

CENTRE FOR DISABILITY
RESEARCH AND POLICY

FACULTY OF
HEALTH SCIENCES



THE UNIVERSITY OF
SYDNEY

Analysis of Community Rehabilitation Assistant Program (CRA) in Fiji

Suva, Fiji July – August 2014

**Professor Gwynnyth Llewellyn, Director
Centre for Disability Research and Policy**

**Faculty of Health Sciences
University of Sydney**

Analysis of Community Rehabilitation Assistant Program (CRA) in Fiji

Suva, Fiji July – August 2014

Centre for Disability Research and Policy
Faculty of Health Sciences
University of Sydney, July 2014

Contact details

Professor Gwynnyth Llewellyn
Faculty of Health Sciences, University of Sydney
PO Box 170 Lidcombe NSW 1825 Australia

T +61 2 93519553

F +61 2 93519468

M +61 411489107

E gwynnyth.llewellyn@sydney.edu.au

Contents

Executive Summary and Recommendations	5-7
Full Report	8-33
1. Background	8
2. Terms of Reference	10
3. Desk Review	10
3.1 Fiji Health System	10
3.2 Legislation, decrees, policy documents and reports	12
3.3 Reports of Non-Government Organisations and International Non-Government Organisations	16
4. CRA Program Analysis	17
4.1 Method	17
4.2 Analysis of information	19
5. Findings	19
5.1 Contribution of CRA program	19
5.2 Issues raised about CRA program	22
5.3 Current review and planning context	28
6. Conclusions and Recommendations	30
6.1 Conclusions	30
6.2 Recommendations	32
Appendices	34-62
Appendix 1	CRA locations and caseload
Appendix 2	2011 CDR MOH sponsored graduates
Appendix 3	Names and titles of key informants
Appendix 4	List of documents accessed
Appendix 5	CBR/CRA Program Coordinator description
Appendix 6	CRA position description and organisational chart
Appendix 7	National Disability Inclusive Health and Rehabilitation Strategic Plan
Appendix 8	Interview Guide
Appendix 9	Example of CRA caseload and contact
Appendix 10	Proposed structure for physiotherapy reform

EXECUTIVE SUMMARY

This report presents the findings from the CRA Program Analysis undertaken in July-August 2014. The recommendations provide direction to enhance and strengthen community based inclusive development in Fiji with particular attention to the CRA Program. The CRA Program Analysis was undertaken by desk review and five days in-country with interviews with key informants.

Fiji's health system was built on a primary care approach at a time when the population was primarily rural and widespread across the Fiji Islands. In the mid-1990s, a foundation rehabilitation skills training course was conducted by the Save the Children Fund to meet the needs of children with disabilities, specifically cerebral palsy. This was the origin of the Community Rehabilitation Assistant (CRA) position which was later incorporated into the Ministry of Health circa 1996.

Over the past twenty years, Fiji has become more urbanised with over 50% of the population now living in population centres such as Nadi and Suva. Since the 1990s when the CRA Program began there has increased NGO community outreach, increased DPO activity including community outreach, the introduction of certified training courses at the Fiji National University and the Australian Pacific Training College in disability and community based development, and additional focus the Ministry of Health on preventive programs and services given the rise in non-communicable diseases.

Within this current context, the CRA program is *significantly under-resourced, roles and functions are not clearly defined, and the CRAs have missed out on much needed and ongoing in-service education and professional development*. In brief, the 15 CRA positions (currently only 12 are being occupied) are not established posts in the Public Service Commission. They are project officer positions offered on contract with renewal annually. The positions are poorly resourced. The only oversight of the CRA Program is via the CRA Program Coordinator who is located at the Tamavua National Rehabilitation Hospital in Suva. In the sub-divisions where CRAs have been for some time, their roles and functions have developed relative to the number and breadth of the tasks required by the senior sub-divisional personnel to whom they report.

Overall, while informants spoke warmly of individual CRAs and their contribution to the public health system, there was concern and frustration at the lack of formal systems and procedures in the CRA Program typically expected in a health system, with confused expectations about the CRA role and function and the responsibilities and accountabilities of the CRA Program Coordinator.

Recommendations

Recommendation 1

That MOH create a senior CRA Program leadership position which is responsible for developing a quality program based on:

- (i) Documentation of scope of practice, standard operating procedures, and referral and clinical pathways that align with expectations of senior sub-divisional and Ministry of Health Headquarters personnel;
- (ii) Appropriate and regular communication and supervisory mechanisms for CRAs in their sub-divisional locations and to the CRA Program Leadership; and
- (iii) Collaboration with other line ministries, Fiji National Council for Disabled Persons, NGOs, DPOs and the training institutions to ensure that the CRA Program fulfils the remit of community based rehabilitation which requires cross-sectoral collaboration.

Recommendation 2

Subsequent to implementation of Recommendation 1, that:

- (i) The CRAs are given in-service training on the quality standards expected of the CRA program and an opportunity to build their expertise, competence and confidence to provide this quality service;
- (ii) There is effective communication about the improved CRA program to all stakeholders at sub-divisional and national hospital level, at MOH HQ, to NGOs, DPOs and the training institutions; and
- (iii) CRAs and the new Program Leadership position provide input into all health, educational and social welfare training courses in Fiji to educate the future workforce on community based inclusive development in Fiji.

Recommendation 3

That a Cross-Sectoral CRA Program Management Committee is established to provide cross-sectoral support to enhancing and strengthening community based inclusive development in Fiji. This Committee would comprise high level appointees from the hospital services and public

health streams in MOH; the focal points on disability from other line ministries; FCDP; NGOs; DPOs; and, the training institutions. The functions of the Committee would be to:

- (i) Support the new CRA Program leadership position;
- (ii) Advocate for the CRA project officer positions to become established posts within the Public Service Commission with the necessary and appropriate resources to support these positions;
- (iii) Provide advice, monitor and evaluate the progress of the revised and improved CRA program;
- (iv) Ensure cross sector collaboration on and advocacy for community based inclusive development;
- (v) Foster collaboration and cross – fertilisation between the training institutions and the community based inclusive development workforce needs of MOH, the NGOs and the DPOs;
- (vi) Promote community based inclusive development by awareness raising and community education.

Recommendation 4

That MOH signal, through the appointment of a National Advisor Disability and Rehabilitation Advisor at MOH HQ, that community based inclusive development is central to MOH Strategic Planning and in particular to strategic planning in relation to NCDs.

Recommendation 5

That the senior CRA Program Leadership position report to the National Advisor Disability and Rehabilitation.

REPORT

1. Background

The situation of rehabilitation services in many low income countries is not well understood. At the same time, the number of people who would benefit from rehabilitation is expected to increase. The WHO/World Bank *World report on disability* (2011)¹ cited prevalence data indicating that approximately 1 billion people or 15% of the world's population has a disability, of which 110-190 million adults experienced very significant disability. This 1 in 7 number is expected to increase due to global population ageing and increased incidence of chronic diseases together with other environmental factors such as injuries from road traffic crashes, climate change, natural disasters and conflict.

Rehabilitation can improve functioning and lead to increased independence and participation in activities such as education, employment, and community life. Indirect benefits of rehabilitation include reduced care responsibilities for other family members and reduced pressure on health systems. However, there are large gaps in access to rehabilitation services in many low and middle income countries, and the quality of rehabilitation services that are provided is often inadequate. In addition, rehabilitation is often not prioritized within the different levels of health planning.

Fiji, as with many other countries in the Pacific region, faces many challenges when providing disability and rehabilitation services. Some of these challenges come from the country's dispersed population with urban centres, a rural interior and even more remote island settings; the nature of the country's geography with limited affordable transport options; changes in decentralisation of the health system followed by re-centralisation in the mid - 2000s; and little socio-economic growth and expansion in the health sector over the past decade. In contrast to other countries in the region, Fiji has a well-established training institution for health workers. This was formerly the Fiji School of Medicine and the Fiji School of Nursing now integrated as the College of Medicine, Nursing and Health Sciences in the Fiji National University. This provides baccalaureate qualifications in physiotherapy and a certificate qualification in disability and community based rehabilitation. The Australia-Pacific Technical College (APTC) also now offers the Australian qualification Certificate IV in Disability at its Suva campus.

Currently there is no national rehabilitation or disability plan for Fiji although one is under development, the *Draft National Disability Inclusive Health and Rehabilitation Strategic Plan 2014-2018*². At the same time, a draft *Fiji Ministry of Health Action Plan for Children with Disabilities* has been prepared³. Appropriate planning and implementation of a national

¹ *World Report on Disability*. World Bank and World Health Organisation, Geneva, 2011.

² *Draft National Disability Inclusive Health and Rehabilitation Strategic Plan 2014-2018* (20th May 2014, provided by Dr Pratima Singh)

³ *Fiji Ministry of Health Action Plan for Children with Disabilities, 2014-2016* (provided by Dr Rachel Devi, Acting National Advisor Family Health)

disability inclusive health and rehabilitation strategic plan and an action plan for children with disabilities requires in-depth examination of current infrastructure, human and financial resources, internal collaborations and external partners, sponsors and donors to begin the work required to build a strong and effective rehabilitation and disability sector.

Community based rehabilitation is one component of a strong and effective rehabilitation and disability sector. Community-based rehabilitation (CBR) has been in place in Fiji for some years although not always under this name. The Community Rehabilitation Assistant program (CRA) was developed initially through training sponsored by Save the Children Fund in the early 1990s, and then taken over by the Ministry of Health (MOH) circa 1996. The Save the Children course was staffed by a physiotherapist, occupational therapist and speech therapist brought to Fiji for this purpose. The course was for 6 months duration and offered a foundation in therapy skills to bring rehabilitation to people with disabilities in the community in Fiji (in the absence of a trained rehabilitation workforce). The Community Rehabilitation Assistants (CRAs) that remain in MOH are based at the sub-divisional level health centres. The current 12 CRA personnel are project officers under the MOH (these are not established posts) (see Appendix 1 for names of the CRAs, their locations and caseloads as per the CRA Program Coordinator figures for early 2013).

Training for community based rehabilitation workers began (again) in Fiji with support from external organisations such as Cerebral Palsy Alliance Australia (CPA) who developed a training program in 2006, the CAL (Competency, Assessment and Consultancy and Local Community Solutions) program. From 2006-2011, 24 local Fijians were graduated from this program with a recognized certificate. In collaboration with the Ministry of Health, who recognised a need for the provision of community level rehabilitation services, and the Fiji School of Medicine (FSM), CPA transitioned the course to a one-year Certificate in Community Disability and Rehabilitation to Fiji National University (FNU) with the first intake of 29 students in 2010. This intake was sponsored by the MOH with the intention that the graduates would be placed in CRA positions throughout the country according to need. Conducting this course through FNU helped bring the role into alignment with the Ministry of Health's requirement that approved posts be filled by qualified personnel. The CPA also assisted to train 10 community disability workers in the Ba region at this time.

The anticipated outcome of MOH employing all graduates from the 2010 program did not eventuate. Some of the graduates are employed as MOH CRAs, others are working as volunteers and others are not working, studying or have taken positions with other organisations (see Appendix 2 for details).

The FNU course now titled the Certificate in Disability and Community Based Rehabilitation continues as a one year certificate course with 12 weeks field placement during this time. This program has a relatively small intake and takes students from around the Pacific.

2. Terms of Reference

- To undertake an analysis of the roles and function of community rehabilitation assistants in the Fijian MOH workforce.
- To make recommendations about the role, accompanying supervisory structure and necessary support (e.g. transport allowances) required to undertake the CRA role.
- To conceive what other future workforce requirements across health and/or other ministries may compliment the role of the CRA and support the practice of community based inclusive development in Fiji.

This piece of work will inform future rehabilitation sector workforce planning and is an activity under the National Disability Inclusive Health and Rehabilitation Strategy being developed by MOH. From the APW, there were three activities to be carried out as follows:

- 3.1 Analysis of roles and function of CRAs in MOH workforce and community based inclusive development in Fiji.
- 3.2 Develop recommendations on administrative, supervisory and resource support to ensure effective and efficient deployment of CRA's within MOH workforce.
- 3.3 Develop recommendations on future workforce requirements to promote and consolidate community based inclusive development in Fiji.

The report details an analysis of the CRA service in Fiji through desk review and interviews and meetings over 5 days in-country in July-August 2014. The convention CRA program or service (as appropriate) is used throughout this report to refer to this particular workforce and its roles and functions within the MOH. Where appropriate, the term CRAs is used to refer to the personnel currently in the Community Rehabilitation Assistant project officer positions. The terms preventive and curative programs are used in this report where appropriate as these terms are used by MOH to refer to Public Health and Hospital Services respectively.

In brief, the meetings held in Fiji included relevant Ministry of Health National Advisers, Medical Officer in Charge Tamavua Rehabilitation Hospital, Physiotherapy Superintendent, Sub-divisional Medical Officers, Sub-Divisional Nursing Sisters and the CRAs in Tamavua rural area and in Suva, Senior Education Officer, Special Education, Ministry of Education, Course Coordinator FNU, CRA Coordinator, Fiji National Council for Disability, and DPO – Spinal Cord Injury Association. Appendix 3 contains the names and titles of all interviewees. Appendix 4 contains the list of documents accessed for this report.

3. Desk Review

3.1 Fiji Health System

Bringing health care and related services to the community level to serve the people is not a new concept in Fiji. Since the 1970's there has been a primary health care (called public health in Fiji) system in place aiming to bring health care to all. Fiji's health system is based on a three-tier model that provides an integrated health service at primary, secondary and tertiary

levels. The public health system in Fiji is managed by the Ministry of Health (MOH) through health facilities in four divisions which are then divided into subdivisions (19).

At the village level, there are Village Health Workers (VHW – Fijian communities) or Community Health Workers (CHW – Indo-Fijian communities). These workers are community members who have been trained in basic health care by the MOH and serve in this role on a volunteer basis. At the next level is the nursing station (101 in total). Nurses are the backbone of the Fiji health care system with the majority of the nursing workforce being three year trained registered nurses with less than a quarter being senior nurses with post-basic specialist skills. Nursing stations are manned by RNs in more isolated areas with stations located in urban areas more likely to be manned by a senior nurse. Community nursing stations complement and function like stations, except that they are built and funded by the community themselves, following approval by the government and according to government standards.

Sub-divisional health centres are the next level in the system (SDHC =77). These may be co-located with a sub-divisional hospital (SDH = 16). The health centres are managed by a medical officer (Sub-divisional Medical Officer – SDMO) or nurse practitioner (Sub-divisional Nursing Sister – SDHS) and receive referrals from nursing stations as well as accepting community patients at the outpatient clinics. The sub-divisional health centres also conduct preventive clinics including for example Maternal and Child Health and Special Diabetes Clinics. The ideal line of referral is for a patient to first seek help from a VHW/CHW or attend at a nursing station using the tiered approach for referral to a health centre or subdivisional hospital. They are then referred higher to a divisional hospital if necessary.

Primary health care and public health care services are managed and administered through four Divisional Health Services (DHS) offices: Central & Eastern combined in Suva; Western in Lautoka; and Northern in Labasa, each led by a Divisional Medical Officer (DMO) and responsible for providing public health services. There are five subdivisions in the Central Division, four in the Eastern Division, six in the Western Division and four in the Northern Division. The four DMOs are responsible to the Deputy Secretary Public Health who heads the Public Health Division in the MOH headquarters in Suva. The sub-divisional hospitals, with an average capacity of 12-40 beds, provide inpatient care and outpatient services within each subdivision. Three area hospitals, smaller in capacity than a subdivisional hospital (usually with no more than 15 beds), complement the subdivisional hospital by delivering services in isolated populations. Sub-divisions are of unequal size in relation to population. For example , the urban Suva sub-division contains over 218,000 people; Tailevu, a rural area not far from Suva, around 20,000; and Rewa, the semi-urban and rural sub-division between Tailevu and Suva, around 84,000 people.

Patients may first see a VHW/CHW or a nurse during an outreach visit or may go to a nursing station, health centre or subdivisional hospital. They may be referred to a higher level health facility: one of the three divisional hospitals (in Suva, Lautoka and Labasa) or the Colonial War Memorial Hospital (CWMH). All consultations, admissions and laboratory and radiological examinations are free to the public in public health facilities, except for some dental and special treatments or those in which patients choose to be admitted to a paying ward. The sixteen subdivisional hospitals and the three divisional hospitals provide a comprehensive range of

services, including core specialist services. The three divisional hospitals and several at subdivisional level also serve as teaching hospitals for nursing and medical students. The Colonial War Memorial Hospital serves as the national referral hospital for Fiji and is available to other countries in the region, as it provides additional specialized services, including renal, cardiac and cancer services. The three urban sub-divisions of Suva, Labasa and Lautoka/Yasawa are within the catchment areas of the three divisional hospitals however they manage and provide the full range of community health services through health centres and nursing stations within both urban and peri-urban areas.

There are three specialized hospitals: St. Giles Psychiatric Hospital; the P.J. Twomey Hospital for tuberculosis and leprosy; and the Tamavua Rehabilitation Hospital. Each divisional and specialized hospital is headed by a medical superintendent who reports to the Deputy Secretary for Hospital Services.

A small private sector includes two private hospitals in Suva (and another under construction) that provide a range of specialized services, several day clinics and 130 private general practitioners located mostly in the urban centres of the two main islands, Viti Levu and Vanua Levu. There is a private maternity hospital in the Western Division (co-funded through government grants) and another one is planned. In rural areas, traditional healers are visited for a variety of health problems, which can range from minor health ailments to more life threatening diseases like cancer and poisoning.

The sub-divisional level is where the CRA service is located within this multi-tier system. The CRAs report to the Sub-Divisional Medical Officer (SDMO) and the Sub-Divisional Health Sister (SDHS) for line management and to the CRA Program Coordinator for program content and professional support. The CRA Program Coordinator position is located at the specialist Tamavua National Rehabilitation Hospital in Suva (Ministry of Health Position Description, CBR/CRA Program Coordinator and Organisation Structure Chart, Appendix 5). This double reporting line involves a cross-over between the two key departments in the Ministry of Health (through their Permanent Secretaries), that is, the Department of Health Services and the Department of Public Health. The Position Description and Organisation Structure Chart for the Community Rehabilitation Assistant are included in Appendix 6.

3.2 Legislation, decrees, policy documents and reports

3.21 Health and rehabilitation

*The Ministry of Health Strategic Plan 2011-2015*⁴ sets out the framework for planning, managing and delivering on seven Health Outcomes. These are:

1. Reduced burden of non-communicable diseases, including reduced obesity and other risk factors.
2. Begin to reverse the spread of HIV/AIDS and control over communicable diseases of public health importance.

⁴ Ministry of Health Strategic Plan, 2011-2015 at <http://www.health.gov.fj/> accessed 23rd July 2014

3. Improved family health and reduced maternal morbidity and mortality.
4. Improved child health and reduced child morbidity and mortality.
5. Improved adolescent health and reduced adolescent morbidity and mortality
6. Improved mental health care
7. Improved environmental health through safe water and sanitation.

There is no specific mention of rehabilitation per se in any of the seven health outcomes. However, within Health Outcome 1 - Reduced burden of non-communicable diseases, including reduced obesity and other risk factors there are seven specific objectives, of which the first is the General NCD Indicator. There are five sub- objectives under this objective, the fourth of which is Community rehabilitation services increased, including advanced training in care-giving.

*The Ministry of Health Non-Communicable Diseases Prevention and Control Strategic Plan 2010-2014*⁵ pays direct attention to NCDs as “the leading cause of morbidity, disability and mortality in Fiji with relatively early age of cardiovascular deaths”. This plan is based on the data available from the 2002 NCD STEPS Survey which showed a high prevalence of diabetes and hypertension in the 25-64 age group (16% and 19.1%). More worryingly 53.2% of cases of diabetes were previously unidentified and similarly a high proportion- 63% of cases of hypertension- were previously unrecognised. Of the known cases, those with active and effective medication and control were limited to only 12.5% and 10.9% of the *known* cases respectively.

More recently, Asante, Roberts and Hall (2011)⁶ noted that despite Fiji having a good standard of health with a life expectancy at birth of around 70 years, the country is now undergoing (as are other Pacific countries) an ‘epidemiological transition now faced with a triple burden of disease: communicable and non-communicable diseases and injuries ... around 82% of deaths in Fiji in 2007 were due to non-communicable diseases and 10% due to communicable diseases (p. 5).

A new NCD Prevention and Control Strategic Plan for the next decade 2015-2020 has been prepared but is not yet publically available. It is understood that this document titled *Non-communicable Diseases Strategic Action Plan 2015-2019* contains “a specific strategy highlighting the provision of sufficient rehabilitation services for NCD-related disabilities and injuries in all divisions in Fiji by 2019”².

The current 2010-2014 NCD plan utilises a preventive and curative framework represented by the causation pathway for chronic diseases and ‘the need to intervene at the common risk factor, immediate risk factor as well as the NCD end of the spectrum’. Two approaches are prioritised. 1. NCD Risk Factor Intervention and 2. NCD Medical Intervention. For each component of the plan in each of these two priority areas there are 5 intervention strategies namely: 1. Environmental intervention, 2. Lifestyle interventions, 3. Clinical intervention, 4.

⁵ *Ministry of Health Non-Communicable Diseases Prevention and Control Strategic Plan 2010-2014* at <http://www.health.gov.fj/> accessed 23rd July 2014

⁶ *A review of health leadership and management capacity in Fiji*. A. Asante, G. Roberts and J. Hall. UNSW Human Resources for Health Knowledge Hub at <http://www.hrhhub.unsw.edu.au/> accessed 23rd July 2014

Advocacy, and 5. Surveillance, monitoring and evaluation. The plan spells out the details for each of the components using results- based approach across the life span. Responsibility for input and outcomes is documented for both primary health care and the clinical service network. Allied health is noted under the clinical service network however there is no specific mention of rehabilitation or CRAs in the document.

Currently there is no National Rehabilitation Plan or Policy for the delivery of rehabilitation services in Fiji. The *WHO Global disability action plan 2014-2021: Better health for all people with disability*⁷ endorsed by the World Health Assembly in May 2014 has offered the opportunity to consider the health challenges faced by people with disability in a national context and to consider appropriate policy, planning and service responses. In addition, the Ministry of Health requested that the Medical Officer in Charge at Tamavua National Rehabilitation Hospital, Dr Pratima Singh to develop, through a series of collaborative, consultative workshops, a *National Disability Inclusive Health and Rehabilitation Strategic Plan*². The draft document has recently been delivered to the Permanent Secretary of Public Health for their consideration. This draft document is included as Appendix 7. There are five objectives in this draft plan each with a number of activities. These objectives are:

- Address barriers and improve access to health care services and programs
- Persons with disabilities have access to quality rehabilitation, including at community level
- Increase provision of assistive devices
- Strengthen community-based inclusive development
- Strengthen disability data and information collection

One specific activity number 2.5 under objective 2, *Persons with disabilities have access to quality rehabilitation, including at community level*, is 'To conduct further analysis and review of the role of the Community Rehabilitation Assistants (CRA) Program'. This report contributes to this activity 2.5.

3.22 Disability

The following information on national legislation about disability and co-ordination mechanisms comes from documents provided by the Fiji National Council for Disabled Persons supported by information provided by key informants.

Fiji's history of providing services to people with disabilities resides primarily in the charitable sector. An early health service development was the ward for psychiatric patients, which is now the St. Giles Hospital. In the mid-1960s, special schools began to cater for the needs of children affected by poliomyelitis, as well as visually impaired and deaf children – for example by

⁷ Draft WHO Global Disability Action Plan 2014-2021: Better health for all people with disability at <http://www.who.int/disabilities/actionplan/en/> accessed May 12th 2014

organisations such as the Fiji Crippled Children Society, the Society for the Blind and the Fiji Red Cross. Special schools have expanded over time; most children with a disability are catered for in a special school in Fiji however in recent years there has been a strong focus on inclusive education with Ministry of Education providing training programs for mainstream teachers, head teachers and principals. An example of one such program is included in Appendix 8. As is the case elsewhere, special schools also often evolved into providing pre-vocational and vocational training and vocational workshops for their students to ensure day occupations following the completion of their school education.

In December 1994, the Parliament of Fiji passed the Fiji National Council for Disabled Persons (FNCDP) Act. The FNCDP reports to the Minister of Social Welfare however is a subsidiary government organisation with its own Director, Executive Director, Board and Advisory and District Committees. NGOs and the increasing number of DPOs in Fiji are all affiliates of the FNCDP. The FNCDP structure with district and local level committees allows for broad consultation with people with disabilities throughout the Fiji Islands.

Starting in 2006, the FNCDP began a series of consultation workshops organised by its District Committees throughout Fiji. This culminated in the *National Policy of Persons Living with Disabilities 2008-2018*⁸ endorsed by the FNCDP and the Ministry of Health, Women and Social Welfare. Twelve strategic priorities with accompanying objectives were presented in this policy document with reference to broader regional initiatives such as *Biwako Millennium Framework for Action* current at that time. According to the *National Policy* document reliable data on the numbers of people with disabilities in Fiji is missing. The 1996 census included questions on people with a disability and identified 3117 people. However this was limited to people who were economically active and aged over 15 years thus limiting the usefulness of this data to understand the number of people overall in Fiji who have a disability including infants, children, older people and those not currently economically active.

The *Fiji Roadmap for Democracy and Sustainable Socio-Economic Development (RDSSSED) 2009-2014* addressed the 'neglect' of disability, noting that 'the area of disability has, over the years, endured considerable development constraints like finance assistance, human resources, technology and infrastructure and the lack of data and statistical information on all areas and forms of disability' (2010, p. vi).

The FNCDP in collaboration with funding agencies including the Ministry for Social Welfare, Women and Poverty Alleviation, conducted a national baseline disability survey in 2008-2009 and published a report in 2010 of the findings titled *Making women with disabilities visible*⁹. This report brought to light quite different figures on disability to that produced from the 1996 census. The total population of people with disabilities was determined to be 11,402 with 5222 women and 6180 men. Based on the 2007 national census, Fiji's total population at that time was 837,271. The survey's findings therefore result in a prevalence rate of 1.4% of Fiji's

⁸ *Fiji Islands. A National Policy on Persons Living with Disabilities. 2008-2018.* Fiji National Council for Disabled Persons with the Ministry of Health, Women and Social Welfare.

⁹ *National Baseline Disability Survey. Making Women with Disabilities Visible (2010).* Fiji National Council for Disabled Persons.

population as persons with disabilities. Given the limitations of the survey particularly in relation to geographical reach, the FNCDP noted that ‘ this figure could increase to 10% or more if all areas in the central, eastern, northern, and western divisions in Fiji were surveyed’ (2010, p. 17).

International documents

UN Convention of the Rights of Persons with Disabilities

Fiji signed the UN Convention of the Rights of Persons with Disabilities (CRPD) and the Optional Protocol on 2nd June, 2010. From this there has been much work put into developing a decree on disability to put into effect the articles of the CRPD in Fijian legislation, governance, strategic planning and implementation. This decree, dated 2013, it is understood, is still awaiting perusal by Cabinet and thought unlikely to proceed until the general election scheduled for September 2014. Currently there is no National Disability and Rehabilitation Plan however consultation workshops² have commenced.

Incheon Strategy Make the Right Real for Persons with Disabilities in Asia and the Pacific

Fiji is a signatory to the *Incheon Strategy Make the Right Real for Persons with Disabilities in Asia and the Pacific*¹⁰. This regional strategy has ten goals each with specific objectives. UNESCAP has prepared a proposed *Road Map for the Implementation of the Incheon Strategy to “Make the Right Real” for Persons with Disabilities in Asia and the Pacific*¹¹ for consideration at the 70th session of ESCAP in Bangkok in early August, 2014. This roadmap offers some guidance at the policy settings level over 2014-2017 which is the time frame up to the mid-term review of the strategy.

3.3 Reports of International Agencies, and International Non-Government Organisations

There have been a number of reports in relation to the health sector in the Pacific over the past ten years. Some are regionally focused; others are country specific. These documents were accessed for *The Pacific Rehabilitation Workforce WHO Discussion Paper Series. Paper No 1* written by Llewellyn, Gargett and Short for WPRO in October 2012 and utilised in the current report. Where more recent information was available it is noted. The reports are referenced in Appendix 4. The reports utilised were:

Regional

- *Mapping Human Resources for Health Profiles from 15 Pacific Island Countries*. The Human Resources for Health Knowledge Hub, University of New South Wales, 2009.
- *Road Safety in the Western Pacific Region: a call for action*. WPRO, 2009.

¹⁰ *Make the Right Real. The Incheon Strategy for People with Disabilities in Asia and the Pacific* <http://www.unescap.org/our-work/social-development/disability> accessed 9th July 2014

¹¹ *Road Map for the Implementation of the Incheon Strategy to “Make the Right Real” for Persons with Disabilities in Asia and the Pacific* <http://www.unescapsdd.org/events/first-session-working-group-asian-and-pacific-decade-persons-disabilities-2013-2022> accessed 9th July 2014

- *Pacific Children with Disabilities*. UNICEF, 2010.
- *Disability at a glance 2010: a profile of 36 countries and areas in Asia and the Pacific*. UNESCAP, 2011.
- *Women and health in the Western Pacific Region: an overview*. WPRO, 2011.
- *WPRO Country Health Information Profiles (CHIPS)*. WPRO, 2011
- *Improving Access to and Provision of Disability Services and Facilities for People with Disabilities in the Pacific*. AusAID and CBM Australia – Nossal Partnership for Disability-Inclusive Development , 2012

Fiji country reports were:

- *The Fiji Islands Health System Review*, World Health Organisation's Asia Pacific Observatory on Health Systems and Policies, 2011.
- *A review of health leadership and management capacity in Fiji*. UNSW Human Resources for Health Knowledge Hub, 2011.

Additional information for the desk review was sought from relevant websites for example Motivation Australia <http://www.motivation.org.au/>, Australia-Pacific Technical College (APTC) <http://www.motivation.org.au/>, CBM-Nossal Partnership http://ni.unimelb.edu.au/nossal-site-old/inclusive_development/disability_inclusive_development/cbm_partnership and Cerebral Palsy Alliance <https://www.cerebralpalsy.org.au/>.

4. CRA Program Analysis

4.1 Method

An interview guide was developed specifically for this project to canvass the views of the broad range of key informants. The guide was developed using a human resources for health framework including the workforce component of the WHO Health Systems Strengthening Framework and Key Components of a Well-Functioning Health System¹², and taking into account the long history of the CRAs in community based work in Fiji. The interview guide is appended in Appendix 8.

Selection of key informants

Following discussion with Dr Pratima Singh, Medical Officer in Charge, Tamavua Hospital (National Rehabilitation Medicine Hospital, NRMH) in person (WHO Workshop, Manila, June 23-25, 2014) and subsequently by email, key informants were recommended to take part in the interviews. The Coordinator of the CRA Program, Mrs Maraia Matakibau who is also based at

¹² Key Components of a Well Functioning Health System, WHO, May 2010 which builds on earlier publications including *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*, WHO, Geneva, 2010

Tamavua Hospital, reports to Dr Singh as Medical Officer, NRMH. Line management responsibility is through the Deputy Secretary Public Health at Ministry of Health Headquarters.

The informants included Ministry of Health National Advisers, Medical Officer in Charge Tamavua Rehabilitation Hospital, Physiotherapy Superintendent, Sub-divisional Medical Officers and Sub-Divisional Nursing Sisters in Tamavua Sub-division (a rural area) and in the urban Suva Health Office (Suva Sub-division), Senior Education Officer, Special Education, Ministry of Education, Course Coordinator FNU, CRA Program Coordinator, Fiji National Council for Disability, and DPO – Spinal Cord Injury Association.

Key informant interviews

17 interviews were conducted over a five-day period in country from 28th July to 1st August 2014 inclusive. The list of key informants and their titles is included in Appendix 3. Every effort was made to interview the personnel nominated by Dr Singh and arranged by Mrs Matakibau before the in-country visit. However due to time constraints, logistical difficulties and time pressures for a number of key informants, this was not possible as noted by asterisk in Appendix 3. Interviews ranged from around 30 minutes to well over an hour depending on arrangements, number of people and available time. Other informants were suggested while in-country and interviewed where time permitted.

The interview guide proved a useful tool to stimulate discussion and to collect data about the CRA position, role and function and more broadly about the health, rehabilitation and disability sectors in Fiji. It allowed for 'testing' out that data in subsequent interviews where appropriate; guiding questioning and discussion to areas of known expertise; and a valuable aide-memoire in the context of interviews with busy people who, not surprisingly, hold a perspective relevant to their particular position in the health, rehabilitation or disability sectors.

Following the first day of interviews it quickly became apparent that many were not familiar with the MOH CRA Position Description which includes the primary purpose of the CRA position and reporting lines. Consequently interviews were followed up (where appropriate) by email attaching the MOH CRA Position Description and Organisation Structure documents for further comment from informants.

Site visits

As proposed, site visits were conducted at the sub-divisional level in one rural and one urban setting. The rural setting, given time and logistical arrangements, was relatively close to Suva in the Central Division. This site visit took place at Korovou Health Centre in the Tailevu Sub-Division approximately one and a half hour express bus travel north of Suva. The urban site visit occurred at the Suva Sub-division in Suva city. At each site interviews were held with key informants who worked together at the Health Centre: the SDMO, SDHS, the Zone Nurse and the CRA.

CRA Position description

According to the Ministry of Health Position Description, the *primary purpose* of the Community Rehabilitation Assistant position is as follows:

This position is responsible for the provision of effective, efficient and quality rehabilitation services to infants, children and adults in the community and ensure that they receive the best of care which will enable them to become self-reliant and as functional as possible to improve their quality of life.

This PD goes on to explain the Role of the Department as:

To implement and promote community based rehabilitation services and primary health care initiatives

And further to describe the Role of the Position as:

To identify people with disabilities as early as possible in life, to assist in accessing rehabilitation services to persons with disabilities and to increase knowledge regarding disability issues as a means of prevention of disabilities in the communities and to be responsible for their health.

The Reporting Relationship is spelt out as follows:

This position reports to the Sub-divisional Medical Officer and the Sub-divisional Nursing Sister, and line management responsibility through the CRA Program Coordinator, National Rehabilitation Medicine Hospital.

4.2 Analysis of information

The data produced from the key informant interviews, the follow up emails and the site visits has been aggregated, analysed and summarised below. The findings address contribution of the CRA program in the health system and to people with disabilities; issues raised about the CRA program presented under leadership and governance, service delivery, health workforce; and a final section on the current review and planning context. Under the first heading more detail about the CRA position is provided.

5 Findings

5.1 Contribution of CRA Program

Unanimously, the CRA program is warmly regarded and seen as an important component of both the clinical and public health system in Fiji. Several strengths of the CRA program were identified as follows.

1. Firstly, key informants spoke about the particular value of the CRAs in *being out and about in the community, providing a service to people with disabilities in their homes, their villages and in urban areas in their neighbourhoods*. This suggests very strong support across the informants for a service such as the CRA program which serves people with disabilities and their families at the most immediate level – in their homes. This was the first and foremost point mentioned by informants with regard to the strength of the CRA program.

This community based level of the CRA program is a critical point given the distances and expense for people with disabilities to access centre based services such as the sub-divisional health centres. If there is no service that can come to the person's home in their village or neighbourhood, individuals with disabilities may not receive any services at all. *The first strength of the CRA program therefore is the focus on serving people with disabilities at the community level.*

Informants were not always sure about the reach of the CRA program in working with children and adults with disabilities in the community across Fiji. There was some concern that the CRA program might not be well-known at the community level. There are very few CRAs compared to the population in the sub-divisions and the CRAs do not have a clear identity – they do not wear uniforms as for example do the other sub-divisional staff.

It is possible too that with the growth of other community based services for people with disabilities in Fiji, it has become less obvious to the community who the CRAs are and what they offer. The Fiji Blind Society for example run a community based worker service (and they wear uniforms), and other services such as the Hilton Special School now also employ a community based rehabilitation worker with support from Fiji National University (FNU). In the Health Centre at Nausori in Rewa sub-division for example, the CRA and a CBR worker from an NGO share an office. That there are other organisations including DPOs employing community based personnel offers further evidence that this outreach model of service into villages and homes is highly valued in the Fijian context. It also means that there will be increasing competition among employers, MOH, NGOs, and DPOs to employ personnel with community based rehabilitation qualifications.

2. The second strength of the CRA program according to informants was its contribution to national health programs particularly preventive programs. There are two components to this as evidenced in the principal accountabilities in the CRA Position Description. The first of these is: *‘To detect any abnormalities in life as early as possible’* and the second: *‘To promote education and awareness raising in disability issues and prevention’*. The first was actioned by CRAs being part of Maternal Child and Health Clinics and the second by their joining screening teams in the community for example, school screening teams and specialist clinics for example for people who already were diabetic. Informants spoke about the potential through these activities to reach more people in the community and that general education and awareness raising was an important part of the CRA role.

At the same time as informants recognised these two stand-out strengths of the CRA program, *very high expectations on what the CRA program should deliver* were observed. The original Save the Children Fund CRA model focused only on curative work with children with disabilities. Now however the CRAs are also expected to work with adults with disabilities. Initially, the CRA program offered basic therapy advice and input to individuals in their homes and communities, in the absence of qualified rehabilitation therapists. Now, as well as performing this home-based therapy support role, the CRAs are expected to do preventive work with all population groups. To reinforce this point, CRAs now spend a greater proportion of their time participating in Maternal Child Health Clinics, Special Diabetic Clinics, immunization programs, school programs, wellness programs and family health programs as well as other specialist clinics in their Health Centres. This preventive work takes up a great deal of time. It appears

that at sub-divisional level where there are widespread vacancies for example for nurses and physiotherapists to engage in preventive (and curative) services, the CRA program is used to 'fill the gap'.

This means that CRAs are being taken away from their primary purpose as documented in their Position Description which is to provide "effective, efficient, and quality rehabilitation services to infants, children and adults in the community" There is a great danger in CRAs taking on all these additional tasks. It means that the CRA program is not able to fulfil its primary purpose given the demands on time and resources. It also means there is not a good understanding about what is the primary purpose of the CRA program. This means that CRAs may have great difficulty in prioritising their workload and may be pulled 'this way and that' by the competing demands at the sub-divisional level. It also means, as was quite clear in the interviews with senior sub-divisional medical and nursing staff, that there is not a specific identity for the CRAs at the sub-divisional health centres where they are located.

There is not time to do everything. Having the CRAs involved in all the preventive work that occurs at sub-divisional health centres may not be the best use of CRA program time for several reasons. The first is that the primary client group of the CRA program – people with disabilities – will not receive the service which is meant to be for them. The second is that the skills and capabilities of the CRAs to work with people with disabilities are not being used effectively and efficiently. The third is that although prevention is important and NCDs are on the increase in Fiji, there will be several generations of people in Fiji with NCD-related disability before the prevention programs take effect. It is critical therefore to have a workforce – the CRA workforce – that provides a service to people with disabilities from MVAs, CVAs, diabetes and other NCDs affecting the Fiji population. The fourth reason is that it is not clear what the exact contribution of CRAs is at the clinics, screening and community education. Although each informant was asked if they could describe the CRA contribution, there was difficulty in doing so except in the case of the MCH clinics. In this case, several informants referred to the competence level of the nurses with regard to assessing delayed milestones and suggested that the CRAs were needed to ensure children with delayed development and/ or disabilities were identified and referred early.

The contribution of the CRAs to all the preventive programs being carried out at sub-divisional level needs close examination. If there is not a unique contribution to preventive programs it may be a better use of time and resources to have clinic, screening and community education teams refer individuals to the CRA program, rather than to have the CRAs participate in all these activities. Being clear about CRA program activities and the balance of work between serving individuals with disabilities and preventive work may be quite a sensitive issue. This is because there are an increasing number of public health programs emanating from MOH HQ in response to the increase in NCDs (for example wellness programs) and also the focus on family health programs by the National Advisors.

Community rehabilitation personnel can and should engage in prevention. Prevention is a very important part of the health service and particularly in relation to NCDs. But the CRA contribution to prevention may be better achieved at the very local level, out in the field which is where they can provide a unique preventive contribution. For example, when visiting a young man following a stroke, the CRA can talk to and educate other young (and older people) in the

village about hypertension and correct diet and physical activity. This type of prevention which builds on real life examples of people in a village, neighbourhood or community is a potential strength of the CVA program which may be currently under-utilised with the focus on team based prevention in clinics or institutional settings such as schools. The local level preventive activities based around needs at the village level can also be carried out in collaboration with the Zone Nurses (or Home Base nurses in sub-divisions where this post also exists).

5.2 Issues raised about the CRA program

Key informants also identified some concerns about the CRA program. These are summarised below under the headings of governance and leadership, service delivery and workforce. Very simply however the concerns were primarily about *the specific role and function of the CRAs* in the health system and *lines of responsibility and communication*.

5.21 Governance and leadership

The CRA position is located at a similar level to registered nurse, dental personnel, dietician and physiotherapist within the sub-divisional structure. Health personnel at this level report to the SDHS and SDMO, who then report up to the divisional level (there are 4 divisions), and from there report lines are directly to the Deputy Secretary for Public Health.

At the same time, the CRAs (paid and volunteer) have a line management responsibility through the CRA Program Coordinator who is based at Tamavua National Rehabilitation Hospital under the Deputy Secretary for Hospital Services. The reporting line for the CRA Coordinator position is via the Medical Officer in Charge Rehabilitation at Tamavua to the Medical Superintendent and then to the Deputy Secretary for Hospital Services as shown in Appendix 5. This 'double/ cross over' reporting line is quite different to that of their sub-divisional colleagues. The structure and reporting lines for nursing and medical personnel are quite straightforward. The reporting lines for the sub-divisional physiotherapists (where these exist) are somewhat similar to the CRAs. That is they report locally to the SDHS and SDMO while having a line management reporting line to the Superintendent Physiotherapist who is based at Colonial War Memorial Hospital as the national referral hospital in Suva.

The governance structure for the CRAs was the cause for concern by all key informants. These concerns are detailed below. There were five areas discussed.

1. The SDHS and SDMO, while accountable for the CRA (given their location and reporting line at the Health Centre), felt poorly prepared to undertake this responsibility. This was due to little or no documentation including policy, guidance or protocols relevant to the CRA position. This situation was in direct contrast to that for other positions for which they were responsible. SDHS and SDMO informants mentioned absence of the following documents which were available for other positions: CRA position description, roles and functions, scope of practice, standard operating procedures, responsibility for provision of tool kits to CRAs including maintenance and replacement, responsibility and funding for CRA professional development. Of concern too was that they did not know what competency levels to expect in a CRA and their responsibility in relation to CRA performance management.

Tellingly, SDHSs reported learning about the CRA role from the incumbent; prior to their tour of duty as an SDHS they were not aware of the CRA program. While individuals in the CRA program had remained over a number of years, nursing and medical staff undertake tours of duty including hospital based placement as well as at sub-divisional or health centre level. This meant that medical and nursing staff may have had no exposure to the CRA program either in their training institution or previous placements prior to arriving at a sub-divisional location. In this instance the lack of expected documentation was particularly frustrating, when they were accountable for this para-professional health worker position. One key informant summed up the situation as the CRA position being 'loosely attached' with a work load primarily determined by demands at the Health Centre with 'all sorts of work being undertaken'.

2. At the sub-divisional level, CRAs prepare an *itinerary for submission* to the SDHS. The ideal situation is that this itinerary is planned in consultation with the Zone Nurse (s) so that where appropriate community education and home based activities can be done together maximising time and utilising the limited transportation available. This ideal appeared to be rarely met. As noted below under service delivery, one of the greatest drawbacks and challenges was being able to get out into the community due to transportation difficulties. CRAs also noted that their itinerary was very circumscribed by the number of clinics which they were required to attend including MCH clinic and the Special Outpatients Clinic for Diabetes which limited their capacity (along with transportation difficulties) to undertake more outreach, home based work.

3. *Monthly and quarterly reporting* on their new and existing case load is provided by the CRAs to their SDHS. Only one form appeared to be standard across the CRA program. This form recorded quarterly activity and appeared to be from an earlier time when the CRA position focused solely on children; there were only four age categories 0-1, 2-5, 6-18 with the last category 19+ the only one which applied to adults. Seven types of disability could be recorded on this form: developmental milestones, physical, speech, hearing, visual, intellectual and multiple (one example of a CRA cases on register and contact is included in Appendix 9). Other forms used by the CRAs for monthly and quarterly reporting appeared to be self-devised and primarily number based: number of cases seen, home visits, community programs, and clinics attended. An additional comments section briefly explained what actions had been taken.

4. *Unclear referral pathways and feedback reporting mechanisms.* It appeared that referral pathways and feedback responsibilities are not documented and that CRAs rely on practices that they have developed over time rather than using a standard form or practice. These appeared to rely on personal knowledge and relationships, which are not reliable ways of providing referral information or feedback. This is also very inefficient when there are rotating staff as is the case with the nursing and medical services at sub-divisional level.

This lack of reliable and standard referral and feedback documentation was of particular concern to those at national specialist hospitals and the national referral hospital. This was because staff in these central locations have to rely on sub-divisional staff to follow up referred clients in the community. Not all sub-divisional hospitals for example have physiotherapists, so therefore there is heavy reliance on CRAs to follow up physiotherapy recommendations from central services such as Tamavua and Colonial War Memorial Hospital. There was concern expressed too that very few clients were referred by CRAs to other health personnel – particularly at the divisional and central levels. This may all be considered part of the overall

concern about CRA scope of practice and standard operating procedures which remain unclear to all – including the CRA program. As one senior staff person asked “What role do they play? This is ambiguous. Do they assess? Screen? Treat? And who and how?”

5. *Lack of clarity about CRA Program budget and resources.* Universally all informants commented on the lack of resources available to support the CRA Program. Although the CRA Position Description refers to assets held by incumbents in the position, this was confirmed by CRAs and senior sub-divisional staff to not be the case. So for example there was no CRA tool kit (although again informants referred to this being part of the original position under the Save the Children Fund program). This appears to be in direct contrast to other personnel at the sub-divisional level who have uniforms and shoes provided as well as appropriate tool kits for clinic and community work. Transportation is an ongoing issue for all sub-divisional staff with itineraries lodged with the clerical officer in the hope of gaining access to the limited Health Centre transport. CRAs are rarely able to access this transport and therefore need to rely on public transport and walking. Although apparently they can claim for bus fares, this did not appear to appease the concerns felt about lack of financial support to travel into the community. This may be another reason why, when community based work is their primary role, the monthly and quarterly reports cited that were cited, provided conflicting evidence of this. That is, the greater proportion of time in these reports was taken up with centre-based clinic, screening and team program work.

6. SDHS’s and SDMO’s reported their *contact with the CRA Program Coordinator* was much less than desirable. This was cause for considerable concern. They expressed a direct need for frequent, regular, organised and sustained communication channels with the CRA Program Coordinator – using either telephone, email, face to face contact, or any combination of the above. This was so they could keep abreast of what the CRA program was offering, changes that were made to the program, could request attendance by the CRA at workshops/ seminars in their sub-division, and provide feedback to the CRA Program Coordinator about the CRAs performance and contribution at the sub-divisional level. The CRA Program Coordinator reported difficulty in keeping up regular communication due to transportation difficulties with no budget to support visits to sub-divisional centres. Several informants mentioned that under the initial Save the Children Fund program there had been a vehicle for use by the Program Coordinator to enable regular visits to CRAs and senior staff in the sub-divisional areas.

7. *Peer support* for CRAs is a neglected area. The CRAs are widespread and do not come together in regular annual or more frequent meetings as is the case for other sub-divisional staff. This was seen to be a significant drawback to ongoing development by both the sub-divisional staff and the CRAs themselves. For the latter it was the area of their greatest concern along with the lack of resources and equipment needed to do their jobs. Because there is no regular CRA program meeting, there is no opportunity for CRAs to share achievements and challenges and to network or bring their collective experiences together to advocate for changes in the system in response for example to changing population needs. This is also a missed opportunity in bringing together the CRAs from the original Save the Children Fund training, those graduating from the Certificate program at FNU, and those undertaking the Certificate IV in Disability at APTC. Given the different foci of these training programs, sharing of knowledge across the CRA program is essential so that all aspects of each type of training are

understood and appreciated rather than personnel taking a dislike to the content of one or more training programs.

8. *Professional development and continuing educational opportunities* within the CRA program were extremely limited. CRAs reported not getting together for many, many months (or even years). An opportunity came about for some CRAs to attend a disability and sport day during the in-country visit; however this happened only due to external sponsorship support with the CRA Program Coordinator noting there was no budget for professional development opportunities for CRAs. The lack of professional development opportunities seriously disadvantages the CRA program as CRAs are now expected to work with adults with disabilities and undertake a wide range of preventive activities not included in the original training or scope of the program. Population health needs are changing as evidenced by the increase in NCDs and the demands on the CRA workforce to participate in population based preventive, screening and clinic programs. As one SDMO commented “If the MOH wants to have this type of workforce, the CRA program needs to be formalised including opportunities for professional development”.

9. *Strategic planning in the CRA program* appears to be missing or if done the documentation was not made available; it was not possible to obtain any documentation about CRA Program Strategic Plan for implementation throughout the CRA Program. Individual CRAs are included in sub-divisional strategic planning activities. Some CRAs develop annual work plans in line with sub-divisional strategic planning and share these with senior sub-divisional staff; the outcomes of these Work Plans differ depending on the sub-division. At one sub-divisional level the SDHS produced a Community Based Rehabilitation Programme Strategic Plan 2010-2014 (not dated or authored). This noted 6 priority areas with strategies, KPIs and responsibilities however these responsibilities related to a much broader set of personnel at sub-divisional level than CRAs.

10. *The data provided by the CRAs at sub-divisional level* did not appear to form part of the regular MOH sub-divisional reporting format. The CRA Program Coordinator aggregates the data from all the CRAs and this is submitted to MOH HQ. However the standard format for MOH statistics comes from the indicators relevant to the Strategic Plan Health Outcomes such as maternal health, immunisation, MCH clinic data, and numbers of outpatient services by type of condition. The CRA data is not inserted into this format at sub-divisional level. This was of concern to the SDMOs and SDHSs as it meant the service was hidden (and neglected) within the MOH structure and processes. As one SDMO noted, “there is no indicator in the data for the CRA service..... How can we know exactly what they contribute?”

5.22 Service Delivery

Good service delivery requires that:

- Transparent and well documented service standards which include scope of practice, standard operating procedures, documentation and communication channels for the program/ service
- Service standards documentation is readily available and understood by all health professionals and other sectors including education and social welfare

- Factors which increase access or barriers to accessing the program/service are well understood and addressed
- People with disabilities, their families and carers know about the service, what the service does, trust the service, want what the service has to offer, can access the service and can afford the service.

There are some challenges and some good opportunities to work towards the CRA program meeting these criteria. There are three stand-out areas to consider.

1. There is overall warm regard for this program as it is the 'arm of therapy in the community'. This exists despite the fact that there is less than desirable information or documentation about the CRA program and what it does and the outcomes it achieves. Informants spoke about the passion and commitment of the CRAs, many of whom had been in their positions for quite a few years.

The CRA program was universally seen by informants as an essential part of the continuum of care into the community for people with disabilities. This role and function that the CRAs play is not undertaken by any other position in the health system. This is a clear strength of this program within the MOH suite of services and programs.

This strong regard for the program model offers an excellent opportunity to build on this support and develop higher standards of service delivery.

2. There is concern that the CRAs are now spending a significant proportion of their time in centre – based located services (clinics, screening programs and community education) rather than being out and about in the community as in point 1 above.

This preventive component of their work was not well understood by informants except in the case of the MCH clinics. Their role in the MCH clinics was understood because as one informant observed the clinic nurses vary in their competency level in screening for delayed milestones. The presence of the CRA and their knowledge of early development ensured early referral of infants and young children with disabilities or delayed development.

However the CRAs are participating in many other preventive and health centre based activities clinics. Despite asking all informants, there were no clear answers provided about the exact contribution of CRAs to these other centre based services and programs.

5.23 Workforce

1. The initial training provided to CRAs was over 2 decades ago and this training was targeted at foundation rehabilitation therapy skills. This was at a time when there were fewer physiotherapists available and all were located either in urban areas or a divisional level. Since that time the physiotherapy workforce in Fiji has grown with more physiotherapists in MOH including some at sub-divisional level, employed by NGOs or serving as international volunteers and in private practice in the community. As well, the Tamavua Rehabilitation Hospital has expanded to include a dedicated stroke unit. In the early days of the CRA program, often the CRA was the only person available who had rehabilitation skills.

Now there are other people in MOH and the NGO and DPO sector who can work with people with disabilities. This presents an opportunity and a challenge for CRAs to work as part of a team, sharing knowledge and making sure individuals are referred to those with more specialist expertise. NGOs and DPOs in Fiji now employ community based workers and two training institutions, FNU and APTC, regularly graduate community based and disability support personnel from their respective programs. There are also opportunities for engaging in ongoing training to become competent in particular skills and techniques, for example the Wheelchair Service Training using the WHO training package, provided by Motivation Australia in collaboration with Spinal Injuries Association and FNU.

Also since that time in the 1990s there have been quite rapid advances in rehabilitation therapy skills. Unfortunately there have been very few opportunities for those in the CRA program to update their rehabilitation therapy skills. Many have learnt their skills 'on the job'. This is not ideal when there are very few professional staff to supervise their learning and competency. As well there have been very few opportunities to expand their skills into other areas where they are now asked to work, for example in preventive programs for adults with NCD's. The absence of ongoing skill development is a lost opportunity within MOH to create a more highly skilled workforce in the CRA program. Training for those working at the community level needs to include theory and rights and empowerment perspectives as well as practical skills. Community based workers are regularly put in positions of making decisions; training on decision making as well as confident referring to others when needed is an essential part of community based workers training.

In the disability sector there have been great advances over the past five years. The UN Convention on the Rights of Persons with Disabilities (2006) brought a more inclusive approach to thinking about people with disability in their communities and their human rights. The release of the *World Report on Disability* (2011) provided the impetus to think about people with disabilities more broadly and other areas of their lives as well as their health. Concepts from the UN Convention and the World Report are included in the Certificate in Disability and Community Based Rehabilitation offered by FNU and the Certificate IV in Disability offered by the APTC. There needs to be an opportunity for the CRA workforce to be informed about all these developments. This is important for building capacity in the CRA workforce and also to prevent criticism and lack of respect for courses which include this content.

The need for understanding the broader lives and context of people with disabilities is particularly important in community based rehabilitation programs. While the health of people with disabilities will always remain important, in the Community Based Rehabilitation CBR Guidelines and Matrix (WHO, 2010), health is only one of five components that need to be considered in providing a CBR program to people with disabilities in the community. The other four components are education, livelihood, social and empowerment. This means again that the CRA program cannot function alone and in isolation from developments in the disability sector in Fiji and the Pacific region. The CRAs now also need to work proactively with the Ministry of Education and the Ministry of Social Welfare at the very least to ensure that the broader range of needs of people with disabilities are catered for.

2. The population of Fiji according to the final count of the 2007 national census was over 837,000¹³. Using the lower figure of 10% for prevalence of disability from the *World Report on Disability* this would result in approximately 83,700 Fijians with a disability. With the higher figure of 15%, the number of people with disabilities in Fiji would be around 125, 500. In 2010, MOH recognised the need to expand the CRA workforce by sponsoring 29 students to undertake the course offered at FNU. Regrettably these graduates were not all employed on graduation.

Over the last decade community based rehabilitation has expanded in Fiji. NGOs and DPOs employ their own CBR workers with differing backgrounds and from various training courses in Fiji and elsewhere. Now there is the possibility of ‘competing’ workforces developing to provide services to people with disabilities in the community. There is a very good opportunity at this early stage to build understanding, respect and cohesion between the CRAs in MOH who remain health based and CBR workers to ensure that there is no overlap between their services or that even greater gaps in service delivery appear.

5.3 Current review and planning context

5.31 Multiple review and planning activities

There are multiple review and planning activities related to children and adults with disabilities happening concurrently in Fiji. The consultation workshops and planning for both the *National Disability Inclusive Health and Rehabilitation Strategic Plan 2014-2018* and the *Fiji Ministry of Health Action Plan for Children with Disabilities 2014-2016* are proceeding apace. Some but not all participants are involved in both planning activities. This has created a quite disparate knowledge base among the key informants, some of whom are aware of the planning activities and others who are not, and some who seem not to have been included.

In this situation it is hard to build trust and confidence in the review and planning processes as equal knowledge is not shared by all. This is particularly true for the CRAs who are typically not included in central planning processes; one mentioned about feeling ‘under the spotlight’ and ‘out of the loop’. This is unfortunate when these review and planning processes relate to the CRAs primary purpose of providing ‘effective, efficient and quality rehabilitation services to infants, children and adults in the community’.

There is clearly a great deal of planning activity related to the National Programs and the National Advisers responsible for public health programs. This appears to be happening in some cases at some distance from those in the other ‘arm’ of the MOH which is the Department of Health Services. While such separation is not unfamiliar in health systems in other countries, this separation and lack of conjoint planning is of extreme disadvantage to strategic planning and action plans for people with disabilities.

¹³ Fiji Bureau of Statistics, <http://www.statsfiji.gov.fj/> accessed 4th August 2014

This is because as is made clear in the *WHO Global Disability Action Plan 2014-2021: Better health for all people with disability* (2014) and other WHO documents including the *World Report on Disability* (2011) and the *CBR Guidelines and Matrix* (2010), people with disabilities need to be able to access mainstream health services for their general health needs as well as have access to specialist services such as rehabilitation and assistive technology. This requires all parts of a health system to be involved with strategic and action planning for health services for people with disabilities. It also requires as included in the *UN Convention on the Rights of Persons with Disabilities* that people with disabilities and their representative organisations (DPOs) are also actively involved in the strategic and action planning processes which affect them and their families and carers.

Further to this, and again as noted in the *UN Convention* and the draft *Disability Decree*, there is a need for collaboration and coordination with other line ministries who provide services to people with disabilities. The Ministry of Education has a clearly designated focal point on disability which is the Senior Education Officer, Special Education at MOE headquarters. Having such a position clearly identified ensures that there is better internal MOE communication in relation to all matters affecting children and young people with disabilities; it also offers a clearly identified point of contact on all matters relating to disability for other line ministries, NGOs and DPOs.

Currently it appears there is no such position in the Ministry of Health. There are National Advisor positions for example on Wellness and also on Family Health, but no National Advisor position on Disability. There would be great benefit in a clearly identified National Adviser on Disability to provide oversight and coordinate matters relating to people with disability in the MOH and to provide a point of contact to other line ministries. There would be an additional advantage in this position being directly responsible for the CRA Program. Currently as a community level program primarily targeting outreach, home based and community level services it appears somewhat oddly positioned in a National Rehabilitation Medicine Hospital yet reporting through to the Deputy Secretary Public Health.

5.32 Specific physiotherapy review and planning activity

With an increased focus on community outreach emanating from the Deputy Secretary Public Health and the National Health Advisors, the Physiotherapy service has been asked to broaden its reach. Currently physiotherapists remain primarily hospital based – in the national referral hospital, at Tamavua Rehabilitation Hospital, and at the four divisional hospitals. There are physiotherapists based at some sub-divisional hospitals, however by report, these personnel also provide only centre-hospital based services not engaging in outreach.

There is an increasing emphasis from MOH on physiotherapists providing out-reach and community based programs to serve the community and particularly to serve both the preventive and curative programs required for NCDs. Accordingly, the Acting Superintendent Physiotherapy has prepared a Physiotherapy Reform Plan to extend the reach of physiotherapy to a community level. The main tool by which this is to be achieved is by bringing the CRA program in under the Physiotherapy service. There would be 19 CRA established posts at HWO 8 reporting through to the Public Health Physiotherapists (HWO5) in each of the four Divisions. There would be 1 established post for a CRA Program Coordinator at HWO7 and this post would report to the Head Public Health Physiotherapist (HWO2) responsible for the four

divisions, with other physiotherapy posts at sub-divisional level in-between. This plan has undergone consultation with physiotherapy staff in the MOH established posts. It is not clear how much more widely the plan has been discussed, although news of the plan is spreading.

At government level there is apparently a commitment to increasing MOH established posts; the Physiotherapy Reform Plan accommodates this by incorporating the CRA program which is now staffed by Project Officers into a number (20) of newly established posts. Concerns were expressed by some informants that this would not be an appropriate structure given that physiotherapy in Fiji is focused on hospital care and not yet confident or competent in outreach or community based work.

Therefore consideration of this plan would benefit greatly from broad consultation with the health, disability, education and social welfare sector, all of which have a concern to ensure the most appropriate governance structure, leadership, service delivery and workforce to provide community based services to people with disabilities. This is considered essential to bring all interested parties 'to the table' to voice their opinions, to consider advantages and drawbacks and to potentially offer improvements or new ideas to create the best possible outcome for the CRA Program and the people with disabilities that this program serves.

6. Conclusions and Recommendations

6.1 Conclusions

The CRA program currently provides the only MOH community based service to people with disabilities and their families. It is well established in one sense – it has been in operation for over 15 years. In every other sense however it is significantly under-established within the overall structure, processes and expected outcomes from the Fiji government health system. Three terms, each of which was used by one or more of the key informants, are used here to summarise the current situation of the CRA program. These terms are Isolated, Hidden and Left Behind. The first three recommendations are organised in relation to these primary dimensions and the opportunities and possibilities that exist to create effective and efficient deployment of CRAs within the MOH workforce.

6.11 Isolated

The CRA Program is isolated in many ways as follows:

- From current developments and planning by the MOH Public Health National Advisors due in part to the location of the CRA Program Coordinator in a specialist hospital setting and the lack of status and respect held for the position. This needs to be rectified as the CRA Program has the potential to be a front line public health program for people with disabilities, their families and carers in the community.
- From planning and development activities in NGOs and DPOs and their collaborations with each other and donors as they actively work to increase their reach to all people with disabilities in Fiji including in rural and more remote areas.

- From the content, revision and implementation of the training programs in Fiji for community based workers: the Certificate in Disability and Community Based Rehabilitation at FNU and the Certificate in Disability at APTC.
- By the CRAs lack of resources relative to other personnel with whom they work. The lack of provided clothing and footwear, equipment and test kits, in-service education and professional development opportunities reinforce the isolation of the CRAs from their sub-divisional peers. It remains unclear why the downgrading of resources to this particular program has occurred.
- By being staffed by project officers, the majority of whom were trained in a technically focused short course now nearly two decades ago. This is in direct comparison to the university diploma and degree trained sub-divisional health personnel with whom the CRAs work.
- By the absence of documentation on processes such as scope of practice, standard operating procedures, and clinical and referral pathways all of which are expected at sub-divisional level by SDMOs and SDHSs.
- By minimal or non-existent communication between the CRA Program Coordinator and senior sub-divisional health staff who are 'left in the dark' about the roles and functions of the CRAs for whom they are accountable.

6.12 Hidden

While the CRA program is considered to be an essential component of the health system because of its reach to homes, villages and neighbourhoods, its contribution to 'enabling them (people with disabilities) to become self-reliant and as functional as possible to improve their quality of life' is poorly understood. The contribution of the CRA program is hidden because:

- There is no oversight at the sub-divisional level to monitor and evaluate the work that the CRAs do.
- The public health preventive work required of CRAs at sub-divisional level appears at times to be outside their expertise and/ or experience which leads to lack of confidence and participation.
- The work that CRAs do with people with disabilities in their homes is 'invisible' to others on the sub-divisional health care teams and in the reporting forms.
- The CRAs when out and about in the community are less likely to be working in a team with a Zone Nurse or Home Base Nurse and so their work goes unrecognised.
- The data collected on CRA specific forms is not aggregated and included within standard sub-divisional reporting forms.
- There is no indicator in the National Health Outcomes and associated data formats to identify and measure CRA input and progress against national health targets.
- There are no guidelines for prioritisation and balancing the curative and preventive work that they are required to do. This means that their work may appear unfocused and lacking consistency and stability.
- There are no formal processes in place for CRAs to effectively work with other line ministries in pursuit of their broader community based rehabilitation remit.

6.13 Left behind

There is warm and positive regard for individuals within the CRA program who are described as committed and passionate. This warm regard means that many informants were keen that CRAs are given opportunities and resources to develop their role and identity and become an integrated part of the health care system. Overcoming the concerns of many informants that the CRA program was not up to the standard required will remain challenging unless leadership and commitment to this program at MOH HQ level occurs. The CRA program to provide a quality service requires:

- A designated place in the health care system, sound program leadership, established posts, and robust support and advocacy at MOH HQ preferably carried out by a National Disability Advisor to ensure adequate resources and innovation.
- An upskilled workforce who are confident in their scope of practice and understand and are competent in their scope of practice.
- Input from the CRAs (who have extensive experience of the 'on the ground' needs of people with disabilities) into the relevant training courses to ensure locally relevant and academically sound certified training programs for the future community based workforce.
- Building bridges with community based workers employed by other stakeholders to create a positive and encouraging culture to facilitate sharing knowledge, expertise, experience and technical skills for people serving people with disabilities.

6.2 Recommendations

Recommendation 1

That MOH create a senior CRA Program leadership position which is responsible for developing a quality program based on:

- (i) Documentation of scope of practice, standard operating procedures, and referral and clinical pathways that align with expectations of senior sub-divisional and Ministry of Health Headquarters personnel;
- (ii) Appropriate and regular communication and supervisory mechanisms for CRAs in their sub-divisional locations and to the CRA Program Leadership; and
- (iii) Collaboration with other line ministries, Fiji National Council for Disabled Persons, NGOs, DPOs and the training institutions to ensure that the CRA Program fulfils the remit of community based rehabilitation which requires cross-sectoral collaboration.

Recommendation 2

Subsequent to implementation of Recommendation 1, that:

- (i) The CRAs are given in-service training on the quality standards expected of the CRA program and an opportunity to build their expertise, competence and confidence to provide this quality service;
- (ii) There is effective communication about the improved CRA program to all stakeholders at sub-divisional and national hospital level, at MOH HQ, to NGOs, DPOs and the training institutions; and
- (iii) CRAs and the new Program Leadership position provide input into all health, educational and social welfare training courses in Fiji to educate the future workforce on community based inclusive development in Fiji.

Recommendation 3

That a Cross-Sectoral CRA Program Management Committee is established to provide cross-sectoral support to enhancing and strengthening community based inclusive development in Fiji. This Committee would comprise high level appointees from the hospital services and public health streams in MOH; the focal points on disability from other line ministries; FCDP; NGOs; DPOs; and, the training institutions. The functions of the Committee would be to:

- (i) Support the new CRA Program leadership position;
- (ii) Advocate for the CRA project officer positions to become established posts within the Public Service Commission with the necessary and appropriate resources to support these positions;
- (iii) Provide advice, monitor and evaluate the progress of the revised and improved CRA program;
- (iv) Ensure cross sector collaboration on and advocacy for community based inclusive development;
- (v) Foster collaboration and cross – fertilisation between the training institutions and the community based inclusive development workforce needs of MOH, the NGOs and the DPOs;
- (vi) Promote community based inclusive development by awareness raising and community education.

Recommendation 4

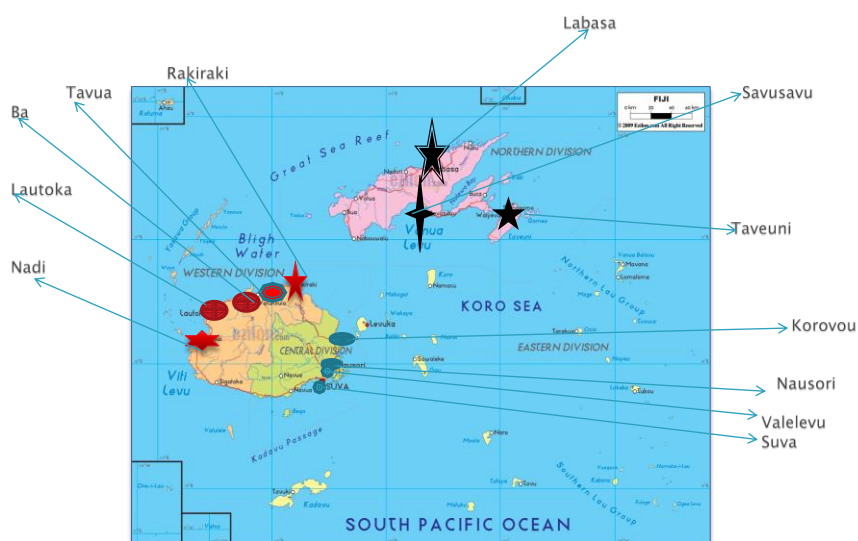
That MOH signal, through the appointment of a National Advisor Disability and Rehabilitation Advisor at MOH HQ, that community based inclusive development is central to MOH Strategic Planning and in particular to strategic planning in relation to NCDs.

Recommendation 5

That the senior CRA Program Leadership position report to the National Advisor Disability and Rehabilitation.

APPENDICES

CRAs Station



Key: Red – Western Division
 : Black – Northern Division
 : Green- Central Division

	Divisions	Subdivision	Station	Case Load
1. Makereta Vuniwaqa	Central	Suva	Suva Health Office	254
2. Iliseva Tuimatanisiga	Central	Suva	Valelevu health Centre	371
3. Vaseva Danford	Central	Rewa	Nausori Health Centre	205
4. Milikiti Tikoduadua	Central	Tailevu	Korovou Health Centre	146
5. Fulori Salabogi	Western	Ra	Rakiraki Health Centre	339
6. Taraivini Nakoli	Western	Tavua	Tavua Health Centre	235
7. Roslyn Wright	Western	Ba	Ba Health Centre	132

8. Satendra Prasad	Western	Lautoka/Yasawa	Lautoka Health Centre	281
9. Vika Naitini	Western	Nadi	Nadi Hospital	408
10. Susana Rika	Northern	Macuata	Labasa Health Centre	137
11. Viniana Sokonawai	Northern	Cakaudrove	Savusavu Health Centre	128
12. Pauline Sukanatabua	Northern	Taveuni	Taveuni Health Centre	130

2011 CDR MINISTRY OF HEALTH SPONSORED GRADUATES

NAMES	NEC REGISTRATION	STATION
1. Ariva Tuvou	Volunteer	Tamavua Rehab
2. Roslyn Agnes Wright	Employed as CRA	Tamavua Rehab
3. Vaseva Vagonegonea Danford	Employed as CRA	Tamavua Rehab
4. Filimoni Mana	Volunteer	Tamavua Rehab
5. Manjula Lata Maharaj	Volunteered but resigned	Tamavua Rehab
6. Sainimere Bulitimai	NEC-SUV- 3-1830	FNU - studying
7. Asenaca Bale	NEC-SUV-3-1829	Judiciary Department
8. Shomal Sushmita Mala	NEC-SUV-5-638	Migrated
9. Lavenia Kalolaini	NEC-SUV-3-1844	USP - studying
10. Maria Nabalea	NEC-SUV-3-1845	At home
11. Nive Mary Williams	Volunteer but resigned	Tamavua ehab
12. Katarina Koroveibau	NEC- SUV-4-2919	FNU studying
13. Derek Kauishay Singh	NEC-SUV-3-1838	FNU Studying
14. Reapi Naikacoa Qeteqetelevu	NEC-SUV-3-1812	FNU studying
15. Sazmin Nisha	NEC-SUV-3-1811	Employed Hilton Org
16. Salote Leweni		home
17. Arieta Sivo	NEC-SUV-4-2922	home
18. Anasovaia Liku	Volunteer but resigned	Tamavua Rehab
19. Aliveta Rokosiga	Peer Educator	Rewa Subdivision
20. Elizabeth Aisea Baines	NEC-SUV-4-2924	Mind Pearl - working
21. Lisi Narara	NEC-SUV-4-2926	At home
22. Lavione Vonouwa Jime	NEC-SUV-5-1944	FNU - studying
23. Monika Nabaro	NEC-SUV-4-2925	FNU - Studying
24. Adi Mole Salusalu	NEC-BA- 1-2563	home
25. Salote Alice Monua T Bau	NEC-SUV-3-1826	home
26. Bonifasio Kata Ratucove	NEC-BA-1-2590	home
27. Alesi Naroko Nasulinibawa	Peer Educator	Rewa Subdivision
28. Shiwangni Karishma	Employed	FRIENDS Fiji
29. Amori Talenayaua	Peer Educator	Kadavu Subdivision

Appendix 3 Names and titles of key informants

(In order of interviews conducted; * not available and could not be re-scheduled)

Monday 28th July

Mrs. Litea Naliva , SEO Special Education, Ministry of Education (focal point on disability)

Mrs. Luisa Tikolevu, Acting Superintendent Physiotherapy, Colonial War Memorial Hospital

Mrs Kaushilya Devi Executive Officer, Fiji National Council of Disabled Persons (Director, Dr. S Yanuyanutawa, not available)

Mr Josco Wakaniyasi, Director, Spinal Injuries Association

Ms Maraia Matakibau, CRA Program Coordinator

Tuesday 29th July

Dr Isimeli Tukana, National Adviser National Centre for Wellness

Dr. Rachel Diva, Acting National Advisor Family Health, MOH

*Mrs. Sureni Farare , CEO Suva Crippled Society

*Mrs. Merelesita Qeleni, Head Teacher Hilton Special School

Wednesday 29th July

Vishwa, CBR Field Worker, Fiji Blind Society

Miriama Vere, Sub-divisional Health Sister, Korovou Health Centre, Tailevu

Dr Ilispaeci Lasaro, Sub-divisional Medical Officer, Korovou Health Centre, Tailevu

Merewaksi Wakesa, Zone Nurse, Korovou Health Centre, Tailevu

Milikiti Tikovuadua, CRA, Korovou Health Centre, Tailevu

Thursday 30th July

Dr Pablo Romakin, Sub-divisional Medical Officer, Suva Health Centre, Suva

Theresa Tuinakelo, Sub-divisional Health Sister, Suva Health Centre, Suva

Makereta Vuniwaqa, CRA, Suva Health Centre, Suva

Maria Waloki, Program Coordinator, Physiotherapy and Disability and Community Based Rehabilitation, Department of Health Sciences, Fiji National University

Friday 30th July

Dr Pratima Singh, Medical Officer, Tamavua National Rehabilitation Hospital, Suva

Ms Maraia Matakibau, CRA Program Coordinator

Appendix 4 List of documents accessed for the Report

World Report on Disability. World Bank and World Health Organisation, Geneva, 2011.

Western Pacific Country Health Information Profiles: 2011 Revision. World Health Organization. (2011).
Accessed at: <http://hiip.wpro.who.int/hiip/chips>

Disability at a Glance 2012. Social Development Division, Economic and Social Commission for Asia and the Pacific, Bangkok, Thailand.

Key Components of a Well Functioning Health System, WHO, May 2010 which builds on earlier publications including *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*, WHO, Geneva, 2010

Draft National Disability Inclusive Health and Rehabilitation Strategic Plan 2014-2018 (20th May 2014, provided by Dr Pratima Singh)

Fiji Ministry of Health Action Plan for Children with Disabilities, 2014-2016 (provided by Dr Rachel Devi, Acting National Advisor Family Health)

Ministry of Health Strategic Plan, 2011-2015 at <http://www.health.gov.fj/> accessed 23rd July 2014

Ministry of Health Non-Communicable Diseases Prevention and Control Strategic Plan 2010-2014 at <http://www.health.gov.fj/> accessed 23rd July 2014

A review of health leadership and management capacity in Fiji. A. Asante, G. Roberts and J. Hall. UNSW Human Resources for Health Knowledge Hub at <http://www.hrhhub.unsw.edu.au/> accessed 23rd July 2014

Draft WHO Global Disability Action Plan 2014-2021: Better health for all people with disability at <http://www.who.int/disabilities/actionplan/en/> accessed May 12th 2014

Fiji Islands. A National Policy on Persons Living with Disabilities. 2008-2018. Fiji National Council for Disabled Persons with the Ministry of Health, Women and Social Welfare.

National Baseline Disability Survey. Making Women with Disabilities Visible (2010). Fiji National Council for Disabled Persons.

Make the Right Real. The Incheon Strategy for People with Disabilities in Asia and the Pacific <http://www.unescap.org/our-work/social-development/disability> accessed 9th July 2014

Road Map for the Implementation of the Incheon Strategy to "Make the Right Real" for Persons with Disabilities in Asia and the Pacific <http://www.unescapsdd.org/events/first-session-working-group-asian-and-pacific-decade-persons-disabilities-2013-2022> accessed 9th July 2014

Fiji Bureau of Statistics, <http://www.statsfiji.gov.fj/> accessed 4th August 2014

MINISTRY OF HEALTH

POSITION DESCRIPTION

Position Title: CBR/CRA Program Coordinator Grade:HW 06 -

Division: Public Health

Location: National Rehabilitation Medicine Hospital

Reports to: Medical Officer, NRMH., Deputy Secretary Public Health

Current Incumbent: Maraia Matakibau

Approved by: PSH

Signature:

Signature:

Date:

Date:

PRIMARY PURPOSE:

is responsible for the function and development of the National Community Based Rehabilitation Programme and assist in promoting, extending and supporting the development of Community Based Rehabilitation Services in accordance with the Ministry of Health Policies and Plans.

POSITION DIMENSION

STAFF:

Indirect Reportees: Community Rehabilitation Assistants, Community Rehabilitation Assistance Volunteers, Students Attachment

Budget: Ministry of Health, Headquarters

Assets: Omnitest Plus – Glucometer, stethoscope, furnitures, stationery, Registered books, Toolkits, therapeutic resources, bags, shoes etc.

NATURE AND SCOPE

1. Reporting Relationship

This position reports to the Medical Officer In Charge National Rehabilitation Medicine Hospital, and line management responsibility through the Deputy Secretary Public Health, at Ministry of Health Head Quarters

2. Role of the Department

To implement and promote community based rehabilitation services and primary health care initiatives.

3. Role of the Position

- To develop and review the Work Plan for CBR program and to ensure that the Policy objectives under the Ministry of Health Strategic Plan are achieved
- To assist in the establishment of disability policies for Fiji by promoting coordination, liaison and networking between ministries/departments and between GO's and NGO's [working with disability]requiring involvement at different level.
- To assist in the selection of the future CRAs in collaboration with the Physiotherapy Course Coordinator and Subdivisional Health Sister.
- To co-ordinate and orientate other technical experts in providing input [where necessary], in providing training of trainer's support
- To ensure the successful conduct of in-service development programme annually.
- To conduct Ward Rounds with the National Medical Rehabilitation Hospital Staff
- To assist the Community Rehabilitation Assistants in accessing rehabilitation support to persons with disabilities
- To provide training on disabilities to the communities

4. Role of Subordinates:

Overall responsibility Role of the Coordinator is to coordinate the CBR programme to be in line with the Ministry of Health's Policies

5. Interpersonal Relationship:

Internal Communication:

PSH, DSPH, Public Health Programme Managers, Medical Officer In-Charge National Rehabilitation Hospital Tamavua

External Communication:

Institutional Rehabilitation Services within the MOH, other government ministries [Social Welfare, Education, I-taukei Affairs etc.] and Non-Government Organization dealing with Disability

6. Challenges & Development

- To upgrade self by attending in-service trainings and any other related training that will contribute to better services
- Assist in the Disability Promotion in Fiji
- Liaise with Accounts section with the release of funds for the Programme Activities
- Provision of effective, accessible and available rehabilitation services in the community
- Continuing preparation for the CRA Pre-service and in-service course and the final consolidation of the Training Manual

7. Authority Level:

Supervision and Developing of Community Rehabilitation Assistants

8. Reporting:

Compiling of Programme's Quarterly Reports to DSPH quarterly and monthly report to Medical Officer In Charge, National Rehabilitation Medicine Hospital

9. Principal Accountabilities

1. To facilitate the development and coordination of Ministry of Health policies and strategies for disability management and Community Based Rehabilitation programme in accordance with identified needs.
2. Gathering and Analysis of information:
 - Assess and prioritize disability and CBR needs
 - Evaluate the effectiveness of service provision and identify issues for program planning
 - Assist the government in reporting to international forums [e.g. ESCAP, Convention on the Rights of the Child, UNCRPD,

- Facilitate the validation and accreditation of the CRA Pre-service Training Course
3. Continue network links and relationship with international and local organization for the purpose of:
 - Sharing learning expertise and resource material in relation to CBR
 - Promoting the dissemination of the CRA Manual/Curriculum
 - Accessing additional resources as appropriate to Ministry of Health Plans
 4. To develop a resource database and information center:-
 - Strengthening systems for accessing relevant materials/information
 - Dissemination and loaning of books, journals, research papers, mobility aids etc.....
 -
 5. To provide advocacy, assistance and technical line management support and supervision of the functioning CRAs:
 - Maintain effective relationship within the Ministry and other Government and Non-Government personnel at each level
 - Effective and efficient CBR systems can be developed
 - Monitor CRA performance
 - Identify training and development needs
 - Regular field visits supports
 - Consultation with SDHS in setting appropriate performance goals as indicated and ensure on appropriate programme to address these in negotiated and implemented
 6. Developing network of links and relationships with international and local organizations for the purposes of:
 - Sharing learning expertise and resource material in relation to CBR
 - Promoting the dissemination of the CRA Curriculum and manual
 - Accessing additional resources as appropriate to Ministry of Health Plans
 7. Promote effective networking in the development of the two-way referral process with a range of health, social welfare and education personnel [e.g. Rehab hospital, physiotherapist, Medical Officers, Public Health Nurses, Social Welfare, Pacific Eye institute, Early Intervention Centre etc....
 8. Develop and coordinate the provision of in-service CRA Training in collaboration with Physiotherapy School, Australian Pacific Technical Training College and School of Social Science [USP] to ensure the maintenance of competency standards and course quality which include:-
 - Technical Training –Neurodevelopment theory and practice, disability prevention and early identification in children and adults and the theory and practice of the development of CBR
 - Community Development Training – Communication, motivation and training for community self reliance in relation to

rehabilitation and disability service provision, conducting community meetings and workshops, networking between communities and organizations in accessing and mobilizing community resources

- Managerial training – Needs analysis, participatory problem solving and decision making, planning, monitoring and evaluation and report writing.

10.Common responsibilities

I have read and understand the requirements of the position as described in the Position Description:

Employee_____

[Print name]

Signature:_____ Date:

MINISTRY OF HEALTH

POSITION DESCRIPTION

Position Title: Community Rehabilitation Assistant Grade:HW 07 -

Division:

Location: Sub-Divisional Health Centre

Reports to: Sub-Divisional Medical Officer, SDHS & CRA Programme Coordinator

Current Incumbent:

Approved by: PSH

Signature:

Signature:

Date:

Date:

PRIMARY PURPOSE:

This position is responsible for the provision of effective, efficient and quality rehabilitation services to infants, children and adults in the community and ensure that they receive the best of care which will enable them to become self reliant and as functional as possible to improve their quality of life.

POSITION DIMENSION

STAFF:

Indirect Reportees: Students during attachments

Budget: Ministry of Health, Headquarters

Assests: Omnitest Plus – Glucometer, stethoscope, furnitures, stationery, Registered books, Toolkits, therapeutic resources, bags, shoes etc.

NATURE AND SCOPE

1. Reporting Relationship

This position reports to the Sub-divisional Medical Officer and the Sub-divisional Health Sister, and line management responsibility through the CRA Coordinator, National Rehabilitation Medicine Hospital.

2. Role of the Department

To implement and promote community based rehabilitation services and primary health care initiatives.

3. Role of the Position

To identify people with disabilities as early as possible in life, to assist in accessing rehabilitation services to person's with disabilities and to increase knowledge regarding disability issues as a means of prevention of disabilities in the communities and to be responsible for their health.

3.1: PLANNING

- To coordinate the implementation of Strategic plan
- To develop annual work plan
- To develop and implement individual work plan
- To provide Annual Budget Submission and expenditure details

3.2: ADVOCACY & TRAINING

- To advocate and create awareness on all level of care [Primary, Secondary and Tertiary]
- To advocate and create awareness on CRA role

3.3: MANAGEMENT AND CLINICAL

- To identify and implement appropriate management of any problems or abnormality

3.4: MONITORING AND EVALUATION

- To provide annual, monthly, quarterly report implementation to superiors
- To update daily activity book and ensure proper documentation and update
- To monitor and evaluate programme using CRAs assessment and all standard forms and timely follow up

3.5: SUPERVISION AND SUPPORT SERVICES

- To provide support for implementation of National Health Programmes
- To provide supervisory role to all Rehabilitation Programme in the Sub-division

4. Role of Subordinates:

5. Interpersonal Relationship: Internal

Communication:

All internal communication are to be forwarded to Sub-divisional Medical Officer through immediate supervisors of the Officer

External Communication:

Submitted through Subdivisional Medical Officer for discretion and approval

6. Training & Development

To attend at least 2 in-service trainings annually and any other related training that will contribute to better services.

7. Reporting:

[Patient Reports] Referral of cases to Physiotherapy services, Dietician, Community Nurses, Medical Officer for further care & management as and when the need arises.

8. Principal Accountabilities

Principal Accountabilities	Objectives	Indicators
-----------------------------------	-------------------	-------------------

To detect any abnormalities in life as early as possible	a] To strengthen the use and importance of the three monthly checklists as a screening tools for babies from birth to 1 year at the MCH Clinic	Early detection and management to appropriate services takes place
	b] To assist in the NCD screening, monitoring & counseling of known diabetic and hypertension patients.	Reduced incidence of secondary and tertiary complications
	c] To conduct visual acuity screening in schools	Timely referrals and intervention for children with low vision and other disabilities detected
	d] To strengthen the importance of recording apgar score during delivery in maternity units	Low apgar score babies are closely monitored, followed up and referred to appropriate services
To promote Education and Awareness raising in Disability issues and prevention	To transfer skills and knowledge through training to persons with disabilities, families, carers and communities on disability issues – causes, prevention and management of disabilities	Families, carer's and communities received and gain adequate knowledge/information and skills through talks, meetings and workshops
	B] To actively participate in any National Programs in combating the causes of disabilities eg. MDA, Nutritional Surveys, NCD, Measels Campaign, HPV,HBV, etc.	Reduce the incidence of communicable and non communicable diseases
	c] Encourage communication liaison, information sharing amongst other government and non-government services	Conduct meetings and referrals to relevant organizations

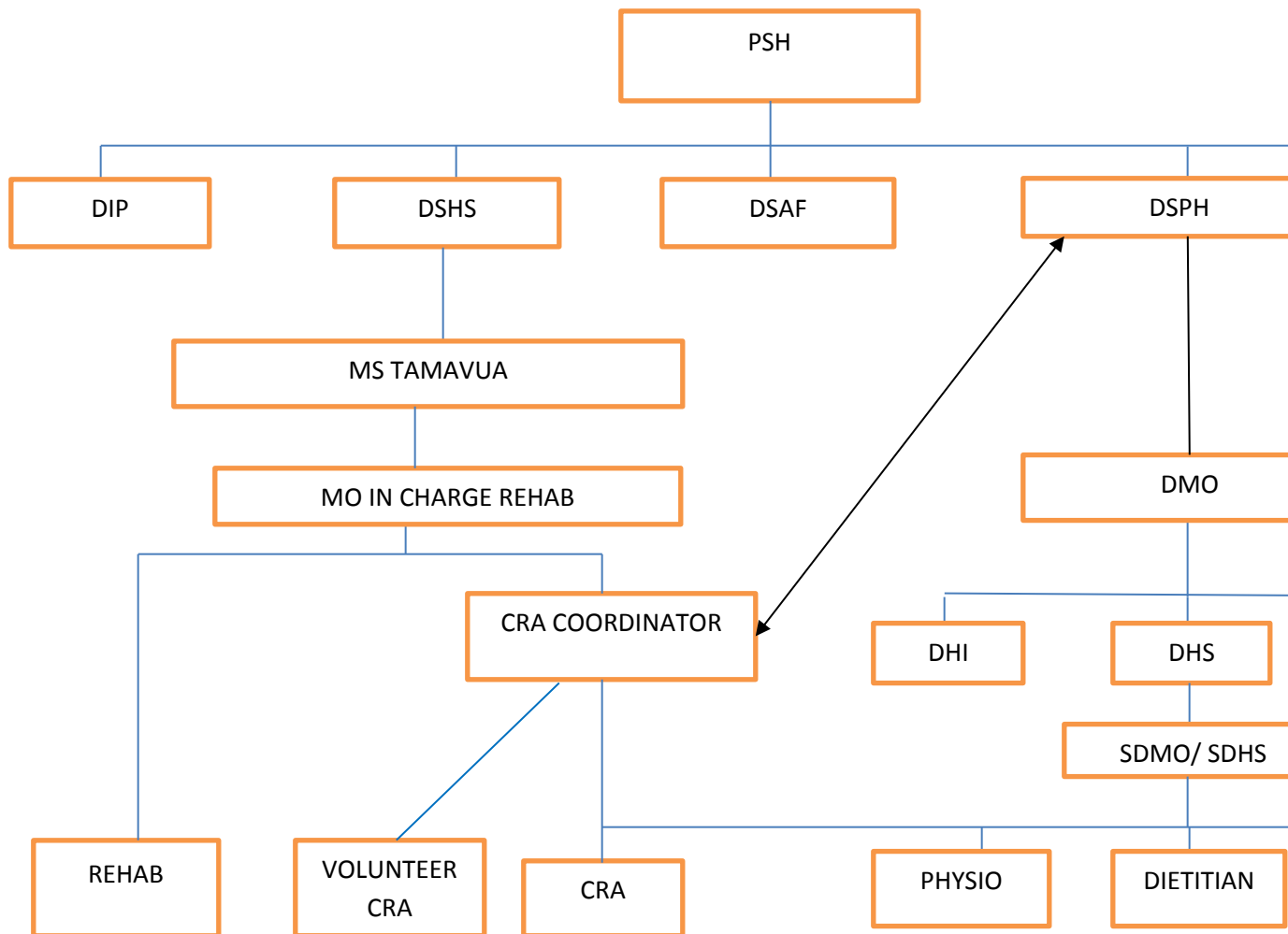
	<p>relation to disability issues and management</p> <p>c] Behavioral changes towards People with disabilities in empowering, mobilizing and motivating the communities</p>	Improved participation & Inclusion of People with Disabilities in the community
To provide community based rehabilitation services throughout their respective Sub-division	<p>a] To ensure that cases are followed up promptly in the clinic or at home, upon referral and identification</p> <p>b] Timely assessment of cases and compilation of rehabilitation plans</p> <p>c] To strengthen the importance of the family member's and communities participation in carrying out rehabilitation plans in the community</p> <p>d]To assist in organizing and designing appropriate rehabilitation aids and equipment from locally available resources</p>	<p>Cases received rehabilitation services either at the clinic or homes</p> <p>Appropriate rehabilitation plan of each cases is in place</p> <p>Family members/communities carried out specific techniques transferred to them</p> <p>People with disabilities have access to aids and equipment which will assist in their rehabilitation, in making a difference and enhance quality of life</p>
To ensure proper Management of all people attended to in the Subdivision	<p>To register all people with disabilities attended to in the Subdivision</p> <p>To keep a record of all cases by filling the assessment forms</p> <p>To record all intervention activities carried out</p>	<p>Update registered of people with disabilities in place</p> <p>All cases forms are documented, updated and completed</p> <p>Intervention activities and improvements in the patients situation are documented/monitored/evaluated</p>

9. Knowledge Skills & Experience:

The position requires:

1. Certificate in Community Disability Rehabilitation or Completion of CRA six months pre-service training
2. Posses the required knowledge and skills to competently carry out responsibilities
3. Should be able to work as a team player
4. Computer literate is essential but not compulsory

ORGANIZATION STRUCTURE



Appendix 7

National Disability Inclusive Health and Rehabilitation Strategic Plan 2014-2018



Introduction:

The incidence of Non-Communicable Diseases (NCD) is on the rise globally. NCD accounts for approximately 63% of morbidity and mortality related mainly to cardiovascular diseases, diabetes, cancers and chronic respiratory diseases.

Globally, it is projected that NCD related deaths will increase by 17% over the next 10 years¹. This is mainly due to the aging population, urbanization, and lifestyle changes including unhealthy diets, physical inactivity, tobacco use and excessive alcohol consumption. There is strong evidence that the NCD burden is shifting from high to low and middle-income countries. Evidence suggests that Pacific Island countries are experiencing the highest rates of NCD risk factors and mortality².

Fiji is in the grip of a non-communicable disease crisis. Cardiovascular disease, diabetes and stroke are the main causes of death in Fiji³. With increasing NCD, it is expected that the number of persons living with disabilities in the community will also rise.

Fiji's rehabilitation sector has well established programs that have developed over a long period and there have been recent new initiatives, including the expansion of beds at Tamavua rehabilitation hospital, increased training of community rehabilitation assistants at Fiji National University and support to increase provision of prosthetic and orthotic devices.

Concurrently increased demand for rehabilitation services has occurred as a result of rising non-communicable diseases such as amputations, stroke and spinal cord injuries. These are placing a strain on existing rehabilitation services.

Statistics for Rehabilitation hospital from January 2006 to June 2012 show that majority of persons accessing rehabilitation services are from the Central Division. This is mainly due to the availability of the centralised rehabilitation services based in Tamavua, Suva. In the past, Rehabilitation Out-Reach clinics have also been limited to the main Island of Viti Levu. This was in part due to easier access to the main health facilities within the main Island, less travel time for the Rehab team that also caters for all the services at the hospital, and financial costs.

The Community Rehabilitation Assistants (CRA) in the community providing rehabilitation services are also limited, both in terms of human resource needs, as well as in their ability to cater for the needs of various types of disabilities resulting from increasing NCD.

World Health Organization (WHO) recognizes disability as a global public health issue. The organization proposes that we provide holistic approach to persons with disabilities at the community level. Improved medical and community rehabilitation services and coverage, provision of appropriate and adequate assistive devices, improved social support services and empowerment at the community level, and networking with service providers and Disabled People's Organization (DPO) may assist in the improved quality of life of those living with disability in Fiji.

World Health Organization has drafted its "Global Action Plan on Disability 2014 – 2021". This document awaits endorsement by the World Health Assembly scheduled in May 2014. The Ministry of Health (Fiji) draft "Non-Communicable Diseases Strategic Action Plan 2015 – 2019" contains specific strategy highlighting the provision of sufficient rehabilitation services for NCD-related disabilities and injuries in all divisions in Fiji by 2019.

Rehabilitation sector now requires strengthening with more strategic approaches to service delivery.

The strategy was developed in close consultation with various stakeholders working with people with disabilities, Disabled Peoples Organisations, and with parents, caregivers and persons with disabilities. Consultation meetings were held in the four divisions in Fiji.

References:

¹WHO, 2010. *Global Status Report on NCDs 2010*. Geneva. WHO

²PIFS Paper for Forum Disability Ministers Meeting: Papua New Guinea 3-4 October 2012. *NCD increases Disability in the Pacific*. 2012

³Roberts, G et al. *The Fiji Islands Health System Review. Health Systems in Transition*. 2011

Vision:

Fijian adults and children with disabilities have the best health they possibly can.

Mission:

To strengthen access and inclusion to quality health and rehabilitation services for people with disabilities.

Principles and Approaches:

- Human Rights-Based Approach.
- Equity Focused
- Integration into Health
- Person Centered Approach, including People with Disabilities
- Multi-sectoral Approach
- Better Integration into the Health System

Goals:

1. People with disabilities accessing better health services
2. People with disabilities have access to comprehensive rehabilitation programs including at the community level
3. Health and rehabilitation personnel have the awareness, knowledge and skills required to meet the needs of persons with disabilities
4. People with disabilities are empowered to make decisions about their health and rehabilitation needs

Objectives:

1. Address barriers and improve access to health care services and programs
2. Improve quality and coverage of rehabilitation
3. Increase provision of assistive devices
4. Strengthen community-based inclusive development
5. Strengthen disability data and information collection

Objective 1: Address Barriers and Improve Access to Health Care Services and Programs

Activities	Key Stakeholders
1.1 Advocate for greater inclusion and equity of the needs of persons with disabilities in future health policy and planning	
1.2 Develop resource materials that outline practical approaches to ensuring physical access and respectful communication	
1.3 Support training of health personnel in the area of disability	
1.4 Better integrate disability and rehabilitation into undergraduate health curricula in Fiji	

Objective 2: Persons with Disabilities have Access to Quality Rehabilitation, including at Community Level

Activities	Key Stakeholders
2.1 To promote early identification and intervention of children with disabilities	
2.2 To increase awareness and provide for rehabilitation within the health sector and across the community	
2.3 To provide Professional development for Rehabilitation Personnel	
2.4 Strengthen development of Rehabilitation Out-Reach Programs	
2.5 To conduct further analysis and review of the role of the Community Rehabilitation Assistant (CRA) Program	
2.6 To increase multi-sectoral collaboration for better coordination and more efficient rehabilitation and	

disability support services	
2.7 To establish further rehabilitation Units/Hubs in the Western and Northern Divisions	

Objective 3: Increase Provision of Assistive Devices

Activities	Key Stakeholders
3.1 Establish system for referral, assessment and delivery of wheelchair and other mobility devices in collaboration with government and other stakeholders	
3.2 Strengthen provision of prosthetics and orthotics through increasing awareness, out-reach clinics, and referrals to Tamavua Hospital and follow-up	
3.3 Strengthen referral of people with disabilities with assistive device needs to vision, hearing, and other appropriate services	

Objective 4: Strengthen Community-Based Inclusive Development

Activities	Key Stakeholders
4.1 Community Rehabilitation Assistants (CRAs) and other relevant stakeholders undertake further community awareness activities and support establishment of self-help groups	
4.2 Develop and disseminate a Fiji Disability Organization and Services Directory in accessible format	
4.3 Community Rehabilitation Assistants (CRAs) undertake local mapping and networking of Disability Stakeholders	

Objective 5: Strengthen Disability Data and Information Collection

Activities	Key Stakeholders
5.1 Advocate for inclusion of Disability Data in census and in Demographic Health Surveys	
5.2 To develop a Rehabilitation Service Data Base including information regarding the unmet service needs	

Appendix 8 Interview Guide

Key Question Areas based on Primary Purpose as per MOH Position Description of Community Rehabilitation Assistant

This position is responsible for the provision of effective, efficient and quality rehabilitation services to infants, children and adults in the community and ensure that they receive the best of care which will enable them to become self reliant and as functional as possible to improve their quality of life.

Health Centre understanding and contribution

- What is meant by rehabilitation?
- Who identifies infants, children and adults needing the above?
 - At village/ community health level?
 - At Health Centre level?
- Are there (documented) referral pathways exist to CRA's who are responsible for rehabilitation?
- What is understood about the needs of persons requiring rehabilitation and who ought to meet these needs and how?
- What is understood about the role and contribution of CRA's in relation to persons requiring rehabilitation?
- What contribution do CRA's make at the sub-divisional health centre level?
- What contribution do CRA's make at the sub-divisional health centre level?
- What contribution do CRA's make at the village/ community level?

Community Rehabilitation Assistants

- What education and training have they received and from which institutions?
- How many are in each country in total and on a per capita basis?
- Who employs them?
- To what extent do they organize their work into teams, and how is this done?
- Do they have and follow guidelines?
- How do the CRA's link to each level of the health system: village health workers, health centres, sub-divisional hospital, divisional hospital, specialist hospital?

Key issues in relation to CRA's

- What are the strengths within the services they offer?
- What are the weaknesses?

- What are the key challenges they experience? Include remuneration, workload and other workplace (support) issues

CBR Matrix

- CBR is about health, education, livelihood, social and empowerment. What role do CRA's play in addressing each of these components and the elements within and how?

CRA's workforce needs

- Which clients and impairment types do they predominantly see?
- What do they offer these clients?

Perspective of people with a disability on CRA's

- What do people with disabilities themselves and their representative organisations see as key to ensuring effective, quality rehabilitation services?

Appendix 9

Example of CRA cases on register and contact

CASE ON REGISTER AND CONTACT AT THE END OF JUNE- 2014

TYPE OF DISABILITY	TOTAL CASES REGISTERED	AGE OF CASES				SEX		RACES			TOTAL CASES SEEN AT HOME
		0-1	2-5	6-18	19+	M	F	F	I	O	
D/Milestone	36	36	4			25	11	22	28	3	8
Physical	143	31	4	46	82	82	59	112	28	3	26
Speech	7	7		2	5						
Hearing	7	3	4			5	2	7			
Visual	10		2	3	5	7	3	8	2		
Intellectual	18		2	9	6						
Multiple	33	2	4	15	12	12	11	19	12	2	4
TOTAL	254	79	20	75	110	131	86	168	50	8	

Proposed structure for Physiotherapy reform

