**Title:** Services for people with communication disability in Fiji: Clinical insights

**Journal:** Journal of Clinical Practice in Speech-Language Pathology

**ISSN:** 2200-0259  **Year:** 2014  **Pages:** 81 - 86

**Volume:** 16  **Issue:** 2

**Abstract:** In Fiji, the government has recognised the importance of services for people with communication disability (PWCD); however, the need for services still exceeds supply, and it is unclear who is providing services to this population. It has been suggested that agents of delivery of intervention can comprise seven groups: qualified speech-language pathologists (SLPs), mid-tier workers, already qualified professionals trained for an additional new role, disability care workers, traditional healers a ...

**URLs:**


Copyright 2015 Speech Pathology Australia. Reprinted with Permission
Services for people with communication disability in Fiji

Clinical insights

Suzanne Hopf

In Fiji, the government has recognised the importance of services for people with communication disability (PWCD); however, the need for services still exceeds supply, and it is unclear who is providing services to this population. It has been suggested that agents of delivery of intervention can comprise seven groups: qualified speech-language pathologists (SLPs), mid-tier workers, already qualified professionals trained for an additional new role, disability care workers, traditional healers and other professionals or family members guided by SLPs. In this paper, the role of each of these groups in the provision of services to PWCD in Fiji was reviewed. Results revealed that qualified SLP services in Fiji are restricted to those provided by international volunteer programs. Numerous other agents of delivery of intervention are available; however, their skill base and intervention methods remain largely unknown. There is a need to identify the skills and practices of non-SLP agents and to consider the potential for future direct SLP input, to ensure timely and adequate services are available to people with communication disability in Fiji.

Fiji, with a population of 837,271 people (Fiji Islands Bureau of Statistics, 2008), is a group of over 300 islands that make up part of the Melanesian group of islands in the south-western Pacific Ocean. It is the regional hub for economic and political activity in the south-west Pacific and has a rich cultural mix, with a remarkable degree of cultural and linguistic diversity (Mangubhai & Mugier, 2006). Communication disability in Fiji is reported to be experienced by 39% of children enrolled in special schools (The Republic of Fiji, Ministry of Education, National Heritage, Culture & Arts, 2012), and 0.1% of the general population (Fiji National Council for Disabled Persons, FNCDP, 2010). The proportion of children with communication disability in mainstream settings is currently unreported in education data. The disparity in special school and general population prevalence figures may reflect a difference in how speech/communication disability was defined in each report.

Fiji has acknowledged its commitment to the development of policies to improve the lives of all people with disability (PWD) in the new national Constitution (The People of Fiji, 2013). In addition, Fiji has ratified the United Nations (UN) Convention of the Rights of Persons with Disabilities (UNCRPD; UN, 2008), and the Incheon Strategy to “Make the Right Real” for PWD in Asia and the Pacific (United Nations Economic and Social Commission for Asia and the Pacific, UNESCAP, 2012). Both of these documents identify the human rights of PWD and outline the principles, duties and obligations of Fiji, as a signatory to overcome social, legal, environmental and political conditions that act as barriers to PWD’s full participation in society. These documents have been incorporated into local policy development, including The Republic of Fiji, Ministry of Education, National Heritage, Culture & Arts, and Youth and Sports, Policy in effective implementation of inclusive education in Fiji (2011). To date, implementation of this policy has included a partnership with the Australian Department of Foreign Affairs and Trade (DFAT) to trial inclusive education practices in five Fijian primary schools (Kelly & Wapling, 2012).

Specific provision for specialist services for people with communication disability (PWCD), such as speech-language pathology, is made in the Ministry of Education 2012–14 strategic plan (The Republic of Fiji, Ministry for Education, National Heritage, Culture and Arts, Youth and Sports, 2012) and inclusive education plan (The Republic of Fiji, Ministry for Education, National Heritage, Culture and Arts, Youth and Sports, 2011). However, while the importance of services for PWCD in Fiji is recognised in these and other government documents (e.g., Fiji Islands Ministry of Health, 2011), it remains unclear how these services are actually being provided, by whom, and in what context.

Responding to the multicultural, multilingual needs of PWCD around the world is a concern of speech-language pathologists (SLPs) (e.g., Buell, 2013; Hartley & Wirz, 2002; Routon & Harding, 2013; Wickendon, 2013; Wylie, McAllister, Davidson, & Marshall, 2013). The issue of service delivery development for PWCD in Fiji was initially raised in 1988 by Pressman and Heah Lee, who conducted an
analysis of Fiji's development priorities, to determine if Fiji was well positioned to commence "professional services in the field of communication disorders" (p. 42). The authors concluded that Fiji's needs would be best met by the use of Fijian paraprofessionals trained by international SLPs. In 2014, Hopf and McLeod reviewed service development and reported that significant policy change has occurred in Fiji to support PWCD. Unfortunately, policy change does not necessarily translate to changes in service development and provision due to financial, political and environmental barriers (Hopf & McLeod, 2014), and it remains unclear as to who is providing services for PWCD in Fiji in the absence of SLPs.

The communication disability model for service development

In considering current and future service provision for PWCD in Fiji, it is useful firstly to identify the main stakeholders and potential agents of service (intervention) delivery. In 2002, Hartley and Wirz developed the communication disability model for service development in Majority World Countries, which outlined a method for considering the needs of the four main stakeholders involved in service provision: PWCD and their families, a country's government, non-government organisations (NGOs), and professionals involved in the delivery of services for PWCD. Wylie and colleagues (2013) have built on Hartley and Wirz's model and outline 12 domains that influence accessibility and availability of services, which ultimately determine if a service is meeting the needs of its people. These domains are: cultural appropriateness of service, sector delivering service, geographical domain, location of service, agent of delivery of intervention, level of intervention, recipients of intervention, focus of intervention, responsibility of services, sustainability of service, and rationalisation of services. A brief review of each of these domains with respect to Fiji is presented in the Appendix.

This paper focuses on only one of these domains, the agents of delivery of intervention. Wylie and colleagues (2013) identify seven categories of agents: qualified speech-language pathologists (SLPs), mid-tier workers, already qualified professionals trained for an additional new role, disability care workers, traditional healers and other professionals guided by SLPs, or family members guided by SLPs. Wylie and colleagues give equal weight to the provision of intervention by SLPs and alternative (non-SLP) service providers, while at the same time acknowledging the important role SLPs may play in sharing knowledge with these other agents. Given Fiji's status as a Majority World Country, and the observed lack of permanently based SLPs in Fiji, it is useful to consider other agents that may be involved in providing service to PWCD. In the following sections, service provision in Fiji is reviewed according to the role of each of the seven agents identified in the framework by Wylie and colleagues.

Qualified speech-language pathologists

Speech-language pathology services in Fiji are provided on an ad-hoc volunteer basis by international government agencies and freelance volunteers. Since 2006, eight qualified SLPs have been employed on short-term contracts (six months to two years) through two international aid agencies. At the time of writing this paper, there were no international aid funded SLPs in Fiji. Personal correspondence with five past volunteers and an article written by Park (2012) revealed that SLP intervention methods in Fiji are diverse and strive to be responsive to the needs of the communities in which the SLPs temporarily live and work (A. Hammond, personal communication, 3 May 2013; L. Joseph, personal communication, 5 March, 2013; M. Sullivan, personal communication, 1 May 2013). Interventions have involved using a mix of 1:1, small group and whole class teaching in addition to conducting parent and teacher in-services. The SLPs indicated that they needed to be adaptable and resourceful in the face of cultural, financial, and technical challenges (Park, 2012).

Two freelance Australian volunteers (Fynes-Clinton, 2011; O’Heir, 2011), and a British SLP working for an NGO (Sweeney, 1988) are the only other recorded SLPs to have worked in Fiji. O’Heir (2011) reports volunteering for a Fijian NGO and providing training sessions for teachers; Sweeney volunteered with a visiting cleft lip and palate surgical team (J. Howell, personal communication, 23 July 2013), while Park (Fynes-Clinton, 2011) provided communication interventions for a young man with severe communication needs. It is likely that there are other SLPs who have visited Fiji and provided therapy services or professional development training to small groups of Fijian children or adults with communication disability. Unfortunately, their presence and activities are unrecorded. Encouragingly, international volunteer management agencies and NGOs are actively seeking SLPs willing to undertake self-funded short-term placements in Fiji.

In the absence of consistent local speech-language pathology services, the author has witnessed Fijian residents, particularly expatriates, taking up internet-based speech-language pathology services via telepractice models with SLPs located in Australia and the United States. Others, for example adults who have had a stroke, are travelling to other countries (e.g., India) to seek short-term rehabilitation.

There are presently no training courses for SLPs in the South Pacific, despite the presence of other allied health courses at a Fijian university (e.g., physiotherapy and dietetics). While the Fiji Island Ministry of Education is actively encouraging the presence of SLPs in Fijian schools, schools will remain reliant on the provision of SLP services by international aid agencies until such time as a better regional solution can be found.
Mid-tier workers

Wylie and colleagues (2013) describe mid-tier workers as those persons who have been trained to work with one group of people with communication disability. Reconceptualising the training of specialists in communication disability is pertinent for many nations where SLP services are limited and PWCDs needs are underserved. In Fiji, mid-tier workers support the work of visiting NGOs for a range of disabilities. For example, in the field of cleft lip and/or palate (CLP), a mid-tier worker trained by a maxillo-facial surgical team from New Zealand works as the conduit between children with CLP, local hospitals and visiting international surgeons (J. Howell, personal communication, 23 July 2013). Mid-tier workers’ interventions are twofold. First, they provide advice and training to parents on how to use adaptive feeding methods to maximise nutritional support for their child with CLP prior and post-surgical intervention. Second, they provide post-surgical review to ensure the success of the procedure and quickly field any concerns regarding infection on to local medical personnel. To the author’s knowledge, mid-tier worker’s services are restricted to feeding and wound management. Children with CLP do not currently appear to receive services for communication development.

Mid-tier workers also work within the Fijian deaf community. For example, three NGOs, the Australian groups Carabez Alliance and Ears Inc. and the international CBM’s Project Heaven, in conjunction with local and visiting international audiometrists and audiologists on “working holidays”, have played an important role in training Fijian mid-tier workers in basic aural care, hearing screening procedures, and sign language (Newall, 2006; Sun Fiji Newsroom, 2008; Vula, 2010).

It is possible that visiting SLPs have also been involved in the training of mid-tier workers. As the previous two examples illustrate, the potential for using mid-tier workers to provide services for PWCD is a viable option for Fiji. Hopefully, SLPs may find greater opportunities to be involved in training future mid-tier workers through face-to-face and internet-based technologies.

Already qualified professionals trained for an additional, new role

There was no evidence found to support the existence of already qualified professionals trained for an additional, new role as agents of delivery of intervention for PWCD in Fiji.

Disability care workers

Disability care workers exist in both health and education settings in Fiji. In the health sector, village (or community) health care workers are often the first point of contact for PWCD seeking support (Roberts et al., 2011). These are volunteer workers, chosen by their communities. They receive six weeks of initial training from the Ministry of Health and thereafter are required to complete one to two days of continuing education training annually (Roberts et al., 2011). The Fiji Islands Ministry of Health recognises the inadequacy of this training, and has consequently included an objective to improve training for village and community health care workers in the 2011–15 strategic plan (Fiji Ministry of Health, 2011, p. 15). There are also approximately ten community rehabilitation assistants (CRA) based in subdivisional hospitals around the country. Roberts and colleagues (2011) report that the CRAs were initially trained by an NGO in the 1990s. This training did not continue and their role in patient rehabilitation has largely been taken over by physiotherapists. Whether they were trained to support PWCD is unknown. In the education sector, special schools employ small numbers of teacher aides to help support children’s needs. These aides receive supplementary training depending on the needs of the child/ren in their care (e.g., instruction in sign language, braille). Finally, there is a small number of residential care facilities in Fiji for children and adults with disabilities (Roberts et al., 2011). The training of workers in these facilities is also unreported.

Beth Sims conducting Fijian teacher training session on project based learning (Photo courtesy of Rise Beyond the Reef)

As can be seen from the examples above, formalised training of workers in this category is minimal and training in communication disability unlikely. Since 2013, the Australia Pacific Technical College has offered a Certificate IV in Disability with a course subject titled “Communicate using alternative and augmentative communication (AAC) strategies” (Australia-Pacific Technical College, 2013). Enrolments in this basic level of training may be useful in identifying disability care workers with a greater interest in communication disability who would benefit from additional specialist training.

Traditional healers

Fijians, regardless of ethnicity, have a rich cultural history with strong belief in the value of traditional healing practices and traditional medicines (Brown, Ward-Panckhurst, & Cooper, 2013; Roberts et al., 2011). Discussions between the author and Fijian parents and teachers reveal that traditional healers are regularly called upon to help children and adults with communication difficulties. While the exact nature of the intervention is unknown, Fijian people have reported the use of herbal medicines (inhaled and ingested), chanting, and digital manipulation of the larynx to be common practices.

Other professionals and family members guided by SLPs

Given the limited numbers of SLPs in Fiji, there has been little in the way of SLP-led training programs for other professionals (e.g., teachers, doctors, allied health workers) or family members. Only volunteer international aid SLPs, with their aim to create sustainable development, consistently provide training to personnel within their host organisation to ensure retention of knowledge and practices.
beyond the term of the SLP's employment (A. Hammond, personal communication, 3 May 2013; L. Joseph, personal communication, 5 March, 2013; M. Sullivan, personal communication, 1 May 2013). Prior to 2013, training provided by volunteer SLPs was usually on a small scale, involving the teachers and carers of children from the facility to which the SLP was attached. Training activities included communication augmentation strategies and/or classroom accommodation and adaption techniques for children with communication disability. However, Joseph (personal communication, 27 November 2013) advised that she was involved in training groups of community health workers during her volunteer placement in Fiji. At the university education level, O’Heir (2011) offered brief accounts of her experience providing professional training to early childhood educators, teachers and dieticians. It is unknown whether these training sessions were repeated with subsequent university student intakes. Additionally, despite reporting the collection of data, no outcomes on the success of any of these interventions have yet been reported.

Limitations
The results reported above are limited in a number of ways. First, the author is not Fijian, and neither were any of the SLPs before her. Thus the author brings with her an outsider's viewpoint. Second, the evidence was obtained predominantly by desktop methods – no direct contact with representatives from non-SLP service providers. This decision was made by the author to ensure that the review did not contravene Fijian government restrictions on research. Any future research can only be enhanced by validating findings with direct consultation and cooperation with Fijian people.

Summary and future directions
There are numerous potential agents of delivery of intervention for PWCD in Fiji. However, there is limited evidence of the existence of “actual” agents of delivery of intervention other than qualified SLPs, who are available intermittently and are typically financed by international aid agencies or individuals. Currently, the numbers and locations of qualified SLPs are insufficient to meet the individual needs of PWCD in Fiji, or the specialist training needs of alternative agents of delivery of intervention. Given that there are no plans to create a speech-language pathology course in Fiji, nor an allocated budget to finance internationally trained SLPs to work in Fijian health or education institutions, PWCD will continue to rely on these potential alternative service providers or look to SLP options outside of Fiji.

One such SLP option is the use of innovative technologies, such as telepractice. Evidence of the efficacy of telepractice as a means of delivering specialist services for PWCD across the world is growing (Crowley & Baigorri, 2011; Theodoros, 2011). In Fiji, access to computers and internet services is improving rapidly. The Fijian government has committed to a knowledgeable Fijian through extensive investment in information and communications technologies (ICT) in health and education sectors. In the health sector, the Pacific Open Learning Health Net, developed in consultation with the World Health Organization, provides a forum for free web-based health care worker education (World Health Organization Regional Office for the Western Pacific, 2013). In education, distance education services are planned (The Republic of Fiji. Ministry for Education, National Heritage, Culture and Arts, Youth and Sports, 2012) and schools in rural and remote areas are establishing the infrastructure required to teach children how to use information and communications technology (The Fijian Government Media Centre, 2013).

SLPs have the potential to improve the skills of alternative agents of intervention for PWCD in Fiji through the use of innovative technologies. ICT can provide a future avenue for SLPs to conduct internet-based training sessions for other agents of delivery of intervention based in Fiji. Any such training would be enhanced by research which explores the current skill base and practices of current alternative agents of delivery of intervention. Once such information is known, supplementary training may be provided to ensure PWCD in Fiji are receiving interventions based on evidence and best practice.

There is little doubt that PWCD in Fiji require long-term, fully funded, linguistically and culturally appropriate services that are developed within the local context. To create a sustainable long-term solution, more information is required to complete the Hartley and Wizr (2002) communication disability model for service development in Fiji. This review has sought to document one important stakeholder in service development, that is, people involved in the delivery of services for PWCD. The review has also provided a brief insight into two other stakeholder groups: the Fijian government and NGOs. However, to complete the picture, more information is required about the PWCD and their families in Fiji. Only through analysis of the realities of life for PWCD in Fiji, and with their active involvement in decision-making, can genuine advocacy efforts commence.

Acknowledgement
The author wishes to thank Anna Hammond, Jess Howell, Lydelle Joseph, Jessica McGrath, Susan Park, Megg Sullivan and Professor Sharyne McLeod for their assistance in the preparation of this manuscript.

References


1 Majority World Countries are those countries which rank the lowest on the Human Development Index (HDI – UNDP, 2013). These countries are sometimes also referred to as "developing", "low income", or "third world".

Suzanne Hopf is an Australian speech pathologist and a PhD student at Charles Sturt University. She has lived in Fiji since February 2009.

Correspondence to:
Suzanne Hopf
School of Teacher Education
Charles Sturt University
Bathurst NSW 2795
email: shopf@csu.edu.au
## Appendix: Aspects of service delivery for people with communication disability (PWCD) in Fiji (based on Wylie et al., 2013)

<table>
<thead>
<tr>
<th>Aspects of service delivery</th>
<th>Fijian context</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain</strong></td>
<td><strong>Sub-domain</strong></td>
</tr>
<tr>
<td>Cultural appropriateness of service</td>
<td>For an individual For a family For a community For a population</td>
</tr>
<tr>
<td>Variable and dependent on agent of service delivery. For example, SLPs who are trained in minority world countries and work as volunteers in Fiji are unlikely to fully understand cultural norms, whereas traditional healers will have a good understanding of cultural norms for their own ethnic group.</td>
<td></td>
</tr>
<tr>
<td>Sector delivering service</td>
<td>Public/government Private sector (for profit) Non-governmental organisation or charity</td>
</tr>
<tr>
<td>Non-governmental organisations or charities typically provide services for PWCD.</td>
<td></td>
</tr>
<tr>
<td>Geographical domain</td>
<td>Urban services Rural services Remote services</td>
</tr>
<tr>
<td>SLP services predominantly urban. Non-SLP services all areas.</td>
<td></td>
</tr>
<tr>
<td>Location of service</td>
<td>Institutional (e.g., hospital, school) Community centres (e.g., health centres, polyclinic, CBR program) Domicile Public domain (e.g., through health promotion messages Remotely (e.g., via home program or telehealth)</td>
</tr>
<tr>
<td>Predominantly institutional (school based); however, a small number of Fijians using telehealth</td>
<td></td>
</tr>
<tr>
<td>Agent of delivery of intervention</td>
<td>Qualified SLPs Mid-tier workers Already qualified professionals trained for an additional, new role Disability care workers Traditional healers Other professionals or family members guided by SLPs</td>
</tr>
<tr>
<td>Evidence for all except &quot;Already qualified professionals trained for an additional, new role&quot;.</td>
<td></td>
</tr>
<tr>
<td>Level of intervention</td>
<td>Primary Secondary Tertiary</td>
</tr>
<tr>
<td>Tertiary</td>
<td></td>
</tr>
<tr>
<td>Recipients of intervention</td>
<td>Individual Immediate circle (e.g., family, friends) Paid or voluntary workers Wider-community</td>
</tr>
<tr>
<td>SLPs provide to all levels of society. Non-SLP provision unknown.</td>
<td></td>
</tr>
<tr>
<td>Focus of intervention – levels of ICF</td>
<td>Impairment Activity Participation Environmental and personal (contextual) influence</td>
</tr>
<tr>
<td>SLPs provide at all levels. Non-SLP provision unknown.</td>
<td></td>
</tr>
<tr>
<td>Responsivity of services</td>
<td>Service is available when the PWCD needs it Service dictates availability and timing of provision</td>
</tr>
<tr>
<td>Service dictates availability and timing of provision.</td>
<td></td>
</tr>
<tr>
<td>Continuity of service</td>
<td>Continuous Sporadic</td>
</tr>
<tr>
<td>Dependent on agent of service delivery. For example, qualified SLPs are sporadic, while mid-tier workers are continuous.</td>
<td></td>
</tr>
<tr>
<td>Sustainability of service</td>
<td>Long-term funding Short-term funding</td>
</tr>
<tr>
<td>Short-term funding (often dependent on local and international donations).</td>
<td></td>
</tr>
<tr>
<td>Rationalisation of services</td>
<td>Equal and equitable access to all PWCD Inequitable access to a restricted group of PWCD</td>
</tr>
<tr>
<td>Inequitable access with some disability status groups receiving greater attention and urban clients receiving the bulk of professional services.</td>
<td></td>
</tr>
</tbody>
</table>