Via local training



Memo - Things to evaluate in the situation analysis

All of the answers to these questions will become criteria for whether or not to promote the use of this training modality.

Does other core training for rehabilitation specialists already exist?

- If there is no occupational therapy or physiotherapy training:
 - Is one of these “specialist” trainings needed to address the needs and demand for specific care in this context?
 - Are foreign-trained occupational and physical therapists already working in the country's reference services?
 - Do the public authorities have the will and capacity to create a training programme at this level?
 - Which local training institutions might be mobilised with a view to ensuring the continuity of training investments?
 - Given that this level of training is often too much for Handicap International to handle alone, what relevant partnerships with training institutes in the North (universities and

other) might be possible? What is HI's added value? How employable will the trained professionals be?

- If physiotherapy training exists, what is its quality?
 - If the quality is poor, does helping improve it seem possible? Is there real will on the part of the training institution and trainers to go in that direction? Note: if not certain, considering a new training programme might be an excellent way to energise and expand the training institution and professionals already on the job.



Example - Rwanda

The development of core occupational therapy training (2012 - 2016) in Rwanda was relevant⁴¹ to the local context:

- Handicap International's local partner facilities had a real need for rehabilitation professionals to handle the needs and demand for specific care services.
- Rwanda wants to be a "model" for health care services in Africa and invests in human resources;
- The main partner, the College of Medicine and Health Sciences (CMHS - formerly the Kigali Health Institute), also offers a Bachelor's degree in physiotherapy and diplomas in prosthetics and orthotics.

Like the physiotherapy training project in Albania, occupational therapist training in Rwanda involved an inter-university partnership, where a sustainable training programme was set up in a "South" university with support from a "North" university, and Handicap International acted as a "facilitator" in the process.



Handicap International's added value

Handicap International does not take a "trainer" role when a standardised core training programme is set up.

For training programmes that are a joint effort between university actors in the South and North, Handicap International's added value – thanks to its experience – is as an interface between the two partners.

To partners in the North, HI offers knowledge of the context, experience in conducting projects, and a view of rehabilitation training that goes beyond just the technical aspects.

University actors in the South, sometimes caught in administrative contingencies preventing them from being as responsive as they would like, find it difficult to identify interlocutors in their midst capable of establishing a sufficiently strong relationship with their partner in the North. Handicap International is able to play that role and make the training course an integral part of a comprehensive development-oriented approach.

⁴¹ From « Evaluation externe transverse de dispositifs de formation en réadaptation dans 5 pays, réalisée en 2015 par STEPS Consulting Social pour Handicap International au Burundi, en Chine, en Haïti, en RDC, au Rwanda » - Synthesis in [toolbox](#).



Cross-cutting caution points for any Bachelor's- or Master's-level core training programme

- **The employability issue** needs to be anticipated as part of a core training programme to ensure that future graduates are employable and, if necessary, there should be a plan to either:
 - Support the employability of future trainees (seek to involve and structure professional organisations, promote the profession, etc.)
 - Or limit the number of students.

→ As with Category I prosthetists and orthotists, who are rarely employed in large numbers due to local facilities' lack of resources, grant-based training is a coherent choice.
- Professionals whose level of training is below that of the young Bachelor's-level graduates about to enter the job market **may be downgraded or even put out of work.**



Example - Rwanda

At the Rwanda project⁴², the university and the Ministry of Higher Education failed to consider the lack of sufficient absorption capacity (potential for new occupational therapist jobs) when planning the cohorts. A new cohort of sixteen students entered the programme every year.



Memo - Aspects of coherence that should be evaluated for initial Bachelor's- or Master's-level training courses

Were the contents of these training courses developed, in reference to the target levels, with support from partners from the academic and professional world?



Example - Rwanda

In Rwanda⁴³, the University of Gand and the Occupational Therapy Africa Regional Group helped develop the occupational therapy degree programme.

1.2 Via grants

This modality should be promoted in contexts where:

- The number of professionals to be trained in a discipline is low (for example: essential need for professionals at this level in reference services and training institutes).
- There is no possibility of organising a standardised core training programme, either completely local or a hybrid (for example, the Bolivian Ministry of Education does not recognise blended learning, i.e., the use of both e-learning and so-called "face-to-face" learning).

⁴² Ibid.

⁴³ Ibid.

- The ministries refuse to allow training at this level to be given by professors who do not hold a Master's degree or doctorate, in accordance with current international agreements (BMD) (in Vietnam, for example).



Memo - Aspects of relevance, coherence, and specific effectiveness to be evaluated when choosing the school and the grantee and for his assuming his post

- Did the choice of the school where the grantee was sent consider the need for international or regional recognition to ensure future recognition in his country?
- Did the choice of grantee take both national criteria and his motivation into account?
- What support will the grantee receive during the training? And what support is planned for his return, especially if he is expected for a service post? What recognition, via the salary grid, will the professional have upon his return for a service post? (This is to ensure that the grantee remains in this type of post and does not try to leave it for a better salary).



Examples – Burundi and the DRC⁴⁴

There are no training programmes for Category I prosthetists or orthotists in Burundi or the DRC.

- For physiotherapists in Burundi and in agreement with the institutes in the respective countries:
 - A Burundian student was chosen to take the physiotherapy training course in Benin.
 - Personnel from Handicap International partner centres are going to be trained at schools in Tanzania (TATCOT) and Lomé (ENAM). These have the advantage of offering certificates recognised by the ISPO.
- On returning to the DRC, the only Category I prosthetist/orthotist will supervise and train the Category II prosthetists/orthotists, with a view to creating a national orthopaedic fitting and orthopaedics centre.



Handicap International's added value

Handicap International's strong relationship with the schools in Tanzania (TATCOT) and Lomé (ENAM) consists of acting as an interface between these schools and the governments seeking Category I and II professionals.

Handicap International also supports the grantees when they assume their posts, especially if they are taking service management posts.

⁴⁴ Ibid.

2. Intermediate-level core training

2.1 Via local training

Handicap International generally provides most of the training at this level, as was the case with the rehabilitation technicians in Haiti. Although Handicap International was the project manager for that training course, it worked with numerous partners locally.



Memo - Aspects of relevance to be evaluated

- Which rehabilitation professionals are needed to handle the needs and demand for quality specific care and orthopaedic devices?
- How strong are the will and capacity of the public authorities?
- How employable will the trained professionals be?



Example - Haiti

Development of the core rehabilitation technician training programme⁴⁵ was relevant to the local context in Haiti:

- Based on the shortage of rehabilitation professionals and the increased needs in the wake of the 12 January 2010 earthquake, it was relevant and legitimate to promote the creation of a new vocational pathway at this level in the rehabilitation field.
- This rehabilitation technician level was adapted to the Haitian context and made it possible for the few Haitian physiotherapists, trained abroad, to become trainers. Their participation was essential to ensuring that the courses would be context-appropriate.
- The education level needed for entry, the number of hours, and most of the curriculum were validated by numerous Haitian partners, including the Haitian Ministry of Health and Haiti's Institut National de Formation Professionnelle (INFP), and by international partners (representatives from Geneva University Hospitals (HUG) and McGill University in Montreal). This gave the curriculum a more formal appearance.

2.2 Via “blended” or “hybrid” learning

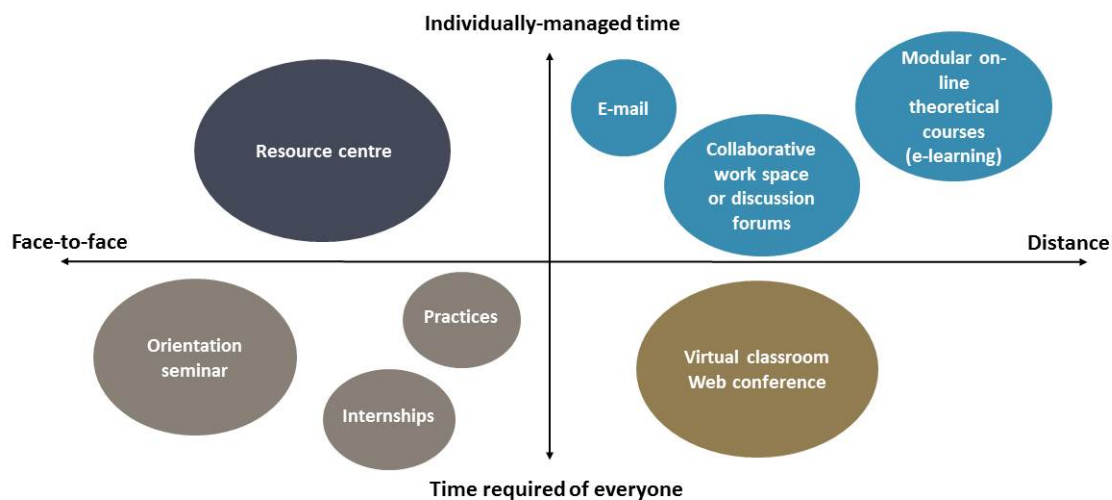
This modality combines periods of both distance and face-to-face learning:

- Theoretical courses are done online, and trainers from the school abroad moderate the discussion forum.
- Practical material is taught onsite by a professor from the foreign school and mentors.

⁴⁵ Ibid.

- Mentors provide guidance on producing orthopaedic devices.
- In addition, as an introduction to this training, there is an orientation seminar to explain the training objectives, outcomes, and methods, and to teach the students how to use the e-learning platform.

Blended learning: Two types of time (individual and group) and two types of space (virtual and face-to-face)



Handicap International chose this modality for ISPO Category II P&O technologists (Haiti) and Category II orthotists and prosthetists (DRC).



Memo - Aspects of relevance, in addition to those above, to be evaluated specifically for the “blended learning” modality

- What qualified professionals are available locally for teaching theoretical classes in orthopaedics? (The lack of any such professionals is a criterion for choosing the blended learning modality). Which, and how many, rehabilitation professionals are needed to handle the needs and demand for quality orthopaedic fitting services? (More than ten professionals must be needed to justify blended learning.) Is there a training pathway for orthopaedic fitting occupations or not?
- Are production needs parallel with the training essential? (Blended learning makes this possible.)
- What would be the likelihood of professionals trained abroad failing to return to their country?
- Is there a possibility of national recognition in addition to international recognition?



Examples – Haiti⁴⁶ and the DRC

The development of a two-and-a-half-year blended learning core P&O training programme was relevant to the local context, based on:

- The enormous need for orthopaedic technologists;
- The lack of a training pathway for orthopaedic fitting;
- The shortage of qualified people to teach the theory locally;
- The need to keep students in the country and thus avoid potential long-term overseas departures;
- The need for international accreditation to facilitate national recognition.

The core P&O training programme in Haiti and orthotist training programme in the DRC, using blended learning, had the following in common: a partnership with the university (Don Bosco) with a strong face-to-face component for practical training and mentored internships. Haiti's programme already had international Category II accreditation, according to the ISPO and PAHO-WHO criteria.



Handicap International's added value

Thanks to its familiarity with the context, Handicap International is positioned as a “facilitator” in the process. In addition, when a training school is unable to make a trainer available locally, Handicap International provides practical training via expatriate trainers.



Caution points

- The success of this modality depends on transparent (via agreements), coherent, and complementary (each must know his own role and that of the others) mobilisation of the various actors: teacher-trainers, workplace mentors, employers, interns, facilitators, and local and international partners. Without clear, harmonised protocols, the mentorship component of blended learning may not function optimally. In addition, having mentors participate when the students are being introduced to the training (objectives, outcomes, and methods), and training them on their role as mentors, is a plus.
- The employability issue is just as important for intermediate-level core training programmes as it is for Bachelor's-level training.
- Contextualising the training to the specifics of the country – in the choice of components for making orthopaedic devices, among other things – is important.
- Because blended learning requires that theory be learned independently, it is crucial to motivate this process during the orientation seminar and beyond.

⁴⁶ Ibid.

3. Post-training as follow-up to a core training programme

Experience has shown the importance of post-training for all core training programmes, no matter what the level. To supplement the detailed discussion of post-training in Part 1, only illustrative example will be given here.



Example - Haiti

Concretely, and summarising, what did post-training for rehabilitation technicians in Haiti consist of?

A two-year post-training pilot project was started, including:

- Support in the services for people who took positions after the first and second cohorts finished;
- Support to maintain mobilisation for those looking for a position;
- Support for implementation of collective professional development plans;
- Continuing education;
- Network creation (for practice-sharing and rehabilitation promotion);
- Support for creating a professional organisation, the initiative of this creation was coming from the rehabilitation technicians.

All of the trainers had been trained in post-training before it was set up, and two half-time post-training manager positions were created.

4. General recommendations for any training programme



Recommendations - Recognition for core training, upgrade training, and continuing education programmes

There are several levels of recognition:

- **Degree programmes**, which award a government-recognised degree.
- **Certificate programmes**, which issue a certificate recognised by the professions. Certificates issued by the ISPO (International Society for Prosthetics and Orthotics) are a part of this framework.
- **Training courses leading to qualification**, which do not issue a degree or title, but do offer students a training certificate. The certificate attests that the trainee has acquired professional skills. Continuing education courses fall into this category. They may be recognised by both professional organisations and employers, provided an agreement was made beforehand.

The recognition issue should be discussed **prior to any training course** and negotiated with the country's authorities and, if relevant, with employers, to ensure that the commitments from each party (partners, Handicap Internationals, and interns/students) are explicit, formalised, and then respected.

For degree programmes, it is essential to consider the intervention country's criteria for recognition, such as:

- The entry requirements (student's level of education, whether tests/interviews are necessary, examiners' qualifications, etc.); The length of the training, with the required percentage of theoretical/practical time and of internship time in the sandwich course (60/40);
- The educational level and degrees, as well as the number of years of experience, required to become a trainer, including mentors;
- Information about the knowledge, know-how and soft skills needed;
- The type and characteristics of the evaluations that will be used to assess all that knowledge and the makeup of the mandatory evaluation panels.

Any failure to meet these criteria will result in recognition being impossible or delayed, hurting motivation because the programme will have to be changed to remedy the situation (see the examples below).

For working professionals, lay the groundwork for recognition (for example, of the ISPO certificate) not only by the government (and hence the public rehabilitation services), but also by private rehabilitation centres, so that the acquired competencies actually have an impact, status- and/or salary-wise, regardless of the practice setting.



Example - Haiti⁴⁷

In an effort to get recognition for the (intermediate-level) core rehabilitation technician training course in Haiti, the number of hours had to be increased substantially – by 1,000 hours – from 1,500 to 2,500 hours in order for trainees to be able to claim the official technician title in accordance with Haitian standards.

In the same context, for recognition of the same training course, the government asked for improvements in the competency guidelines to facilitate recognition: “Although the competencies are well-defined, the team should consider all three types of knowledge. They only considered two of them, yet soft skills are essential to this type of training, given that these professionals will have to deal with patients directly”.

The core training courses, which took place abroad (via grants) or were given as part of a blended learning framework, have led (or will lead) to an ISPO certificate attesting to the actual acquisition of the target professional competencies, but are not yet recognised in the country. That is why parallel efforts by Handicap International and its partners to ensure that the title is taken into account and makes professional advancement easier are so important.

⁴⁷ From « Evaluation externe transverse de dispositifs de formation en réadaptation dans 5 pays, réalisée en 2015 par STEPS Consulting Social pour Handicap International au Burundi, en Chine, en Haïti, en RDC, au Rwanda ». See synthesis in [toolbox](#).

Efforts in this direction are going to begin for the training programme in the DRC. But obtaining national recognition for that programme would require getting it onto the list of paramedical degrees (which are university degrees in Congo), and getting the two-year programme accepted as equivalent to a three-year programme – for physiotherapists, in particular. The programme does not yet have any equivalent in the “Bachelor’s/Master’s/Doctorate” (BMD) system, which suggests that there will be numerous problems harmonising the national systems and having coherent international recognition.

These examples are not intended to discourage, but rather to encourage a high degree of rigour.



Recommendations - Assembling the expatriate team in charge of training

- Participating expatriate project managers and trainers/mentors must themselves be professionals in the occupation they teach;
- In addition, for their recruitment, proven experience in facilitating training courses is important, and at least one of them should be capable of designing and facilitating the core training, post-training, and continuing education courses.

These two points ensure Handicap International professionalism and are “success factors” for the training programmes.

5. Training of trainers

Given that a trainer who comes from the intervention context and a rehabilitation occupation is one of the key elements of a training programme, there are several modalities for making that happen:

- **A Training of Trainers course held locally before the core training programme:** Using rehabilitation professionals who come from the intervention context but who received their core training in another country (for example, Haitian physiotherapists trained in neighbouring countries were recruited and then trained to be trainers for the core rehabilitation technician training course).
- **A Training of Trainers course held after the core training programme:** With new graduates from the first cohort of a local core training course (this was done, for example, in the Balkans after the first cohort of physiotherapists graduated).



Recommendations - Recruit and train roving mentors/Training of Trainers

- The lack in several services of professionals from the occupation being taught requires – for internship supervision – recruitment and training of a roving mentor to fill mentorship gaps. This happened, for example, in Haiti with the blended learning-based training for P&O technologists. The Training of Trainers course needs to be constructed as a true training plan concomitant with any core training programme. Handicap International will keep a paper trail for this training course, to help get the authorities and/or other partners to recognise the trainer position.



Caution points

- The internship mentors need to be considered in the same way as the theoretical and practical course trainers. The quality of training depends on them, too. They should therefore be given training and guidance. Their role in the training, including the evaluation, needs to be made clear to everyone⁴⁸. They should also be involved in constructing and enriching the curriculum. That participation is one of the main facilitators of an effective training.
- To ensure that internship mentors/trainers are involved and available, it is essential that the heads of services/centres recognise their function and the need for further training for their service/centre's professionals.

⁴⁸ A document summarising the internship mentor's role can be found in the [toolbox](#).

1. Create an occupational therapy/physiotherapy core curriculum

Explore the possibility of creating a two-year occupational therapy/physiotherapy core curriculum, to be followed by one or two years of specialisation. This can be modelled on the current experience in Colombia.

Criteria for promoting the use of this modality:

- Interest and possibility of recognition by the national authorities and professional organisations.
- Interest and possibility of international recognition



Caution points

Efforts to get support from international and national bodies should consider their possible resistance to change, due to a likely desire to protect each profession.

Once the occupational therapy/physiotherapy core curriculum has been developed, offer supplementary training modules, if necessary, to already-trained and working mid-level rehabilitation technicians so they can have access to one of these specialties, should they want it.

2. Include the professional development plan aspect in all trainings

What does a professional development plan mean? Helping each student come up with a professional development plan is a part of project-based learning. The professional development plan is a source of motivation, encourages involvement, serves as a guiding thread for learning, and lends meaning and interest to capacity (knowledge, know-how, and soft skills) development. It also encourages the entrepreneurial/pioneer spirit. This is especially important for promoting a new profession. This teaching method does not exclude objective-based teaching⁴⁹, but is complementary to it.

What is a professional development plan? We will begin by defining what a professional development plan is not. A professional development plan is not a career plan – e.g., becoming a civil servant (having a particular status) or becoming the manager of a service (having a particular position).

⁴⁹ For example, being able to take a history, identify the signs of pain, or conduct a clinical evaluation of the beneficiary and his environment (social and physical).

In general, a professional development plan in rehabilitation is about one or more determinants of access to the services and improving the quality of the services provided. For example, regardless of which service the professional works in, his professional development plan might involve improving reception in the service, prevention/awareness-raising, patient education, etc.

It will thus be part of a service development plan (see graphic below).



Example - Haiti

A single experiment was done in Haiti, as part of the training for the second rehabilitation technician cohort⁵⁰.

It should be noted that project-based teaching helped give everyone more motivation. Working on a project was, and still is, energising!

One support supervisor in the last internship said: “With the introduction of professional development projects, it was impressive to see the difference in terms of the students' aspirations and motivation”.

Technical and methodological training is therefore not enough, in the long-term, in contexts where rehabilitation is new. Student motivation and commitment are essential for quality reception and services, innovation, etc.

Numerous professional development plans came out of it. There was a group plan to raise awareness about the complications of vascular accidents (stroke) and on the value of rehabilitation amongst the population in six areas of Port-au-Prince and in the provinces, including in Jacmel.

⁵⁰ See the report from the l’Evaluation participative du projet de formation des techniciens de réadaptation, Haïti, avril 2015, Maryvonne De Backer – Available in [toolbox](#).

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- [Prosthetics and Orthotics: Programme Guide. Implementing P&O Services in Low-Income Settings: A guide for planners and providers of services for persons in need of orthopaedic devices](#). A collaborative effort of 35 organizations and agencies, Endorsed by The International Society for Prosthetics and Orthotics. 2006
- Handicap International. [Physical and functional rehabilitation in long-standing \(long-term\) refugee camps](#). 2015
- Handicap International. [Access to services for persons with disabilities](#). 2010

Introduction to the toolbox (available on [HInside](#))

The toolbox is intended for use by the teams, including the education managers charged with helping design and define the training mechanism, recruit and train the trainers, design the training curriculum, recruit the students, implement the training, and evaluate and monitor professional training courses falling with the scope of rehabilitation activities.

Even if training projects are already underway, teams are strongly encouraged to reread their intervention procedure in the light of the framework document and the tools that are offered and to identify any new priorities or actions that need to be incorporated.

The tools are not about adopting stereotypical approaches or making everyone's practices the same, but on the contrary, about having the resources to create higher-impact, context-appropriate and realistic training courses. The idea is to be able to take advantage of HI's wealth of rehabilitation experience so that each team does not have to reinvent the wheel – like the core training guidelines – and can devote more time to contextualising them, training local trainers, supporting the students, etc.

The toolbox, to which new documents are added regularly, is organised as follows:

1. Design

- Identifying the training needs based on an in-depth situation analysis
- Developing appropriate training responses: defining the mechanism in accordance with the chosen training type and modality (creating the logical framework, working out partnership agreements, etc.)
- Recruiting and training the trainers, including internship mentors
- Designing and then capitalising on the training curriculum.

2. Implementation (activity guidelines, validating acquired experience, role of the internship mentor, etc.).

3. Evaluation and monitoring of the trainees and the training (training evaluation report, etc.).



Types and modalities of training for physical and functional rehabilitation professionals

Professional skill-building is an essential component of Handicap International's strategy of supporting capacity-building for local actors and professionals providing care to people with disabilities.

For the past several years, Handicap International has been supporting the emergence and development of rehabilitation-related training pathways as a way to contribute to the creation and viability of quality rehabilitation services, and access to them, in reconstruction and development contexts.

An external cross-cutting evaluation of Handicap International-sponsored rehabilitation training programmes in five countries, conducted in 2015, allowed an in-depth analysis of Handicap International's training practices and positioning in a variety of intervention contexts. Its recommendations and discussion of lessons learned served as the basis for this supplementary policy paper on training actions for rehabilitation professionals.

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