

COMMENTARY

Services for people with communication disability in Fiji: barriers and drivers of change

SC Hopf, S McLeod

Charles Sturt University, Bathurst, New South Wales, Australia

Submitted: 10 October 2013; Revised: 16 November 2014; Accepted: 28 February 2015; Published: 21 July 2015

Hopf SC, McLeod S

Services for people with communication disability in Fiji: barriers and drivers of change
Rural and Remote Health 15: 2863. (Online) 2015

Available: <http://www.rrh.org.au>

ABSTRACT

Context: The World Health Organization's *World report on disability* calls upon all nations to 'remove the barriers which prevent [people with disabilities] from participating in their communities; getting a quality education, finding decent work, and having their voices heard' (p. 5). People with communication disability (PWCD), as a consequence of their atypical communication, may be more likely to be excluded from society, and denied their basic human rights, than other people with disability. Fiji, a multicultural and multilingual nation in the south-western Pacific Ocean, has limited services for PWCD. Service providers in Fiji include disability care workers, special education teachers, traditional healers, and a small number of visiting volunteer speech-language pathologists. This paper outlines the historical and current barriers to, and drivers of change for, service development for PWCD in Fiji.

Issues: Five barriers to service development for PWCD in Fiji were identified. (1) A major structural barrier is the small population size to develop appropriate infrastructure including professional education programs. (2) Geographical barriers include the dispersed geography across 300 islands, low population density, the rural–urban divide, and risk of disaster from cyclones and flooding. (3) Linguistic diversity, while culturally important, can present a barrier to the provision of quality services that are available in the languages spoken by PWCD. (4) Cultural barriers include historical political instability, although Fiji has become more stable due to the recent democratic elections. The social climate affects development of services that are appropriate for different dominant cultural groups. (5) Financial barriers include low gross domestic product, low financial security and low human development index; however, the financial outlook for Fiji is steadily improving due to the change in political stability.

Lessons learned: Three levels of drivers of change were identified. Macro-level drivers included Fiji's endorsement of international policy and increased globalisation (eg tourism). Meso-level drivers of change included receipt of foreign aid and support from international non-government organisations, development of disability-inclusive legislation and policy within Fiji, and strengthening of government policies that support disabled people's organisations. Micro-level drivers of change included



establishment of disabled people's organisations by consumers, adoption of disability-inclusive policy and procedures by service providers, and changes in the perceptions of disability within the general community. Fijian prevalence data confirms that there is an underserved population of PWCD in need of specialist services. Significant advocacy work in the disability field by Fijian and international disabled people's organisations has led to the Fiji government signing international policy (eg Convention on the Rights of Peoples with Disabilities), inclusion of disability rights in national legislation (eg 2013 Constitution of Fiji Islands) and localised policy and practice documentation (eg inclusive education policy by the Fiji Islands Ministry of Education). Continued service development is required if Fijians with communication disability are to have their needs met. The drivers of change at all levels are positioned well to overcome current barriers to change; however, a coordinated approach including macro-, meso-, and micro-level drivers is required to ensure the future development of adequate services for PWCD in Fiji.

Key words: agents of change, barriers and drivers of change, communication disability, Fiji, service development, speech-language pathology.

Context

Fiji is a group of more than 300 islands in the south-western Pacific Ocean. Fiji's strategic place in the regional economy, historical immigration patterns and rich cultural mix contribute to this small country a remarkable degree of cultural and linguistic diversity. Fiji's population of more than 800 000 is from mixed ethnic backgrounds: 57% indigenous iTaukei-Fijian, 37% Fijian-Indian, with Indian subcontinent ancestry, and 6% of either Pacific island, European or East Asian ancestry¹.

Information about people with communication disability (PWCD) in Fiji is scarce, with prevalence of Fijians with communication disability reported in two public documents. The first, a 2010 survey by the Fiji National Council for Disabled Persons (FNCDP), reports that less than 1% of Fijians with a disability have a communication disability (approximately 1.4% of the total population)². The second report, from the Fiji Islands Ministry of Education, National Heritage, Culture and Arts, states that 39.2% of children enrolled in special schools have a 'speech disability'(p. 27)³. This latter figure is closely aligned with international expectations from other majority world countries; for example, Wylie and colleagues indicate 25–49% of all African people with disability experience communication disability⁴.

Services for PWCD in Fiji are limited. Hopf reviewed agents of service delivery for PWCD in Fiji and found a small number of qualified speech-language pathologists (SLPs) had visited Fiji in the past 25 years as volunteers predominantly providing one-to-one intervention and ad-hoc paraprofessional training to parents and teachers⁵. Additionally there was evidence of alternative service providers (eg traditional healers, mid-tier workers, disability care workers) with a largely unknown skill base and methods of intervention. Pressman and Heah Lee also explored service provision for PWCD in Fiji⁶. In the absence of in-country speech-language pathology services in Fiji, the authors recommended the use of paraprofessionals trained by SLPs and audiologists. Such a recommendation resonates with current international trends promoting the use of community-based rehabilitation (CBR) workers and population-based approaches to the provision of health services⁷. Unfortunately, the Pressman and Heah Lee⁶ recommendation from 25 years ago to provide long-term paraprofessional training in Fiji has not been realised⁵. Currently, there are no speech-language pathology professional preparation courses in Fiji, despite the development of courses for other allied health services offered through the Fiji National University (eg physiotherapy, pharmacy and dietetics)⁸, and speech-language pathology courses in countries surrounding the region (eg Australia, Guam, Hawaii, New Zealand)⁹.



SLPs from around the world have long been concerned about the mismatch between service delivery accessibility and availability and the needs of PWCD^{4,10-15}. These authors, and others, persistently challenge SLPs to engage in an ongoing discussion of service delivery re-evaluation to ensure SLPs are proactive in meeting the needs of PWCD. However, as Cheng⁹ illustrates in her summary of services in the Asia-Pacific region, speech-language pathology growth remains disparate, with the needs of PWCD remaining unmet in many Asia-Pacific nations due to the influence of country-specific sociopolitical, geographical, cultural and linguistic factors.

The aim of this article is to describe the barriers to development of services for PWCD in Fiji and to document the macro-, meso-, micro-level drivers of change as potentially facilitative for future service development in Fiji.

Issues

Consideration of the barriers and drivers to change for service development was recommended by Price¹⁶. Use of this terminology has consequently been applied in development of services in majority world contexts for people with disability^{17,18} and specifically people with communication disability⁴. An overview of the barriers and drivers to change for Fiji, based on the recommendations of Wylie and colleagues⁴, is provided in Table 1 and will be described below.

Barriers to development of services for PWCD in Fiji

Five barriers to the development of services for PWCD were identified by Wylie and colleagues: structural, geographical, linguistic, cultural and financial⁴. These barriers were applied to the Fijian context following a review of available literature including international and Fijian legislation, policy and practice documents.

Structural barriers: The Fiji 2007 census¹ revealed a small multicultural population of less than 900 000 people. In comparison with other middle-income majority world

countries that have begun to develop services for PWCD¹⁹, Fiji has a small and diverse population, which potentially restricts the scope and availability of resources (eg financial and human resources, tertiary education).

Geographical barriers: Fiji's more than 300 islands are spread over a distance of 18 271 km². The 100 inhabited islands of Fiji have a relatively low population density of 47.1 people per km²²⁰. However, a little over half of all Fijians actually live in major urban centres, where the bulk of paid employment is found. Specialist health and education services for Fiji tend to be located in the capital city or other major urban centres. The need for Fijians to travel long distances at significant personal cost may be considered a barrier to accessing service provision. Disaster risk is also a potential barrier to development of Fijian services and infrastructure. Fiji is considered the 19th most at-risk nation in the world due to its high likelihood of cyclonic weather and flooding²¹.

Linguistic barriers: Fiji has three official languages: English, Fijian and Hindustani²² and significant numbers of speakers of Fiji Hindi, other non-standard indigenous Fijian languages (eg Lauan), Rotuman, immigrant languages (eg Chinese) and Fiji sign language²³. In urban areas and in the domains of education, politics and industry, Fiji English is the language that dominates²³. Due to linguistic diversity there is often a mismatch between home language and the vernacular taught in schools. There may also be a linguistic mismatch between PWCD seeking services and the language of the service providers.

Cultural barriers: Fiji has experienced political instability in the form of three political coup d'états, in 1987, 2000 and 2006. Military rule was in place from 2006 until democratic elections were held in September 2014. It is envisioned that democracy will bring in a new period of political stability. The new government was elected on a platform of racial equality. This should have an impact on the social climate that has historically been hampered by conflict amongst the two dominant ethnic groups: iTaukei Fijian and Fijian Indian.



Table 1: Barriers and drivers of change to support people with communication disability in Fiji

Barriers to change	Structural	1. Population size
	Geographical	1. Geography 2. Population density 3. Rural–urban divide 4. Disaster risk
	Linguistic	1. Linguistic diversity
	Cultural	1. Political stability 2. Social climate
	Financial	1. Gross domestic product 2. Financial security 3. Human development index
Drivers of change	Macro-level	1. Endorsement of international policy 2. Increased globalisation
	Meso-level	1. Receipt of foreign aid and support from international NGOs 2. Development of disability-inclusive legislation and policy 3. Strengthening of government policies that support DPOs
	Micro-level	1. Establishment of DPOs by consumer representatives 2. Adoption of disability inclusive policy and procedures by service providers 3. Perceptions of disability within the general community

NGO, non-government organisation. DPO, disabled people's organisations.

Financial barriers: Fiji has experienced small but steady growth on the human development index (HDI) since 1980²⁴. For example, in 1980 Fiji had a HDI of 0.587, in 2000 Fiji had a HDI of 0.674, and in 2014 the HDI was 0.724, and was ranked 88th in the world. The gross domestic product (GDP) per capita in 2014 was \$7552.21²⁴. Fiji's financial security, as ranked by Moody's, is considered B1 stable²⁵. The economy has been consistently hampered by persistent trade and budget deficits, making it one of the world's largest per capita recipients of aid²⁶.

Fiji's small population, slow growth performance in improving human development, recent history of political instability, high risk of disaster and perceived financial insecurity in international markets are key barriers to the development of services for PWCD in Fiji. With a return to democracy in Fiji from September 2014, concerns of political instability and financial insecurity may be partially alleviated in the future.

Drivers of development of services for PWCD in Fiji

In Fiji, a range of drivers of change are potentially facilitative for future service development in Fiji. Price identified three

potential levels of change: macro-, meso- and micro-level. Macro-level changes are disability policy drivers that are deemed external and distant from an organisation (eg international conventions)¹⁶. Meso-level changes also act from an external point but are deemed close to the organisation (eg government policy). Micro-level changes are internal to the organisation, and thus by design are also close (eg staff member opinion, company guidelines). Using this framework, available literature, including legislation, policies and practices pertaining to communication disability in Fiji, was reviewed, and policy drivers at all levels were identified.

Macro-level drivers of change: At the macro-level there are two significant drivers. The first of these is Fiji's active involvement in international policy development and resultant targets to achieve on behalf of all people living with a disability as a result of its membership in international human rights groups and signatory status to international frameworks and mandates. For example:

- In 1993, Fiji signed the United Nations Convention on the Rights of the Child²⁷.



- In 1995, Fiji ratified the United Nations Convention on the Elimination of All Forms of Discrimination Against Women²⁸.
- In 2000, Fiji ratified the United Nations Millennium Declaration²⁹ and Millennium Development Goals (MDGs)³⁰, which include MDG2: universal education.
- In 2000, Fiji signed the Dakar Framework for Action and pledged to achieve Education for All targets³¹.
- In 2003, Fiji endorsed the Biwako Millennium Framework and the Biwako Plus Five³². Both documents pledge action towards an inclusive, barrier-free and rights-based society for all persons with disability in Asia and the Pacific.
- In 2004, Fiji signed the 1983 International Labour Organisation Convention 159 on Vocational Rehabilitation and Employment³³.
- In 2009, Fiji endorsed the Pacific Regional Strategy on Disability at the first Pacific ministerial meeting on disability organised by the Pacific Islands Forum Secretariat³⁴.
- In 2010, Fiji signed 2008 UN Resolution 62/170 on the United Nations Convention of the Rights for People with Disabilities (UNCRPD)³⁵.

The second macro-level driver relates to increasing globalisation of world concepts, through international tourism, multimedia and information and communications technology. Fijians consequently have a greater chance of having contact with people from other countries (eg as a tourist travelling internationally, a recipient of a service provided by an international volunteer or a participant in an online community). These contacts provide opportunities for the sharing of new thinking, techniques and ideologies that subsequently influence future policy development. An example of international practice influencing Fijian practice is the development of the Pacific Open Learning Health Net. Developed in consultation with WHO, it offers free web-based learning modules for healthcare workers. It is supported by 38 learning centres located in 12 Pacific Island countries³⁶. Information for these courses is sourced from around the world.

Meso-level drivers of change: Considering the meso-level drivers of policy development, three powerful contributors to change are evident. First, foreign aid and international non-government organisations contribute a small amount to Fiji's national budget; it remains important in some ministerial portfolios as a backup to budget shortfalls³. Foreign aid agencies in Fiji have traditionally come from Australia, Canada, Japan, New Zealand and the UN. Within these countries and organisations, there is an increasing emphasis upon disability and quality-of-life issues, mandated under article 32 of the UNCRPD, which has led to development of disability-inclusive international development assistance programs^{35,37}. One example, the Disability-Inclusive Development Reference Group, has been effective in facilitating exchange of information between non-government organisations, Fijian disabled people's organisations and international equivalents³⁷. They have also been critical in improving awareness of the CRPD and the social model approach to disability³⁸. In addition, international policy and strategies (eg Development for All Strategy³⁷) have given legitimacy to required Fijian legislative changes and budgetary allocations.

Government legislation and policy is the second meso-level driver. As stated in the macro-level discussion, Fiji's government has committed to international mandates for improving the lives of people living with a disability³⁹. Importantly, these commitments have been translated into meso-level action within the policy and procedure documents of major governmental ministries^{3,40}. In addition, the government established the Fiji National Council for Disabled Persons (FNCDP) in 1994. The FNCDP observes a human rights model of disability³⁹. They are responsible for policy development and coordination of disability services across ministerial portfolios and monitoring of groups of people with disability in Fiji. The FNCDP 2008–2018 National Policy on Persons Living with Disability clearly supports provision of specialist services for people living with a disability. In addition to recognition of the need for capacity building it calls specifically for 'strengthen[ed]...capacity of [community-based rehabilitation] officers, and other professionals (e.g., speech therapists, sign language



interpreters, occupational therapists, etc.)'(p. 15)³⁹. Such policy development is indicative of Fiji's concerted attempts to close the 'implementation gap' that has previously existed between legislative adoption of disability-inclusive policies and ground-level implementation of those policies. Such a gap is reportedly present in other majority world countries and considered a major barrier to change^{17,18}.

The other meso-level driver is the strengthening of Fijian government policies that support disabled people's organisations. Fiji is a member of regional organisations with an interest in the welfare of people with disabilities. Key agencies include the Pacific Islands Forum Secretariat and the Pacific Disability Forum. Both agency websites provide links to local and international agencies with an interest in disability services in Fiji. As a member of such forums, Fiji has subscribed to their philosophies and has developed policy in accordance with their recommendations.

Micro-level drivers of change: The micro-level drivers of change can be viewed from three perspectives: that of consumer representatives, service providers and the general community. With regards to consumer representatives, Fiji has a strong and committed network of disabled people's organisations supported by the national Fiji Disabled Persons Federation (previously Fiji Disabled Persons Association). Importantly for PWCD in Fiji, Fijian disabled people's organisations are committed to 'including people with all types of impairments'(p. 60)⁴¹.

Service providers for PWCD in Fiji include people within the health and education sectors. Both sectors are in the early stages of adopting disability-inclusive practices within their own plans, policies and procedures. Prior to school entry, services for Fijian children with speech, language and literacy difficulties are the responsibility of the Fijian Ministry of Health. The ministry coordinates more than 900 village clinics, 1245 nursing stations, three area hospitals, 76 health centres, 19 subdivisional medical centres, three divisional hospitals, and three specialty hospitals with tuberculosis, leprosy and medical rehabilitation units⁴². Provision of specialist rehabilitation services for PWCD is not presently a

primary goal of the ministry; their focus is on reducing child mortality rates⁴⁰. Speech-language pathology services are not currently available to support children prior to school entry, nor at any time for adults who have acquired communication and/or swallowing difficulties.

Support for children with speech, language and literacy needs during the school years is provided by the Fijian Ministry of Education. Historically, children in Fiji who are identified with additional needs are educated in one of 19 segregated schools, referred to locally as 'special schools'³. Tavola states that 'segregated schools mostly have mixed disability and mixed age enrolments and offer primary schooling of a very limited quality and with poor educational outcomes. Some are more care centres than schools.' (p. 7)⁴³. In addition, Tavola reports that 'the majority of children living in rural, remote and scattered islands [with additional needs] have typically not attended school at all' (p. 7)⁴³. The Fiji Islands Ministry of Education developed the Policy in Effective Implementation of Inclusive Education in Fiji associations (eg Fiji Physiotherapy Association), and section 7 contains a wish to use 'speech therapists' (p. 11)⁴⁴. Fijian special education teachers actively seek professional development opportunities locally and internationally³. Furthermore, in 2013, recruitment for special education needs coordinators in all education districts commenced to support the implementation of country-wide inclusive schools³.

Professional organisations in Fiji with an interest in supporting PWCD may include teachers' unions and health workers' unions. Data on staff perceptions of working with people with a disability or specifically PWCD is limited to the field of education⁴⁵. Daveta found that teachers from different school settings supported inclusive education for children with mild disabilities only and indicated that children with severe disabilities should attend a special school⁴⁵. These teachers identified several factors that ultimately acted as barriers to inclusion: severity and type of disability, perceived extra workload, inadequate pre- or in-service training, a lack of specialist teacher support, a lack of government funding, a lack of commitment from the Ministry of Education, and lack of consultation with teachers on development of inclusive



policy or curriculum⁴⁵. Reflecting similar findings of international research in this area⁴⁶, Daveta's findings are important to consider given the recent trial of mainstream schooling children with disabilities by the Fijian Ministry of Education³⁸.

The other driver at the micro-level relates to community expectations. There is limited information about Fijians' expectations for services for PWCD. The information provided by teachers as already discussed⁴⁵ and general comments on community perceptions of disability in review documents³⁸ suggest community expectations for PWCD may be low. It is possible that community expectations may currently be acting as a barrier to policy development, rather than a driver.

Lessons learned

Much has happened in Fiji over the past 25 years with respect to financial and political stability and growth, and macro- and meso-level drivers of change. However, not enough change has happened for PWCD in Fiji. Prevalence data confirms that there is a population of PWCD in need of services, yet services remain minimal and PWCD remain underserved. Fijian community organisations (eg Fiji Disabled Peoples Association and their affiliates) and government portfolios (eg FNCDP, Ministry of Education, Ministry of Health, Ministry of Social Welfare) have made positive steps towards service development for PWCD, including:

- adopting a human rights approach to disability and signatory status to the UNCRPD
- improving community awareness of disability issues
- facilitating disability-inclusive government and ministry policies (eg for inclusive education)
- recognising the need for specialist services in other allied health disciplines (eg dietetics and physiotherapy)
- conducting epidemiological research into disability prevalence

- committing to a 'knowledgeable Fiji' through extensive investment in information and communications technology⁴⁷
- maximising the limited speech-language pathology services that are available to date, especially with regards to capacity building
- undertaking risk reduction activities to reduce the impact of natural and economic calamities
- returning to democratic governance.

Unfortunately, local development of services for PWCD has not been a priority for Fiji. The national health system has prioritised primary health care and preventative services, focusing on poverty reduction, prevention of non-communicable and infectious disease, improving sanitation, and health system efficiency. These are erstwhile areas of intervention, though such priorities are at the expense of providing rehabilitation services for people already with disability.

The analysis presented highlights the opposing forces at work in developing services for PWCD in Fiji. Whilst progress has been made in many areas of disability development, change for PWCD remains static. The exact reasons for this are not obvious. Buell states that 'addressing any one demand or supply barrier in isolation will not engender sustainable change within a service or improve access for service users ... change requires energies to be directed across sectors' (p. 35)¹¹. In Fiji, it is possible that forces driving change are not working collectively due to the ad-hoc and intermittent supply of specialist knowledge about communication disability in Fiji. The authors suggest that, as per Buell's recommendation, Fiji requires a coordinated approach that combines the driving forces at all levels of Fijian society before true momentum for change to services for Fijian PWCD is achieved.

Individuals and organisations need to capitalise on these gains for people with disabilities to ensure that services for PWCD are significantly enhanced. A coordinated approach to service development for PWCD from education, health, and private sectors is required to sustain change. Most importantly,



sustainable change will need to be driven from within the Fijian community and informed by the knowledge of PWCD in Fiji, their supporters and current service delivery agents.

Acknowledgements

The first author wishes to extend her gratitude to the Fijians and visiting volunteers who have contributed to the discussions that underpin this writing. The first author acknowledges support from a Charles Sturt University Post-Graduate Research Scholarship (CSU-PGRS) and the second author acknowledges support from an Australian Research Council Future Fellowship (FT0990588).

References

1. Fiji Islands Bureau of Statistics. *Statistical News. Census 2007 results: Population size, growth, structure and distribution. No. 45.* (Online) 2008. Available: <http://www.statsfiji.gov.fj/index.php/2007-census-of-population> (Accessed 11 June 2013).
2. Fiji National Council for Disabled Persons. *Making women with disabilities visible: National baseline disability survey.* (Online) 2010. Available: <http://www.fncdp.org/docs/WomenDisabilitiesSurvey.pdf> (Accessed 28 May 2013).
3. Fiji Islands Ministry of Education, National Heritage, Culture & Arts. *Annual Report 2012.* (Online) 2012. Available: <http://www.education.gov.fj/index.php/resources/ministry-2012-annual-report> (Accessed 23 August 2013).
4. Wylie K, McAllister L, Davidson B, Marshall J. Changing practice: implications of the World Report on Disability for responding to communication disability in under-served populations. *International Journal of Speech-Language Pathology* 2013; **15(1)**: 1-13.
5. Hopf SC. Services for people with communication disability in Fiji: Clinical insights. *Journal of Clinical Practice in Speech-Language Pathology* 2014; **16(2)**: 81-86.
6. Pressman DE, Heah Lee H. Speech and language problems: a developing-country perspective in the Asian and Pacific region. In: S Gerber, G Mencher (Eds). *International perspectives on communication disorders.* Washington DC: Gallaudet University Press, 1988; 20-45.
7. World Health Organization. *Community Based Rehabilitation (CBR) guidelines.* (Online) 2010. Available: <http://www.who.int/disabilities/cbr/guidelines/en/index.html> (Accessed 12 August 2013).
8. Fiji National University. *Fiji National University.* (Online) 2013. Available: www.fnu.ac.fj (Accessed 11 September 2013).
9. Cheng L-RL. Emerging issues in health and education in Asia-Pacific: a focus on speech-language pathology. *Folia Phoniatrica et Logopaedica* 2010; **62(5)**: 238-245.
10. Barrett H, Marshall J. Implementation of the World Report on Disability: developing human resource capacity to meet the needs of people with communication disability in Uganda. *International Journal of Speech-Language Pathology* 2013; **15(1)**: 48-52.
11. Buell S. A perspective from Bolivia on the implications of the World Report on Disability for people with communication disabilities. *International Journal of Speech-Language Pathology* 2013; **15(1)**: 32-36.
12. Hartley S. Service development to meet the needs of 'people with communication disabilities' in developing countries. *Disability and Rehabilitation* 1998; **20(8)**: 277-284.
13. Hartley SD, Wirz SL. Development of a 'communication disability model' and its implication on service delivery in low-income countries. *Social Science & Medicine* 2002; **54(10)**: 1543-1557.
14. Roulstone S, Harding S. Defining communication disability in under-served communities in response to the World Report on Disability. *International Journal of Speech-Language Pathology* 2013; **15(1)**: 27-31.



34. Pacific Islands Forum Secretariat. *Disability SDWG Brief 14. Disability inclusive development in Pacific Island countries*. (Online) 2013. Available: [http://www.forumsec.org/resources/uploads/attachments/documents/14-%20Disability%20SDWG%20Brief%20\(19April%2013\)%20FINAL.docx](http://www.forumsec.org/resources/uploads/attachments/documents/14-%20Disability%20SDWG%20Brief%20(19April%2013)%20FINAL.docx) (Accessed 16 September 2013).
35. United Nations. Convention on the Rights of Persons with Disabilities (CRPD). (Online) 2006. Available: <http://www.un.org/disabilities/convention/conventionfull.shtml> (Accessed 12 August 2013).
36. World Health Organization Regional Office for the Western Pacific. *Pacific Open Learning Health Network (POLHN) 2013*. Available: <http://courses.polhncourses.org> (Accessed 30 June 2015).
37. Australian Agency for International Development (AusAID). *Development for all: towards a disability-inclusive Australian aid program 2009–2014*. Canberra, ACT: AusAID, 2008.
38. Kelly L, Wapling L. *AusAid. Development for all strategy. Mid-term review. Report*. (Online) 2012. Available: <http://dfat.gov.au/about-us/publications/Documents/dfa-mtr.pdf> (Accessed 30 June 2015).
39. Fiji National Council for Disabled Persons, Fiji Islands Ministry of Health Women and Social Welfare. *Fiji Islands: a national policy on persons living with disabilities (2008–2018)* (Online) 2008. Available: http://fncdp.org/docs/2008-18_NationalDisabilityPolicy.pdf (Accessed 30 June 2015).
40. Fiji Islands Ministry of Health, World Health Organization: Pacific Region. *Shaping Fiji's health: strategic plan 2011–2015*. (Online) 2011. Available: http://www.wpro.who.int/health_services/fiji_nationalhealthplan.pdf?ua=1 (Accessed 30 June 2015).
41. Rhodes D, Macanawai S, Tawaka K, James, R. *Capacity development for effective and efficient disabled people's organisations in Pacific Island countries. Pacific report*. (Online) 2013. Available: <http://www.apids.org/USERIMAGES/PDF%20Pacific%20Report%202013%20eCopy.pdf> (Accessed 30 June 2015).
42. WHO country cooperation strategy for Fiji: 2013–2017. (Online) 2012. Available: http://www.wpro.who.int/countries/fji/who_pacific_fiji.pdf (Accessed 2 April 2013).
43. Tavola H. 'Addressing inequalities: disability in Pacific island countries'. Paper presented online at the 'Addressing inequalities' global thematic consultation. Available: <http://www.worldwewant2015.org/node/291975> (Accessed 20 August 2013).
44. Fiji Islands Ministry of Education National Heritage Culture & Arts and Youth and Sports. *Policy in effective implementation of inclusive education in Fiji*. (Online) 2011. Available: <http://www.education.gov.fj/images/Legislation/Policies/POLICY%20IN%20EFFECTIVE%20IMPLEMENTATION%20OF%20INCLUSIVE%20EDUCATION%20IN%20FIJI.pdf> (Accessed 21 August 2013).
45. Daveta ML. 'Inclusive education for children with disabilities in Fiji: teacher perspectives and attitudes'. Masters Thesis. Hamilton, The University of Waikato, 2009.
46. Avramidis E, Norwich B. Teachers' attitudes towards integration/inclusion: a review of the literature. *European Journal of Special Needs Education* 2002; **17**(2): 129-147.
47. Fijian Government Media Centre. *Opening of Lomaivuna secondary school telecentre by Prime Minister Commodore J. V. Bainimarama*. (Online) 13 June 2013. Available: <http://www.fiji.gov.fj/Media-Center/Speeches/Opening-of-the-Lomaivuna-Secondary-School-Telecent.aspx> (Accessed 19 August 2013).