Review of Diploma of Community Based Rehabilitation at Solomon Islands National University

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University of Sydney, NSW 2006, Australia

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Executive summary

Overview

Community-based rehabilitation (CBR) began in the Solomon Islands in the early 1990s, under the Ministry of Health and Medical Services. CBR was seen as a way to bring much needed rehabilitation services to the village level – particularly in the context of few services available for people with disabilities (except in the urban capital) and the population being widely spread in rural and remote locations.

Since that time CBR has evolved internationally from a primarily health focused approach into one which addresses inclusion at the community level for people with disabilities and other vulnerable groups. CBR is now defined as a universal strategy for this purpose. The WHO 2010 publication – *Community-based Rehabilitation Guidelines* has, as its sub-title, *Towards community-based inclusive development*. These Guidelines are accompanied by a Matrix which spells out five essential elements: health, education, livelihood, social and empowerment with accompanying components to be addressed to ensure inclusion of people with disabilities in the community.

Building on this development, the first Pacific CBR Forum was held in 2012 followed by a Pacific CBR Plan of Action. The second Pacific CBR Forum held in 2015 was dedicated to reviewing progress and expanding existing CBR programs as well as introducing CBR in other Pacific nations.

Training in CBR around the world initially followed a health and rehabilitation orientation, and this was the case in the Solomon Islands. From early certificate courses in the early 2000s, a two year Diploma of Community-Based Rehabilitation was developed at the then Solomon Islands College of Higher Education (now Solomon Islands National University). This Diploma of CBR had its first intake in 2011, a second intake in 2013, and a third in 2015. Given the advances in conceptualisation of community-based rehabilitation since that time, and the strong focus on CBR the Pacific way in the Pacific region, WPRO commissioned a review of the Diploma in CBR in 2013. For various reasons this was not completed until 2015. This Report details the background, aims, methods and findings of this review.

The Review proceeded by way of desk review, face-to-face meetings and telephone and email communications with the key stakeholders in the Solomon Islands. These were Mrs Elsie Taloafiri, Coordinator, Community Based Rehabilitation Unit, Rehabilitation Division, Ministry of Health and Medical Services; Mrs Goretti Pala, Community Based Rehabilitation Course Coordinator, SINU, Ms Ana Burggraaf, Lecturer, SINU; and Mr Casper Fa'asla, President, People with Disabilities Solomon Islands.

Major findings from the Review are briefly summarised: first, from the literature; second, from reflections of the key stakeholders to the exposure draft of this report; and third, following consultations during an in-country visit in mid-December 2015.

The literature on CBR training

- CBR programs worldwide have developed according to the local context.
- Training programs in CBR can be differentiated into two distinct groups according to the foundation framework of the curriculum. These are *Individual Rehabilitation Intervention* or *Inclusion in the Community and Empowerment*.
- CBR training programs that attempt to combine both frameworks are in danger of sending 'mixed messages' to students and key stakeholders including employing authorities.
- Clarity about the expected role of the CBR field worker in a particular country is essential so that CBR training programs can ensure content matches these expectations.
- There have been some attempts to identify competency-based curricular content to overcome the challenges of integrating the two frameworks mentioned above.

Reflections from key stakeholders to Exposure Draft of the Report

- DipCBR graduates in the Solomon Islands have restricted employment opportunities due to the limited number of Ministry of Health and Medical Services CBR Field Worker posts. There are now expanding opportunities in other sectors.
- There have been limited opportunities for SINU staff to re-develop the curriculum in line with international developments including the WHO matrix, despite their wish to do so. There is a strong desire to broaden the reach of CBR beyond MHMS to other ministries, NGOs and community organisations.
- Including young people with disabilities and also family members and carers as students in the DipCBR would be a major contribution to inclusion of people with disabilities in Solomon Islands society and set an excellent role model for all.
- Requests from other sectors to include sector-relevant material, for example from school education, or livelihood/ employment are putting pressure on expanding the DipCBRcourse beyond two years.
- Some graduates from the 2011 (graduated 2012) and 2013 (graduated 2014) cohorts remain unemployed. This does not augur well for career pathways and progression.
- With expansion of CBR programs in other Pacific nations, there is a potential role for the SINU DipCBR to be the leading CBR training program for the Pacific region.

Summary points from in-country visit, December 2015

- There is a growing demand for disability trained workers in the Solomon Islands following national policy initiatives for people with disabilities, a focus on inclusive education, and the rising incidence of NCDs.

- The number of DipCBR graduates exceeds available MHMS CBR Field worker posts,the number of which (with few exceptions) remain static.
- Policy initiatives to support inclusion of people with disabilities in the community now require multi-sector coordination for implementation and sustainability. The emerging Disability Coordinating Committee could take the lead for this purpose.
- The DipCBR curriculum needs to be revised and updated to reflect advances in thinking on community-based inclusive development and the WHO guidance documents
- In the context of the increasing incidence of NCDs in the Solomon Islands, building multi-sector collaboration is essential to ensure a trained workforce for prevention and management. DipCBR graduates are ideally positioned as front line community health education personnel (prevention) and community inclusion personnel (management of the sequalae of NCDs).

Recommendations

Recommendation 1

That serious consideration is given to curriculum revision using the WHO Matrix and Guidelines as the foundation framework.

Short term actions

- Consider expanding content in the second year of the program in 2016 to include additional focus on education, livelihood, social, and empowerment in line with the WHO Matrix and Guidelines. Health is currently well covered.
- Consider revision of student forms for example assessment forms in line with WHO Matrix and Guidelines elements
- Consider inclusion of case studies/ stories of successful participation by people with disabilities related to education, livelihood, social and empowerment. Ideally, the case studies/ stories would be complemented by lectures/ tutorials from people with disabilities themselves

Longer term actions

- Full revision of the curriculum prior to 2017 cohort to align with the WHO Matrix and Guidelines
- Identify colleagues in other universities in Australia and elsewhere and invite them formally to become ‘critical friends’ to support this revision process
- Consider changing the course name to Diploma Community-based Inclusive Development in line with international developments
- Establish a high-level Course Advisory Committee comprising all relevant Ministries, International and National non-government development organisations, and private companies. The role of this Course Advisory Committee would be to advocate for the DipCBR program, and to network and expand opportunities for employment of

DipCBR graduates and student placements

- Proactively recruit staff and students with disabilities to demonstrate inclusion of people with disabilities and provide role models for students
- Provide opportunities for family members and carers to train as CBR Field Workers
- Develop a pre-requisite Certificate course for potential DipCBR students who do not meet the eligibility requirements but have strong vested interests in enrolling in the program, for example, students with disabilities and family members and carers of persons with disabilities

Recommendation 2

That attention is given now, led by SINU and the MHMS, to the unemployment situation of 2012 and 2014 DipCBR graduates and definitely before the graduation of the 2015 cohort.

Short term actions

- Establish a cross sector committee at the most senior level of management of SINU and MHMS and including other ministries, INGOs and NGOs to resolve the unemployment situation of DipCBR graduates
- If MHMS posts in sufficient numbers are not likely to become available in the short term, the Committee investigate alternative solutions to ensure that this well trained cadre of community based health workers is not lost to other employment opportunities/ careers

Longer term actions

- The Committee identify, using up to date census, disability prevalence, and NCDs incidence figures the projected number of community-based rehabilitation (inclusive development) field workers required over the next 10 years
- The Committee work with SINU to ensure staffing and resources are adequate to meet the projected demand for recruitment into the DipCBR over the next 10 years

Recommendation 3

That the School of Nursing and Allied Health Sciences develop promotional materials which clearly articulate the contribution of the DipCBR. This would fulfill three purposes:

- to ensure clear understanding by multiple stakeholders of the role and contribution of CBR Field Workers for the inclusion of people with disabilities in the Solomon Islands community;
- to provide recruitment information about the program to attract sponsored and private students from other Pacific nations embarking on community-based rehabilitation programs; and,
- to provide potential students in the Solomon Islands with information about the program and their future contribution to the Solomon Islands community.

1. Background

1.1 Brief overview of Community based rehabilitation development

Community based rehabilitation was introduced by the World Health Organisation in 1976. The primary concept underlying CBR at this time was that rehabilitation should be home based with the care and responsibility for rehabilitation being given to the person with disability, their family and family helpers supported by local community members who were typically health workers. The publication of *Training in the community for people with disabilities*[1] assisted local workers to train and supervise family members. Other publications such as *Disabled village children: a guide for community health workers, rehabilitation workers and families*[2] were also used for this purpose. At this time, CBR programs focused primarily on bringing practical rehabilitation techniques to the community level in the absence of these skills being available at hospitals or health centres in (primarily) low and middle income countries.

Over the thirty-year period since its introduction, CBR has developed across 90 countries in all regions of the world and has changed considerably. The Joint Position Paper issued by the ILO, UNESCO and WHO in 2004 defined CBR as "a general strategy within community development for the rehabilitation, poverty reduction, equalization of opportunities and social inclusion of all people with disabilities"[3] . This paper also confirmed CBR as a multi-sectoral approach which operates at community level to promote people with disabilities accessing services available to all other community members, and focuses on their social, community and economic inclusion. While rehabilitation techniques remain a component of CBR when required, CBR now addresses five key components of health, education, livelihood, social and empowerment reflecting the multi-sectoral approach of CBR. The multi-sectoral approach championed across the UN agencies and represented in the five elements is articulated within the WHO 2010 publication *Community based rehabilitation CBR guidelines*[4] subtitled *Towards community-based inclusive development*.

[1] Helander, E., Mendis, P., Newlson, G., & Goerdt, A. (1989). *Training in the community for people with disabilities*. (www.who.int/disabilities/publications/cbr/training/en/) Introduction. Accessed 14th September 2015.
[2] Werner, D. (2009). *Disabled village children* (2nd ed). Berkeley, California: Hesperian Foundation (http://hesperian.org/wp-content/uploads/pdf/en_dvc_2009/en_dvc_2009_fm.pdf) Accessed 14th September 2015.
[3] International Labour Organisation, United Nations Educational, Scientific and Cultural Organization, World Health Organization (2004). *CBR: A strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities*. (http://www.who.int/disabilities/publications/cbr/en/) Accessed 14th September 2015
[4] WHO (2010). *Community-based rehabilitation: CBR Guidelines*. (http://www.who.int/disabilities/cbr/guidelines/en/) Accessed 14th September 2015.

1.2 Overview of development of training in community based rehabilitation in the Solomon Islands

Community based rehabilitation was introduced into the Solomon Islands in the late 1980s. At this time 5 day intensive training workshops were conducted with personnel from the Cumberland College of Health Sciences (now University of Sydney) WHO Collaborating Centre in Rehabilitation working with rehabilitation personnel and local community workers[5]. These training workshops used adult learning practices to empower local workers to advocate for social inclusion and community participation of people with disabilities by developing a CBR community development program in their local communities. Emphasis was placed on working collaboratively with associations of people with disabilities and people with disabilities in the local community and identifying needs and solutions that were community developed and led. Much of the work needed, as the participants in the Solomon Islands workshops noted, was paying attention to the person not the disability and working to assist people with disability to be included in everyday community life[5].

Following the setting up of the CBR Unit within the Solomon Islands Ministry of Health and Medical Services (MHMS), this unit conducted CBR training during 1994-1996. This was done as a series of workshops in which the CBR workers from around the country attended a six weeks theory component in Honiara followed by return to their communities and back again to Honiara to consolidate their practical learning with additional theoretical components[6].

Three further events influenced the development of training in CBR. Dr Alice Pollard reviewed the CBR program in 2001. The Solomon Islands Government (SIG) endorsed the *Solomon Islands National Policy on Disability* in June 2005[7]. The *Report of the Solomon Islands National Disability Survey 2005*[8] recommended two priority areas for development in disability. The first was institutional strengthening including long term training needs for CBR workers. The second was outreach and networking including capacity building for people with disabilities and their families and community organisations. This report located the central responsibility for developing a Strategic and Implementation Plan with the CBR Unit (CBRU) in MHMS as "at the forefront in providing services and resources to PWDs in all

[5] Twible, R. L. & Henley, E. C. (1993). A curriculum model for a community development approach to community-based rehabilitation. *Disability, Handicap & Society, 81* (1), 43-47. Doi: 10.1080/02674649366780031. Accessed 14th September 2015.
[6] Solomon Islands College of Higher Education School of Nursing & Allied Health Sciences & Ministry of Health & Medical Services. *Full course proposal Diploma in Community Based Rehabilitation.* July 2009. Supplied by Ms Goretti Pala, Course Coordinator, March 2015.
[7] Ministry of Health and Medical Services Community Based Rehabilitation Programme, November 2004. *Solomon Islands National Policy on Disability, 2005-2010.* Accessed 14th September 2015.
[8] Solomon Islands Disability Survey Project, Community Based Rehabilitation Division, Ministry of Health and Medical Services, Solomon Islands Government, July 2006. *Solomon Islands Nationwide Disability Survey 2005. A way forward to working with people with disabilities in Solomon Islands 2006-2010.* Supplied by Ms Elsie Taloafiri May 2012.

provinces"[8] (p. 11). However, it also highlighted the critical importance of a collaborative multi-sectoral approach including government ministries, NGOs, DPOs and faith based organisations to implement the recommendations. Implementation was to take place within the policy context of the *Solomon Islands National Policy on Disability, 2005-2010.*

In response to the training needs of CBR workers, a pilot certificate of CBR (initially planned as an Associate Diploma in Occupational Therapy) was implemented across 2006 to 2008. This was done through a partnership between CBRU-MHMS and the Solomon Islands College of Higher Education (SICHE). Evaluation of this certificate (from which there were 7 graduates) and the presence of Ruth Langmead, an Australian volunteer occupational therapist based at CBRU, led to the development of a full course proposal for a Diploma in Community Based Rehabilitation at SICHE[6] . Following approval of the final curriculum by the Academic Board of SICHE in 2009, the first intake of students began in 2011, with a second intake in 2013 and the third intake in 2015.

2. Current Review of Diploma of CBR at Solomon Islands National University (SINU)

2.1 Overview

The Solomon Islands faces a number of challenges in providing rehabilitation services to people with disability. It features a dispersed population of over 555,000 spread over more than 1000 islands. There are very few specialist rehabilitation professionals available in the country and their services are focused at hospital based services at the national level[9][10]. In this context, in the early 1990s the Solomon Islands embraced community based rehabilitation as a way to bring rehabilitation services to the community.

As noted above, training of CBR workers in the Solomon Islands has been through a number of iterations over the two and half decades since CBR first appeared in the country, with the most recent being the 2 year Diploma of Community Based Rehabilitation at the Solomon Islands College of Higher Education, now SINU.

The opportunity exists, in the context of two cohorts of graduates with a third cohort currently undertaking the Diploma course, to undertake a review of the curriculum in light of recent developments in CBR internationally. At the forefront of these developments was the publication by WHO in 2010 of the *Community based rehabilitation: CBR guidelines*[4],

[9] Llewellyn, G., Gargett, A., Short, S. (2012) *The Pacific Rehabilitation Health Workforce* (Draft submitted to World Health Organization Western Pacific Regional Office)
[10] WHO. Asia Pacific Observatory on Health Systems and Policies. Solomon Islands Health Systems Review. *Health Systems in Transition*, *5(1)*. Accessed 14th September 2015

popularly known as the WHO CBR Matrix and Guidelines. Throughout this document the phrase WHO CBR Matrix and Guidelines will be used.

2.2 Purpose of the review

The specific purpose of the review was to examine the curriculum of the Diploma of Community Based Rehabilitation at SINU within the context of CBR training and education internationally and the national context of CBR in the Solomon Islands. Key questions were developed after consultation with key personnel from the Ministry of Health and Medical Services, SINU and People with Disabilities Solomon Islands who participated in the ALAF Program on CBR Monitoring and Evaluation in Sydney March 2013[11].

2.3 Key questions

1. To what extent does the course curriculum prepare graduates to:
    1. enhance quality of life for people with disabilities, their families and carers by facilitating access to health, education, livelihood and social sectors and
    2. facilitate the empowerment of people with disabilities, their families and carers by promoting their inclusion and participation in decision-making.

2. How well does the course curriculum align with:
    1. the requirements of the health, rehabilitation and disability sectors and
    2. broader employment, training and human resource initiatives in the Solomon Islands?

The review questions were to be answered in two ways. First, the curriculum review question, Key Question 1 was to be answered in the first instance in September – October 2015. This was to be done by desk review of curriculum materials, available documents on the Solomon Islands context, and illuminated by telephone or Skype interviews and email exchanges with the three key stakeholder representatives. These were Elsie Taloafiri, Coordinator, Community Based Rehabilitation Unit, Rehabilitation Division, Ministry of Health and Medical Services; Goretti Pala, Community Based Rehabilitation Course Coordinator, SINU, Ms Ana Burggaraaf, Lecturer, SINU; and Casper Fa'asla President People with Disabilities Solomon Islands.

Following additional discussions/ interviews/ email exchanges on the basis of a preliminary report, a short field visit to discuss the draft report was to be undertaken in early December 2015. Telephone exchange with Dean, Verzilyn Isom, School of Nursing and Allied Health Sciences SINU, identified questions of interest to the university in relation the Diploma of CBR course as follows:

- Does the course meet the standard expected?

[11] Casper Fa'asala, President, Persons with Disabilities Solomon Islands / Elsie Taloafiri, Coordinator, Community Based Rehabilitation Unit, Rehabilitation Division, Ministry of Health and Medical Services / Goretti Pala, Community Based Rehabilitation Course Coordinator, Solomon Islands National University.

- Is the course responsive to need?
- Is there a possibility of the Diploma becoming a degree course?
- Could the Diploma be positioned as a regional course and attract students from around the region?

It was envisaged that a second phase would be required in 2016 to address Key Question 2.

2.4 Methods used in the review

1. Desk review of the literature on Solomon Island disability and rehabilitation context: government reports, national plans, legislation, NGO reports, regional agency reports, internal and external program evaluations.
2. Mapping of the Diploma of Community Based Rehabilitation curriculum to the WHO CBR Matrix and Guidelines.
3. Information gathering and interviews with the 3 key stakeholders named above during the week of September 14th 2015.
4. Follow up visit of 2-3 days in week of December 7th 2015

3. Desk review

3.1 Diploma of Community Based Rehabilitation, SINU Public documents

The public documents about the Diploma of Community Based Rehabilitation are available on the Solomon Islands College of Higher Education website. This Diploma program is situated within the School of Nursing and Allied Health Sciences at SINU. In this context it sits alongside a Diploma of Public Health, a Diploma of Nursing (Pre-service) and a Bachelor of Nursing degree. A description of the Diploma of Community Based Rehabilitation is found at **http://www.sinu.edu.sb/SNAHS/snahsDCBR.html** and attached as Appendix 1.1. Descriptions of the 20 units which make up the two year full time Diploma are found at **http://www.sinu.edu.sb/SNAHS/snahsDCBRUnitDescriptions.html#CPS8** and are included in Appendix 1.2. The entry requirements for the Diploma are found at **http://www.sinu.edu.sb/Forms/SINU%202015%20Course%20Requirements.pdf** and are included in Appendix 1.3.

3.2 Documents provided by Course Coordinator

As with any higher education course, not all documents pertaining to a course are publically available. Additional documents provided by Ms Goretti Pala, CBR Course Coordinator include:

- July 2009 Solomon Islands College of Higher Education, School of Nursing and Allied Health Sciences & Ministry of Health and Medical Services *Full Course*

Proposal, Diploma in Community Based Rehabilitation[6]

- Unit outlines for the 20 units offered to the 2011 intake
- Unit outlines for the 20 units offered to the 2013 intake
- Unit outlines offered for the first 10 unit of studies offered to the Semester 2, 2015 intake

Ms Pala, CBR Course Coordinator also provided a useful narrative of the development of the Diploma from the earliest inception as a certificate program to the current day.

Note that in 2015, SINU reduced the teaching weeks per semester from 16 to 14. The 2015 unit outlines were designed for a 16 week teaching semester; SINU CBR Diploma staff are adjusting teaching content to 14 weeks for units being taught from Semester 2, 2015. Week 15 is retained for review, face to face assessments and study vacation; Week 16 is examination week.

3. 3 Diploma of Community Based Rehabilitation entry, intake and outcomes

Entry requirements for the Diploma of Community Based Rehabilitation course code HDCBR taken from the SINU Course Offerings for 2015 and Entry Requirements document attached in Appendix 1 are:

- High School Education up to level of Form 6 or 7 (Science or Arts) OR
- Previous Education in Public Health or Related Fields AND
- Work Experience/ Employment with CBRU, MHMS and Recommendation for Further Studies by CBR National Coordinator AND
- Verbal and Written English Skills as per Form 5 Education Standard and less than 40 years of age
- Minimum One Month Work Experience with Occupational Therapist, Physiotherapist in the NRH to gain basic understanding of people with disabilities.

In relation to the three intakes into this Diploma of Community Based Rehabilitation the following information was provided by Ms Pala, CBR Course Coordinator.

‘2011 saw the first intake of students for the diploma CBR within the School of Nursing and Allied Health Sciences at SICHE. The first intake was made up of 23 students (13 male and 10 female). They ranged from the ages of 21 to 40 years. 6 of these students had previous basic in-service level CBR training and had been working as CBR aides. The remaining 17 students were all new to CBR and disability. Sixteen out of the 23 students graduated with a Diploma of CBR in December 2012.

The second intake was in 2013 with a total of twenty-seven students (11 males and 16 females). By this time, the government of Solomon Islands had passed and gazetted the act that saw SICHE turned into the Solomon Islands National University (SINU). This cohort was

made up of a majority of young school leavers, and just one matured student who used to be a primary school teacher in one of the provinces. Their age ranges from 20 to 34 years. At the end of their study, 21 of them graduated with a Diploma of CBR.

In 2015, we have the third cohort, a total of 25 students (11 females, 14 males) age ranges from 20 to 40 years. There are 3 in-service students in this cohort who have had some form of CBR training and are current staff of the Ministry of Health and Medical Services'.

Further the numbers for the 1st intake were recommended by MHMS; for the 2nd and 3rd intakes, the number of students entering the Diploma was determined by SINU, with most who applied being admitted. Table 1 details the employing organisation, geographical location and primary role/ function of the graduates from the two completed cohorts.

TABLE 1 EMPLOYMENT OF GRADUATES FROM 2011 AND 2013 COHORTS PROVIDED BY MS GORETTI PALA

Cohort	Employer	Geographical location	Primary role/Function
2011 (16 graduates)	MHMS 7 graduates	2 based at Physiotherapy dept. NRH	National referral hospital rehab aide./CBR worker
		3 based at CBR unit, MHMS headquarter	Therapy and assistive devices for Honiara city council and/or NRH.
		1 based at Gizo hospital, Western Province	Providing rehabilitation for Gizo hospital patients and rural centres
		1 CBR fieldworker at Guadalcanal Province	Rural health centre CBR worker
	SINU 1 graduate	Based at Kukum Campus, SINU Honiara	Teaching of Dip.CBR students
	Bethesda 1 graduate	Bethesda Vocational Centre	Teaching and support for students at the training/vocational centre
	Kirakira Provincial Health 2 graduates	Kirakira Provincial Hospital in Makira Province	Providing rehabilitation for Kirakira hospital patients and rural centres
Cohort	**Employer**	**Geographical location**	**Primary role/Function**
2013 cohort (21	MHMS 1 graduate	Based at Lata hospital, Temotu Province	Providing rehabilitation services for Lata hospital patients and rural centres

graduates)	Redcross Special Development centre 1 graduate	Special development centre, Honiara	Teacher/rehabilitation aide
	Kokonut Pasifiki 1 graduate	Kokonut Pasifiki company, Honiara	Work place job support for persons with disability
	SINU – employed on part time basis 2 graduates	SINU, Kukum campus, Honiara	Engaged in SINU's rehabilitation teaching clinic as masseurs

4. Course structure and units of study in Diploma in Community Based Rehabilitation

4.1 Full Course Proposal 2009

Prior to examining the course structure and units offered in the Diploma course it is essential to understand the foundations upon which this course was built. As noted in the *Full Course Proposal for the Diploma in Community Based Rehabilitation*[6], the course was developed in line with the existing Job Description Form (JDF) of CBRU fieldworkers within the MHMS (p.14).

The major function of the Diploma graduates (built upon the JDF) was "to work with people with disabilities, families and communities at the community level to improve the quality of life of people with disability through providing services, assistance in accessing services, creating awareness and advocating for people with disability" (*Full Course Proposal*[6], p.14). Major areas were delineated as follows: Work with People with Disability, Work with Families of People with Disability; Work with Communities; Administration and Paperwork; Program Management Tasks; and Education Role.

These job descriptors were translated into four course objectives:

Objective 1: Therapy Outreach Skills
Objective 2: Community Rehabilitation Skills
Objective 3: Community Development Skills
Objective 4: CBR Practice Skills and Fieldwork

The course was proposed at Diploma level, to be of two years duration of full time study over 4 semesters, with 20 units in total and 5 units per semester.

Curriculum Development Taskforces were set up for each of the four course objectives of the curriculum. The Therapy Outreach Skills taskforce was primarily drawn from professional

therapy staff at the National Referral Hospital, Honiara. The Community Rehabilitation Skills and CBR Practice Skills and Fieldwork Taskforces were primarily staffed by CBRU with a representative from PWDSI. The final taskforce for Community Development Skills comprised the Course Coordinator who was based at MHMS as an AYAD volunteer and a health promotion representative.

In sum, the Diploma course was built upon an existing job description for CBRU fieldworkers within the MHMS. This job description had been designed from a health and medical perspective focused on rehabilitation. This health and medical/ rehabilitation perspective became the foundation for the curriculum design of the Diploma in CBR. This means therefore that the philosophy (foundation) of the curriculum comes from a health and medical perspective. This is apparent in the details of the course objectives taken from the Full Course Proposal. For example, under Objective 1: Therapy Outreach Skills, the primary task is for students to become familiar with particular impairments and health conditions. Building on this knowledge students will to be able to assess people with disabilities with regard to their functioning in self-care and grooming/ hygiene; leisure and social activities; and work and productivity; and subsequently plan, implement and evaluate and intervention (therapy) program containing short and long term goals to improve function and quality of life.

4.2 Course description, overview and unit descriptions

The Diploma course is situated within the School of Nursing and Allied Health Sciences at SINU. The health and medical curriculum foundation discussed above is consistently represented at each level of documentation. For example, the course description available on the SINU website reads as follows:

The Diploma of Community Based Rehabilitation is a 2 years course designed to respond to the findings of a WHO study of SI population suffering from some form of disabilities. To address this, the course looks at the body functions in Semester 1 and then goes into methods and ways of addressing some of the common disabilities. The course involves a lot of fieldwork for greater student experience and understanding of the various types and forms of disabilities and ways of addressing them (**http://www.sinu.edu.sb/SNAHS/snahsDCBR.html**).

The Course Overview which presents the units by semester and year is located at the same web address. The unit descriptions are accessed by clicking on the first unit of study. Of the 20 units in the Diploma, nearly half (9) are devoted to biological foundations/ medical conditions/ and therapeutic or community health interventions (physical, speech, occupational, and health promotion); a further one-third (8) to Fieldwork and professional practice; with the remaining 2 units addressing community development through project planning and CBR.

This means that the Diploma course is heavily weighted in both theory and practice units to health and rehabilitation interventions at the level of the individual. This is also evident in the unit descriptions which are accessed by clicking on the first unit of study (see http://www.sinu.edu.sb/SNAHS/snahsDCBRUnitDescriptions.html#TOS1).

This health/ rehabilitation perspective is to be expected given the history of how the course developed. It is also to be expected when those most closely involved with teaching the Diploma both from SINU and MHMS and the National Referral Hospital in Honiara (NRH) are allied health/ rehabilitation professionals. In addition, there are very few rehabilitation/ allied health professionals in the Solomon Islands. So there is a high level of observable need and demand for rehabilitation/ allied health interventions which outweigh the services available. This adds another driver to retain a course primarily focused on individual rehabilitation interventions.

In other countries, a health and rehabilitation interventions course of this nature is more likely to be called Rehabilitation Therapy or Rehabilitation Aide or Allied Health Assistant. These courses prepare students to carry out rehabilitation interventions at the level of the individual. As with the Diploma of CBR at SINU they do pay attention to the community context in which the individual lives; the teaching staff have done a commendable job in introducing community content, however the primary focus remains on the individual. The focus is on the individual's health condition or impairment, their current functioning status, and interventions (including assistive devices and equipment) which can improve functioning, quality of life and participation.

In some contexts, Rehabilitation Therapy or Allied Health Assistant courses permit students to specialise in one of the following: Physiotherapy OR Occupational Therapy OR Speech Pathology OR Podiatry. Typically where specialisation is available, all students take prerequisite or foundation units, compulsory common units, and then core speciality units and elective units (see for example, descriptions of such an arrangement in a Certificate in Allied Health Assistance at http://www.royalrehabcollege.com.au/courses/certificate-iv-in-allied-health-assistance/

5. Current international and regional context in relation to CBR

The strong health/rehabilitation foundation of the Diploma of CBR at SINU is in contrast to regional and international developments in community based rehabilitation since the early 2000's. As noted above, for the last decade CBR has been understood as a community development strategy first and foremost. CBR as a *community inclusive development strategy* is designed to reduce disadvantage for people with disabilities and to advocate for

their inclusion in all levels of community life, thus equalising their opportunities with their non-disabled peers[4, 5,12, 13].

This community development orientation comes from a human rights and equity framework aligned with the UN Convention on the Rights of Persons with Disabilities[14]. As noted in the WHO CBR Matrix and Guidelines: "Inclusive development is that which includes and involves everyone, especially those who are marginalised and often discriminated against "[4] (p.20). The focus of community inclusive development strategies therefore is not the individual with disabilities and their health and rehabilitation needs (although if relevant these are addressed) but rather a focus on building strong communities where people with disabilities participate in all aspects of everyday life as do their non-disabled peers – in attending school, receiving health care, having a livelihood, participating in social and cultural events, and becoming empowered, advocating with others for equality of opportunities for people with disabilities.

Over the six year period since the initial course proposal for the Diploma of CBR there have been significant international, regional and sub-regional developments in community based rehabilitation. Some of the publications and events during this time include the release of the WHO *Community based rehabilitation CBR guidelines* in 2010[4], the *World Report on Disability* in 2011[12], the 1st Pacific Islands Community Based Rehabilitation Forum in June 2012, the 1st CBR World Congress in Agra in November 2012, and the WPRO Consultation Meeting for the Pacific and South East Asian on the Global Disability Action Plan in Manila, October 2013. Key stakeholders Goretti Pala, Community Based Rehabilitation Course Coordinator, SINU; Elsie Taloafiri, Coordinator, Community Based Rehabilitation Unit, Rehabilitation Division, Ministry of Health and Medical Services; and Mr Casper Fa'asla, President People with Disabilities Solomon Islands, have also been involved in one or more DFAT funded ALAFs in Australia in this time.

5.1 Recent regional documents

Three recent regional documents clearly articulate the human rights, equalization of opportunities, and equity foundations of CBR for the Pacific. The first document is the Communique, *First Pacific Islands Community Based Rehabilitation Forum*, held at Nadi, Fiji, June 2012 which explains this community inclusive perspective on CBR. This was a far-sighted document in light of the recent developments to consider CBR as fundamental to community based inclusive development. In the Pacific where CBR is now keenly sought but yet to be well established (except in a few countries), CBR is a solid foundation for governments and civil society to implement the processes of community based inclusive development (CBID). Community based inclusive development is about bringing all

[12] WHO (2011) *World report on disability*. Geneva: WHO. Accessed 14th September 2015.
[13] UNESCAP (2012). *Incheon Strategy to "Make the Right Real" for persons with disabilities in Asia and the Pacific.* Bangkok: UNESCAP. Accessed 14th September 2015.
[14] United Nations (2006). *Convention on the rights of persons with disabilities*. Accessed 14th September 2015

stakeholders together to implement strategies to include all people in the community who are particularly vulnerable to poverty and disadvantage. This includes people with disabilities, older people and particularly older women faced with poverty. Community based inclusive development is also about including all children (boys and girls and those living in remote, inaccessible places) in school with educational opportunities to ensure sustainable livelihood development for all.

Note that several points in the Communique stress the community based inclusive development potential for CBR in addition to points which specifically address involvement of people with disabilities. These points begin as follows:

- CBR is a strategy that can be used to disseminate and implement the CRPD
- CBR is a comprehensive inclusive development strategy
- CBR is a dynamic, progressive and evolving strategy
- CBR is a strategy in which persons with disabilities play a central role, define their own needs and become empowered
- CBR builds strong equitable communities
- CBR is a catalyst for change in individuals, families and communities
- CBR is an effective strategy in all areas of development, including health, education, livelihoods and social development
- CBR benefits the whole community and not only persons with disabilities

The contribution of CBR to community based inclusive development will be highlighted further in the recommendations in this report.

The second regional document is the *Pacific CBR Plan of Action 2012-2014* which built on the work done at the 1st Pacific Regional Forum in 2012 and particularly on the points noted in the Communique. There are 6 objectives contained within this plan all of which have detailed actions to implement the objectives.

Of relevance to this Report is Objective 5 which states:
To increase human resource capacity for CBR in the Pacific and ensure people with disabilities are integrally involved in this. Under this objective there are five actions (page 8 of the *Pacific CBR Plan of Action*). Two of these five actions specifically address educational institutions in the Pacific. These two actions are:

- Support utilisation of the forthcoming WHO CBR Guidelines training package in the Pacific
- Increase CBR training opportunities for people with a disability.

These two actions: utilising (or developing) training packages for CBR and increasing CBR training opportunities for people with a disability will be discussed further in the recommendations section of the Report.

The third regional document that is relevant to this Review comes from the CBR Asia-Pacific Network. Their website is at **http://www.cbrasiapacific.net/**. Their Mission statement (in

part) reads:
"The main goal of CBR is "Community for All" with persons with disabilities as contributors and "Agents of Change" in their countries. We promote an inclusive, barrier-free and right-based society for all." This is in line with the 2010 WHO CBR Matrix and Guidelines which is subtitled *Towards community-based inclusive development*. The focus in the WHO document on community-based inclusive development is often overlooked. This is unfortunate although not surprising given that many of the earlier CBR programs (1980s-1990s) focused primarily on health and rehabilitation of people with disabilities at the community level. The paradigm shift which has been occurring since the establishment of the CRPD and the publication of the 2010 WHO CBR Matrix and Guidelines has yet to be fully implemented in CBR training programs (and CBR programs) around the world. Regrettably there is still some way to go before people with disabilities are consistently regarded as contributors and agents of change in their countries and where community for all means everyone in the community regardless of age, gender, impairment or disability, poverty, and ethnicity.

5.2 Second Pacific CBR Forum

The 2nd Pacific CBR Forum was held in Nadi, 29th-30th September 2015. Pauline Kleinitz, Technical Lead, Disability and Rehabilitation, WPRO, WHO in her presentation to the Forum summarised CBR and service development in terms of needs, progress and future steps for the Pacific countries. She noted the critical importance of CBR as Community-based Inclusive Development (CBID) in which empowerment is the nucleus or foundation of any CBR program. She also noted that people with disabilities and their family members need to be leading decision-making processes, with nothing imposed on people with disabilities and their families. Rather in line with CRPD, persons with disabilities and their families are enabled to achieve equal rights and opportunities.

Ms Kleinitz also provided a useful historical perspective on CBR in the Pacific noting that it had existed for 10 years or more in PNG, Fiji, Solomon Islands, Samoa and Vanuatu – and that there was renewed support for CBR since the 1st Pacific CBR Forum in 2012. She further noted that the joint approach between Pacific Disability Forum, Pacific Island Forum Secretariat and WHO had worked to provide direct support to countries to improve and strengthen existing CBR programs as well as direct support to countries to develop new CBR programs and building regional capacity development and information sharing.

Ms Kleinitz summarised the specific **Pacific Flavour** to CBR as follows:

- Rights based approach – in line with CRPD
- CBR supports implementation of national disability policies
- Government ownership of CBR programs
- For new CBR programs, promotion of lead disability ministries to take ownership of CBR
- For established CBR programs, encouragement in line with CBR guidelines to broaden the focus of CBR from health to the other components

- Building on the Pacific Strengths, especially strong communities and families.

The Pacific flavour to CBR as articulated above, the regional CBR documents described above and the recent 2nd Pacific CBR Forum are all important components of the context in which CBR in the Solomon Islands is developing and particularly the approach, focus and content of the Diploma of CBR at SINU.

6. Overview of Diploma offered in 2011, 2013, 2015

Examination of the documents available for this Desk Review include the *Full Course Proposal* and the 20 unit outlines for the first two cohorts of 2011 and 2013 and the course schedule, overview, unit descriptions and 10 unit outlines for the current stage of the 2015 offering. These show that overall the curriculum remains essentially the same as the one proposed in 2009.

The first year of the course is primarily dedicated to theory courses (units) with Fieldwork Practice integrated in both semesters, with one day per week in Semester 1 and 2 days a week in Semester 2. The second year of the course follows a different pattern with substantial clinical practice block placements in semesters one and two. In Semester 1, Year 2, two theory courses of 6 weeks duration occur alongside a Fieldwork unit of one day per week. This is followed by a two weeks block of the WHO Wheelchair Service Training Program -Basic course with the remaining weeks of semester comprising a 6 week block Clinical Practice placement.

Review of the unit of study outlines for each intake year demonstrates iterative changes built on the experience of the Course Coordinator and staff teaching on the Diploma including occupational therapists on placement from Australian Volunteers International and staff from local NGOs and MHMS staff. MHMS –CBRU staff, SINU teaching staff and members of PDWSI have been involved in international (CBR conferences) and regional opportunities over the past five years. In addition, there have been learning opportunities for PWDSI funded by Australian Aid - Australian Leadership Award Fellowships (ALAFs) and Disability Rights Fund (2009, 2010, 2011), and more recently an Australian Development and Research Award (ADRA) 2012-2016 with Monash University. Despite these building capacity initiatives for PWDSI members, the organisation and its members appear to have very little input into, or involvement with the Diploma course. This is most unusual given the emphasis that is placed in publications on CBR (e.g. WHO CBR Matrix and Guidelines[4]) of the critical importance of engaging people with disabilities in planning, delivering and monitoring and evaluating CBR programs and training.

Availability of new international documentation and regional work-shopping of materials such as the WHO CBR Matrix and Guidelines, and professional development for those

involved in the Diploma course such as through ALAFs, have begun to influence unit content. For example, in the 2011 course the foundation resource in the unit CRS1 Introduction to Community Based Rehabilitation was the 2004 ILO, UNESCO and WHO Joint Position Paper[3]. By 2015, the foundation resource for CRS1 is the WHO CBR Matrix and Guidelines[4]. In addition, the WHO CBR Matrix now forms the structure for five weeks teaching in CRS1. Each of the five weeks addresses an element of the Matrix illustrated by case studies. As yet however, content from the WHO CBR Matrix and Guidelines has not found its way into the other 19 units in the Diploma course.

Another example comes from the integration of an international standard course available on wheelchair prescription into the curriculum. The unit TOS7 Seating and Positioning, usually offered in 1st semester 2nd year has been replaced. This unit content was based on Motivation Australia's Fit for Life Training program. The replacement material is the WHO Wheelchair Service Training Program-Basic (WHO WSTP-B). This is typically offered as an intensive block course of 5 days training with an additional 3 days clinical practice. WSTP-B was piloted in this format in May 2012 with all 18 students from the Diploma course. This 5 day time frame was considered too short for deep student learning, thus the WSTP-B will now be offered in the Diploma as a 2 weeks block training unit in Weeks 7-8 of Semester 1, Year 2.

Over the five year period in which the course has been offered three times – 2011, 2013, and 2015 – there have also been changes in the documentation for each unit. This is commensurate with a course which began in a college of higher education and is now offered at the national university. Typically there are more details provided in the 2015 unit outlines on unit learning outcomes, unit assessment, assessment description, supplementary examination, teaching hours and methods, and the teaching schedule with week, theory content, hours and tutorial supplemented by recommended textbooks or readings.

Some 2015 unit outlines however remain under-developed with few or no textbooks or references cited. Instead where textbooks are not available, selected readings and resources are given to students in a binder. This is a practical approach to providing a 'handy' manual and particularly for those students who work in more remote rural areas where there is little or no access to internet resources. An example of this is TOS5 Activity as Therapy which includes expansive readings and resources within the unit outline.

The efforts of the teaching staff in attempting to incorporate up to date information from conferences, courses and new international and regional publications are to be applauded. That said the overall course structure and units of study remain essentially the same as in the initial curriculum, partly due to the detailed and intensive process required to change content. Similarly the content and resource materials for most units of study remain essentially the same as offered to the initial intake of students in 2011.

Iterative adjustments year to year at the unit level are typical in higher education courses without substantive changes in overall course structure and reorganisation or redesign of

units of study. In many higher education institutions, to make sure substantive changes can be made if required, there are mandatory schedules for course reviews. These schedules typically work on a five year cycle and require an extensive and full course review, involving Academic Board, staff, students, graduates and external stakeholders. This process provides the opportunity for and actively encourages in-depth analysis of a curriculum at all levels. This means review of all components of the curriculum including the philosophical/ theoretical foundations as well as the course structure, sequencing of units, unit content and resources and materials.

6.1 Tension in Diploma of CBR

There is an inherent tension in the Diploma of Community Based Rehabilitation which is likely to increase over time without substantive changes in the course. This relates to the curriculum foundation based on a health and medical/ rehabilitation perspective compared to the current understanding of CBR as a community inclusive development strategy within which rehabilitation is only one component within one of five elements (health).

The tension is also derived from the course as initially proposed in June 2009 coming from a certificate course originally designed as an Associate Diploma of Occupational Therapy. This philosophical foundation is reflected in unit names and content. For example, titles such as Professional Practice, Fieldwork, and Activity as Therapy reflect a rehabilitation therapy theoretical and practice orientation. Further, the specificity and content of units devoted to Foundations of Physical Therapy and Physical Rehabilitation (of which there are two) and Foundations in Speech Therapy reflect the course orientation towards individual rehabilitation treatment/ intervention planning. In other words, the primary orientation of the Diploma course is about providing rehabilitation services to address activity and self-care, mobility, seating and positioning, and communication for individuals with disabilities within the community.

This approach which is useful for a Rehabilitation Therapy or Therapy Assistant course is in contrast with the accepted human rights and equalization of opportunities foundation which underpins the international understanding of community based rehabilitation. For example, the opening lines of the 2004 ILO, UNESCO and WHO Joint Position Paper reads as follows: “Community-based rehabilitation (CBR) promotes collaboration among community leaders, people with disabilities, their families, and other concerned citizens to provide equal opportunities for all people with disabilities in the community”[3] (p.1).

The WHO CBR Matrix and Guidelines align with the UN Convention on the Rights of Persons with Disabilities. The Matrix and Guidelines document clearly states that “CBR is a multifaceted bottom-up strategy which can ensure the Convention makes a difference at the community level. While the Convention provides the philosophy and policy, CBR is a practical strategy for implementation. CBR activities are designed to meet the basic needs of people with disabilities, reduce poverty, and enable access to health, education, livelihood and social opportunities – all these activities fulfil the aims of the Convention”[4] (p. 26).

Article 27 Habilitation and Rehabilitation of the Convention states that habilitation and rehabilitation programs "enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life"[14] (Article 27). Clearly health and rehabilitation programs are fundamental to active participation in the community. However in and of themselves they do not constitute, for persons with disabilities, full inclusion and participation in all aspects of life which is the aim of community based rehabilitation.

Further in the WHO Matrix and Guidelines, health is only one of five elements. The other elements are education, livelihood, social and empowerment. Within health, rehabilitation and assistive devices are only two of five components. The other four are health promotion, prevention, and medical care. As noted in the WHO CBR Matrix and Guidelines, " In addition to implementing specific activities for people with disabilities, CBR programmes will need to develop partnerships and alliances with other sectors not covered by CBR programss to ensure that people with disabilities and their family members are able to access the benefits of these sectors"[4] (p.24).

The Italian Aid Agency, AIFO have produced an on-line introductory course explaining community based rehabilitation. This course which based on the WHO CBR Matrix and Guidelines that can be found at **http://english.aifo.it/disability/courses/basics_cbr/index.htm**. After a general introduction to CBR the course explains each of the five components. At the end, there are some self-test questions. This on-line course is a very useful starting point to begin discussions about the foundation/ philosophy that is required for training programs in CBR. And, in particular, how a curriculum might be structured to ensure that graduates are prepared to work in ways consistent with the WHO CBR Matrix and Guidelines.

Currently, the strong health and medical/ rehabilitation and therapy foundation of the SINU Diploma of CBR offers very few opportunities to bring recent developments in international thinking and published material on CBR into the curriculum. There are only (at best) three units which openly articulate a community (rather than an individual) orientation. It would be possible to rewrite these to include up to date human rights/ equity/ community inclusive development approaches to CBR. However these units would still remain as less than one-seventh of the Diploma program. This is a very important point. Students derive their perspectives and their understandings of their role as graduates from the orientation of the curriculum. When a curriculum has a strong health and medical/ rehabilitation/ therapy orientation focused on providing services to individuals, this is what students will expect to do as graduates. (It is also what others expect them to do as this is what the course they have studied prepares them to do).

In contrast, when students are in a course with a strong community inclusive development foundation, they expect to be community facilitators. This means working with DPOs and self-help groups in the community, developing relationships with other sectors and advocating for people with disabilities to have equitable opportunities in daily community

life. (And again, this is what others expect them to do, as this is what their course has prepared them to do). Their efforts then are not focused on providing services to individuals. Instead their efforts are focused on working with each sector – education, livelihoods, social, community as well as health – as all sectors impact on the lives of people with disabilities.

7. Approaches to CBR training internationally

7.1 Overview of development of CBR training models

The CBR worker is pivotal in the realisation of CBR as outlined in the WHO Guidelines (Mannan et al, 2012; Mannan & MacLachlan, 2010). As CBR has advanced around the world, the issue of the skills required to be a CBR worker and the type and level of training have surfaced. Initially, and in some countries, those implementing CBR were health-related rehabilitation professionals who saw CBR as an excellent way to bring basic rehabilitation techniques to the village level (Thorburn, 2000). This approach was particularly popular where villages were isolated from major centres, travel distances were great, and there was no or very little outreach of health-related rehabilitation services from major hospitals in urban centres. In these countries when training for CBR workers was introduced it was most likely to be planned and implemented by health rehabilitation professionals and within this medical/ health and rehabilitation/ therapy perspective (as was the case in the Solomon Islands).

In other countries where non-government organisations were working at the community level, they saw in community-based rehabilitation, an opportunity to bring a human rights and equity approach to including people with disabilities in their local communities. This model was popular in those countries with strong local community governance and where NGOs and INGOs were very active building on the ideas promoted in the 1993 *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*[15] which was the precursor international instrument to the UN Convention on the Rights of Persons with Disabilities. In these countries, when training for CBR workers was introduced, it was most likely to be planned and implemented by NGOs and INGOs in the development sector utilising community development/ empowerment approaches (as was the case in some countries in the African sub-continent) (Ojwang & Hartley, 2002).

In practice CBR programs on the ground have developed in response to the local context and vary greatly. They do not have a unified purpose, neither are CBR programs static (Thorburn, 2000). Rather these programs develop over time in relation to changing needs in the country

[15] United Nations (1993). *The standard rules on the equalization of opportunities for persons with disabilities*. New York: United Nations. Accessed 14 September 2015

context, to influences from national, regional and international trends in CBR, and, in some areas of the world, to rapid country development with expanding expectations of the services (including health rehabilitation) which ought to be provided by government for all in the community.

In sum, the way in which CBR programs have developed depends on the context. The WHO CBR Matrix and Guidelines[4] for example provides an Annex (pp. 67-70) in the Introductory Booklet with four different management structures for CBR: CBR programs at local level, CBR programs at district/ sub-district level by local government or NGOs; CBR programs by public-private partnership; and CBR programs by Ministry of Health. These four different examples of management structures illustrate the variety of organisational approaches to CBR. Program development, design and management structure all influence the location of training, curriculum foundation, level and length of training and expectations of graduates in their CBR worker role.

Turmusani, Vreede & Wirz (2002) in discussing ethical issues in CBR programs suggest a more detailed analysis of the existing types of CBR programs. For these authors, the first type is programs which provide effective rehabilitation activities for children and adults with disabilities. This type of program is easily recognizable as CBR as health rehabilitation (and was described briefly above). The second type of CBR programs are those that work with communities to ensure people with disabilities are included in the community. This type was also described briefly above and can be thought of as CBR programs addressing equalising opportunities. The remaining four types of CBR programs identified by these authors could be thought of as sub-types of CBR as equalising opportunities model. The areas of focus for these remaining four are:

- Mainstreaming such that all community development programs should include people with disabilities and the CBR program focuses on facilitating this
- Poverty is the most important issue for improving the lives of people with disabilities therefore income generating activities or loan schemes are the primary activity
- DPOs are emphasized as the providers of services as they are most appropriate for assisting people with disabilities
- The inequality of the position of people with disabilities in the community is highlighted such that the CBR program focuses on addressing societal and attitudinal barriers.

Several writers have focused their attention on the multi-skilled nature of the role of the CBR worker. Not surprisingly, the type of program (as per above as health rehabilitation OR as equalization of opportunities) to which the authors refer influences the type, level, and nature of the skills thought to be needed for CBR workers. The WHO CBR Matrix and Guidelines acknowledges the wide range of CBR training programs that exist. To illustrate the relationship between philosophy or nature of CBR and the objectives and expected outcomes of training programs we have analysed a number of CBR training programs from different continents. The results of this analysis are included as a table in Appendix 2.

The foundation for this analysis was the two contrasting types of CBR programs as already described. Review of readily accessible training programs online and accompanying relevant materials resulted in determination of each training program as primarily the first type – that is, health rehabilitation, described in the table as *individual rehabilitation intervention* or the second type, that is addressing equalization of opportunities described in the table as *inclusion in community and empowerment.* As can be seen from this table in Appendix 2 and as noted in the WHO CBR Matrix and Guidelines, "(they) are all different in terms of their content and duration, and offered by a variety of providers. For example, in some countries tertiary institutions offer diploma course for CBR personnel, whereas in other countries training programs many not be accredited and may only last for a few weeks or months"[4] (p. 55).

7.2 Issues discussed in the literature in relation to CBR training programs

To identify papers addressing CBR training programs, an expansive (but not exhaustive) three stage search process was undertaken. The first stage was a Google scholar search using the search terms community based rehabilitation and qualification" and "community based rehabilitation and diploma". The reference lists of these papers were then hand searched for additional references addressing CBR training. At the same time, experts in the field of CBR and particularly CBR training were contacted. Emeritus Professor Sally Hartley provided helpful assistance including the on-line repository of *Community-Based Rehabilitation (CBR) as a Participatory Strategy in Africa* (Hartley, 2002) an edited collection of papers from a 2001 conference in Uganda which addressed many issues in relation to CBR program development, implementation and training. The third stage was the identification of online information about CBR training courses which was then analysed and presented in Table 2.

There are four primary themes evident in this literature about training for CBR programs. These are: underlying concepts of disability; expected role of CBR personnel; breadth of skill set required; and, expectations of the training program. Each is discussed in turn.

7.21 Underlying concepts of disability

This theme speaks to the tension inherent in the SINU DipCBR mentioned earlier. That is, training programs which have been designed based on a health and medical/ rehabilitation and therapy perspective attempting to incorporate the more recent (2000s and on) thinking about CBR as a community inclusive development strategy. Wirz (2000) identified this tension, clearly noting that professional therapy training programs have historically been based on an impairment or medical model of disability. She notes that this is also inconsistent with a rights based framework in which disability is understood as arising from barriers to participation in society.

Wirz (2000) goes on to argue that in a medical or impairment model the professionals are regarded as experts with knowledge in diagnosing and treating impairments that they pass on to service users at their discretion. This sets up a power imbalance between professional and service user and is counterproductive to an ethos of empowering people with disability. It is also unlikely to focus attention on the environmental and social barriers, given that the focus is on impairment rather than the interaction of the person with disability and their environment. For Wirz (2000) there are a number of strategies that therapists trained in this medical/ impairment model need to embrace in order to work effectively in CBR programs. These include: Giving up exclusive rights to knowledge about impairments; working as trainers; developing referral patterns; listening to people with disabilities and framing intervention around disability rather than impairment; and, being innovative in service planning.

A later paper by Rule (2013) is useful to understanding the outcomes of a CBR training program which was changed following the release of the WHO CBR Matrix and Guidelines. She noted that there was inconsistency between the stated objectives of the course and the delivery of course content, resulting in confusion for students in terms of their understanding of disability. For Rule (2013) it is critical that there is coherence between values and ethos, official documentation, and delivery of training to not send *mixed messages* to students. She offers some practical suggestions for training delivery that is consistent with a 'CBR as equalization of opportunity' program. These include employing empowered people with disabilities as trainers to provide relevant role models for students. Settings for field training are also considered critically important. Practical experiences in hospitals and health services overtly (and covertly) reinforce a health/medical impairment orientation. Whereas, placements with NGOs or DPOs working in the community and focusing on advocacy and inclusive development provide exemplars for a curriculum founded on an equalization of opportunities approach.

7.22 Expected role of CBR personnel

In her 2000 paper, Wirz (2000) refers to three types of CBR personnel which are found in some contexts (although not in others). She identifies: Grass roots (level one) workers who deliver service in a community; mid-level workers who organise and support these workers; and professionals to whom referrals can be made from the community or who refer users to the community. This paper primarily discusses mid-level worker training as in the African context, as Wirz (2000) notes much of the training is focused at this level. However even here where this level of worker is relatively common there is variation in the role that they play. She asks the question: are these mid-level workers primarily supervisors or are they program managers? How their role is understood and constructed will influence the type of training they receive (or more precisely, ought to receive). She postulates for example, that if the role is primarily one of supervisor, then this mid-level worker will require training that focuses on skills and knowledge that they can pass on to the grass roots worker. If however, the CBR mid-level worker is primarily a program manager they require management and problem solving skills.

Workforce for CBR is a major theme for authors writing about CBR. This is particularly so in the absence of agreed international, regional or national CBR training standards (and purpose, context, level, content and so on). In this situation, the training considered necessary will reflect the types of CBR programs with which stakeholders are familiar. In other words, the role of the CBR worker will vary from program to program and will reflect the way in which that program has evolved to meet need in the local context (Ojwang & Hartley, 2002; Sharma & Deepak, 2001). In addition, the roles that CBR personnel will take on as graduates clearly influence the type of training they receive (this is discussed in more detail below).

A frequently posed question is: Will the training focus on skills and knowledge, or will it focus on problem solving and creative thinking? If a CBR program is primarily health rehabilitation, it is more likely to require training which emphasizes the supervisory role from its mid-level workers. This is because the focus in such a program is on provision of skilled intervention for individuals. On the other hand if a CBR program focuses on equalization of opportunities, training addressing management skills would be more appropriate. This is because graduates will be required to coordinate different strategies for building relationships across sectors, facilitating access to services, advocacy and empowerment work with persons with disabilities and their families.

7.23 Breadth of skill set required

Several authors have commented on the breadth of skills required for CBR personnel irrespective of the program type **(**Maclachlan, Mannan & McAuliffe, 2010; Fabian, McInerney & Rodrigues, 2005). So for example, in CBR as health rehabilitation programs, personnel require skills across multiple professions (such as physiotherapy, occupational therapy, speech pathology) and knowledge of many different health conditions (predicated on providing interventions related to impairment type). In CBR programs which address equalization of opportunity other skills are required across a broad range of information provision, advocacy, negotiating, facilitating, building relationships, community building, and building capacity in empowering activities. Courses which have attempted to integrate an equalization of opportunities approach into an existing health rehabilitation curriculum face certain difficulties. Although individual units may focus on one or other of the two program types identified, the proportional weighting of each approach needs to be considered as well as the *mixed messages* that students are likely to receive.

The difficulty with integrating two quite different philosophical approaches into one curriculum led Maclachlan et al. (2011) to suggest that CBR training would be significantly advanced if training programs were based on a skills needed model rather than a staff type approach as is currently the case. So for example where currently units may be titled *foundations of physiotherapy* this assumes that the skills 'owned' by physiotherapy are relevant to CBR personnel. The alternative approach proposed by these authors, is the identification of the tasks required by CBR personnel as suggested in the WHO CBR Matrix and Guidelines. Training programs would then be developed based on needed skills not professional identities.

Along these lines, Lorenzo, VanPletzen and Booyens (2015) sought to identify the competencies of community disability workers (CDWs) in rural areas of South Africa, Botswana and Malawi. They interviewed community disability workers about their work experiences and identified three themes of competencies: integrated management of health conditions and impairment within a family; negotiating for disability inclusive community development; and coordinated and efficient inter-sectoral management systems. These authors concluded that the community disability worker position (the term used in their study) must be recognised as a cross-disciplinary role. Note that the latter two themes fit well within a CBR program as equalization of opportunities approach. However, the first theme may be more relevant in a CBR as health rehabilitation program. This finding illuminates the tensions that may exist within CBR programs (and therefore the competencies identified by workers in those programs). It also suggests the urgent need to attend more closely to the training needs of CBR workers so that they are well trained to work within the WHO CBR Matrix and Guidelines approach.

A frequently posed question is how much time ought to be dedicated to each area within the syllabus. Rule (2013) undertook to answer this question by analysis of a CBR course in South Africa that included empowerment as a key outcome. Her analysis of the teaching program demonstrated that despite this particular key outcome, almost half of the time was dedicated to health based interventions. She suggested this reflects the underlying philosophy of the CBR training course. This provides another example of the importance of a coherent and consistent suite of units of study aligned with the curriculum/ foundation. It may be the case that since the release of the WHO CBR Matrix and Guidelines that some (or perhaps many) CBR training courses have taken on some components and key objectives as part of their curriculum language but have not yet changed the overall curriculum philosophy to embrace the change from health rehabilitation to equalization of opportunities.

It has been observed that many CBR training programs are affiliated with health professions either in the host institution or the professional background of educators who design and teach the CBR program. This is the case for example with the Diploma of Community Based Rehabilitation located within the School of Nursing and Allied Health Sciences at SINU. It is also the case with the one year Certificate in Disability and Community Based Rehabilitation at Fiji National University. This course is based in the College of Medicine, Nursing and Health Sciences at this university.

Rule, Lorenzo and Wolmarans (2006) describe the difficulties that can arise from this affiliation. In South Africa she notes that a cadre of community rehabilitation facilitators (CRFs) were trained by a program that was started at the Institute of Urban Primary Health Care and continued at CBR Education and Empowerment (CREATE). The course attempted to integrate rehabilitation therapy skills and social inclusion. Interestingly, the CRFs were allowed to register with the Occupational Therapy Board which then permitted their employment within the Department of Health. However the outcome of this was that the

CBR training required accreditation (as per the Occupational Therapy Board requirements). The changes required by the Board demanded a focus on Occupational Therapy skills which is not surprising. However these changes would not be reflective of the CBR programs in which CRFs work and that provide services that are broader than therapy alone. Unfortunately it was not possible to find out how this situation was resolved (or not).

7.24 Expectations of training

The last theme which is evident in the literature is that of potentially differing expectations between educators and students (trainers and trainees, in some contexts). Wirz (2000) identifies three areas where expectations may diverge.

The first of these is in relation to the objectives of training. For example, are the reasons that students undertake a course the same as the reasons for educators/ trainers that offer the course? Students could have a range of reasons underneath their motivation and desire to do a CBR training course. These could include greater chance of employment, improving skills and knowledge, or interest in and desire to improve the lives of people with disabilities. This could influence the extent to which they learn what the course providers have identified as objectives for the course. In some courses, a weighting is given in relation to entry criteria for people with disabilities, and for students who have a family member or are familiar with people with disability. This is one way in which the philosophical foundations of a course oriented to equalization of opportunities can be made transparent and put into action.

The second is related to training process. The question here relates to what do students undertaking the course expect from the type of training they will receive? What style of learning are they used to from previous education experiences? In courses which accept high school leavers, experienced community development personnel, and people with disabilities for example, the students' background education experiences will be diverse and potentially not compatible. An additional concern expressed by Wirz (2000) is that in many educational systems a passive style of learning is pre-eminent. Students entering a CBR training program from high school (or indeed as mature age learners) may have a great deal of difficulty with teaching styles and learning materials which require problem solving and creativity. This is particularly problematic in CBR training programs which address equalization of opportunities given the inherently flexible and accommodating approach that students need to learn to work effectively with the needs of the community, available resources, collaborative (or not) partnerships and so on.

The third area relates to course content and expectations of learner outcomes. The questions here become: Are the course participants expecting to learn facts or develop the ability to find answers? Are they expecting to develop skills or increase their confidence as practitioners? Clearly the stage at which the students enter the training program can influence the second question. For example currently in the 2015 intake for the SINU DipCBR there are students who are currently employed as CBR personnel. Their expectations and the prior learning they bring to the training program will differ markedly from that of the

majority of students who are school leavers. Further, CBR programs that primarily promote health rehabilitation techniques require greater absorption of facts. This is because emphasis is placed on learning about medical diagnosis, impairments and health conditions. Rehabilitation techniques too need to be learned and mastered (typically under supervision) to ensure that the student will graduate as a safe, competent beginning practitioner.

These requirements are in stark contrast to those in a CBR training program which primarily come from an equalization of opportunities standpoint. (That is, knowledge of the lives of people with disabilities in their local context understood within the international human rights and equity perspective embodied in the UN Convention on the Rights of Persons with Disabilities and practically applied in the WHO 2010 CBR Matrix and Guidelines). In this case, the student must work to understand and embody attitudes of equal participation about people with impairments, and understand the disabling influence of social, physical and cultural environments. And, they must work to do this in the face of community attitudes of stigma, and de-personalisation and exclusion of people with disabilities and their family members. They are required to review and reflect on how they too embody these negative community attitudes (as a member of their community). They need to learn skills and strategies to negotiate through and across the disadvantage and discrimination involving the people with disabilities with whom they work. This understanding requires a different order of learning (and practice) to that required to learn rehabilitation therapy techniques. In sum, the philosophical foundations of the CBR programs in the local context and the expected role for CBR workers will influence the design and implementation of training in the three areas outlined above.

7.25 Conclusion

This brief analysis of the collated literature highlights the critical importance of identifying and making transparent the philosophical foundations – the curriculum foundation – before considering whether a particular education or training program is appropriate for a particular context or setting. Too often, educational programs attempt to meet 'everyone's demands'. In the context of CBR that may mean health rehabilitation at the community level (as in the earlier iterations of CBR) as well as equalization of opportunities (in line with the UN Convention and the WHO CBR Matrix and Guidelines).

The literature point to the importance of, in the first instance, identifying the purpose of the curriculum not only as it is written in the official documents but also by analysis of the setting in which it is hosted. Secondly, it is critical to identify the drivers in the university and community that are influencing the course educators and the host institution in developing the curriculum and offering the CBR course. And thirdly, the need to identify the shared (or not) understanding by the key stakeholders of the purpose and intent of the CBR training program and the philosophical foundation on which it is based. When there is a shared understanding of these matters, the course curriculum will more closely align with the multiple (and often competing demands) placed on course content, educators and the students who undertake the program.

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8. Reflections from key stakeholders to exposure draft

The exposure draft was delivered to four key stakeholders from SINU, MHMS and PWDSI in the last week of September 2015. Their responses provide further insights into the development of CBR training in the Solomon Islands, the current staffing context related to CBR designated positions, the resources demands and lack of consistent staffing and stability in the DipCBR, and their perspectives on ways forward for CBR training in the Solomon Island context.

8.1 CBR designated positions in the Solomon Islands

The Ministry of Health and Medical Services is the designated focal point for disability in the Solomon Islands. There have been some changes in structure within this ministry with the physiotherapy department incorporated into a Rehabilitation Division. This Division along with the CBR department within this division comprise the focal point for disability.
Staff designated for CBR are employed primarily by MHMS. Some are permanent public servants; others are direct wage employees and particularly this is the case in the provinces. There are a small number of the just over 30 designated CBR staff in the Solomon Islands (number supplied by Ms Elsie Taloafiri) employed by a department or agency other than MHMS. These are 1 employed by Ministry of Education and Human Resource Development, 3 by Kokonut Pacifiki, 1 at Bethseda Disability Centre and 2 at SINU. Also, although MHMS positions are designated as CBR Field Workers not all are filled by DipCBR or previous SINU qualified staff. Five of the positions include untrained CBR workers who are waiting for MHMS scholarships to undertake the SINU DipCBR. Others may be filled for example in Maliata by a Physiotherapist or worker designated as Prosthetic Technician (to undergo training in 2016). It is also the case that DipCBR graduates enter MHMS positions at Level 4/5 and are expected to undergo a 6 month internship. On successful completion of this they may be offered a public service post at Level 5.5. Table 2 presents information on the current MHMS CBR designated public servant positions by province and training qualifications.

TABLE 2 MHMS PUBLIC SERVANT CBR DESIGNATED POSITIONS (OCCUPIED CURRENTLY)

Province	No. of CBR workers	Training Cert. (2006–2008)	Training Dip 2012	Training Dip 2014	Untrained CBR worker	In training intake 2015	Technician	CBR Provincial Coordinator / Other staff
Temotu	2	1	1					PH Nurse In-charge
Makira	4	1	2	0	1			PH Nurse In-charge
Guadal-canal	4	1	1	0	1			Physiotherapy Assistant
Isabel	1	1 (Training now in DipCBR)				1		PH Nurse In-charge
Malaita	4				2		1	Physiotherapist
Honiara City Council	1	1						PH Nurse In-charge
Western	3	1	1		1			Physiotherapist
Rennbel	0							NIL
Central	1	1						PH Nurse In-charge
Choiseul	2	1			1 (training now in DipCBR Now)	1		PH Nurse In-charge
National Office	11		4			2	1	4
Total	33							

8.2 Resources demand on developing Diploma of CBR curriculum

The DipCBR was initially developed with input from expatriate volunteer clinicians. In this situation it is not unusual for much of the curriculum content, unit outlines and teaching resources to be quite fundamental and without supplementary teaching materials. Course materials typically also strongly reflect the volunteer's own professional background rather than the broader approach as for example required in CBR training particularly so since the

release of the WHO CBR Matrix and Guidelines. It is unusual for volunteers to have experience in developing curricula; often volunteers are new graduates who are recruited because of their professional qualifications in a health sciences discipline, and where their only resources are the course materials they received when attending university. In addition, many guest lecturers are usually involved in early developments within a course such as this: this inevitably leads to lack of consistency over time including loss of materials if these are not secured at the time of teaching. Having a consistent bank of well organised and documented course materials requires good computer or hard storage filing systems, and consistent staffing with the time and resources available to ensure keeping these materials current. All of these factors have influenced the development of the DipCBR over the last few years – so that the staff who were teaching the first and second intakes were faced with the situation of designing lectures and tutorials at the same time as teaching. The situation with the return of the Course Coordinator, Ms Goretti Pala, will become more stable over the next few years.

Two areas for future development were expressed by those teaching on the DipCBR. The first is broadening the focus of the course from health to include the other CBR components present in the WHO CBR Matrix and Guidelines. This is considered a *priority task* by the staff and every effort is being made to do so within the constraints of time available, and resources to support these efforts. It was noted that the unit outlines available for this Review do not always accurately reflect the quantum of information included in the course from the WHO CBR Matrix and Guidelines. (This reflects the situation noted above where the teaching materials are not as well organised as staff would like and formal documents such as unit outlines not up to date and reflecting the material taught). One example of where the WHO CBR Matrix and Guidelines have been extensively used is in CDS 2 (both in 2012 and in 2014). Much of the material in this unit, Project Planning in Community Development, is based on the Introductory Booklet from the WHO CBR Matrix and Guidelines in which four stages of the Management Cycle are identified: situation analysis, planning and design, implementation and monitoring, and evaluation.

8.3 Priorities for the future

Each of the four key stakeholders were asked to consider their priorities for the future of the Diploma of CBR at SINU and what they would like to see coming out of this Review. The following section presents and analysis and synthesis of perspectives from these key stakeholders informed by understanding of the Pacific and international context. This is arranged under several headings. The first is influence in the government and community sectors.

8.31 Influence in the government and community sectors

There is a strong desire to ensure the DipCBR reflects international practice incorporating the WHO CBR Matrix and Guidelines. This includes ensuring that CBR is understood in the

Solomon Islands, fundamentally, as a community based inclusive development approach. This requires a marked shift in current thinking in the Solomon Islands about CBR as primarily about health-related rehabilitation at the community level to one where CBR is the foundation of community based inclusive development.

It is understood that the curriculum will need to be dynamic to represent best practices in CBR education and training as these develop internationally. This is critically important to ensure that the Diploma has international standing and is therefore regarded highly by government in the Solomon Islands and governments in other Pacific Islands.

The anticipated international standing of the DipCBR and leadership from the university is critically important to influence government policy makers and civil society organisations and their management to understand and utilise CBR as the foundation for community-based inclusive development. The leadership of the university in this respect cannot be over-estimated in influencing the higher levels of government discussion and policy making; and, at the community level, through the work of the graduates from the DipCBR. There is an opportunity through university leadership and capacity building in the Ministry of Health and through the input of DipCBR graduates to bring about a change in national policy about disability from a 'special needs' group approach to one of community based inclusive development for all.

Following on from these two points, strong leadership from SINU in presenting CBR as community based inclusive development and influencing government and CSOs in this regard will have flow on effects in sectors other than health (currently the focal point for disability). Importantly, a flow on effect is anticipated in education and with the Ministry of Education. This will ensure that all children are enrolled in school and provided with the learning opportunities required to succeed in education and to progress to a sustainable livelihood. It is also anticipated that strong leadership from the university utilising the community based inclusive development approach inherent in CBR can influence employment and poverty reduction policy and programming by governments and civil society.

8.32 Broadening the student base

There is a high level of motivation to ensure the DipCBR meets the academic standards and requirements of SINU. This is understandable and certainly necessary for regional and international recognition of the course. There is however a particular challenge for university regulations and processes that may not take account of the requirements derived from the rights based underpinnings of CBR. The WHO Guidelines and Matrix is underpinned by the CRPD and draws attention to empowerment and building capacity in people with disabilities and their families. Essentially this means that CBR training programs need to involve persons with disabilities –as students, in curriculum advisory capacity roles, and as teachers. These requirements can be in tension with university management when accepting students with disabilities may not have been previously considered (or needed accommodations are not in place); having external stakeholders having a say in curriculum

matters is not accepted practice within the university; and, employing people with disabilities as teachers on the basis of their lived experience and qualifications in leadership and advocacy does not sit easily with university control over staffing, curricula design, and student enrolment

To reiterate, CBR is a community inclusive development approach aligned with the philosophy of the CRPD. It is then to be expected that students with disabilities will enter – and succeed – in the DipCBR. Graduates with disabilities from this course will be well placed to bring this university level educational qualification and their lived experience (and that of their families) to influence policy development and programs at all levels of government and civil society. Because of the long history of children and young people with disabilities being excluded from school and/ or offered limited educational opportunities there may need to be a transition strategy to ensure young people with disabilities can attend university and enrol in the DipCBR. One approach to this could be to offer a pre-requisite Certificate program to build capacity for persons with disabilities to enter university at the diploma level.

Such a program would benefit more than young people with disabilities. There is a potential student cohort of parents and caregivers of persons with disabilities, community field workers, church leaders, women and youth leaders in the Solomon Islands who could undertake such a certificate course with a view to enrolling in the DipCBR. This would create a critical mass of concerned, committed individuals with lived experience, who, as Diploma graduates would be leaders in moving the Solomon Islands forward as a nation committed to inclusive communities for all.

8.33 Graduate opportunities across sectors

The current focus of the DipCBR is health related which as noted earlier is not surprising given the history of CBR in the Solomon Islands, the qualifications of the teaching staff, the close relationship with MHMS , and the opportunities for graduates from the course. The key stakeholders are knowledgeable about developments internationally in CBR and are familiar with and experienced in applying the WHO CBR Guidelines and Matrix in different contexts (for example, in monitoring and evaluating CBR programs). They are acutely aware of the potential to broaden the curriculum content to enable graduates to work in sectors other than health. There is much discussion about how to do this. Several options have been suggested, for example, developing new programs which contain an additional year of classes to specialise in a particular field such as education or livelihood. Another option could be graduates from the DipCBR gaining additional qualifications from already existing programs for example in Special Needs Education.

These options are however resource intensive for students (time, funding and materials) as these would add up to a year or even two years to their initial two year Diploma course. Another alternative would be to consider re-design within the existing DipCBR curriculum. There are two complementary approaches worthy of consideration for implementation together in developing the DipCBR curriculum. The first is ensuring overall curriculum

content is broadened to include more equal weighting in each of the five key components of CBR: health, education, livelihood, social and empowerment. This as noted earlier in the Report would bring the DipCBR into line with best practice CBR education internationally.

The second and complementary approach is devising sector pathways in the latter part of the two year structure. This would allow the students to gain additional knowledge and capacity and better prepare them for employment in a sector of their choice. The approach requires the development of sector related units for the last semester of second year, and the development of placements with in-depth practical placement projects in the relevant sector. Given that curriculum development is resource intensive it would be expected that these sector pathways would be developed one at a time, not attempted concurrently. It would also be expected that a pragmatic approach would be taken; that is the first sector pathway would be developed where there are already strong existing relationships and networks. This is essential so that the curriculum content, the placement and the in-depth placement project are developed in collaboration with key stakeholders from the sector. Education/ schooling may be appropriate as the first sector pathway to be developed; followed for example, by developing a sector pathway in vocational training/ livelihood/ employment.

8.34 Pathways for career progression

Identifying career pathways is an immediate and longer term concern for staff teaching on the DipCBR and other stakeholders. At an immediate and practical level, it appears there may be no more MHMS CBR positions until 2017 (after the current round of advertisements in late November 2015). Questions arise such as: Will the graduates be employed in positions commensurate with their university education? In what sectors will the graduates be employed? Will they be employed in positions which utilise their skills and capacities?

There is also a need to consider sustainable positions (rather than short term contract funding) and rewarding careers over time. The issue of graduate employment is of concern not only to MHMS but potentially also in other ministries and other fields. The employment of graduates from the first two cohorts demonstrates positions in other sectors than health. This is in line with the foundation of CBR as community based inclusive development however there is a question of whether the students have adequate skills to work in sectors beyond health. To overcome this concern, teaching staff have been developing other placement opportunities to give students exposure to other agencies and different areas of practice such as in supporting employment of people with disabilities and a SINU Teaching Rehabilitation Clinic. A more coordinated and proactive multi-sectoral approach to the employment of DipCBR graduates could be undertaken by the proposed coordinating committee under the new Disability Inclusive Development Policy. A coordinated multi-sectoral approach would bring key stakeholders from each sector together with teaching staff to develop multi-sector placement opportunities (to ensure student skills) and graduate deployment. Note that 8.33 above suggests a curriculum re-design and development approach which also takes into account this multi-sectoral and collaborative approach.

Another area for consideration is the career progression of graduates. There are two aspects to this. The first is career progression within the employing agency. This is outside the direct responsibility or control of the university. It is however within the mandate of the university to prepare graduates for future leadership and management positions in their chosen field, including high level negotiation skills. This recognises that over time some graduates will move into leadership and management positions; it also recognises that all community workers such as CBR practitioners need to be familiar with leadership and management requirements, challenges and processes (at a beginning level as befits a Diploma course). This requires the DipCBR to include beginning level curricular content in leadership, management and negotiation.

The second is the eligibility of DipCBR graduates for entry to other university courses including those in health and rehabilitation, education and special education, employment and vocational counselling, and community development and advocacy. One example reflects the likely need for many more rehabilitation professionals in the Solomon Islands over the short to medium term. One way to do this would be to gain recognition for the SINU DipCBR as prior learning for entry to a health professional baccalaureate course in the Pacific or further afield. Given the strong relationships between the Solomon Islands and the University of Sydney, Queensland University of Technology and Monash University underpinned over recent years with Department of Foreign Affairs and Trade programs and sponsorship, ensuring eligibility of SINU DipCBR graduates to degree programs at these universities could be investigated.

8.35 Relevant to other Pacific countries

The DipCBR and predecessor CBR training courses in the Solomon Islands have a long history of producing CBR workers in the Pacific context. Other Pacific countries (with the exception of Fiji and Papua New Guinea) are in the early stages of implementing CBR programs and considering the requirements for their CBR workforce. The Solomon Islands through its Dip CBR at SINU is well placed to build capacity in the CBR workforce across the Pacific. There are several actions that need to be undertaken to achieve this outcome. The first is that the DipCBR is developed to reflect international best practice so that the graduates are held in high regard both within their own Pacific countries and also internationally. That the DipCBR reflects international best practice in CBR training is also important so that the graduates can, if they so desire, pursue career pathways at degree and higher degree levels in the Pacific and internationally. A second requirement is that the DipCBR represents the CBR Pacific flavour as outlined by the CBR regional documents and summarised by Ms Pauline Kleinitz in her recent address to the 2nd Pacific CBR Forum. This will be critical to attract students from other Pacific countries and also to the governments of other Pacific nations sponsoring these students and to students paying their own way. A third action is to ensure that eligibility requirements, costs, and resources required are appropriate and readily met by intending students from other Pacific nations.

9. Summary points from country visit December 2015

A two day country visit was undertaken in mid-December with two full days of meetings 10-11th December. People involved in these meetings are listed in Appendix 2. Many of the points identified *in the Preliminary Report: Exposure Draft, 31st October 2015* were mentioned. New points were added by the DipCBR graduates (employed, not employed, part-time employed) and the employing organisations. This section presents a summary of these points with reference to earlier sections before moving to the final section on recommendations.

Point 1 Growing demand for disability trained workers

There is a growing demand for disability trained workers in the Solomon Islands. There are several reasons. First, continuing momentum in national government policies about supporting people with disabilities, and movement towards ratification of CRPD (Solomon Islands signed the Convention in 2008, but has not yet ratified). Second, there is now an Inclusive Education Policy soon to be taken to Cabinet, which details the supports needed to include children and youth with disabilities in school. Third, as SINU staff have worked with private companies/ organisations to include people with disabilities (and gained student placements), managers have realised the contribution that can be made by workers who are experienced with people with disabilities. There is also in principle support to increase the number of MHMS CBR Field Worker posts, however with the exception of several new posts announced in late November 2015, the supply of graduates continues to exceed employment opportunities.

The DipCBR graduates are in a good position to fill expanding roles with people with disabilities as well as the traditional MHMS CBR Field Worker positions. However as is often the case, new employment settings identify additional skills they would like the CBR graduates to have. This can lead to the CBR program staff feeling pressured to meet 'everyone's demands' (which often means that a program meets no one's specific needs). Suggestions such as another year of specialist training for example in nurse aide or special education skills would create a three year trained diploma graduate. This would involve costs to students and to the University. Without there being clearly identified positions available to graduates both in the MHMS Public Service, the MOE Teaching Service, and in private companies/ organisations, extended training may only exacerbate the number of unemployed graduates (which is an unsatisfactory situation discussed further below).

Extending the current two year DipCBR therefore would require very careful consideration by all parties involved: the university, MHMS, MOE and employing organisations. This should not be a decision for the university alone. Other solutions may be more viable. For example,

revising the curriculum to provide a broader knowledge base for graduates in line with potential employment opportunities, for example, in livelihood (private companies), empowerment (NGOs and INGOs), social (NGOs, social welfare agencies). This could be achieved by using the WHO CBR Matrix and Guidelines as the foundation framework for the curriculum. This would permit a more equal weighting to each component: health, education, livelihood, social and empowerment and would not require extending the current two year course. Consideration could also be given to including a focus stream in the last semester as (presented earlier in Section 8.33 on pp.35-36) so that students were more 'work-ready' for the emerging employment contexts. Curricula revision and design always needs to take into account emerging fields, as graduates employment will be for the next 20 or 30 years.

Point 2 Number of DipCBR graduates exceeds positions available

Some DipCBR graduates from the 1st intake/ graduated 2012 and 2nd intake/ graduated 2014 remain unemployed or employed part time (not in MHMS). This is of concern. First, it is a waste of highly trained human resources for the country. Unemployed graduates reported being supported by their families and doing little each day. Second, these graduates perceive that the MHMS has let them down by not providing posts. They see themselves in a very different position compared to other graduates of the highly regarded School of Nursing and Allied Health Sciences. Third, another cohort of students will graduate in 2016. Without established positions, the number of unemployed DipCBR graduates will be quite large. This is very worrying.

The SINU DipCBR program staff have put efforts into expanding employment opportunities for example in special education (San Isdro), vocational training (Bethseda) and private companies (Kokonut Pacifici). However the size of the problem is such that resolving the mismatch between numbers of graduates and positions available is beyond the resources/ capabilities of one organisation. There needs to be a national coordinated response by the highest level of management at MHMS, SINU, MOE, and involving stakeholders from other agencies including private companies/ organisations and development agencies. This would follow precedents in other countries where high level management is responsible to ensure there is not a waste of well-trained human resources. The unemployment situation requires resolution before it worsens with the addition of the 2016 graduate cohort.

Point 3 Building national and multi-sectoral coordination and resolve to support the inclusion and participation of people with disability

There have been positive national policy initiatives to include people with disabilities in the Solomon Islands community. Policy implementation gains will occur with employment of CBR Field Workers whose training and role is to achieve community inclusion and participation. To ensure this potential is realised requires national and multi-sectoral coordination for planning and implementation of policy for inclusion and participation of people with disability. This means bringing together policy and planning in MHMS with MOE and with the work of SINU and People with Disabilities Solomon Islands and other interested parties.

The emerging Disability Coordinating Committee provides an excellent potential opportunity to undertake this national disability policy planning and implementation role. It is not possible to achieve inclusion and participation of people with disabilities in the community when each ministry, the training institution, DPOs, and employing organisations separately develop policy and plans and strategies. Why is this so? Because separate policy making and planning results in 'ownership' of particular parts of people's lives – yet the lives of people with disabilities and their families cross all sectors. Thus, there must be coordinated, collaborative responses at every level in the community from the high level Disability Coordinating Committee right through to collaboration and coordination between public health/ community nurses and CBR field workers at the village level.

A highly appropriate framework for these discussions at each level is the WHO CBR Matrix. This Matrix covers each component of community inclusion and participation: health, education, livelihood, social and empowerment. This structure assists all stakeholders to understand inclusion in the community and to realise and implement their department or agencies role and contribution to the process.

Point 4 Updating current focus of DipCBR curriculum to reflect WHO guidance documents on CBR

SINU DipCBR staff have already taken many steps to incorporate the WHO CBR Matrix and Guidelines in the curriculum. However, currently heavier weighting is given to health (therapy, assistive devices, and modifications). This is because the curriculum as originally intended was to supply graduates for MHMS positions. The situation has changed. There are not enough MHMS posts (more are needed and promised); importantly, opportunities to include people with disability are expanding in education, empowerment, social and livelihood. There is a need now for curriculum revision to align with current and likely future expansion of roles for DipCBR graduates. Specifically, introducing the WHO CBR Matrix and Guidelines as the conceptual framework for the DipCBR program is suggested. The recent WHO document, *Capturing the difference we make. Community-based rehabilitation*

indicators manual[16], will complement and support this curriculum review. Taking these two steps would align the DipCBR program with best practice internationally. Two further steps would assist the DipCBR staff and SINU in this endeavour. The first is identifying fellow academics at international universities to act as 'critical friends' to discuss and finalise a revised curriculum. The second step would complement the first. This step involves setting up a Course Advisory Committee. Ideally this Committee would comprise high level personnel from the Solomon Islands from DPOs, private companies and not-for-profit organisations as well as government departments, who are committed to inclusion and participation of people with disabilities. This type of Course Advisory Committee with these external stakeholders play a valuable can assist with 'opening doors' into the wider community as well as provide their reflections on the DipCBR curriculum.

Aligning the DipCBR with best practice internationally is critical. First, it will provide graduates with international knowledge, skills and behaviours. This is important for the Solomon Islands and important for the graduates if they wish to pursue further studies. Second, it will position the course as a leading regional program in Community-based Rehabilitation. This will offer the opportunity to recruit students from other Pacific nations. In line with developments internationally, consideration could be given to changing the name of the course to Community-based Inclusive Development. Three, it will place the Solomon Islands in a good position to implement the requirements of the UN Convention on the Rights of Persons with Disabilities, and once ratified, to report against these requirements. Lastly, it is important to note that current students (2015 intake) who provided input during the in-country visit expressed their satisfaction with the DipCBR, they were excited about and committed to making a different for people with disabilities when they graduate, and, volunteered that all units were interesting and stimulating. They did express some concern about the unit taught by non-university staff from the CBRU however they put this down to CBRU staff being very busy and having little time for preparation.

Point 5 Ensuring CBR is a sustainable national Multi-sectoral program utilising CBR trained workforce

It is clear from these five summary points that there is high regard for CBR and the contribution of CBR field workers. However the full potential of the DipCBR program and its graduates is not yet being realised. SINU staff report for example it is difficult to attract resources for CBR positions when there are competing national priorities such as infectious disease epidemics and national disaster emergencies. The profile of CBR for the whole community needs to be raised considerably, over and beyond the contribution to the health sector. This can be challenging when persons with disabilities have been 'out of sight' in the community and disability is thought of as a liability.

[16] WHO (2015). *Capturing the difference we make. Community-based Rehabilitation Indicators Manual* (2015) Available at http://www.who.int/disabilities/cbr/cbr_indicators_manual/en/

There is however an excellent opportunity to change this situation. There is an increase in non-communicable diseases (NCDs) in the Pacific and the Solomon Islands. CBR is an essential service to *preventing and managing the outcomes* of NCDs. For example, for cardio-vascular disease (and stroke), diabetes (and amputations), and road traffic accidents (and brain and spinal cord injuries). CBR workers are ideally placed as frontline community health education personnel (prevention of NCDs) and frontline community inclusion and participation personnel (management of the sequalae of NCDs).

Showcasing the prevention and management role of CBR personnel in NCDs is best done utilising the WHO CBR Matrix and Guidelines complemented by stories of successful prevention programs and inclusion of people with disabilities following an NCD outcome. This is best done by partnerships and collaboration across the institutions and organisations involved: SINU (CBR and Nursing staff), PWDSI, DipCBR graduates employing organisations, MHMS and WHO regional and country offices. The CBR Matrix assists governments to understand the importance of the contribution of community-based inclusive development to national health priorities, specifically NCDs.

10. Recommendations

Recommendation 1

That serious consideration is given to curriculum revision using the WHO Matrix and Guidelines as the foundation framework.

Short term actions

- Consider expanding content in the second year of the program to include additional focus on education, livelihood, social, and empowerment in line with the WHO Matrix and Guidelines. Health is currently well covered
- Consider revision of student forms for example assessment forms in line with WHO Matrix and Guidelines elements
- Consider inclusion of case studies/ stories of successful participation by people with disabilities related to education, livelihood, social and empowerment. Ideally, the case studies/ stories would be complemented by lectures/ tutorials from people with disabilities themselves

Longer term actions

- Full revision of the curriculum prior to 2017 cohort to align with the WHO Matrix and Guidelines
- Identify colleagues in other universities in Australia and elsewhere and invite them formally to become 'critical friends' to support this revision process
- Consider changing the course name to Diploma Community-based Inclusive

Development in line with international developments

- Establish a high-level Course Advisory Committee comprising all relevant Ministries, International and National non-government development organisations, and private companies. The role of this Course Advisory Committee would be to advocate for the DipCBR program, and to network and expand opportunities for employment of DipCBR graduates and student placements
- Proactively recruit staff and students with disabilities to demonstrate inclusion of people with disabilities and provide role models for potential students
- Provide opportunities for family members and carers to train as CBR Field Workers
- Develop a pre-requisite Certificate course for potential DipCBR students who do not meet the eligibility requirements but have strong vested interests in enrolling in the program, for example, students with disabilities and family members and carers of persons with disabilities

Recommendation 2

That attention is given now, led by SINU and the MHMS, to the unemployment situation of 2012 and 2014 DipCBR graduates and definitely before the graduation of the 2015 cohort.

Short term actions

- Establish a cross sector committee at the most senior level of management of SINU and MHMS and including other ministries, INGOs and NGOs to resolve the unemployment situation of DipCBR graduates
- If MHMS posts in sufficient numbers are not likely to become available in the short term, the Committee investigate alternative solutions to ensure that this well trained cadre of community based health workers is not lost to other employment opportunities/ careers

Longer term actions

- The Committee identify, using up to date census, disability prevalence, and NCDs incidence figures the projected number of community-based rehabilitation (inclusive development) field workers required over the next 10 years
- The Committee work with SINU to ensure staffing and resources are adequate to meet the projected demand for recruitment into the DipCBR over the next 10 years

Recommendation 3

That the School of Nursing and Allied Health Sciences develop promotional materials that clearly articulate the contribution of the DipCBR. This would fulfil three purposes:

1. to ensure clear understanding by multiple stakeholders of the role and contribution of CBR Field Workers for the inclusion of people with disabilities in the Solomon Islands community;
2. to provide recruitment information about the program to attract sponsored and

private students from other Pacific nations embarking on community-based rehabilitation programs; and,

3. to provide potential students in the Solomon Islands with information about the program and their future contribution to the Solomon Islands community.

Appendix 1 SINU Public documents on Diploma of Community Based Rehabilitation

Appendix 1.1 SINU Diploma of Community Based Rehabilitation – Course Description
http://www.sinu.edu.sb/SNAHS/snahsDCBR.html

The Diploma of Community Based Rehabilitation is a 2 years course designed to respond to the findings of a WHO study of SI population suffering from some form of disabilities. To address this, the course looks at the body functions in Semester 1 and then goes into methods and ways of addressing some of the common disabilities. The course involves a lot of fieldwork for a greater student experience and understanding of the various types and forms of disabilities and ways of addressing them.

Course Overview:

YEAR 1	
SEMESTER 1 UNITS	**SEMESTER 2 UNITS**
TOS1 Foundation in Human Biology 1 TOS2 Foundation in Human Movement CRS1 Introduction to Community Based Rehabilitation CPS1 Professional Practice CPS2 Fieldwork 1	TOS3 Medical Conditions and Disability TOS4 Foundations in Physical Therapy and Physical Rehabilitation TOS5 Activity as Therapy TOS6 Foundation in Speech Therapy CPS3 Fieldwork 2

YEAR 2	
SEMESTER 3 UNITS	**SEMESTER 4 UNITS**
TOS7 Seating and Positioning TOS8 Foundations in Physical Therapy and Physical Rehabilitation (two) CRS2 Social Determinants of Health CPS4 Fieldwork 3 CPS5 Fieldwork 4	CPS6 Fieldwork 5 CDS1 Health Promotion and Education CDS2 Project Planning in Community Development CPS7 Fieldwork 6 CPS8 Fieldwork 7

Appendix 1.2 Diploma of CBR - Unit Descriptions
http://www.sinu.edu.sb/SNAHS/snahsDCBRUnitDescriptions.html#CPS8

YEAR 1
TOS1 Foundations in Human Biology
This unit aims to provide a basic understanding of the human body and how it functions. This knowledge will be a foundation for learning about disabling conditions & the impact on human function. Within this unit students will study each of the body systems their structure and function.
TOS2 Foundations in Human Movement
This unit aims to provide students with a basic understanding of how the human body moves. This knowledge will assist students to understand conditions that affect the musculoskeletal system and when/ why/how physical therapy interventions are implemented. Areas of study include musculoskeletal anatomy, surface anatomy, assessment intervention and evaluation of range of movement, basic neurology in context of function, childhood development, and the prevention of secondary disability.
CRS1 Introduction to Community Based Rehabilitation
This unit will introduce students to the Community Based Rehabilitation strategy and the social and human rights models of disability. This unit will give students the theory that will aid them in practicing in the community appropriately. Students will learn the role and function of community based rehabilitation; and national, regional and international legislation, policy and programs that support disability and community based rehabilitation.
CPS 1 Professional Practice
This unit will prepare students with self management and professional practical skills for application in the classroom and workplace. Topics covered within the unit include communication and study skills, and law and ethics. This unit endeavours to groom professional and successful students and graduates.
CPS 2 Fieldwork One
This unit aims to improve students understanding of disability and the impact of the environment on disability. Students will be given the opportunity to make astute observations within a practical setting. Observation skills will be developed in the classroom using the International Classification of Function framework for disabling environments.
TOS3 Medical Conditions and Disability
This unit aims to equip students with an understanding of how different conditions present in the context of functional limitations and disability. It will provide students with a pivotal understanding of the primary disabilities experienced in the Solomon Islands i.e. cerebral palsy, stroke, amputation. Areas of study include biomechanical, sensory motor; sensory, cognitive and psychiatric disabilities.

TOS4 Foundations in Physical Therapy and Physical Rehabilitation
This unit aims to equip students with the rehabilitation skills required to assess, improve & maintain a persons function in activities of daily living. These skills will be important in assisting a person with a disability to have equal access and participation in the community. Areas of study include mobility and transfers, activity participation, and community access across the lifespan.
TOS5 Activity as Therapy
This unit aims to equip students with the ability to design and use creative interventions that will assist people with disabilities in physical, psychosocial and mental/cognitive areas. This unit will promote creative thinking when working with people who have a disability including devising therapeutic activities that use the natural environment as a resource to prevent secondary disability or improve an existing impairment.
TOS6 Foundations in Speech Therapy
This unit aims to equip students with basic speech therapy knowledge and skills for application to case studies. This unit will teach students specific skills to be used when working with children and adults who have a language and communication disability. Specific topics studied include aphasia, dysarthria, swallowing disorders, language development, speech sound disorders, cerebral palsy, augmented & alternative communication, hearing loss and cleft palate.
CPS3 Fieldwork Two
This unit aims to prepare students for clinical assessment prior to intervention planning. The opportunity will be provided to develop these skills in the workplace. Teaching will address assessment through observation, history taking and environmental assessments. Principles of clinical record keeping will also be taught.
YEAR 2
TOS7 Seating and Positioning
This unit aims to equip students with knowledge and skills required to assist people with a disability to maintain a functional seated posture. These skills will allow graduates to ensure the person with a disability has maximum opportunity to be included in day-to-day activities and to prevent secondary disabilities. Students will study introduction to seating, wheelchair prescription principles and creative modified seating.
TOS8 Foundations in Physical Therapy and Physical Rehabilitation (two)
This unit aims to equip students with practical skills in problem solving creatively, designing and making adaptive equipment, mobility devices and therapy toys & tools. This unit focuses on using the natural environment and local resources to ensure initiatives are sustainable, cost-effective and suitable for the client's environment. Students will learn design and woodwork skills for seating modifications & creations, mobility devices, adaptive equipment and therapy toys and tools.

CRS2 Social Determinants of Health
This unit aims to develop the students understanding of the social model of disability. It endeavours to assist students to plan and apply interventions which address the social determinants of health I in the community to improve opportunities for people with a disability.
CPS4 Fieldwork Three
This unit aims to prepare students for working in isolation with clinical reasoning skills for assessment, intervention and evaluation planning. Graduates will be working in often independent contexts and will need to be able to use good reason to support their decision making. These skills will be developed in a fieldwork placement. This unit will specifically address clinical reasoning in assessment, intervention & evaluation planning, selection of different types of interventions and using evaluation within clinical reasoning.
CPS5 Fieldwork Four
This unit provides students with the opportunity for integrated application of learning from semesters 1, 2 and 3. A block fieldwork placement will be offered for students to demonstrate these skills and abilities.
CPS6 Fieldwork Five
This unit provides an opportunity for students to consolidate their therapy outreach skills with ongoing supervision and accountability to support ongoing best work practices.
CDS1 Health Promotion and Education
This unit aims to equip students with the skills required to facilitate increased awareness and attitude change in the community regarding disability. Graduates will be required to promote human rights, equality and abilities of people with disabilities. Principles of health promotion & health education, educating community groups, education/advocacy with local leaders, educating family members are topics that will be covered in this unit alongside disability prevention.
CDS2 Project Planning in Community Development
This unit aims to equip students with the skills required to run community programs that increase the community's capacity to include people with a disability. Such community capacity building primarily takes the form of local development projects. Topics that will be introduced include introduction to needs assessment, program design & implementation and program evaluation.
CPS7 Fieldwork Six
This unit is intended to provide students with the opportunity to apply community development skills with a relevant community project. Students will be completing a fieldwork placement within a provincial village. The project will be specific to disability and/or related topics. Students will be given the opportunity to create, design, implement and evaluate this project.
CPS8 Fieldwork Seven
This unit is intended to consolidate therapy outreach skills and provide opportunities to follow up on clients from Fieldwork 3. The primary purpose of this unit is to give students the opportunity to review client progress and display case load management techniques across an extended time period.

Appendix 1.3 Health related diplomas – entry requirements

http://www.sinu.edu.sb/Forms/SINU%202015%20Course%20Requirements.pdf

SCHOOL OF NURSING & ALLIED HEALTH SCIENCES			
DIPLOMA & DEGREE COURSES			
HDN	**Diploma of Nursing (Pre-service)** **Entry requirements:** • Male or female between ages 19-35 years • Satisfactory Academic Standard which meet the following criterias: • Satisfactory completion of Form 6 or 7 with good Grades in Science, Maths and English, GPA 2.5 and above and Satisfactory Character Reference - non-smoker and betelnut chewer • Form 5, trained and working as a Registered Nurse-Aid for Minimum 5 years may be considered.	**Semester 1**	**3 Years**
HDPH	**Diploma of Public Health** **Entry Requirements:** • High School Education up to level of Form 6 or 7 (Science or Arts) OR • Previous Education in Public Health or Related Fields AND • Work Experience/Employment with Public Health Unit, MHMS with Recommendation for Further Studies by Director Public Health AND • Verbal and Written English Skills as per Form 5 Education Standard and less than 40 years of age.	**Semester 1**	**2 Years**
HDCBR	**Diploma of Community Based Rehabilitation** **Entry Requirements:** • High School Education up to level of Form 6 or 7 (Science or Arts) OR • Previous Education in Public Health or Related Fields AND • Work Experience/Employment with Public Health Unit, MHMS with Recommendation for Further Studies by Director Public Health AND • Verbal and Written English Skills as per Form 5 Education Standard and less than 40 years of age. • Minimum One Month Work Experience with Occupational Therapist, Physiotherapist in the NRH to gain basic understanding of people with disabilities.	**Semester 1**	**2 years**

BRIDGING PROGRAMME			
HPHBN	**Bridging Programme (Bachelor of Nursing)** **Entry Requirements:** • Registered Nurse without level 6 Diploma attained at SICHE or other recognised Institutions. • Individuals who have a Diploma of Public Health and Diploma of Teaching attained at SICHE.	**Semester 1 & 2**	**12 Weeks**
HBNAC	**Bachelor of Nursing (Acute Care)** **Entry Requirements:** 1. Normal Entry Criterion for this Degree is: University Entrance 2. Registered Nurses may enter directly into the 4th year if they meet the following criteria: • A Practicing Registered Nurse(RN) with a minimum of two years Post Registration Practice plus one of the following: • Hold a Diploma of Nursing in SICHE or Equivalent or • Holds a Certificate in Nursing and has Completed an Inservice Diploma, a Bridging Programme or Equivalent Course or • Has Completed another 3 year Nursing Programme and has Completed an Inservice Diploma, a Bridging Programme or Equivalent Course.	**Semester 1**	**1 Year**
HBNPHC	**Bachelor of Nursing (Primary Health Care)** **Entry Requirements:** 1. Normal Entry Criterion for this degree is: **University Entrance** 2. Registered Nurses may enter directly into the 4th year if they meet the following criteria; • A Practicing Registered Nurse(RN) with a minimum of two years Post Registration Practice plus one of the following: • Hold a Diploma of Nursing in SICHE or Equivalent or • Holds a Certificate in Nursing & has Completed an Inservice Diploma, a Bridging Programme or Equivalent Course or • Has Completed another 3 year Nursing Programme plus Completion of an Inservice Diploma, a Bridging Programme or Equivalent Course.	**Semester 1**	**1 Year**

HBNMID	**Bachelor of Nursing (Midwifery)** **Entry Requirements:** 1. Normal Entry Criterion for this Degree is: University Entrance • Entrance to the Degree for those who are **not** Registered Nurses must also demonstrate Fitness as a Registered Nurse. • Fluency in English Language, Writing, Reading, Speaking and Comprehension. 2. Registered Nurses may enter directly into the 4th year if they meet the following criteria: i. A Practicing Registered Nurse(RN) with a Minimum of 2 Years Post Registration Practice plus one of the following: ii. Hold a level 6 Diploma of Nursing in SICHE or Equivalent or iii. Holds a Certificate in Nursing & has Completed an Inservice Diploma, a Bridging Programme or Equivalent Course or iv. Has Completed another 3 year Nursing Programme plus Completion of an Inservice Diploma, a Bridging Programme or Equivalent Course. 3. Registered Nurse from outside Solomon Islands Enrolment **must** provide evidence of the Appropriate Nursing Registration and Practicing Certificate for the country from which they come from and Academic Evidence as in 2 (i – iv)	**Semester 1**	**1½ Years**

Appendix 2 Examples of CBR training courses

Appendix 3 Stakeholders who informed this report

Name	Position	email
Elsie Taloafiri	Director, MHMS CBR Unit	etaloafiri@moh.gov.sb
Goretti Pala	Course Coordinator CBR, SINU	goretti.pala@sinu.edu.sb or goretipala@gmail.com
Ana Burgaraaf	Lecturer, DipCBR Program, SINU	ana.burggraaf@sinu.edu.sb
Casper J Fa'asala	President PWDSI	genderalert@gmail.com
Gideon Row	Principal Education Officer, Bethseda Disability Support and Training Centre	
Audrey Aumua	Undersecretary, Health Improvement WHO Country Office	aumuaa@wpro.who.int
SINU DipCBR graduates	9 graduates 2012, 2014 without full time employment	
National Referral Hospital, Honiara	Rehabilitation Department staff as below	
Lora Sangoinao	CBR Field worker post (PT assistant) (2013-2014 Field Worker)	
George Hage	CBR Field worker post (PT assistant)	
Bremer Abana	CBR Field worker post (CBR field worker in community)	
SINU		
Verzilyn Isom	Dean, School of Nursing and Allied Health Sciences, SINU	dsnahs@sinu.edu.sb
Ben Bezo	Assistant Dean Academic Affairs, School of Nursing and Allied Health Sciences	
Reuben Maau	Lecturer, Clinical Placements, School of Nursing and Allied Health Sciences	
Sira Tauriki	Lecturer, DipCBR program, SINU	crariki@gmail.com
SINU current students	Mabel Qiladudulu, Margaret Silari, Gabriel Sipolo, Robert Varnagi, Grace Teka (from CBR National Office)	

Frank Sanders	Kokonut Pacific http://www.kokonutpacific.com.au/index.php fjsanders@me.com

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