NATIONAL DISABILITY INCLUSIVE HEALTH AND REHABILITATION ACTION PLAN

2023-2027

Contents

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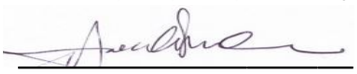
Foreword by **Minister for Health**

The pressing need to fortify rehabilitation services worldwide, particularly in low− and middle−income nations, cannot be overstated. This necessitates ensuring that affordable and high−quality services are readily available to all in need, not only to uphold their fundamental human rights but also to improve their overall health outcomes and foster social and economic advantages.

As articulated in Sustainable Development Goal 3, which espouses universal health coverage, nations must strive to promote equitable access to all types of health services, including rehabilitation. Progress towards universal rehabilitation coverage is far from uniform worldwide, with historical neglect by many governments contributing to underdeveloped and inadequately coordinated services, especially in countries with limited health investment. It is critical to bolster the capacity of countries to prepare for the projected surge in demand for rehabilitation services due to an aging populace, the escalating prevalence of non−communicable diseases, and the increasing number of individuals grappling with injury−related consequences.

Rehabilitation services offer myriad benefits to both individuals and society, including communities and national economies. Investing in rehabilitation augments human potential by enabling individuals with health conditions to attain and maintain optimal functioning, enhance their health, and participate fully in life, such as in education and employment, thereby bolstering their economic productivity. Notably, rehabilitation for children maximizes their development, with far−reaching implications for their involvement in education, community activities, and, later, their employment prospects.



Dr Ratu Atonio Rabici Lalabalavu,
Minister for Health & Medical Services,
Fiji.

Rehabilitation can expedite hospital discharge, prevent readmissions, and enable people to reside in their homes for extended periods. Although the economic benefits linked to these outcomes are often only apparent in long−term analyses, their impact can be profound.

With such a compelling case for increasing rehabilitation services as part of primary care, Fiji has taken the lead regionally with the development of National Disability Inclusive Health and Rehabilitation Action Plan 2023−2027. This document paves the way for increasing the scope of disability and rehabilitation services and aligns our commitment towards SDG 3.

National Disability Inclusive Health and Rehabilitation Action Plan 2023 −2027 has only been possible after a committed effort by multiple stakeholders. This includes MHMS Rehabilitation Services, Tamavua−Twomey Hospital staff, Australia's Fiji Health Program, Motivation Australia, Fiji Council of Person with Disabilities and associated associations. It's taken over 5 years to come up with this Action Plan with COVID−19 related disruptions but now with the endorsed plan in place, it's time to mobilize resources and adhere to the Ministry's commitment.

This commitment is already being complemented by the construction of a new rehabilitation hospital in Tamavua by KOICA, this could not have come at a better time. A new strategy with support from development partners paves the way to make this thematic area a long−term success and I look forward to being part of these new innovations.

I wish all the stakeholders the very best and look forward to the materialization of the Action Plan

Message from the **Permanent Secretary for Health**

I present to you the Ministry's **National Disability Inclusive Health and Rehabilitation Action Plan 2023-2027**, which clearly outlines the strategic priorities and sets the compass for the Ministry for the next 5 years.

It is the collective outcome of a very comprehensive inputs of multisectoral discussions looking at disability inclusiveness at the centre stage, and where we can all take cue from. This action plan clearly will contribute to Fiji's pathway in achieving Universal Health Coverage by ensuring that we reach the unmet and the unreachable.

The Rights of Persons with Disabilities Act 2018 protects the rights of persons with disabilities, and not only establishes the National Council for Persons with Disabilities, but also setting out rights including the right to work and employment, non−discrimination, equal recognition before the law, freedom from exploitation, access to justice, health, participation in political life and adequate standard of living and social protection. The National Disability Inclusive Health and Rehabilitation Action Plan addresses inclusive socio−economic development so that we can improve the social well−being and livelihoods of persons with disabilities. So, we leave no one behind but in unity we join hands for the desired vision.

In line with the Fijian Government commitment, whereby every citizen, irrespective of where they reside, or socioeconomic status are not deprived the equitable and accessible health services. The long−awaited Action Plan will provide us with the prime opportunity to re−design rehabilitation services, focusing on well planned expansion of rehabilitation health services closer to where Fijians live, while uplifting the specialized care and support for Fijians with functional disabilities.

This plan, therefore, has a more in−depth focus on the delivery of rehabilitation services where there will be decentralization of specialized clinical and public rehabilitation health services. Truly, the Ministry will not achieve the outcomes and indicators if it works in isolation. Thus innovatively, we will engineer smarter ways to expand the availability of rehabilitation care and support in communities, and smarter means of doing this for persons with disabilities living in hard−to−reach locations.

We will better the collaboration between stakeholders, in leadership and governance, so that resources can produce a better return of investment and that the elevated information system can be used by stakeholders for policy and evidence driven actions. I end to encourage research in rehabilitation health to produce evidence driven interventions and factual science for policy development and actions.

I must thank World Health Organization, AusFacility, Motivation Australia and other stakeholders for their unwavering support to assist Fiji produce the 5−year action plan through a well−orchestrated stakeholder participation and "the new find" partnership systems.

Message from the **National Council for Persons with Disabilities**

As the national coordinating body for all organizations dealing with the care and rehabilitation of persons with disabilities in Fiji, the National Council for Persons with disabilities is grateful to the government of Fiji through the Ministry of Health and Medical Services and the Australian government through the Fiji Program Support Facility in the adoption of a National Disability Inclusive Health and Rehabilitation Action Plan.

Inclusion is a fundamental human right, and persons with disabilities should have equal access to health services and rehabilitation programs. The establishment of the National Disability Inclusive Health and Rehabilitation Action Plan will address the specific health and rehabilitation needs of persons with disabilities and provide them with the necessary support and services to live full and healthy lives. It will also address some of the barriers that persons with disabilities may face in accessing health care, such as physical and communication barriers, lack of knowledge and training among health care providers, and discrimination.

Its implementation will have a significant impact on the lives of persons with disabilities in Fiji through improved access to health services, increased awareness and understanding of disabilities, enhance rehabilitation services and empowerment of persons with disabilities. Its impact on persons with disabilities will be significant and will lead to improved health outcomes for pesons with disabilities, including better management of chronic conditions and reduced rates of secondary health complications. This will also support persons with disabilities in regaining their independence and improving their quality of life.

The National Council for Persons with Disabilities is looking forward in collaborating with the Ministry of Health and Medical Services, developing partners and relevant stakeholders for the effective implementation of the plan. On behalf of the disability sector in Fiji, the National Council for Persons with Disabilities acknowledged the continuous support of the government of Fiji through the Ministry of Health and Medical Services and the Australian Government through the Fiji Program Support Facility in moving towards an inclusive, barrier free and rights–based society for persons with disabilities in Fiji.

Message from the **Fiji Disabled Peoples Federation**

The Fiji Disabled Peoples Federation (FDPF) is a collective body comprising four major affiliates, each of which is managed and led by individuals with disabilities. These affiliates include the Fiji Association of the Deaf (FAD), Psychiatric Survivors Association of Fiji (PSA), Spinal Injury Association of Fiji (SIA), and the United Blind Persons of Fiji (UBP). Since its inception, the FDPF has been acknowledged as the primary voice for people with disabilities in Fiji.

As per Article 26 of the United Nations Convention on the Rights of Persons with Disabilities, which pertains to habilitation and Rehabilitation, the state is obligated to adopt effective and appropriate measures, including support services, to enable people with disabilities to achieve and maintain maximum independence, full physical, mental, social, and community inclusion, and participation in all aspects of life. This includes enhancing and expanding comprehensive habilitation and rehabilitation services and programs in areas such as healthcare, employment, education, and social services, which support community participation and inclusion and are available to people with disabilities in their own communities, including rural areas. The development of initial and ongoing training for professionals and personnel working in habilitation and rehabilitation services, as well as knowledge about the use of assistive devices and technologies designed for people with disabilities, is also to be promoted.

The Organisations of Persons with Disabilities (OPDs) will continue to collaborate towards the inclusion of people with disabilities and provide their full support for the implementation of the National Disability Inclusive Health and Rehabilitation Action Plan, ensuring that the participation of individuals with disabilities is realized.

The FDPF acknowledges the government, specifically the Ministry of Health and Medical Services, World Health Organization, Fiji Program Support Facility and other stakeholders for engaging with the Organisations of Persons with Disabilities to contribute to the inclusive health and rehab action plan.

Acknowledgements

The authors of this action plan would like to acknowledge all of the contributors to the drafting process. The consultations, reviews and feedback from the various stakeholders improved the overall quality and relevance of Disability Inclusive Health and Rehabilitation Action Plan 2023–27. The MHMS would like to acknowledge the support of the Tamavua Twomey staff, WHO, OPDs and CSOs for their ongoing support and acknowledge all of the internal and external stakeholder who attended consultations and workshops in the drafting process. The authors would also like to acknowledge the persons with disabilities, their families and caregivers who provided valuable contributions to the action plan.

The MHMS would also like to acknowledge the Fiji Program Support Facility and Motivation Australia for their role in supporting to progression of this plan from draft document for review to finalisation.

See Annex A for a list of consultation participants.

Accessibility

Accessibility has been considered when writing and formatting this document to enable broad access to the content, including for people who use screen readers. Both a PDF and word document format are available for ease of use with a screen reader.

Clarification Of Terms

Persons with disabilities	**Those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation on an equal basis with others**[1]
Rehabilitation	Rehabilitation is a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment. It is characterized by interventions that address impairments, activity limitations and participation restrictions, as well as personal and environmental factors (including assistive product) that have an impact on functioning[2].
Health condition	Health condition refers to a disease (acute or chronic), disorder, injury or trauma. It may also include other circumstances such as pregnancy, ageing, stress, congenital anomaly, or genetic predisposition.
Universal Health Coverage	Universal health coverage is defined as ensuring all people have access to the quality promotive, preventive, curative and rehabilitative health services they need, while also ensuring people do not suffer financial hardship when accessing these services[3]
Assistive product	Assistive devices and technologies are those whose primary purpose is to maintain or improve an individual's functioning and independence to facilitate participation and enhance well−being. Assistive devices may also help prevent impairments and secondary health conditions. Examples of assistive devices and technologies include wheelchairs, prostheses, hearings aids, visual aids, and specialized computer software and hardware that increase mobility, hearing, vision, or communication capacities[4].
Inclusion	Inclusion is a universal human right. The aim of inclusion is to embrace all people irrespective of race, gender, disability, medical or other need. It is giving equal access and opportunities and removing discrimination and intolerance (removal of barriers). It affects all aspects of public life.
Disability	Disability refers to the interaction between individuals with a health condition (e.g., cerebral palsy, Down Syndrome and depression) and personal and environmental factors (e.g., negative attitudes, inaccessible transportation and public buildings, and limited social supports).[5]

1 Fiji Rights of Persons with Disabilities Act 2018

2 WHO. Rehabilitation: key for health in the 21st century Retrieved from http://www.who.int/disabilities/care/KeyForHealth21stCentury.pdf?ua=1

3 WHO. Universal health coverage. Retrieved from http://www.who.int/healthsystems/universal_health_coverage/en/

4 WHO. Assistive devices and technology. Retrieved from http://www.who.int/disabilities/technology/en/

5 WHO. Disability and Health Retrieved from https://www.who.int/news−room/fact−sheets/detail/disability−and−health

List of Acronyms

AMU	**Assets Management Unit**
APL	Assistive Products List
CIU	Construction Implementation Unit
CPD	Continuing Professional Development
CRA	Community Rehabilitation Assistant
CWMH	Colonial War Memorial Hospital
OPDs	Organisations for Persons with Disabilities
FDPF	Fiji Disabled People's Federation
FIM	Functional Independence Measure
NCDP	Fiji National Council for Persons with Disabilities
FNU	Fiji National University
FPBS	Pharmaceutical & Biomedical Services Centre
HIV	Human immunodeficiency virus
MDS	Mobility Device Service
MDSC	Mobility Device Services Committee
MHMS	Ministry of Health and Medical Services
NCDs	Non−communicable diseases
NGO	Non−government organisation
NRMH	National Rehabilitation Medicine Hospital
PAS	Patient Administration System
POLHNE	Pacific Open Learning Health Net
PPT	PowerPoint presentation
SDG	Sustainable Development Goals
SIA	Spinal Injuries Association
TB	Tuberculosis
UHC	Universal Health Coverage
WHO	World Health Organisation

1. Executive Summary

The *National Disability Inclusive Health and Rehabilitation Action Plan 2023–2027* outlines relevant background information, including the current picture of rehabilitation in Fiji, and provides a summary of some of the key barriers people face in accessing inclusive health and rehabilitation services. It also includes goals, objectives and activities that when implemented will support disability inclusive health and rehabilitation services in Fiji.

The 2017 Fiji National Census found 13.7 percent of Fiji's population to have a disability with a total of 113,595 persons (aged three and above) reporting at least one functional challenge, or disability[6]. Disability is recognised by the World Health Organisation (WHO) as a global public health concern, human rights issue and development priority[7]. Persons with disability consistently experience lower education levels, less opportunity for employment, greater poverty and poorer health outcomes. With additional barriers in accessing health care services, the inclusion of persons with disability in health planning is essential.

Rehabilitation maximizes people's ability to live, work and learn to their best potential[8], and is a key component of health service delivery. Due to the ageing of the global population along with increasing rates of non–communicable diseases, mental health disorders and incidence of injuries, there is a growing need for rehabilitation services to be available and integrated within multiple levels of health services[9].

While Fiji has seen some significant improvements in population health over the past few decades, particularly with the reduction of the burden of communicable disease, this has been marred by a concurrent increase in the prevalence of non–communicable diseases (NCDs). The combined impact of NCDs and other health conditions contributes to Fijians losing, on average, nine years of full health through years lived with morbidity and functional impairment[10]. There is a strong case for strengthening rehabilitation services in order to positively impact on this trend and increase the health, well–being, inclusion and participation of all children and adults in Fiji.

The vision of the Ministry of Health and Medical Services (MHMS) is 'a healthy population' and the MHMS aims to achieve this by empowering Fijians to achieve optimal health and well–being through delivery of cost effective, quality and inclusive health services[11]. This is reflected in the MHMS National Strategic Plan 2020–2025, which is organized according to three strategic priorities. The focus of the first priority is to reform public health services to provide a population–based approach for diseases and the climate crisis. The second priority is to increase access to quality, safe and patient focused clinical services. The third priority is to drive efficient and effective management of the health system. Through an integrated approach to public health and by strengthening the continuum of care for patients, the MHMS is working to improve the health and well–being of all Fijians and combat the social determinants that affect people's lives, especially the lives of the most vulnerable and marginalised[10].

[6] Fiji Government, 2018. Fiji Bureau of Statistics Releases 2017 Census Results. Retrieved from http://www.fiji.gov.fj/Media–Center/Press–Releases/Fiji–Bureau–of–Statistics–Releases–2017–Census–Res.aspx
[7] WHO, 2015. WHO global disability action plan 2014–2021. Better health for all people with disability, Geneva: WHO
[8] WHO, 2017 Rehabilitation in Health Systems Guidelines
[9] WHO, 2017. Rehabilitation and Disability in the Western Pacific. Manila, Philippines

[10] WHO, 2015. Fiji: WHO Statistical Profile. Retrieved from http://www.who.int/gho/countries/fji.pdf?ua=1
[11] MHMS Strategic Plan 2020–2025 page 3, available at: https://www.health.gov.fj/wp–content/uploads/2020/05/Strategic–Plan–2020–2025–1.pdf

In line with both the health and disability policy objectives, the *National Disability Inclusive Health and Rehabilitation Action Plan 2023–2027* has a vision of contributing to the optimal health and functioning of all Fijian adults and children, particularly those with impairments and disabilities. This Action Plan is grounded in human rights, with a focus on equity and multi–sectoral participation for better integration of health care needs and services of persons with disabilities in the existing health systems.

The development of this Action Plan began with stakeholder consultations in 2013 and has since been informed by further consultations[12], as well as by national, regional and global developments. The primary stakeholders involved in the development of this Action Plan were from Health, however consultations with other key stakeholders were prioritised. This included the National Council for Persons with Disabilities (NCPD), Ministry of Women and Poverty Alleviation, Ministry of Local Government, Ministry of Education Heritage & Arts, I–taukei Affairs, Organisations of Persons with Disabilities (OPDs), Non–Government Organisations (NGOs), caregivers and persons with disabilities.

With the vision that ***All Fijian adults and children, including persons with disabilities, achieve optimal health, functioning and well-being through Inclusive Health and Rehabilitation Services; supporting their attainment of their full potential***, this Action Plan outlines priority steps that can be taken by the MHMS in coordination with other stakeholders to strengthen Fiji's existing health system towards the accessibility of general health services for children and adults with disabilities; and building rehabilitation and assistive product services for all. It is proposed that this will be attained by working toward two key goals, whilst achieving four objectives.

GOAL 1: Inclusive health: Children and adults with disabilities have access to inclusive health services at community, primary, secondary and tertiary levels.

GOAL 2: Rehabilitation: MHMS rehabilitation and assistive products workforce strengthened; and rehabilitation and assistive products services being accessed by all who may benefit

- **Objective 1:** Reduce barriers and improve access to health care services and programs for all adults and children including those with disabilities
- **Objective 2:** Improve the quality and reach of rehabilitation and assistive product services at community, primary, secondary and tertiary levels.
- **Objective 3:** Strengthen disability specific data and information collection throughout the MHMS health information system.
- **Objective 4:** Increase multi–sectoral collaboration for better coordination and more efficient rehabilitation and disability support services at all levels.

Implementation of this Action Plan will require clear direction, coordination and resourcing. It is recommended the MHMS form a Disability Inclusive Health and Rehabilitation Committee to lead on operationalizing this Action Plan. This will include the development of annual work plans, provision of oversight, monitoring, review and evaluation. To further support effective coordination and mobilizing of resources it is recommended that MHMS recruit a Disability Inclusive Health Coordinator and a Rehabilitation Coordinator. These posts are likely to be instrumental in enabling the implementation of the Action Plan, given the time constraints on the existing stretched inclusive health and rehabilitation workforce.

Internal resources in Fiji that could contribute towards the implementation of the Action Plan include the existing health and rehabilitation workforce, tertiary training institutions such as Fiji National University (FNU), Organisations of Persons with a Disability (OPDs) and NGO service providers. External

[12] See Appendix A for a list of official consultation activities

resources include donors, development partners, health and rehabilitation service providers and or tertiary training institutions in neighbouring countries (Australia and New Zealand).

The Action Plan currently offers a high−level overview of recommended activities. While some budget indication has been provided; further work is required in detailed consultation with relevant MHMS departments and personnel to inform specific strategies, timelines and budgets. Confirming first year priorities and carrying out this more detailed work planning would ideally be led by the recommended Disability Inclusive Health and Rehabilitation Committee, in consultation with other relevant stakeholders, and carried out by the recommended Coordinators.

The WHO Health System Building Blocks have been used as a tool to ensure that the suggested objectives and activities appropriately cover all areas of building a sustainable health service. This plan has been checked to ensure it covers all the components appropriately. The building blocks include; (1) Leadership and governance, (2) Service delivery, (3) Health system financing, (4) Health workforce, (5) Medical products, vaccines and technologies and (6) Health information systems[13].

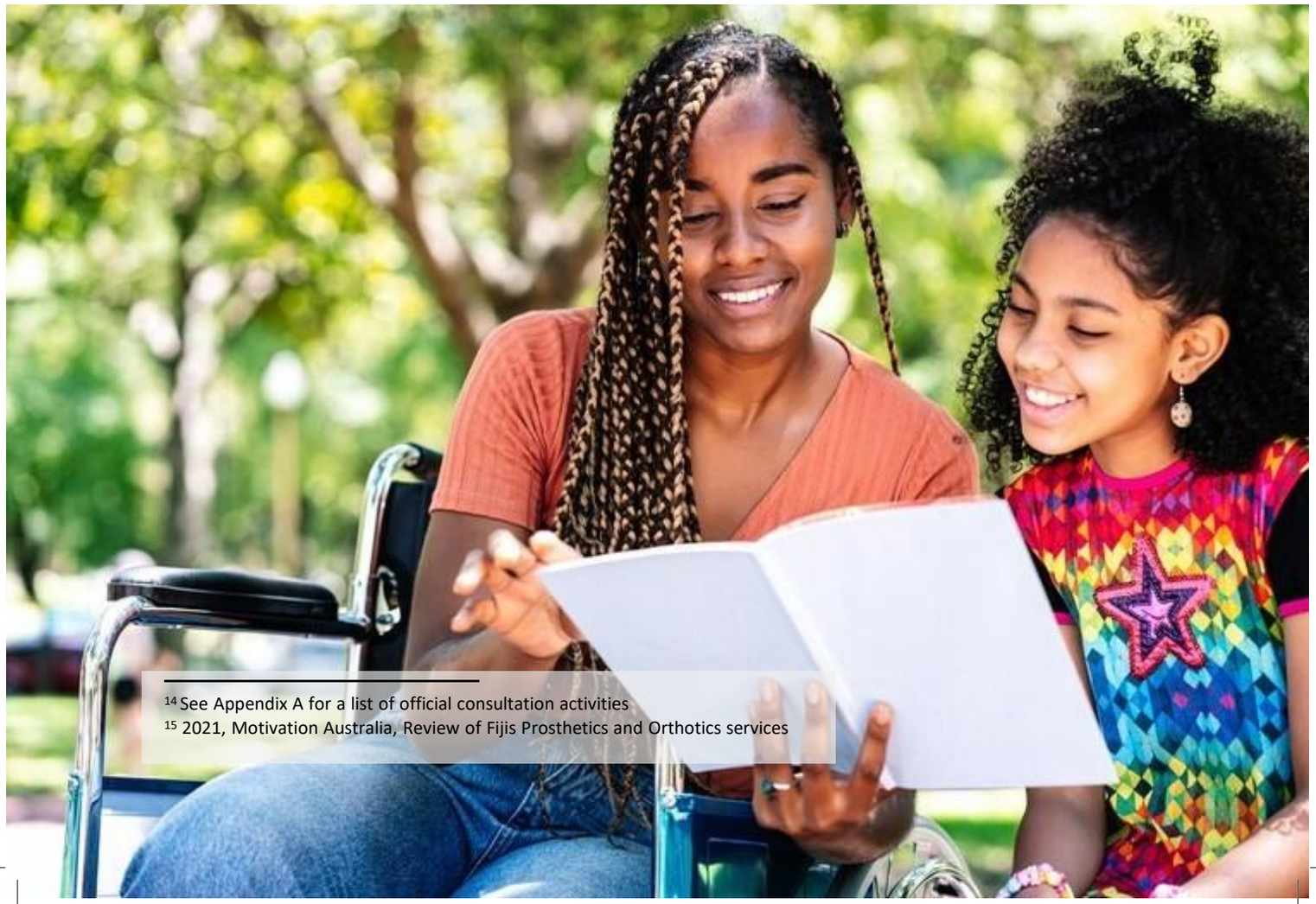
[13] 2019. WHO Rehabilitation in Health systems: Guide to action

2. Introduction

The development of this *Disability Inclusive Health and Rehabilitation Action Plan 2023–2027* began with stakeholder consultations in 2013. Held in four Divisions, these consultations took in the views and suggestions of 75 individuals from Government and civil society; and enabled the initial formation of a plan to strengthen inclusive access to health and rehabilitation services in Fiji. Growing from this beginning in 2013, the Action Plan has been informed by further consultations[14] as well as by national, regional and global developments. The Action plan was reviewed again through consultation workshops in 2022 to update the plan and assure it meets the needs of the sector for the planned period.

This document lays out relevant background information to the proposed Action Plan, including a summary of what is meant by disability inclusive health, an overview of rehabilitation and relevant disability and rehabilitation frameworks. A current picture of rehabilitation in Fiji is provided as well as a summary of some of the key barriers people face in accessing inclusive health and rehabilitation services identified through consultations.

The Action Plan is divided into two goals, focusing on inclusive health and rehabilitation, which are supported by four objectives. Activities outlined under each objective in the Action Plan focus on those actions that are the responsibility of the Ministry of Health and Medical Services (MHMS) as the leading health service provider in Fiji. It is intended that the Action Plan complement Fiji's existing national commitments outlined in the Fiji Rights of Persons with Disabilities Act 2018, the Fiji MHMS Health Strategic Plan 2020 − 2025 and recommendations from the Prosthetics and Orthotics (PO) review from 2021[15]. A Wellness Strategic plan 2022−2030 when released, will be informed by this Action Plan to ensure they align. The head of wellness and NCD's (MHMS) has been involved in the co−design of this Action Plan.



[14] See Appendix A for a list of official consultation activities
[15] 2021, Motivation Australia, Review of Fijis Prosthetics and Orthotics services

3. Background Information

3.1. Disability inclusive health

The World Health Organisation (WHO) estimates there to be more than 1 billion people worldwide living with a disability[16], equating to approximately 15% of the adult population[17]. The 2017 Fiji National Census found 13.7 percent of Fiji's population to have a disability with a total of 113,595 persons (aged three and above) reporting at least one functional challenge, or disability[18]. Disability is recognised by WHO as a global public health concern, human rights issue and development priority[19]. Persons with disability consistently experience lower education levels, less opportunity for employment, greater poverty and poorer health outcomes.

Persons with disabilities have the same general health care needs as others. However, WHO estimates they are:

- Twice as likely to find health care providers' skills and facilities inadequate for their needs
- Three times more likely to be denied health care
- Four times more likely to be treated badly in the health care system[20].

With additional barriers in accessing health care services, the inclusion of persons with disabilities in health planning is essential. To achieve the Sustainable Development Goals (SDGs) and 'leave no−one behind', efforts must be made to remove barriers and increase accessibility for persons with disabilities to the Fiji's health services.

3.2. Rehabilitation

Rehabilitation encompasses a range of interventions aimed at optimizing the functional abilities of a child or adult. Rehabilitation maximizes people's ability to live, work and learn to their best potential[21], and is relevant for anyone with a functional impairment including persons with disabling health conditions, children and adults living with a disability and people who are ageing and experiencing functional losses.

While rehabilitation services can be delivered in many settings, rehabilitation is a key component of health service delivery. This is recognized within the definition of Universal Health Coverage (UHC): "UHC means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective...".

Due to the ageing of the global population coupled with increasing rates of non−communicable diseases, mental health disorders and incidence of injuries, there is a growing need for rehabilitation services to be available and integrated within multiple levels of health services, from primary to tertiary settings[22].

3.3. Relevant frameworks

[16] WHO, World Bank, 2011. World Report on Disability, Geneva: WHO
[17] WHO, 2017. Rehabilitation and Disability in the Western Pacific. Manila, Philippines
[18] Fiji Government, 2018. Fiji Bureau of Statistics Releases 2017 Census Results. Retrieved from http://www.fiji.gov.fj/Media−Center/Press−Releases/Fiji−Bureau−of−Statistics−Releases−2017−Census−Res.aspx
[19] WHO, 2015. WHO global disability action plan 2014−2021. Better health for all people with disability, Geneva: WHO
[20] WHO Better health for people with disability infographic. (Source: WHO, 2011. World report on disability)
[21] WHO, 2017 Rehabilitation in Health Systems Guidelines
[22] WHO, 2017. Rehabilitation and Disability in the Western Pacific. Manila, Philippines

Global and regional commitments: In focusing on disability inclusive health services and strengthening rehabilitation, the Action Plan supports existing Fiji Government commitments and strategies. This includes Fiji's commitment to global and regional frameworks and conventions: Sustainable Development Goals, Universal Health Coverage, the Convention on the Rights of Persons with Disabilities and the Incheon Strategy to Make the Right Real for persons with disabilities[23].

National commitments:

- The Fiji Rights of Persons with Disabilities Act 2018 recognises the rights of persons with disabilities in Fiji to enjoy the highest attainable standard of health with access to free or affordable quality health care close to their community.
- The Fiji MHMS Health Strategic Plan 2020 – 2025 aims to provide a more integrated service for rehabilitative care across the different levels of the health system and strengthened services for children and the elderly.
- The MHMS previous Non–Communicable Diseases Strategic Plan 2015 – 2019 identifies rehabilitation as a key component of health care for persons with non–communicable diseases (NCDs). The new Wellness Strategic Plan 2022–2030 is currently being drafted and will incorporate the components of the Action Plan.

The Disability- inclusive Health Services Toolkit (WHO): A Resource for Health Facilities in the Western Pacific Region supports the rights of persons with disabilities to have the same access to health services as persons without disabilities. The Toolkit provides practical guidance to managers and staff of health–care facilities and services, health policy–makers, and non–governmental organizations on identifying and addressing barriers to health information and services. The Toolkit supports the achievement of universal health coverage (UHC) by ensuring everyone can access health information and can benefit equally from health services.[24] It is anticipated that a training package for this toolkit will be released during the relevant years of this strategic plan.

Rehabilitation Competency Framework: Competency frameworks are a key tool for aligning the workforce with population needs through supporting competency–based education and training and regulatory standards, and the development of instruments for performance appraisal and gap analysis, among other applications. This framework is focused on strengthening rehabilitation services but not specifically on disability inclusion.

3.4. Fiji health trends impacting on the need for rehabilitation

Fiji has seen some significant improvements in population health over the past few decades. Total expenditure on health has increased; maternal and infant health outcomes have improved; under five child mortality has decreased; and there has been a decrease in communicable disease[25].

The reduction in the burden of communicable diseases has however been marred by a concurrent increase in the prevalence of NCDs. These conditions are now the main cause of death in Fiji, accounting for over 80% of total deaths; on average, and 30–40% of premature deaths before the age of 60[26].

Admission statistics from the National Rehabilitation Medicine Hospital (NRMH) indicate the impact on health and rehabilitation services driven by NCDs. In august 2020 – July 2021, 54.1% of people

[23] UN, 2018. Incheon Strategy to Make the Right Real for persons with disabilities
[24] WHO, 2020 Disability–inclusive health services toolkit, WHO https://apps.who.int/iris/handle/10665/336857
[25] MHMS, 2015. National Strategic Plan 2016–2020
[26] MHMS, 2017. Health Status Report 2016.

admitted for in−patient treatment had a stroke; while of the out−patient case load 60% had amputations and 19% a stroke[27]

While increased risk of morbidity is primarily attributed to NCDs, other causes of morbidity in Fiji that should be considered when planning inclusive health and rehabilitation include: neuro−psychiatric conditions; injuries; maternal, neonatal and nutritional deficiencies; communicable diseases; respiratory diseases; musculoskeletal diseases; and human immunodeficiency virus (HIV), tuberculosis (TB), and malaria[8]. NRMH reports that in august 2020 − July 2021, 24% of those admitted for inpatient treatment had spinal cord injuries[28].

The combined impact of NCD and other health conditions contributes to Fijians losing, on average, nine years of full health through years lived with morbidity and functional impairment[29]. There is a strong case for strengthening rehabilitation services in order to positively impact on this trend and increase the health, well−being, inclusion and participation of children and adults in Fiji.

3.5. Rehabilitation and assistive product services in Fiji

In Fiji, there is a well−established infrastructure for health services that supports a continuum of care including community based primary health care services, three divisional hospitals and sixteen sub−divisional hospitals[30]. Hospital based services provide acute and ongoing rehabilitation services to a range of service users. Referrals from these services are to community−based rehabilitation, other hospital departments or to the prosthetics and orthotics department.

The Colonial War Memorial Hospital (CWMH) serves as the national referral hospital. St. Giles Psychiatric Hospital provides specialized psychiatric care and Tamavua/Twomey Hospital blends three specialized hospital services (Tuberculosis unit, Leprosy and Dermatology, and Rehabilitation).

As Fiji's only dedicated physical rehabilitation centre, the National Rehabilitation Medicine Hospital (NRMH) is integral in the delivery of health and rehabilitation services, focusing in particular on the rehabilitation of adults with spinal injuries, traumatic injuries, amputation and other health conditions. Situated in Tamavua, NRMH has a bed capacity of 20, however facilities need renovation.

Figure 3.5.1 Current package of rehabilitation services

Current Services	
Hospital based Services	**Community based services**

• Acute based services (Divisional and sub−divisional hospitals) and Sub−acute to chronic services (National Rehab Medicine hospital)
• Focused on:
  ○ Referrals
  ○ Provision of therapy and follow up
  ○ Prescription of mobility devices
  ○ Referrals
	• Community Rehabilitation Assistants (CRA) working in the community
	• Physiotherapists at sub−divisional hospitals
	• Focused on:
	  ○ Empowering PWDs and their families/care givers
	  ○ Health promotion
	  ○ Early identification
	  ○ Interventions in the homes of clients

[27] Singh, Rehab Annual Report August 2020−July 2021
[28] Singh, Rehab Annual Report August 2020−July 2021
[29] WHO, 2015. Fiji: WHO Statistical Profile. Retrieved from http://www.who.int/gho/countries/fji.pdf?ua=1
[30] Snowden et al. 2013. Non−communicable diseases and health system responses in Fiji. Nossal Institute for Global Health, University of Melbourne.

○ Provision of therapy and follow up ○ Prosthetic and Orthotic services ○ Patient and family education ○ Caregiver training program for inpatients	○ Maintaining and sharing appropriate data ○ Follow ups ○ Referral facilitation ○ Networking with Stakeholders at the sub−divisional level
Outreach services (All districts)	
• Hospital based clinics and home visits • Multi−disciplinary staff working with local CRA, Physiotherapists and Zone Nurses • Focused on: ○ Prosthetic and orthotics assessments, measurements, Fitting and gait−training ○ Prescription of mobility aids ○ Supply medical supplies ○ Physiotherapy services ○ Family education ○ Referrals (other services and specialists) ○ Home assessments	

In recent years NRMH has initiated a regular mobile rehabilitation service (outreach programme) in an effort to increase the geographical reach of their specialist rehabilitation services. Reviewed in 2017, the outreach programme was recognized as being 'highly relevant and well aligned with the international and national priorities and commitments of the Government of Fiji, and national health needs, particularly those related to non−communicable diseases'[31]. Many of the recommendations made through the review align with the goals, objectives and actions outlined in the Action Plan.

In 2021 a review of the prosthetics and orthotics services was completed by Motivation Australia and recommendations for strengthening the services were put forward. This P&O review considered the Disability Inclusive Health and Rehabilitation Action Plan Zero Draft. Following recommendations made, in 2021−22 plans to upgrade the inpatient and outpatient departments have been put in place, with both renovations starting in 2022. The inpatient renovations will allow for a more purpose−built rehabilitation facility that is more disability inclusive. This will also help to meet service demands while a rebuild of the Tamavua Hospital is occurring to significantly increase the capacity and resources of the rehabilitation department.

As services develop throughout the period of this Action Plan it will be essential that the suggested objectives and activities are monitored and evaluated to ensure the desired outcomes are being achieved.

Baker, 2017, Evaluation of Fiji Mobile Rehabilitation Service (Draft Report).

WHO BENEFITS FROM REHABILITATION?

Rehabilitation services benefit health and society, for individuals, communities and national economies.

Investment in rehabilitation increases human capacity by allowing persons with a health condition to achieve and maintain optimal functioning, by improving their health and by increasing their participation in life, such as in education and work, thus increasing their economic productivity.

For children in particular, rehabilitation optimizes development, with far−reaching implications for participation in education, community activities and in later years, work.

Rehabilitation can also expedite hospital discharge, prevent readmission and allow people to remain longer in their homes.

Rehabilitation in health services, WHO 2017

The MHMS rehabilitation workforce consists primarily of physiotherapists, community rehabilitation assistants (CRAs), doctors and nurses. Managed by the superintendent physiotherapist based at CWMH, there are currently 51 physiotherapists (56 positions available) operating in eighteen locations across MHMS services. These personnel provide in−patient and out−patient rehabilitation services to both children and adults. Recent initiatives led by physiotherapists include the in−formal establishment of multi−disciplinary rehabilitation teams (physiotherapy and medical personnel) at CWMH, Lautoka and Labasa. These initiatives have focused on priority needs including stroke and diabetic foot management. Physiotherapists are also based at NRMH, within Early Intervention Centres and Special Schools.

The CRA programme is managed as part of NRMH services. There are currently nine CRAs within the MHMS workforce. Two of these staff operate from the NRMH, and the remainder work at Sub−Division level[32] CRAs are responsible for the early identification, promotion and implementation of primary health care initiatives, rehabilitation and referral to specialized services. They provide an important link for people in rural and remote areas, who otherwise would not be able to access health or rehabilitation related services and play a role in preventing secondary conditions and co−morbidities, promoting function, providing health information and supporting family members. The numbers of CRAs employed under the MHMS has declined in recent years reducing the reach of the CRA programme after the retirement of the CRA coordinator in June 2021 and the position was not funded after this time.

There are some assistive products made available to Fijians and these include prosthetic and orthotic devices, walking aids, wheelchairs, some vision and hearing assistive products and a limited range of self−care equipment. The Prosthetic Department at the NRMH is staffed by one prosthetist and three splint makers. This team provides below knee prosthetic limbs using the exo−skeletal Jaipur Limb technology to patients at no cost. In 2017, the Department introduced the endo−skeletal type prosthesis supporting BKAs and AKAs. Regular supplies of the components are donated by the LDS church and prosthesis are provided free of charge. More recently, the MHMS has been supported by the AusFacility to trial the use of International Committee of the Red Cross (ICRC) components for prosthesis.

Non−Government Organisations (NGOs) support the work of health professionals in the care and provision of assistive devices for persons with disabilities. This includes collaborative initiatives to

[32] CRAs are based at Sub−Division level in Suva, Rewa, Tailevu, Tavua, Lautoka/Yasawa, Nadi and Cakaudrove.

strengthen the provision of walking aids and wheelchairs independently and in coordination with MHMS physiotherapists; and the implementation of a hearing screening programme and provision of hearing aids. Despite these initiatives, existing assistive product services are limited in capacity, scope and reach; with only a minority of those who need assistive products being able to access them.

ASSISTIVE PRODUCTS IN THE CONTEXT OF REHABILITATION

Assistive products include any item or piece of equipment that helps a child or adult carry out tasks they might not otherwise be able to do well or at all. Examples include: wheelchairs, prostheses, orthoses, walking aids, hearing aids, white canes, low vision aids.

The provision of assistive products is often a key intervention within rehabilitation services. Assistive products help reduce the impact of impairment and increase, maintain, or improve the ability of people to carry out daily activities, and be an active part of family, community and civil life.

In 2016, WHO launched the priority assistive products list (APL), which includes 50 priority assistive products The list provides member states with a model from which to develop a national priority assistive products list according to national need and available resources. The APL can be used to guide product development, production, service delivery, market shaping, procurement, and reimbursement policies.

3.6. Decentralization of services

Strategic priority 2.2 from the Fiji MHMS Strategic Plan 2020–2025[33] aims to strengthen and decentralise effective clinical services, including rehabilitation, to meet the needs of the population. Decentralisation presents large opportunities for differing levels of action and different stages in its purpose of providing the service to all Fijians.

Both strengthening of the service and decentralising are important components as without a strong central service, it is not effective to spread the already limited resources. It is recommended that an external review of the current services and needs for strengthening undertaken to develop recommendations for the process of strengthening and decentralisation. The P&O review completed by Motivation Australia in 2021 outlines how this process could occur for the P&O services. Starting with strengthening the central service, developing hub type workshops and working towards have services based in all districts.

3.7. Identified barriers and challenges

Consultations towards the development of the Action Plan[34] identified specific barriers and challenges to disability inclusive health and rehabilitation. The barriers (details in Annex G) can be categorized and summarised under the following domains:

Service Provision:

- Services are urban centred and currently not receiving the required funding
- Poor communication across departments and services
- Disability inclusivity of services requires improvement

[33]Fiji MHMS 2020, Strategic Plan 2020–2025
[34]Reports on the Stakeholder Meeting on the Development of National Rehabilitation Medicine Strategic Plan 2014 – 2018

Workforce:

- There is a lack of staff required to fill the roles
- A lack of specialised staff filling highly skilled roles

Access to services:

- Physical access to buildings is difficult for those with mobility disabilities
- Distance of travel for services users is a challenge for many services users
- Lacking strong referral pathways between services
- Clients cannot easily access information about services available

In addition, studies have demonstrated challenges with accessing rehabilitation. For example, one study showed that only a few people who survived stroke accessed the available rehabilitation services of the MHMS and the length of stay and access to rehabilitation was inadequate for over half of these people[35]. Another study highlighted the need to strengthen diabetes screening and enhance intervention programmes since uncontrolled diabetes is the most significant factor associated with amputations in the country[36].

3.8. Effects of Global Pandemics and Disasters

In the previous four (2019−2022) years the global health landscape has seen significant changes due to the COVID−19 pandemic causing significant challenges to health systems worldwide. Additionally, Fiji's natural environment and geographical location places it at risk of naturally occurring disasters. This has highlighted the importance of reducing risk and preparing for various types of disasters. Disability inclusion is an important component to consider when responding to disasters and pandemics to ensure that everyone's right to access healthcare is achieved.

Fiji Emergency Medical Assistance Team (FEMAT)

FEMAT has been established to strengthen Fiji's ability to respond to large scale emergencies and provide acute medical treatment and support. The MHMS strategic plan for 2020−2025 outlines the goal; 'FEMAT's role strengthened as part of the overall response to outbreaks and disasters as well as deployment for outreach services, including a range of medical and emergency services.'

The groups developed from the activities in this Action Plan should assist FEMAT with understanding the disability inclusion requirements for disaster response. FEMAT will also be consulted as part of the stakeholder networks of rehabilitation to assist with improved preparedness for disasters and better planning for outreach services.

[35]Waloki, et al. Stroke Rehabilitation in Fiji: are patients receiving services. Public Health Action 2014; 4(3) 150 − 154.
[36]Kumar, et al, Descriptive Analysis of Diabetes−related amputations at the Colonial War Memorial Hospital, Fiji, 2010 − 2012. Public Health Action 2014; 4(3): 155 − 158

4. Action Plan Overview

4.1. Vision

All Fijian adults and children, including persons with disabilities, achieve optimal health, functioning and well−being through Inclusive Health and Rehabilitation Services, supporting the attainment of their full potential.

4.2. Summary of goals and objectives

The two overarching goals for this action plan are:

- GOAL 1**: Inclusive health:** Children and adults with disabilities have access to inclusive health services at community, primary, secondary and tertiary levels.
- GOAL 2**: Rehabilitation:** MHMS rehabilitation and assistive products workforce is strengthened; and rehabilitation and assistive products services are being accessed by all who may benefit.

There are four objectives and 11 activities that have been developed, to achieve the goals of the action plan. The objectives and activities all align and contribute to various building blocks of a health system as suggested by WHO.

Figure 4.2.1

Objectives	Activities	WHO Building Blocks
1. Reduce barriers and improve access to health care services and programs for all adults and children including those with disabilities	1.1. Address inclusion and equity of access to health services by children and adults with disabilities in health policy, planning and budgeting. 1.2. Raise awareness and train health personnel in practical ways to increase disability inclusion 1.3. Reduce physical barriers to health facilities	Service Delivery, Health Workforce, Financing, Leadership and Governance
2. Improve the quality and reach of rehabilitation and assistive product services at community, primary, secondary and tertiary levels	2.1. Increase awareness of the need and demand for rehabilitation within the health sector 2.2. Strengthen rehabilitation services at tertiary and secondary levels (hospital based); and primary and community levels (outreach) 2.3. Strengthen and expand mobility device services (walking aids, wheelchairs, prosthetics) 2.4. Strengthen provision of basic assistive products for vision, hearing and other 2.5: Expand the expertise and skills of MHMS personnel in rehabilitation and assistive product service delivery	Service Delivery, Health Workforce, Health Information, Medical Products, Vaccines and Technologies, Leadership and Governance
3. Strengthen disability specific data and information collection throughout the MHMS health information system	3.1. Ensure inclusion of disability in health surveys including demographic health surveys; facilitate analysis and dissemination of survey findings 3.2. Increase evidence base to strengthen disability inclusion, and effectiveness of rehabilitation and assistive products services	Health information, Service Delivery
4. Increase multi−sectoral collaboration for better coordination and more efficient rehabilitation and disability support services at all levels.	4.1. Develop National Rehabilitation and Disability Network	Leadership and Governance, Service Delivery, Health Workforce, Health Information

4.3. Guiding principles

Implementation of the Action Plan will be guided by the following principles:

- **Integrated services:** Actions will focus on increasing the integration of disability inclusive health, rehabilitation and assistive product services into the Fiji health system and where−ever possible between primary, secondary and tertiary levels.
- **Equitable services:** Attention will be given to addressing inequities and disparities between different social, demographic, economic and geographical groups. In recognition of health being a fundamental human right, there will be targeted actions to ensure all people have equal opportunities to access the resources they need to improve and maintain their health. Gender should also be used a lens when considering, planning, implementing and evaluating all activities.
- **Person centred services:** Service users, including children and adults with disabilities, will be given every opportunity to be informed, active participants in the planning, delivery and choices to be made regarding their health, rehabilitation and assistive product services.

4.4. Time frame and costs

The Action Plan covers a five−year period from 2023−27. It is expected that the Plan be reviewed mid−term and modified to reflect progress and achievements; new information; learning; and changes in context. Therefore, there is greater detail in those activities identified as priorities in the first 1−3 years.

Indicative costs are included; however, it should be noted that these are estimates. It is expected that more comprehensive costings will be undertaken in the process of the preparation of each annual work plan.

4.5. Implementation strategy

Implementation of the Action Plan will require clear direction, coordination and resourcing. It is recommended that the MHMS form a Disability Inclusive Health and Rehabilitation Committee to lead on operationalizing the Action Plan, including development of each annual work plan and provision of oversight as activities are implemented.

Many of the activities described in the Action Plan require effective coordination and mobilizing of existing resources in Fiji or externally. For this reason, the Action Plan also recommends the recruitment of a Disability Inclusive Health Coordinator (to lead on objective 1) and a Rehabilitation Coordinator (to lead on objectives 2, 3 and 4). These posts are recommended as key to facilitating the implementation of the Action Plan, particularly given the time constraints on an already stretched inclusive health and rehabilitation workforce. Job descriptions including an indicative salary band for these two posts can be found in Annex B.

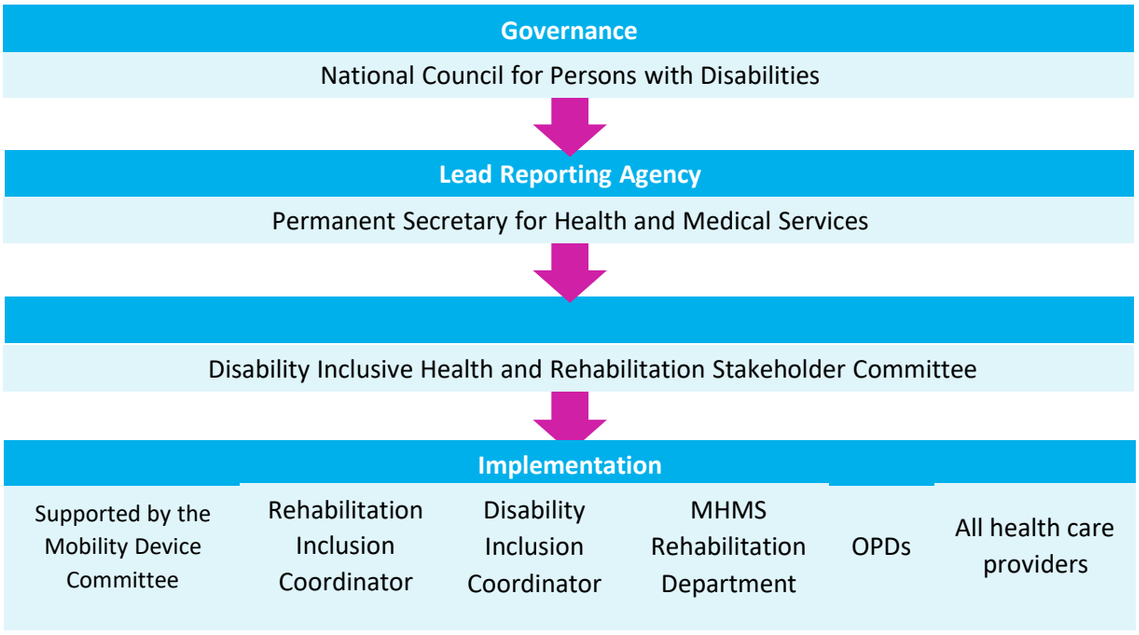
Internal resources in Fiji that could contribute towards the implementation of the Action Plan include the existing health and rehabilitation workforce, tertiary training institutions such as Fiji National University (FNU), Organisations of Persons with Disabilities (OPDs) and NGO service providers. External resources include donors, development partners, health and rehabilitation service providers and or tertiary training institutions in neighbouring countries (Australia and New Zealand).

The Action Plan currently offers a high−level overview of recommended activities. While some budget indication has been provided; further work is required in detailed consultation with relevant MHMS departments and personnel to inform specific strategies, time−lines and budgets. Confirming first year priorities and carrying out this more detailed work planning would ideally be led by the recommended Disability Inclusive Health and Rehabilitation Committee, in consultation with other relevant stakeholders, and carried out by the recommended Coordinators.

4.6. Governance structure

Strong and clear governance over the implementation of the Action Plan will strengthen the activities and help to clarify who is responsible for ensuring the Action Plan outcomes are achieved. The suggested governance structure has been outlined below. With agreement this can be adjusted however it is recommended that clear governance is maintained to assist with clear decision−making processes and responsibility. The structure is outlined in 3.6 below.

Figure 4.6.1



4.7. Monitoring, Evaluation and Learning (MEL)

Monitoring, evaluation and learning are essential elements of the action plan. By monitoring clearly defined meaningful indicators we can measure our progress towards outcomes and goals. The element of 'learning' is crucial for continuous quality improvement processes, demonstrating where we don't reach expected outcomes, we need to assess the reasons and adjust our interventions or strategies. A mid−and end−term evaluation will assist us to know about the effectiveness and efficiency of our work and give valuable insights for future programming.

The monitoring and reporting on implementation of this action plan will be the responsibility of the proposed Disability Inclusive Health and Rehabilitation Stakeholder Committee. Effective and regular monitoring will serve to ensure progress is being made, the Action Plan continues to be relevant, and to inform the Action Plan mid−term and final review and evaluation. Close consultation and liaison within the monitoring and evaluation process with health, disability, education and social welfare stakeholders in Fiji will be important. It will ensure that implementation of this Action Plan effectively supports overall national strengthening of Fiji's capacity to meet national and regional disability rights, health and sustainable development commitments.

A robust and detailed annual MEL framework needs to be developed and accompany each annual work plan. The MEL framework needs to clearly articulate:

- The indicators to be used
- Baseline data
- Set targets for the annual period and overall project period

- Data sources to be used (means of verification)
- The frequency of measuring the indicator
- The person responsible

Annex D shows a template which has examples based on the overall goals of the action plan, details need to be completed once the annual activities are determined.

Indicators

Indicators need to be meaningful and easily measurable and should also be valid, reliable, relevant, actionable and ideally also internationally feasible and comparable. Indicators that require baseline data are ideally currently collected or need to be collected before interventions start. The final indicators will be decided on by the Disability Inclusive Health Stakeholder Committee. Indicators can come from the WHO Rehabilitation Indicator Menu[37] or be locally developed. A list of potential indicators are included in Figure 3.7.1.

Considering equitable access to services, it will be of significant importance that sex disaggregated data is collected for all indicators at all levels, so that any disparities can be addressed with relevant interventions. The 2015−2019 Rehab Hospital data (combined outreach, clinic, admissions) show that of the 7952 service contacts, 63% were by males, while only 37% were by females. This demonstrates a large gender disparity in accessing rehab services and the importance that sex disaggregated data plays.

Figure 4.7.1: Objectives, activities and potential indicators

Objectives	Activities	Potential Indicators
1. Reduce barriers and improve access to health care services and programs for all adults and children including those with disabilities	1.1. Address inclusion and equity of access to health services by children and adults with disabilities in health policy, planning and budgeting. 1.2. Raise awareness and train health personnel in practical ways to increase disability inclusion 1.3. Reduce physical barriers to health facilities	1.1.1 List of names of policies that had disability inclusion and access added at review date. 1.1.2 % of new policies that contain disability inclusion. 1.1.3 Budgeting for disability inclusion and access. 1.1.4 Expenditure for disability inclusion and access 1.2.1 Disability inclusion relevant resources developed, training delivered, no of events, participant numbers, cadre of health staff, pre−and post−tests 1.3.1 No of access audits of health facilities conducted 1.3.2 No of recommendations from audits actioned
2. Improve the quality and reach of rehabilitation and assistive product services at community,	1.1. Increase awareness of the need and demand for rehabilitation within the health sector 1.2. Strengthen rehabilitation services at tertiary and	2.1.1 Health professionals' awareness raising activities, resources developed, sessions held, no of participants by cadre 2.2.1 Role delineation assessment − staff audit − staffing levels

[37] WHO, 2019. Rehabilitation Indicator Menu, A tool accompanying the Framework for Rehabilitation Monitoring and Evaluation (FRAME)

Objectives	Activities	Potential Indicators
primary, secondary and tertiary levels	secondary levels (hospital based); and primary and community levels (outreach) 1.3. Strengthen and expand mobility device services (walking aids, wheelchairs, prosthetics) 1.4. Strengthen provision of basic assistive products for vision, hearing and other 1.5. Expand the expertise and skills of MHMS personnel in rehabilitation and assistive product service delivery	2.2.2 No of SOPs, guidelines, frameworks developed and socialised 2.2.3 No of outreach services conducted 2.3.1 No of wheelchair repairs, maintenance conducted by facility 2.3.2 No of prosthetics fitted by facility 2.3.3 No of wheelchairs fitted by facility 2.3.4 No of prosthetic–orthotic personnel in training 2.3.5 No of services provided at satellite services 2.4.1 Audit of existing services completed 2.5.1 Training needs assessment conducted, and relevant PD sessions held 2.5.2 No of referrals between OPDs and MHMS
3. Strengthen disability specific data and information collection throughout the MHMS health information system	3.1 Ensure inclusion of disability in health surveys including demographic health surveys; facilitate analysis and dissemination of survey findings 3.2 Increase evidence base to strengthen disability inclusion, and effectiveness of rehabilitation and assistive products services	3.1.1 No of new indicators related to disability inclusion and service tracking added to PAS 3.1.2 Evidence of new indicators used in service planning 3.2.1 No of locally conducted research pieces relevant to disability and rehab
4. Increase multi–sectoral collaboration for better coordination and more efficient rehabilitation and disability support services at all levels.	4.1 Develop National Rehabilitation and Disability Network	4.1.1 National disability and rehabilitation network established, TOR developed, no of meetings conducted

4.8. MEL Plan

Monitoring and Learning: Some service data will be extracted from routine monthly reports and analysed and reported 6–monthly. The 6–monthly progress towards meeting the target needs to be discussed in the proposed Disability Inclusive Health and Rehabilitation Stakeholder Committee, where achievements should be celebrated, and shortfalls analysed so that actions for correction can be made. Annual data reports need to be prepared and presented in a user–friendly way to ensure that annual service planning is based on data and progress made.

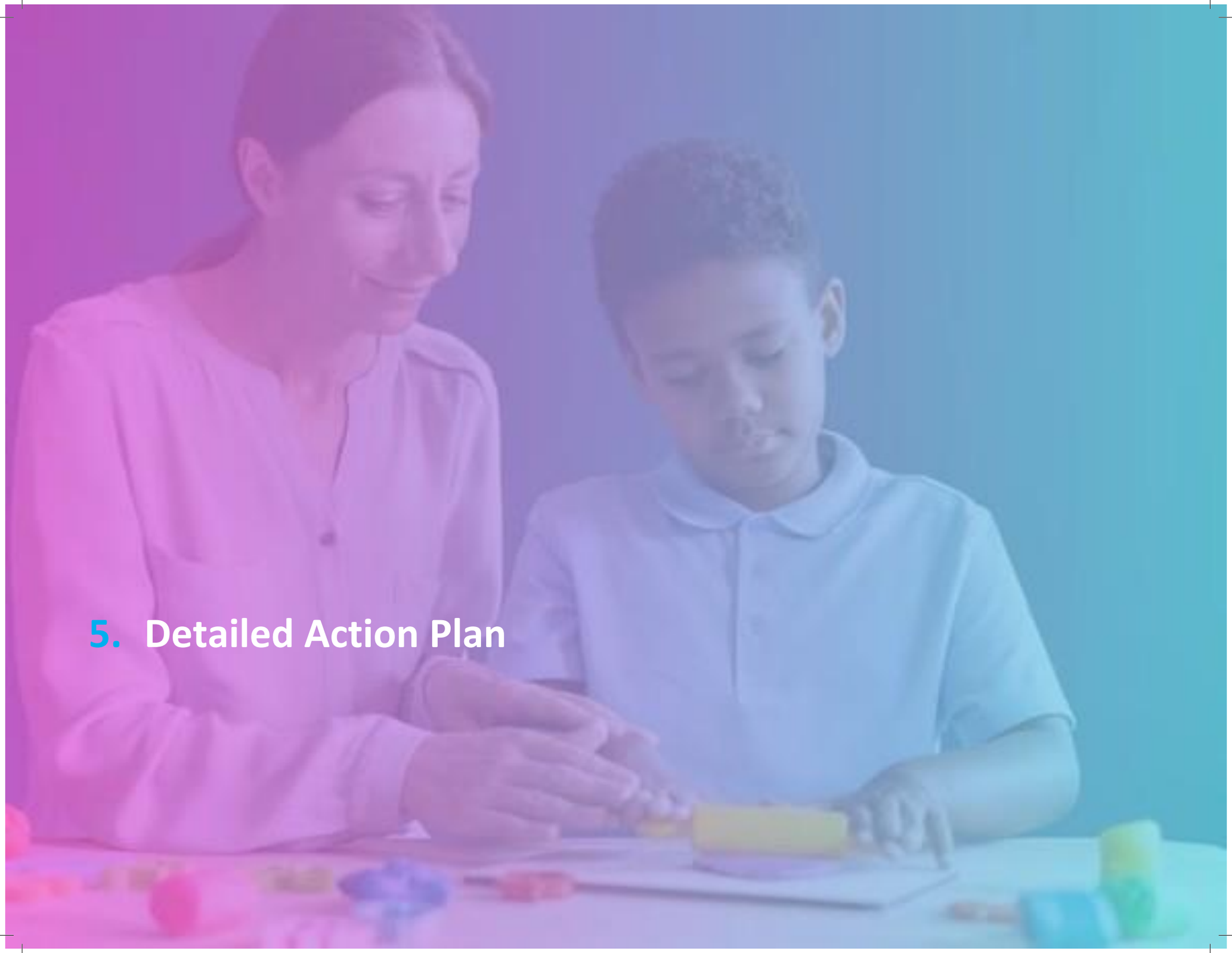
Evaluation: is suggested that a mid−term review is conducted, providing a platform to take correctional measures if needed and to document strategies that have worked well to achieve the goals. An evaluation should be conducted towards the end of the 5 years, early enough to feed into the development of a follow−on plan. Mid−term and end line evaluation should be conducted externally and multiple stakeholders need to have the opportunity to provide feedback.

4.9. Suggested Review

A new Action Plan for 2026−2030 should be developed in 2025 following a review of the achievements and remaining activities of this Action Plan. Considerations should be made for changes to the health and disability systems and learnings from this plan. Stakeholders will be given the opportunity to report on their role in the current Action Plan and suggestions for the new Action Plan.

4.10. Responsibility

It is the responsibility of the Rehabilitation and Disability Inclusion Coordinators to action the activities and ensure that they are being implemented. This includes liaising with the relevant departments and staff who may need to be responsible, accountable, consulted or informed. These roles will be governed as outlined in 4.6 of this report.



5. Detailed Action Plan

5.1. Objective 1: Reduce barriers; improve access to health care services for all adults and children including those with disabilities

Activity 1.1: Address inclusion and equity of access to health services by children and adults with disabilities in health policy, planning and budgeting.

Sub activities	Responsibility	Time frame	Budget implication FJD
1.1.1. Support principles of disability inclusion in all new health policies, plans and guidelines and budgeting processes.	Disability inclusion coordinator with oversight from the Disability Inclusive Health and Rehabilitation Committee.	2023 to 2027	Cost neutral (included in duties of disability inclusion coordinator)
1.1.2. Ensure annual budgeting includes resourcing of prioritized disability inclusion activities (for example identified in the Action Plan).		2023 to 2027	

Activity 1.2: Raise awareness and train health personnel in practical ways to increase disability inclusion

Sub activities	Responsibility	Time frame	Budget implication FJD
1.2.1. Develop Fiji specific training resources (such as PPT, posters, hand−outs and social media) to facilitate heightened disability inclusive awareness of health personnel and promote practical skills in disability inclusive health	Disability Inclusion Coordinator to lead, seeking input from OPDs, Fiji National Council for Persons with Disabilities (NCDP), MHMS Training Unit, NRMH, rehabilitation personnel. NRMH and OPD team to deliver Division workshops External advisor recommended to support initial content development.	2023	Illustrations, lay−out, reproduction 5,000
1.2.2. Run disability inclusion introduction workshops in each division for senior health services personnel; using training resources developed (see above) and WHO disability inclusive health services toolkit training		2023 to 2024	Workshops (staff travel, refreshments, printing) 20,000
1.2.3. Support senior personnel of division health services to use disability inclusion training resources within routine in−service and continuous professional development for personnel at community, primary, secondary and tertiary health facilities		2023 to 2027	Cost neutral – (If integrated with existing in−service and CPD)

Sub activities	Responsibility	Time frame	Budget implication FJD
1.2.4. Use material developed and lessons learned from the above activities to develop a Disability Inclusion in Health Services on–line module (for example hosted by POLHN[38]) providing an introduction to inclusion for persons with physical, sensory, communication and cognitive impairments in mainstream health services; to enable on–going disability inclusive health continuing professional development (CPD) opportunities for MHMS health personnel.	Disability Inclusion Coordinator to confirm opportunities to develop online resource with potential hosts; and implement.	2025 to 2026	10,000
1.2.5 Integrate disability inclusive training in undergraduate training for clinical health services personnel	Disability Inclusion Coordinator to liaise with relevant FNU Heads of Departments.	2023 to 2027	Requires detailed discussion with FNU

Activity 1.3: Reduce physical barriers to health facilities

Sub activities	Responsibility	Time frame	Budget implication FJD
1.3.1. MHMS Assets Management Unit (AMU) to ensure new building works (renovations and new construction) conform to accessibility standards defined in the Fiji Building Code	Disability Inclusion Coordinator to liaise with AMU Manager	2023 to 2027	Cost neutral (existing legislated commitment)
1.3.2. Develop a checklist for use by AMU managers for internal fixtures and fittings accessibility measures that can be readily included in new building works (for example height of sinks, reception benches, information boards)	Development of internal fixtures and fittings accessibility checklist led by Disability Inclusion Coordinator; supported by an external accessibility consultant; with input from NCDP and Fiji Disabled People's Federation (FDPF) representatives.	2023	8,000

[38] Pacific Open Learning Health Network

Sub activities	Responsibility	Time frame	Budget implication FJD
1.3.3. Run an accessibility workshop to introduce the developed checklist to AMU managers and counterparts in Ministry of Economy Construction Implementation Unit (CIU) and Ministry of Infrastructure and Transport (Building Department).	External accessibility consultant and OPD representatives.	2023 to 2027	5,000

5.2. Objective 2: Improve the quality and reach of rehabilitation and assistive product services at community, primary, secondary and tertiary levels

Activity 2.1: Increase awareness of the need and demand for rehabilitation within the health sector

Sub activities	Responsibility	Time frame	Budget implication FJD
2.1.1. Develop a basic training tool that introduces rehabilitation (what is it, who needs it) and existing rehabilitation opportunities in Fiji; and disseminate to health personnel through Division Workshops.	Rehabilitation Coordinator to develop; disseminate through Division Workshops (see 1.2)	2023	Illustrations, lay–out, reproduction 2,000
2.1.2. NRMH, CWMH and Division Hospital Rehabilitation Hubs (see 2.2) to establish and maintain waiting lists for rehabilitation services in order to identify, monitor and report unmet needs.	Rehabilitation Coordinator to liaise with Heads of Departments to develop a standard waiting list; consolidate and report on lists to Disability Inclusive Health and Rehabilitation Committee.	2023 to 2027	Cost neutral (integrated into existing departments and record keeping)
2.1.3. NRMH, CWMH and Division Hospital Rehabilitation Hubs (see 2.2) to implement a standard tool to objectively measure and report on the impact of rehabilitation for individuals[39].	Rehabilitation Coordinator to liaise with each department to provide support to personnel to agree on standard impact tool; train on and use tool; analyse and report on results.	2023 to 2027	3,500 per annum (Meetings and workshops)

[39] The Functional Independence Measure (FIM) is recommended as a validated and internationally recognized tool; and is already in use in some departments

Sub activities	Responsibility	Time frame	Budget implication FJD
2.1.4 An external review undertaken by a technical group (suggested by WHO) of the current package of services and the strengthening of disability inclusive health at all levels of the health system. Including a design of the ideal appropriate rehab service package for Fiji.	Rehabilitation Coordinator and Disability Inclusive Health and Rehabilitation Stakeholder Committee to liaise with WHO and external technical group	2023 to 2025	Cost dependant on level of review requested 5–15,000

Activity 2.2: Strengthen rehabilitation services at tertiary and secondary levels (hospital based); and primary and community levels (outreach)

Sub activities	Responsibility	Time frame	Budget implication FJD
2.2.1. Tertiary: Strengthen rehabilitation services at NRMH including renovation of the wards and clinic facilities; maintaining the current number of beds (20).	Rehabilitation Coordinator, under direction of Disability Inclusive Health and Rehabilitation Committee, with medical superintendents, rehabilitation personnel, user representatives and other stakeholders to draft budget and plan for strengthening NRMH and rehab Hubs.	2023	Year one: travel and meeting costs 1,000 Years two–five to be informed by plan.
2.2.2. Secondary: Formally establish in–patient and out–patient rehabilitation hubs at CWMH, Lautoka and Labasa Hospitals including allocation of dedicated beds[40] and a dedicated multi–disciplinary medical and allied health rehabilitation team.		2023 to 2027	
2.2.3. Clinical practice guidelines: Build on existing work by rehabilitation personnel and drawing on available best practice guidelines (with reference to less resourced settings) to establish and implement clinical practice guidelines for acute, sub–acute and longer–term rehabilitation of priority areas: stroke, amputation, spinal cord injury and paediatrics.	Rehabilitation Coordinator to support clinical practice working groups; seeking input from Fiji based or external rehabilitation experts.	2023 to 2027	Recommend budget provision for at least 1 meeting; and 1 consultation per annum to drive this forward.
2.2.4. Primary and community: Continue existing outreach programme from NRMH to primary health services and	NRMH rehabilitation outreach team, liaising with secondary level	2023 to 2027	$50,000 per annum

[40] Recommended to begin with six dedicated beds at CWM and four each at Lautoka and Labasa Hospital

Sub activities	Responsibility	Time frame	Budget implication FJD
communities; prioritizing people less able to travel to secondary or tertiary level facilities.	rehabilitation hubs, primary health services and community networks.		
2.2.5. Rehabilitation Referral pathways: Ensure clear referral pathways between rehabilitation teams in secondary and tertiary hospitals to and from primary and community level facilities to support and strengthen rehabilitation outreach services and the health component of community−based rehabilitation.	Rehabilitation Coordinator to communicate with heads of departments and OPDs. Oversight from the Disability Inclusive Health and Rehabilitation Committee	2023 to 2027	Cost neutral
2.2.6. Establish clear referral pathways and systems for children and adults to and from health, rehabilitation and assistive product services to other sectors such as education, livelihoods, social and community services.			
2.2.7. Publish and maintain on the MHMS website a description of MHMS rehabilitation and assistive product services including contact details for each department.	Rehabilitation Coordinator, liaising with relevant MHMS Health Information, Research and Analysis Department.	2023 to 2027	Cost neutral

Activity 2.3: Strengthen and expand mobility device services (walking aids, wheelchairs, prosthetics)

Sub activities	Responsibility	Time frame	Budget implication FJD
2.3.1. Continue regular adult wheelchair services delivered by NRMH; delivered by trained clinical personnel (physiotherapy and CRA) and technical personnel (prosthetic−orthotic technicians).	Physiotherapy departments	2023 to 2027	1000 per annum (replacement tools and consumables)
2.3.2. Continue adult and paediatric wheelchair clinics at CWMH delivered by trained clinical personnel (physiotherapy and CRA) and technical personnel (technicians already trained).	Physiotherapy departments Medical Superintendent at each Hospital to formalize technician positions	2023 to 2027	1000 / per annum / service site (replacement tools and consumables) Technical posts
2.3.3. Implement adult and paediatric wheelchair clinics at Lautoka, Labasa and Savusavu Hospitals delivered by trained clinical		2023 to 2027	

Sub activities	Responsibility	Time frame	Budget implication FJD
personnel (physiotherapy and CRA) and technical personnel (linking with outreach services provided by NGO wheelchair service providers)			
2.3.4. Establish and support Mobility Device Services (MDS) Committee (see Annex C for summary TOR) to ensure coordination between MHMS, Ministry of Social Welfare, NGO wheelchair service providers, donors and development partners active in wheelchair provision.	Rehabilitation Coordinator to act as secretariat for MDS Committee	2023 to 2027	800 / annum (meetings, photocopying)
2.3.5. Strengthen and expand lower limb prosthetics, orthotics and diabetic foot off–loading services including: train and recruit an additional two prosthetic–orthotic personnel and establish satellite prosthetic and orthotic services at Labasa Hospitals supported by the NRMH prosthetic–orthotic department.	NRMH and Labasa Hospital Medical Superintendents plan expansion of prosthetic services, in consultation with rehabilitation personnel.	2023 to 2025	Varying costs[41] (see footnote) 150,000[42] (Set–up – see footnote)
2.3.6. Implement consistent procurement of appropriate walking aids, wheelchairs, prosthetics and orthotics components and materials to supply MHMS mobility device services.	Rehabilitation Coordinator, with external advisor, to work with Pharmaceutical and Biomedical Service Centre (FPBS) to build mobility device procurement capacity.	2023 to 2027	2,500 (procurement advice

[41] Training costs: Human Study Course prices are variable, total costs will depend on location of course and duration of course. Recommended that flights, visas and accommodation will be included

[42] **Estimation Per site**: Tools, equipment, materials; freight and installation; not including room renovation if required; not including technical input and project management

Activity 2.4: Strengthen provision of basic assistive products for vision, hearing and other

Sub activities	Responsibility	Time frame	Budget implication FJD
2.4.1. Map existing vision, hearing and other assistive products provision already carried out in Fiji (consulting with MHMS, Social Welfare, Education, NGOs, OPDs and development partners); and plan for strengthening services	Rehabilitation Coordinator; under the direction of Disability Inclusive Health and Rehabilitation Committee; in consultation with stakeholders; potentially with support of external consultants.	2023	4,000 (Travel, meetings)

Activity 2.5: Expand the expertise and skills of MHMS personnel in rehabilitation and assistive product service delivery

Sub activities	Responsibility	Time frame	Budget implication FJD
2.5.1. Regular in−service training for rehabilitation personnel, prioritizing high demand services including stroke, amputee rehabilitation, spinal cord injury and paediatrics.	Rehabilitation coordinator, seeking internal and external input to develop and deliver in−service training.	2023 to 2027	5,000 / annum (For travel, meetings, contribution to costs of visiting external advisors)
2.5.2 Coordinate with the Fiji National University (FNU) to integrate rehabilitation specialties into existing medical and allied health training and establish post graduate rehabilitation specialties.	Rehabilitation Coordinator to liaise with FNU.	2023 to 2027	Cost neutral

5.3. Objective 3: Strengthen disability specific data and information throughout the MHMS health system

Activity 3.1: Ensure inclusion of disability in health surveys including demographic health surveys; facilitate analysis and dissemination of survey findings

Sub activities	Responsibility	Time frame	Budget implication FJD
3.1.1. Analyse 2017 national census data relating to disability and health; to understand the potential impact on disability inclusive health and rehabilitation planning	Disability Inclusion and Rehabilitation Coordinators; seeking input from data and disability experts as needed.	2023 to 2027	Cost neutral
3.1.2. Coordinate with MHMS Health Information Systems to explore the feasibility of implementing: • Inclusion of disability / permanent impairment identifiers in the MHMS Patient Administration System (PAS) • Centralised data system to track provision of mobility devices • Centralised data system to track rehabilitation treatments	Disability Inclusion and Rehabilitation Coordinator in consultation with the Research, Innovation, Data analysis & Management unit and IT (RIDAMIT)	2023 to 2027	Cost to integrate some disability indicators into PAS is low if only a few fields; cost of 'specialist modules' to track service delivery is between 30–100,000.
3.1.3. Review current policy and procedures for sharing of data (unidentified) between all stakeholders. Work with Disability Inclusive Health Stakeholder Committee and Research, Innovation, Data analysis & Management unit and IT (RIDAMIT) to develop and promote policies that support a collaborative data process	Disability Inclusion and Rehabilitation Coordinators and Disability Inclusive Health Stakeholder Committee in consultation with Research, Innovation, Data analysis & Management unit and IT (RIDAMIT)	2023 to 2025	Cost neutral

Activity 3.2: Increase evidence base to strengthen disability inclusion, and effectiveness of rehabilitation and assistive products services

Sub activities	Responsibility	Time frame	Budget implication FJD
3.2.1. Strengthen and support research on disability inclusive health, rehabilitation and assistive products provision.	Disability Inclusion and Rehabilitation Coordinators under the direction of the Disability Inclusive Health and Rehabilitation Committee; in consultation with stakeholders; potentially with support of external consultants.	2023 to 2027	Cost neutral initially; potential to fund specific activities through research grants.
3.2.2. Collaborate with national and international training and/or research institutions to strengthen and build human resource capacity in the area of disability research.		2023 to 2027	

5.4. Objective 4: Increase multi-sectoral collaboration for better coordination and more efficient rehabilitation and disability support services at all levels.

Activity 4.1: Develop National Rehabilitation and Disability Network

Sub activities	Responsibility	Time-frame	Budget implication FJD
4.1.1 Establish representative national rehabilitation and disability network working group to develop scope and expectations of network. Network will work with rehabilitation coordinator to establish MOUs between MHMS services and OPDs	Disability Inclusion and Rehabilitation Coordinators to liaise with all rehabilitation and disability stakeholders	2023 to 2025	Cost neutral
4.1.2 Launch network through national meeting/symposium open to all stakeholders whereby priorities and plans for the network can be discussed and first network committee selected.	Disability Inclusion and Rehabilitation Coordinators to liaise with National working group	2023	5,000 / annum (For travel, meetings)
4.1.3 MHMS, NGOs, Donors and other organisations to consult with network during the development or expansion of any new rehabilitation, disability or health services.		2023 to 2026	Cost neutral or build into planning costs

6. ANNEX

6.1. Annex A: List of consultations (in reverse chronological order)

1. **National Disability Inclusive Health and Rehabilitation Action Plan multi sectoral workshop supported by Tetra Tech (Fiji Program Support Facility)**

A multi−sectoral workshop was held with the following people **(Nadi, March 22nd to 24th 2022)**

Ministry of Health and Medical Services (MHMS)

- Dr. Mike Kama
- Dr. Pratima Singh
- Dr. Nikansha Kumar
- Dr. Devina Nand
- Dr. Miliakere T. Nasorovakawalu
- Dr. Marica Mataika
- Dr. Alan Biribo
- Dr. Oripa Bune
- Dr. Ilisapeci Vereti
- Dr. Kelerayani Namudu
- Dr. Judith Kotobalavu
- Dr. Dave Whippy
- Sister Sesenieli
- Dr. Redwan Al−Karim Bhuiyan
- Dr. Susana Nakalvu, Divisional Medical Officer West
- Dr. Rigamoto Taito

Organisation for Persons with Disability (OPDs)

- Leslie Tikotikoca, Spinal Cord Association
- Danielle Mallam, PSA
- Nafitalai Bai/Ponipate, National Council for Persons with Disabilities
- Luisiana Aca, Counter Stroke Fiji
- Joschco Wakaniyasi, Pacific Disability Forum
- Marion Driver, Viti Spinal Injury Association

AusFacility

- Lanieta Tuimabu, AusFacilitu
- Roneel Kumar, AusFacility

Social Welfare

- Salote Biukoto, Social Welfare

Ministry of Education, Heritage and Arts (MEHA)

- Salesh Deo, Ministry of Education, Heritage and Arts

Itaukei Affairs

- Jesoni Kuvuyawa, Itaukei Affairs Board

2. **Near final draft consultations (Suva, April 2018)**

Individual meetings were held with the following people:

- Muniamma Gounder, A/Director Policy and Planning, MHMS
- Roneel Sukhu, Acting Manager, Asset Management Unit, MHMS
- Ada Moadsiri, Technical Officer, NCDs, Division of Pacific Technical Support
- Shivnay Naidu, Director Health Information Systems, MHMS
- Dr. Eric Rafai, Deputy Secretary for Public Health, MHMS, Chair of NCDP Health Advisory Committee; Dr. Sitiveni Yanuyanutawa, Executive Director, Fiji National Council for Persons with Disabilities (NCDP); and Mrs Kush Prasad, NCDP

3. **MHMS Rehabilitation workshop (Suva, November 28th-30th 2017)**

National Rehabilitation Hospital

- Dr. Pratima Singh, HOD National Rehab Hosp
- Dr. Shradha Shilta, Medical Officer, National Rehab Hosp
- Dr. Shitanjni Wati, National Rehab Hospital
- Sr. Akata Parker, Sister In−Charge
- S/n Alchana Deo, Clinic Nurse
- S/n Jenny Sokimi, Senior Nurse In−Charge
- S/n Sheenal Kumar, Nurse
- Debbie Williams, Physiotherapist In−Charge
- Akira Mitamura, JICA Volunteer
- Maraia Matakibau, CRA Coordinator

Central division

- Dr. Kapil Swamy, Medical Officer Raiwaqa
- Dr. Raisha Kant, Medical Officer Makoi
- Dr. Asnita Ashvini, Medical Officer Valelevu
- Makereta Vuniwaqa, CRA Suva
- Filimoni Namana, CRA Suva
- Vaseva Danford, CRA Navua
- Ashneel, A/Superintendent Physiotherapist
- Sainimere Bulitimai, Physiotherapist CWMH
- Selina Lewa, Stroke Nurse CWMH
- Vasiti Natobe, Nurse Neuro−Surgical Dept
- Minisha Prasad, Nurse Medical Dept
- Mosese Kotobalavu, Prosthetist
- Leone Vulaca, Prosthetic Technician

Western Division

- Vika Naitini CRA Nadi
- Satendra Prasad CRA Lautoka
- Talisa Whippy Physiotherapist, Military Hosp
- Reshma Prasad Physiotherapist Lautoka

Northern Division

- Joanna Maiwalu, Physiotherapist In−Charge Labasa
- Monica Nand, Physiotherapist Savusavu

Eastern Division

- Laisani Nakete, Physiotherapist Levuka

Civil society, Organisation of Disabled Persons and Non-Government Organisations

- Jope Kikau, SIA member
- Roy Osborne SIA member
- Laniana Serukalou, SIA member
- Jane Savou, CRA with SIA
- Thato Thupayagale, Australian Volunteer Occupational Therapist with SIA
- Iakope, Fiji Disabled Persons Federation
- Joshco Wakanayasi, Fiji Disabled Persons Federation
- Lusiana Aca, Counter Stroke Fiji

4. **Stakeholder consultation meeting on draft rehabilitation strategic plan (7th August 2015)**

- Paediatric Doctor x 1
- Physiotherapy Superintendent − Luisa
- Physiotherapist Lautoka
- Physiotherapist Sigatoka − Akeneta
- Senior Education Officer Special Education x 1
- Early Intervention Centre x 1
- Spinal Injury Association
- NA Family Health
- MO In Charge Rehab
- CRA Coordinator
- CRA − Korovou
- CRA Lautoka
- Sr. In−Charge − Sr. Parker
- CBID Officer Nausori − Litia
- FDPF Rep
- SDHS Suva − Central
- DHS − Eastern
- Zone Nurse − Korovisilou
- Communty−Based Nurse − Sr. Arieta
- FNU − Ms Maria Waloki
- Project Officer Child Health − Sereana

5. Division level consultations on draft rehabilitation strategic plan (2013)

Representation included family members (13), persons with disabilities (23), health professionals (27), village health workers (8), youth representatives (2), Ministry of Social Welfare representatives (2), Social Workers (2), WHO representative (1), Senior citizens representative (1), Women's group representatives (4), Town councillor (1), Provincial administrators (2), Ministry of education, special education (2), NCDP representative (1), faith based organisations (1), District officer (1), Representative from MHMS NCD team (3).

Number of participants by location:

- Suva – 25 participants
- Levuka – 30 participants
- Labasa – 28 participants
- Nadi – 19 participants

6.2. Annex B: Draft job descriptions for coordinator posts

Disability Inclusion Coordinator Job Description

Role	Disability Inclusion Coordinator
Location	Ministry of Health and Medical Services, Suva
Unit/Division	Central/Eastern, Western & Northern Divisions – Hospital & Public Health
Reports to	MHMS Disability Inclusive Health and Rehabilitation Committee, Medical Superintendent, Tamavua Twomey Hospital
Liaises with	Rehabilitation Coordinator, MHMS staff, NCDP, Relevant NGO's including OPDs, Relevant Stakeholders, FNU staff and students, NRMH Rehabilitation staff, FNU, External advisor/s, MHMS Assets Management Unit (AMU)
Subordinates	N/a

The Position: The position will provide support to strengthen the capacity of MHMS to provide disability inclusive health services. The position will assist in staff training and development and work towards improved inclusive standards of practice. It will also be expected that the position will provide effective administration so as to monitor disability inclusive practices in the health system.

Key Responsibilities: The position will achieve its purpose through the following:

1. Provide strategic support for the integration of the principles of disability inclusion into all new health policies, plans and guidelines and budgeting processes.
2. Ensure annual budgeting includes resourcing of prioritized disability inclusion activities, including those identified in the National inclusive health and rehabilitation Action Plan 2023–2027.
3. With support from data experts, analyse 2017 national census data relating to disability and health with recommendations made regarding the disability inclusive health planning.
4. Develop Fiji specific training resources (such as PPT, posters, hand–outs) to facilitate greater disability inclusive awareness of health personnel; and promote practical skills in disability inclusive health.
5. Support delivery of disability inclusion training to health personnel across all divisions.
6. Develop online resources to enable ongoing disability inclusive health CPD opportunities for MHMS health personnel.
7. Work with relevant Heads of Departments at tertiary institutions to integrate disability inclusion training in undergraduate training for clinical health services personnel.
8. Liaise with Rehabilitation Coordinator, NCDP and other sectors to establish clear referral pathways for children and adults to and from health and rehabilitation services to other sectors such as education, livelihoods and community services.
9. Advocate for and coordinate disaggregated disability data collection within MHMS Health Information Systems.
10. Development of accessibility checklist, advocating for new MHMS building works to be conform to accessibility standards.

Key Performance Indicators:

1. MHMS policies, plans and budgets are reflective of a commitment to disability inclusion
2. Development of training materials within agreed time frames
3. Delivery of training to MHMS staff
4. Progress made in developing online trainings and integration of training into relevant undergraduate trainings

5. Monitors and reports on disability inclusive health practices to the Disability Inclusive Health and Rehabilitation Committee
6. Attendance at relevant meetings and submission of reports within agreed time frames

Qualifications: The successful applicant will have relevant qualifications in health care and experience in providing disability related services. It is desirable that the applicant have additional training and qualifications in disability (for example, Certificate IV in Disability).

In addition to these necessary qualifications, the following Knowledge, Experience, Skills and Abilities are required to successfully undertake the role of Disability Inclusion Coordinator:

Knowledge and Experience:

1. 8−10 years of experience working within the Fijian Health services
2. Practical understanding and ability to apply approaches to disability inclusion
3. Experience developing and delivering improved standards of health services
4. Experience in developing and delivering training material
5. Knowledge of United Nations Convention of Rights of People, Fiji's National policy for persons living with Disability Living with Disabilities 2008 − 2018 and Rights of Persons with Disabilities Act 2018
6. Sound understanding and knowledge of relevant MHMS health plans, with commitment to the implementation of the National inclusive health and rehabilitation Action Plan 2023−2027
7. Understanding of the Fijian Constitution (2013) and applicable laws of Fiji

Skills and Abilities:

1. Ability to monitor and report against agreed work plan
2. Strong verbal and written communication skills
3. Effective stakeholder consultation skills
4. Sound presentation and training skills
5. Demonstrated ability to effectively work within a team
6. Demonstrated ability to analyse and contribute to solutions to complex problems, in a resource constrained environment.
7. Demonstrates an integrated service approach, with a commitment to supporting the principles of equity and person−centred services
8. Administrative and supervisory skills

Statement on equal opportunity: Recognising that equal employment opportunity is a matter of social justice and sound management, MHMS encourages all people to apply regardless of gender, age or ethnicity. Persons with a lived experience of disability are especially encouraged to apply

Rehabilitation Coordinator Job Description

Role	Rehabilitation Coordinator
Location	Ministry of Health and Medical Services, Suva
Unit/Division	Central/Eastern, Western & Northern Divisions – Hospital & Public Health
Reports to	MHMS Disability Inclusive Health and Rehabilitation Committee, Medical Superintendent, Tamavua Twomey Hospital
Liaises with	Rehabilitation Coordinator, MHMS staff, NCDP, Relevant NGO's including OPDs, Relevant Stakeholders, FNU staff and students, NRMH Rehabilitation staff, FNU, External advisor/s, MHMS Assets Management Unit (AMU)
Subordinates	N/a

The Position: The position will provide support to strengthen rehabilitation services across Fiji, including assisting in staff training and development, improved standards of clinical practice and increased awareness of and referral to rehabilitation services. It will also be expected that the position will provide effective administration so as to monitor rehabilitation needs and quality of rehabilitation services.

Key Responsibilities: The position will achieve its purpose through the following:

1. Liaise with Heads of Departments to develop a standard waiting list in order to identify, monitor and report unmet rehabilitation needs.
2. Map existing assistive products provision in Fiji and plan for strengthening of these services
3. With support from data experts, analyse 2017 national census data relating to health with recommendations made regarding rehabilitation planning.
4. Collaborate with relevant stakeholders to draft a budget plan for strengthening rehabilitation at both secondary and tertiary levels.
5. Develop a presentation on rehabilitation in Fiji and deliver to health personnel working at the divisional level.
6. Develop and deliver regular in–service training for rehabilitation personnel, prioritizing high demand services.
7. Work with clinical practice working groups to develop and implement clinical practice guidelines for rehabilitation of priority areas: stroke, amputation, spinal cord injury, paediatrics.
8. Liaise with rehabilitation personnel to agree on a standard rehabilitation outcome measure and train personnel on the use of the measure.
9. Work with relevant Heads of Departments at tertiary institutions to integrate rehabilitation into existing medical and allied health training and establish post graduate rehabilitation specialties.
10. Publish and maintain a description of rehabilitation services on MHMS website.
11. Establish and support the Mobility Device Services (MDS) Committee, acting as secretariat for the committee.
12. Ensure consistent procurement of walking aids, wheelchairs, prosthetics and orthotics components to supply MHMS mobility device services.
13. Establish clear referral pathways between rehabilitation teams in secondary and tertiary hospitals and from primary and community level facilities.
14. Liaise with Disability Inclusion Coordinator, NCDP and other sectors to establish clear referral pathways for children and adults to and from rehabilitation services to other sectors such as education, livelihoods and community services.
15. Advocate for and coordinate disaggregated data collection within MHMS Health Information Systems.

Key Performance Indicators:

1. Work plan developed, supported by data and mapping of rehabilitation and assistive product services
2. MHMS budgets are reflective of a commitment to developing rehabilitation services
3. Development of presentation and training materials within agreed time frames
4. Delivery of in−services to MHMS staff
5. Clinical practice guidelines have been developed and are being implementing
6. Standard rehabilitation outcome measure in use across rehabilitation services
7. Mobility device services strengthened, reflected by MDS committee meeting regularly and consistent procurement of devices
8. Progress made in the integration of rehabilitation into relevant tertiary training courses.
9. Monitoring and reports on rehabilitation priority needs presented regularly to Disability Inclusive Health and Rehabilitation Committee
10. Attendance at relevant meetings and submission of reports within agreed time frames

Qualifications: The successful applicant will have relevant qualifications in clinical health care and experience in providing rehabilitation services. A Bachelor of Physiotherapy or medical rehabilitation qualifications are desirable. In addition to these necessary qualifications, the following Knowledge, Experience, Skills and Abilities are required to successfully undertake the role of Rehabilitation Coordinator.

Knowledge and Experience:

1. 8−10 years of experience working within the Fijian Health services
2. Understanding of current evidence−based approaches to rehabilitation
3. Experience developing and delivering improved standards of health and rehabilitation services
4. Experience in developing and delivering training material
5. Experience in procurement
6. Knowledge of United Nations Convention of Rights of People, Fiji's National policy for persons living with Disability Living with Disabilities 2008 − 2018 and Rights of Persons with Disabilities Act 2018
7. Sound understanding and knowledge of relevant MHMS health plans, with commitment to the implementation of the National inclusive health and rehabilitation Action Plan 2023−2027
8. Understanding of the Fijian Constitution (2013) and applicable laws of Fiji

Skills and Abilities:

1. Ability to monitor and report against an agreed work plan
2. Strong verbal and written communication skills
3. Effective stakeholder consultation skills
4. Sound presentation and training skills
5. Demonstrated ability to effectively work within a team
6. Demonstrated ability to analyse and contribute to solutions to complex problems, in a resource constrained environment
7. Demonstrates an integrated service approach, with a commitment to supporting the principles of equity and person−centred services
8. Administrative and supervisory skills

Statement on equal opportunity: Recognising that equal employment opportunity is a matter of social justice and sound management, MHMS encourages all people to apply regardless of gender, age or ethnicity. Persons with a lived experience of disability are especially encouraged to apply.

6.3. Annex C: Summary Terms of Reference for Mobility Device Service

Mobility Device Services Committee (MDS): Terms of Reference

V2: November 2017– DRAFT FOR FURTHER REVIEW AND DISCUSSION AT 2ND MDS COMMITTEE MEETING

1. Background

1.1. Mobility devices

Personal mobility means the ability to move in the manner and at the time of a person's own choice. This includes moving about at home, outside the home and in the wider community. Personal mobility also means being able to move from one surface to another, for example getting out of bed, getting up from a chair, and getting in and out of a vehicle.

Being able to move is important for all areas of life for girls, boys, women and men. Being mobile has a big impact on health, social and economic life, and enables access to education and employment. **The right to mobility is clearly stated in article 20 of the CRPD.** For many persons with a mobility impairment, an appropriate mobility device is needed for them to be able to secure their right to personal mobility. Accessible environments that consider the mobility needs of people are also important.

1.2. Definitions

Mobility devices include walking aids, wheelchairs with or without modifications, lower limb prosthetics and orthotic devices.

Mobility devices	Assistive products to help a person with a mobility impairment be able to move around more.
Wheelchair	A device providing wheeled mobility and seating support for a person who has difficulty in walking or moving around (WHO, Wheelchair Guidelines, 2008)
Manual wheelchair	A wheelchair propelled by the user or pushed by another person (WHO, Wheelchair Guidelines 2008)
Powered wheelchair	A wheelchair that is moved with the assistance of a motor
Lower limb prosthesis	A device used to replace a missing part of a person's foot or leg
Lower limb orthosis	A brace, splint or other external device which supports a person's foot or leg to either prevent un−wanted movement; or assist movement
Walking aid	A device used to increase the personal mobility of a person who has difficulty walking. Walking aids include crutches, walking frames and walking sticks
Appropriate mobility device	A mobility device that meets the user's needs and environmental conditions; provides proper fit and postural support; is safe and durable; is available in the country; and can be obtained and maintained and services sustained in the country at the most economical and affordable price (adapted from WHO, Wheelchair Guidelines 2008)

1.3. Mobility device provision in Fiji: summary of status as of February 2018

This Committee recognises that considerable improvements in access to mobility device services in Fiji have been achieved through the collaborative efforts of individuals and organisations in the past decade. Some particular achievements include:

- Integration of basic level wheelchair service delivery training (based on the World Health Organisation Wheelchair Service Training Package) into the curricula of physiotherapists and Community Rehabilitation Assistants (CRAs) at the Fiji National University – resulting in a significant increase in awareness and capacity of the physiotherapy and CRA workforce in effective provision of basic level wheelchairs;
- Strengthening of the Spinal Injuries Association (SIA), a key non–Government wheelchair service provider including establishment of a training 'mobility device service' team able to carry out home based services in Suva, outreach to Divisions, and some centre–based services (using facilities at NRMH)
- Building an increased network of Ministry of Health and Medical Services (MHMS) wheelchair service sites in partnership with physiotherapy departments and hospital administration (Colonial War Memorial Hospital, Labasa Hospital, Lautoka Hospital and Savusavu Hospital) including training of both clinical personnel (physiotherapists and community rehabilitation assistants) and technical personnel (wheelchair assembly, repair and maintenance).
- Strengthening of partnerships with donor agencies and in particular a significant increase in support from the Latter–day Saints Charities in provision of appropriate, new wheelchairs and walking aids (to the SIA)
- Trials of prosthetic devices at the National Rehabilitation Medical Hospital to improve the quality of components and therefore increase positive outcomes for prosthetic users.
- Recent introduction of a focused 'paediatric' wheelchair and seating service at Frank Hilton Organisation.

Despite these achievements there remains a significant unmet need for appropriate mobility devices amongst Fiji's population. Some specific challenges include:

- Lack of service coverage meaning that services are largely centralised, there is in–sufficient stock and an in–sufficient trained work force to meet the demand;
- Reliance on external donors for products, only a small (and in–sufficient) budget for procurement of prosthetic components and no MHMS budget allocation for procurement of walking aids and wheelchairs;
- Lack of agreed minimum standards that would support effective procurement, training of personnel, service delivery and data collection;
- No formal 'mobility device technical roles' identified in MHMS staffing structures;
- Only one Prosthetist, and no personnel with International Society of Prosthetics and Orthotics recognised Prosthetic–Orthotic training.

This Committee recognises the hard work and commitment of many individuals working to increase access to mobility device services. The Committee has been formed to work constructively to address some of the challenges listed above.

2. Purpose

2.1. The overall purpose of this Mobility Device Services Committee (MDSC) is to increase consistent and sustainable access for children and adults to appropriate mobility devices provided by trained personnel through professional services.

2.2. The group specifically serves to:

a. Increase effective coordination and consistency between mobility device service providers in Fiji.
b. Work collaboratively to strengthen mobility device services focusing on:
    - The development of minimum standards for:
        - Mobility devices
        - Training and/or qualifications of personnel providing mobility devices
        - Service delivery
        - Data collection

- Identifying and implementing strategies to:
  - Ensure sustainable procurement of mobility device products. Procurement includes receipt of donated equipment and purchase of equipment.
  - Increase the reach of mobility device services including considering how to reach more people, from more locations, with a wider range of devices
  - Increase the number of personnel trained and able to carry out mobility device service delivery
- Effective and coordinated MDS data collection, analysis and reporting systems.

c. Raise awareness and where appropriate provide advice on accessibility in and around the home in relation to use of mobility devices.

3. Duration

3.1. The MDSC has been formed for a two−year period, commencing November 30th 2017. The duration may be extended, depending on a review of the Group's success and continued relevance.

3.2. The MDSC plans a mid−term review of progress in November 2018.

4. Membership

4.1. Lead agency: The MDSC is led by the Ministry of Health and Medical Services; as the Government agency with responsibility for inclusive health and rehabilitation service delivery.

4.2. MDSC membership has been determined to ensure input from: Fiji Government Departments (Ministry of Health and Medical Services, Ministry of Women, Children and Poverty Alleviation), Government and Non−Government mobility device service providers, training institutions, Disabled Persons Organisations, donor and/or development partners.

4.3. Taking into consideration point 4.2, membership is made up of representatives from the above organisations with sufficient seniority; appointed by each of the following organisations as follows:

Organisation		Number	Position
Ministry of Health and Medical Services (MHMS)	National Rehabilitation Medicine Hospital	1	MO in Charge
	Physiotherapy	1	Superintendent Physiotherapist
	Community Rehabilitation Assistants	1	CRA Coordinator
Ministry of Women, Children and Poverty Alleviation	Social Welfare Department	1	Principal Welfare Officer
Fiji National University	School of Physiotherapy	1	Head of Department
Disabled Persons Organisation and Service Provider	Spinal Injuries Association	1	Coordinator Mobility Device Services
		1	Executive Director
Non−Government Service Provider	Frank Hilton Organisation	1	CEO
Donor agency	Church of Jesus Christ of Latter−day Saints	1	Welfare Officer
Development agency	Motivation Australia	1	Project Officer

4.4. Any other organisation may join on invitation from the MDSC if a need arises.

5. Roles and responsibilities

5.1. The roles and responsibilities of the MDSC as a **whole** are to:

- Work together towards achieving the overall purpose of the MDSC (as described in 2.1)
- Recognise the rights of persons with disabilities to personal mobility (article 20 of the CRPD)
- Make decisions in consultation and with people who use mobility devices

- Drive quality standards of mobility device services in Fiji, considering devices, training, services and data.

5.2. The roles and responsibilities of **individual** MDSC members are to:

- Represent their organisation and stakeholder group at MDSC meetings, for example by: consulting with other members of their organisation and users of mobility devices; accurately presenting their organisation and stakeholder groups' needs and views; feeding back outcomes of meetings to appropriate people in their organisation and stakeholder group.
- Prepare for meetings by reading meeting documents ahead of each meeting and completing any agreed tasks.
- Support implementation of decisions by the MDSC in their organisation's mobility device service practises and advocacy.
- Be a resource to support MDSC members tasked to carry out MDSC projects / activities.
- Use opportunities to advocate for strengthening access to mobility device services in Fiji.
- Ensuring short term objectives and tasks are met as set at by the MDSC.

6. Functioning of the MDSC

6.1. The position of Chair will be held by the Medical Officer in Charge at the National Rehabilitation Medicine Hospital, as mandated by the Permanent Secretary of the MHMS.

6.2. A secretariat will be established to manage the business of the MDSC, including:

- Maintaining a drop box containing meeting documents, key and reference documents for the Committee etc.
- Under the direction of the Chair:
  - Preparation of agendas
  - Drafting and circulation of minutes
  - Convening each meeting
  - Monitoring achievement of tasks

6.3. MDSC members are responsible for printing of meeting documents for themselves

6.4. Meetings will be held quarterly, in Suva

6.5. Agenda and meeting papers

- Meeting agendas and any supporting documentation (for example reports on progress by MDSC members) will be prepared and circulated (via drop box) at least one week in advance of scheduled meetings
- Meeting minutes will be prepared by the secretariat, a draft reviewed and approved by the Chair, and then circulated (via drop box) at least one week after scheduled meetings. Meeting minutes will be adopted at the next meeting of the MDSC.

6.6. Accessibility: Meeting venues and proceedings will be accessible to facilitate equal participation.

6.7. Decision making: To be completed in discussion at next meeting

6.8. Dispute Resolution: MDSC members will work collaboratively towards a common purpose and aim to reach consensus wherever possible. However, it is recognised that some issues may arise that are contentious, and a consensus decision may in this case be difficult. In these situations, the Group, led by the Chair may use any of the following strategies:

- Use research and evidence based best practice to inform decisions
- Seek external input to facilitate further discussion

6.4. Annex D: WHO building blocks of the health system

THE SIX BUILDING BLOCKS OF THE HEALTH SYSTEM	REHABILITATION COMPONENT
 **LEADERSHIP AND GOVERNANCE**	• Laws, policies, plans and strategies that address rehabilitation. • Governance structures, regulatory mechanisms and accountability processes that address rehabilitation. • Planning, collaboration and coordination processes for rehabilitation.
 **FINANCING**	• Health expenditure for rehabilitation. • Health financing and payment structures that include rehabilitation.
 **HEALTH WORKFORCE**	• Health workforce that can deliver rehabilitation interventions – including rehabilitation medicine, rehabilitation-therapy personnel, and rehabilitation nursing.
 **SERVICE DELIVERY**	• Health services that deliver rehabilitation interventions, including in specialized rehabilitation hospitals, centres, wards and units; in tertiary and secondary hospitals and clinics; in primary health care facilities and in community settings.
 **MEDICINES AND TECHNOLOGY**	• Medicines and technology commonly used by people accessing rehabilitation, particularly assistive products.
 **HEALTH INFORMATION SYSTEMS**	• Data relevant to rehabilitation in the health information systems, such as population functioning data, rehabilitation availability and use data, and rehabilitation outcomes data. • Research relevant to rehabilitation policy and programmes.

6.5. ANNEX E: Terms of reference (TOR) for Disability Inclusive Health and Rehabilitation Committee

Disability Inclusive Health and Rehabilitation Committee: Terms of Reference

V1: April 2022 – DRAFT FOR FURTHER REVIEW AND DISCUSSION AT 2ND COMMITTEE MEETING

1. Background

1.1. Mobility devices

This committee has been formed to provide opportunity for governance, monitoring and evaluation of the Disability Inclusive Health and Rehabilitation Action Plan 2023−2027. The committee will be made up of members of various backgrounds and workplaces to provide a national approach that involves a representation of all stakeholders.

Another major role of committee members is to champion disability inclusion in their workplace and professional actions.

1.2. Disability Inclusive services in Fiji:

This Committee recognises that considerable improvements in disability inclusive health and rehabilitation services in Fiji have been achieved through the collaborative efforts of individuals and organisations in the past decade. To continue these improvements a National Disability Inclusive Health and Rehabilitation Action Plan for 2023−2027 has been created. The goals, objectives, activities and sub activities within the Action Plan have been agreed upon as steps towards increasing disability inclusion in health and rehabilitation.

This Committee recognises the hard work and commitment of many individuals working to increase access to health and rehabilitation services.

2. Purpose

2.1. The overall purpose of this Disability Inclusive Health and Rehabilitation Stakeholder Committee formed to provide opportunity for governance, monitoring and evaluation of the Disability Inclusive Health and Rehabilitation Plan 2023−2027.

2.2. The group specifically serves to:

a) Increase effective coordination and consistency between Rehabilitation service providers in Fiji.
b) Work collaboratively to improve disability inclusion in all forms of Rehabilitation and health.
c) Provide continuous monitoring and evaluation of the Action Plan and reporting on progress to the Permanent Secretary for Health and Medical Services.
d) To provide support and guidance to the implementing partners of the Action Plan.

3. Duration

3.1. The committee will meet 2 time per year to perform its purpose and it is recommended that it meet 3 times within its first year of establishment to set indictors and elect chairpersons and secretary

3.2. The committee will support the external review process at 3 years into the Action Plan to help progress towards actions in the final 2 years of the Plan.

4. Membership

4.1. The committee will be made up of representations from both the MHMS in at least 3 districts; including Rehabilitation Department Representative, FEMAT and MHMS planning division. The committee will also include representatives from OPD's in various districts and types of services provided (e.g., Mobility devices, social welfare, Paediatric, Mental Health). Additionally, a representative from the Ministry of Women, Children and Poverty Alleviation should be included.

4.2. It is recommended that the committee should have a representation of men and women, people who live with a disability and service providers.

4.3. Any other organisation may join on invitation from the Committee if a need arises.

5. Roles and responsibilities

5.1. The roles and responsibilities of the Committee as a **whole** are to:

- Work together towards achieving the overall purpose of the Action Plan
- Recognise the rights of persons with disabilities and in particular, their right to inclusion
- Make decisions in consultation with those implementing the Action Plan

5.2. The roles and responsibilities of **individual** MDSC members are to:

- Represent their organisation and stakeholder group at meetings, for example by consulting with other members of their organisation; accurately presenting their organisation and stakeholder groups' needs and views; feeding back outcomes of meetings to appropriate people in their organisation and stakeholder group.
- Prepare for meetings by reading meeting documents ahead of each meeting and completing any agreed tasks.
- Support implementation of decisions by the committee in their organisation's practice.
- Use opportunities to advocate for disability inclusion in Fiji.

6. Functioning of the MDSC

6.1. The position of Chair will be elected from within the group and can be re−elected after at least 3 meetings have occurred.

6.2. A secretariat will be established to manage the business of the Committee, including:

- Maintaining a shared online folder containing meeting documents, key and reference documents for the Committee etc.
- Under the direction of the Chair:
  - Preparation of agendas
  - Drafting and circulation of minutes
  - Convening each meeting
  - Monitoring achievement of tasks

6.3. Committee members are responsible for printing of meeting documents for themselves

6.4. Meetings will be biannually, in Suva with online participants

6.5. Agenda and meeting papers

- Meeting agendas and any supporting documentation will be prepared and circulated at least one week in advance of scheduled meetings
- Meeting minutes will be prepared by the secretariat, a draft reviewed and approved by the Chair, and then circulated at least one week after scheduled meetings. Meeting minutes will be adopted at the next meeting.

6.6. Accessibility: Meeting venues and proceedings will be accessible to facilitate equal participation.

6.7. Decision making: To be completed in discussion at next meeting

6.8. Dispute Resolution: Committee members will work collaboratively towards a common purpose and aim to reach consensus wherever possible. However, it is recognised that some issues may arise that are contentious, and a consensus decision may in this case be difficult. In these situations, the Group, led by the Chair may use any of the following strategies:

- Use research and evidence based best practice to inform decisions
- Seek external input to facilitate further discussion.

6.6. Annex F: Monitoring & Evaluation (M&E) Framework Template

	GOAL 1 **Inclusive Health** Children and adults with disabilities have access to inclusive health services at community, primary, secondary and tertiary levels.	**Outcomes**	**Outputs**
INDICATOR	No (%) of PLWD accessing health services		
DEFINITION How is it calculated?	• % of total service users • By gender and age (women, girls, men, boys) • By community • By primary, secondary, tertiary level		
BASELINE What is the current value?	TBC		
TARGET What is the target value	Note: consider census data of 13.7% PLWD when setting target		
DATA SOURCE How will it be measured? (Means of verification)	Extracted from routine monthly data sources (health service access data)		
FREQUENCY How often will it be measured?	Extracted monthly, analysed 6–monthly		
RESPONSIBLE Who will measure it?	**Rehabilitation/Disability Inclusion Coordinator**		
REPORTING Where will it be reported?	6–monthly progress report		

	GOAL 2 **Rehabilitation** MHMS rehabilitation and assistive products workforce strengthened; and rehabilitation and assistive products services being accessed by all who may benefit	**Outcomes**	**Outputs**
INDICATOR	• No of people who access Rehab and AT services. • Rehab and AT workforce		
DEFINITION How is it calculated?	• By gender and age (women, men, girls, boys) • By location • Rehab and AT workforce • No (%) of positions filled according to role delineation policy		
BASELINE What is the current value?	TBC		
TARGET What is the target value	100%		
DATA SOURCE How will it be measured? (Means of verification)	• Extracted from routine monthly data sources (rehab and AT services access data) • HR records		
FREQUENCY How often will it be measured?	• Extracted monthly, analysed 6monthly. • Annually		
RESPONSIBLE Who will measure it?			
REPORTING Where will it be reported?	• 6–monthly progress report • Annual progress report		

6.7. Annex G: Barriers and Challenges Identified

Barriers and challenges identified in consultations	Impacting on
Urban−centric services; limited resource allocation; in−sufficient coordination between different agencies; limited funding support for the resources and work−force needed to provide consistent rehabilitation and assistive product provision; reliance upon donated equipment (assistive product); negative perceptions and attitudes about disability and towards persons with disability; poor state of repair of the NRMH discouraging service users and their families from using the service; lack of waiting lists or other record of un−met need making it difficult to advocate for services	Service scope, reach and quality
Rehabilitation personnel shortages; limited awareness of disability inclusive health care amongst health personnel; limited specialist training in rehabilitation and assistive product provision, in particular occupational therapy, speech therapy, prosthetics−orthotics, assistive products technicians.	Workforce capacity
Inaccessible health service buildings and information (physical and other barriers); limited access to transport in rural and maritime areas; in−accessible transport; high cost of transport, particularly to services from rural areas; limited coordination and networking between existing rehabilitation services and OPDs; lack of awareness of available services, particularly of those in rural areas.	Access to services