

# Samoa Integrated Mobility Device Services (SIMDES) Project design

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## 1. Introduction

Following the completion of the Programme Design Document (PDD) for the overall Samoa Disability Programme 2013-17, Department of Foreign Affairs and Trade (DFAT) contracted Motivation Australia (MA) to write a detailed project design document for the Mobility Devices Service (MDS) project (under outcome 3(i) of the overall PDD). Remote and in-country consultations with over 40 people involved were made between 19<sup>th</sup> September and 2<sup>nd</sup> October 2013, by Kylie and Ray Mines.

This document is intended to provide a detailed project design for outcome 3(i) *Integrated Mobility Device Service* of the PDD. In addition, links between this project and the broader SDP are identified and two broader recommendations relating to transportation and rehabilitation have been made.

The PDD addresses the international, regional and country disability context in which the overall Samoa Disability Programme exists. Therefore, this document addresses the aspects of context as they relate to mobility disability specifically; but not to disability in general which is comprehensively covered in the PDD.

## 2. Executive summary

There is currently no formal Government provision in Samoa of mobility device services for children and adults with a permanent mobility disability. Existing provision of wheelchairs is un-coordinated and inequitable. People who have funds are able to seek assistance outside of the country; the provision under the Accident Compensation Corporation addresses only a minority of wheelchair users; and donated equipment is provided on the basis of people identified by the donating organisations. There is also currently no lower limb prosthetics service functioning in Samoa, despite a rapid growth in demand as a result of an increase in diabetic related above and below knee amputations. A small number of individuals who are able to, travel overseas (with private, family or insurance funds) to access prosthetics services. Other mobility devices including orthoses, walking frames and crutches are also largely un-available.

The purpose of this four year project, titled: Samoa Integrated Mobility Device Services (SIMDES); is to create consistent, equitable and sustainable access to appropriate mobility device provision for women, men, girls and boys with a mobility disability in Samoa. The budget to implement this project is part of the broader Samoa Disability Programme (SDP), and is shown in the PDD budget annex as AU\$877,500. The costs for monitoring & evaluation (M&E), child protection and gender equity activities are listed separately in the SDP budget and therefore not included in the MDS implementation budget. The recommended actions for transportation and rehabilitation are also not costed as part of the MDS budget.

There are a number of key stakeholders engaged in the SDP. The Ministry of Women, Community and Social Development (MWCSO) are the coordinating Ministry and focal point for disability for the Government of Samoa (GoS), and therefore have ownership of the wider SDP. The NHS is the government agency responsible for the delivery of mobility devices services, and therefore the primary implementation partner for this project. NOLA, the National Disabled Persons Organisation, play a key role as the disability advocacy body in Samoa, and are an important link between the SDP and the primary beneficiaries of the programme. The specific relationship and roles of these three stakeholders needs to be clearly defined within SIMDES.

It is proposed that the MDS will be housed in a new purpose built building (planned and funded under the Samoa SWAP) in the grounds of the old section of *Tupua Tamasese Meaole* hospital (TTM) in Apia. Establishing and building the capacity of the centre-based service in the hospital will form a large portion of the project. However it is essential that there is a strong emphasis on activities to build capacity to carry out aspects of mobility device service provision in the community, through Government and Non-Government organisations. This will require a great deal of cooperation and coordination with the NGOs who have been providing the majority of mobility devices to date, to ensure that the new services are relevant and responsive to the needs of people with mobility disabilities in the community. This represents a major challenge for the SIMDES project.

In general, reactions to the proposed project during the consultations were overwhelmingly positive; with some caution amongst NGOs regarding the NHS owning an activity that to date it has not shown great interest in or dedicated many resources to addressing. That said, the NHS management team were extremely positive about the project and demonstrated their commitment to working with the community of NGOs/DPO and people with mobility disabilities to ensure the new services meet their needs.

As with other countries in the region (with the possible exception of Physiotherapists in Fiji), there is an identified lack of allied health professionals in Samoa. With only one qualified Samoan Physiotherapist (PT) currently employed by the NHS (and the Physiotherapy degree in Fiji taking four years to complete); it will be crucial for this project to address the need for more people to be trained through short courses in the clinical skills related to mobility device provision. It is important that any strategies developed during the project in this area take into consideration the MOH's Allied Health Council report, career pathways and the question of accreditation; as well the practical issues of implementing a four year project. It is also essential that the Prosthetics & Orthotics service employs at least one Category II Prosthetist Orthotist (PO), which generally involves three years of training. Training a second PO is recommended in order to increase the capacity of the new team to provide services for the growing number of lower limb amputees due to diabetes related complications, and to provide contingency if either of the POs were to leave the service. Therefore training clinical personnel represents the second major challenge for the SIMDES project.

This project represents a tremendous opportunity for all Samoan stakeholders; with broad government support; a brand new purpose-built facility; potential for new career pathways and professionals; and the building of an active community of NGOs/DPO. The PDD embraced the idea of integrating services for wheelchairs, supportive seating, Prosthetics & Orthotics (P&O) and other devices (such as walkers, crutches, walking sticks, white canes, etc), into one mobility device department. This would be the first implementation of the strategy in the Pacific to integrate all services from the beginning.

The MDS project plan encompasses a diverse range of specialist inputs in order to achieve the desired objectives. Given this diversity, in the context of the current capacity of the NHS and NGO service providers at this time, it is recommended that the MDS project is implemented through the engagement of a specialist technical partner that works closely with the NHS, NOLA (as the peak representative body of people with a disability) and engages with the MWCSO.

### 3. Scope of proposed services

**Mobility Device Service (MDS)** – The proposed MDS will provide basic wheelchairs, intermediate wheelchairs (supportive seating), Prosthetics & Orthotics (P&O) services and other devices (such as walking frames, crutches, etc) from one single service entry point. In the scenario where aspects of mobility device service provision are provided in the community (aspects that are feasible to provide safely in the community, through personnel with less training and without workshop facilities); the initial referral point, centralised database, stock of devices and coordinating body will be the centre-based service at the main hospital in Apia.

1. **Basic level wheelchair service** - A basic level wheelchair service is able to provide a wheelchair and cushion to women, men, girls and boys who have a mobility impairment, but who can sit upright without the need for additional postural support.
2. **Intermediate level wheelchair service** - An intermediate level wheelchair service is able to provide wheelchairs and supportive seating to women, men, girls and boys who have a mobility disability, and need additional postural support in their wheelchair to help them to sit upright.
3. **Prosthetics & Orthotics (P&O)** – A prosthesis is an artificial device used to replace a missing body part. In this context, the terms ‘prosthesis’ or ‘prosthetic limb’ are used primarily to describe a lower limb prosthesis. An orthosis is an orthopaedic device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. Lower limb orthoses may be used to enhance mobility.
4. **Other mobility devices** – are any other devices which aid mobility but are not part of the previous three groups of devices, including (but are not limited to) axilla and elbow crutches, walking sticks, walkers, white canes and others.

The estimated capacity of the service, based on the staff proposed in the organisation chart (Appendix A) is listed in the table below:

**Table 1: Service capacity calculations**

[TABLE REDACTED: Commercial in confidence]

## 4. Broader recommendations

As well as forming the foundation for this detailed project design document, the in-country consultations with stakeholders raised a small number of broader issues which lie in the periphery of the scope of this element of the SDP, however are central to the lives of people with disabilities:

### 4.1. Transportation

Both the accessibility and affordability of transportation is a major barrier to people with disabilities accessing services, earning livelihoods, attending school and generally participating in Samoan society. This barrier is even more significant for people with smaller incomes living in remote villages and on other islands. People with mobility disabilities are unable to mobilise without the appropriate mobility device, making transportation to the mobility device service (where they can access the appropriate device) a critical step in the process. Transportation is a broader societal issue which starts with, but extends beyond the need to travel to the mobility device service, and beyond the scope of this project.

*Motivation Australia propose that accessible and affordable transportation be addressed as part of the broader health plan or the SDP. A twin track approach is recommended:*

- 1. An accessible vehicle for the MDS to ensure that in the short term clients can get to the new services*
- 2. A Transportation Strategy written in collaboration with NOLA, NHS, MWCSD and other stakeholders. This would need to address both the physical access to public transport and the cost of essential travel to access services. This could be organised under the Samoa National Policy for People with Disabilities which contemplates access to transport under core strategic outcome area six.*

### 4.2. Rehabilitation

The purpose of rehabilitation is to maximise an individual's functional ability through a coordinated plan of individually tailored activities, implemented by a multi-disciplinary allied health team. Article 26 of the CRPD<sup>2</sup> outlines the importance of rehabilitation for people with disabilities to begin as early as possible, to be based on a *multi-disciplinary assessment of individual needs*, to take place in their own communities in order to support participation and inclusion in all aspects of society. It includes promoting *"the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation"*. Rehabilitation is possibly the most significant interface between the health and disability sectors.

In many countries the provision of assistive devices, of which mobility devices is one sub-category, exists within the broader framework of rehabilitation. The provision of mobility devices and rehabilitation activities compliment and support each other. There is an identified lack of allied health professionals in Samoa, and planning to train Physiotherapists, Occupational Therapists, Speech & language Therapists, Podiatrists and other allied health professionals as a priority is one part of the solution. A well researched and pragmatic rehabilitation plan for Samoa is also essential to create the framework for these new disciplines and services at the NHS.

*Motivation Australia recommends that in the context of increasing rates of NCDs such as Stroke and diabetes, and the broader consideration of disability issues in Samoa, that:*

- 1. A strategy for the implementation of rehabilitation as part of National Health Services be developed as a priority. We further propose that a comprehensive Community-Based Rehabilitation (CBR) programme be a fundamental component of a national rehabilitation strategy for Samoa.*

2. *Scholarships be considered for one Prosthetist Orthotist to train at Mobility India in Bangalore, India (part of this project, see budget section 12); two Physiotherapists to train at FNU in Suva, Fiji; one Podiatrist; one Occupational Therapist and one Speech & Language Therapist to train at appropriate locations in the region in order to start the broader allied health sector in Samoa.*

## 5. Sector analysis

The PDD addresses the international, regional and country disability context in which the overall Samoa Disability Programme (SDP) exists. The following section therefore addresses the aspects of context only as they relate to mobility disability specifically; but not to disability in general which is comprehensively covered in the PDD.

### 5.1. International

The CRPD<sup>1</sup> and the Standard Rules on the Equalization of Opportunities for Persons with Disabilities<sup>2</sup> create rights to mobility devices because it is universally recognised that an appropriate mobility device is a precondition to enjoying equal opportunities and rights, and for securing inclusion and participation for persons with a mobility disability. Independent mobility makes it possible for people to study, work and participate in family and community life. Without mobility devices, people with a mobility disability are unable to participate in mainstream developmental initiatives, programmes and strategies that are targeted to the poor, such as are embodied in the Millennium Development Goals, the Poverty Reduction Strategies and other national developmental initiatives.

The Samoa Integrated Mobility Device Services (SIMDES) project is based on the principles established in the World Health Organization (WHO) *Guidelines On The Provision Of Manual Wheelchairs In Less Resourced Settings*<sup>3</sup> and the *Joint Position Paper On The Provision Of Mobility Devices In Less Resourced Settings*<sup>4</sup> which both promote the strategy of integrating Basic and Intermediate level wheelchair and Prosthetic and Orthotic (P&O) services. The *Prosthetics and Orthotics Programme Guide for Implementing P&O Services in Low-Income Settings* concludes that "P&O programmes must work closely with other rehabilitation services in an integrated, holistic approach to disability"<sup>5</sup>.

### 5.2. Regional

The smaller and more isolated populations of the Pacific Region spread over many islands present unique development challenges. Natural, economic and social characteristics of Pacific Islands that have a significant impact on the lives of people with mobility disabilities include; climate (temperature and humidity), corrosive saline environment, buildings raised off the ground to avoid flooding, high cost and difficulty of transport between islands, lack of industrialised production leading to a reliance on imported goods, widespread reliance on subsistence farming and fishing for livelihoods, limited access to communications and information technology, attitudes towards people with disabilities and the largely rural physical environment.

This project is in line with the first core outcome of the DFAT Development for All Strategy: *improved quality of life for people with a disability* and includes several activities which are included in the *indicative areas for action* from the Pacific Island Forum's *Pacific Regional*

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<sup>1</sup> United Nations (2006) *Convention on the Rights of Persons with Disabilities (UNCRPD)*. [www.un.org](http://www.un.org)

<sup>2</sup> United Nations (1993). *Standard Rules on the Equalization of Opportunities for Persons with Disabilities*. [www.un.org](http://www.un.org)

<sup>3</sup> World Health Organization (2008). *Guidelines On The Provision Of Manual Wheelchairs In Less Resourced Settings*. Geneva

<sup>4</sup> World Health Organization (2011). *Joint position paper on the provision of mobility devices in less-resourced settings*. Geneva

<sup>5</sup> The Swiss Agency for Development & Cooperation and Landmine Survivors Network (2006). *PROSTHETICS AND ORTHOTICS PROGRAMME GUIDE: Implementing P&O Services in Low-Income Settings*. Retrieved from [http://www.usispo.org/assets/pdf/Programme\\_Guide\\_Final\\_Version.pdf](http://www.usispo.org/assets/pdf/Programme_Guide_Final_Version.pdf) on 11.04.12.

*Strategy on Disability 2010-2015* (although this document doesn't explicitly contemplate the provision of assistive devices). The Incheon Strategy to "Make the Right Real" for Persons with Disabilities in Asia and the Pacific includes access and availability of assistive devices in its goals. Specifically Target 3.D is to:

"Halve the proportion of persons with disabilities who need but do not have appropriate assistive devices or products"

Motivation Australia have identified that an integrated approach to establishing mobility device services in the Pacific region is a more efficient use of scarce resources<sup>6</sup>. To date, the provision of mobility devices in the Pacific Region has not been approached in an 'integrated' manner; with Basic and Intermediate level wheelchair and Prosthetic and Orthotic (P&O) needs generally being addressed separately.

### **5.3. Country context**

Many of the nations in the Pacific are considered Small Island Developing States (PSIDS) and among the smallest and most remote countries on earth. The natural, economic and social systems of Pacific Islands are extremely vulnerable to external shocks because of their: small size, remoteness, reliance on external demand and supply (eg: most Pacific Islands are net food importers), narrow resource base, exposure to global environmental challenges (particularly the effects of large scale natural disasters and Climate Change) and present unique development challenges. These and other factors contribute to approximately a third of Pacific Island nations being on the UN's list of Least Developed Countries (LDC), including Samoa<sup>7</sup>.

As the PDD states: *"The exact number of people with disabilities or the proportions of different kinds of impairments in Samoa are not known"*. Anecdotal information from Samoan stakeholders consulted and observation (because of the lack of reliable data) support the Pacific Islands Forum Secretariat<sup>8</sup> statement that:

"The number of persons with disabilities is increasing as a result of high rates of diabetes, increasing number of traffic and industrial accidents; increasing life expectancy and the lack of early identification, intervention and referral services."

Samoa appears to have a similar demographic of people with disabilities to other Pacific Island nations. This includes children and adults with cerebral palsy, diabetic amputation, spinal cord injury (SCI), traumatic brain injury, leprosy, stroke (CVA), post polio and frail old age. Many other conditions are likely to be present, however due to the limitations in diagnostic skills and lack of data collection, may not be clearly identified.

There is a significant un-met need for appropriate mobility devices in Samoa. Despite the lack of Samoa specific data, utilising WHO<sup>9</sup> and WHO & ISPO<sup>10</sup> figures it is possible to estimate the number of Samoans who require wheelchair and P&O services. The best published data on further breakdown of wheelchair users is from the UK<sup>11</sup> and demonstrates that the majority of

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<sup>6</sup> Motivation Australia (2012) *Integrated Mobility Device Services Phase 1*. Unpublished report commissioned by WHO

<sup>7</sup> [www.un.org](http://www.un.org)

<sup>8</sup> Pacific Islands Forum Secretariat (2009). *Pacific Regional Strategy on Disability 2010-2015*. [report] Rarotonga.

<sup>9</sup> WHO. (2006). *Guidelines on the provision of manual wheelchairs in less resourced settings*.

<sup>10</sup> WHO & ISPO. (2005). *Guidelines For Training Personnel In Developing Countries For Prosthetics And Orthotics Services*

<sup>11</sup> Legrand, I. (2004) *Meeting user's needs: The case for the introduction of outcome measures*. NHS Purchasing & Supply Agency, Reading, UK

wheelchair users require some kind of modification to their wheelchair to be able to be safely supported and mobile<sup>12</sup>.

Samoa population	1% of the population need a wheelchair [WHO 2006]	0.5% of people need a P&O device [WHO & ISPO 2005]	Total estimated wheelchair and P&O users combined
194,320 [2012 estimate]	1,943	972	2,915

approx. 35% require basic wheelchair service	approx. 65% require intermediate wheelchair service
680	1,263

Table 2: Estimates for numbers of service users in Samoa

The provision of assistive devices is part of core strategic outcome area four of the *Samoa National Policy for People with Disabilities (NPPD)* introduced in 2011:

"Assistive devices are essential for improving the mobility of people, the overall quality of life and in ensuring greater independence. The greatest challenge in this area is in rural areas where mobility issues are most difficult to address and assistive devices are most difficult to deliver because of the lack of services and follow-up to train people in their uses. Strengthening the provision of community based services will be crucial to improving the lives of people with disabilities in Samoa and establishing community centres for repair and maintenance of assistive devices which could, at the same time, provide employment opportunities for people with disabilities could be explored."

The NPPD highlights the challenges of access for people living in rural villages, the lack of coordination between stakeholders and limited resources; as well as the benefits of Community Based Rehabilitation (CBR) initiatives.

#### 5.3.1. **Current NHS mobility device provision**

Mobility device provision by the NHS is currently adhoc; and largely reliant upon receipt of second hand donated items. The hospital physiotherapy department has developed a relationship with United Kingdom (UK) based organisation PhysioNet, which donates second hand equipment no longer fit for purpose in the UK. Most wheelchairs provided are cross folding, orthopaedic style wheelchairs. Remaining stock from the last donation are attendant propelled style wheelchairs with small rear wheels – prohibiting independent mobility. The physiotherapy department has one physiotherapist (degree trained in Fiji) and one physiotherapy aide (CRA diploma, Fiji). Neither has received training in the provision of wheelchairs.

The current orthotics staff of four make wooden axilla crutches and repair donated wheelchairs. They reportedly made 254 pairs of wooden axilla crutches in 2012, and now make approximately 20 per month. These crutches are sold to clients for 20 WST. At least one second hand donated lower limb prostheses was reported as having been provided.

<sup>12</sup> The UK research is not specific about disability or diagnosis, but based on need for modification to the off-the-shelf wheelchairs; for example for increased postural support or pressure relief. It supports the anecdotal and observed experience over twenty years, that the majority of wheelchair users require a more complex level of clinical and technical intermediate service.

The two more senior staff both learned how to make prostheses (using lamination, wood and PP technology) and orthoses (thermo-plastics) on short courses in the 1990s. Both went to Hong Kong for 6-8 months (~1992), one went to Japan for 6mths (~1997) and the other to Fiji for 5 months (~1994: working under Moses at Tamavua with 3 others from Pacific countries). The training these personnel have received is well below the recommended training for Prosthetist Orthotists as outlined by the International Society for Prosthetics and Orthotics (ISPO). Two younger staff with certificate II level carpentry training from Don Bosco school have been recently employed and participate in fabricating wooden crutches and repairing wheelchairs.

#### **5.3.2. *Current mobility device provision by non-government service providers***

The majority of wheelchairs being provided in Samoa are through adhoc distribution of donated often second hand devices by un-trained personnel. Most of the wheelchairs sighted during the programme design visit were basic cross folding, orthopaedic style wheelchairs; however reportedly some more active wheelchairs have been donated in the past. A donation of 550 Free Wheelchair Mission (FWM) 'Gen II' wheelchairs coordinated by the SVSG (Samoa Victims Support Group), is on its way to Samoa; and reportedly will be distributed by volunteers to 'those in need'. The durability of the Gen II wheelchair in the Samoan context is as yet un-proven.

New Zealand NGO Altus Trust, working in partnership with a New Zealand seating service has been a regular provider of donated wheelchairs along with the provision of in-formal training to personnel of the Samoa Spinal Network and Loto Taumafai Special School.

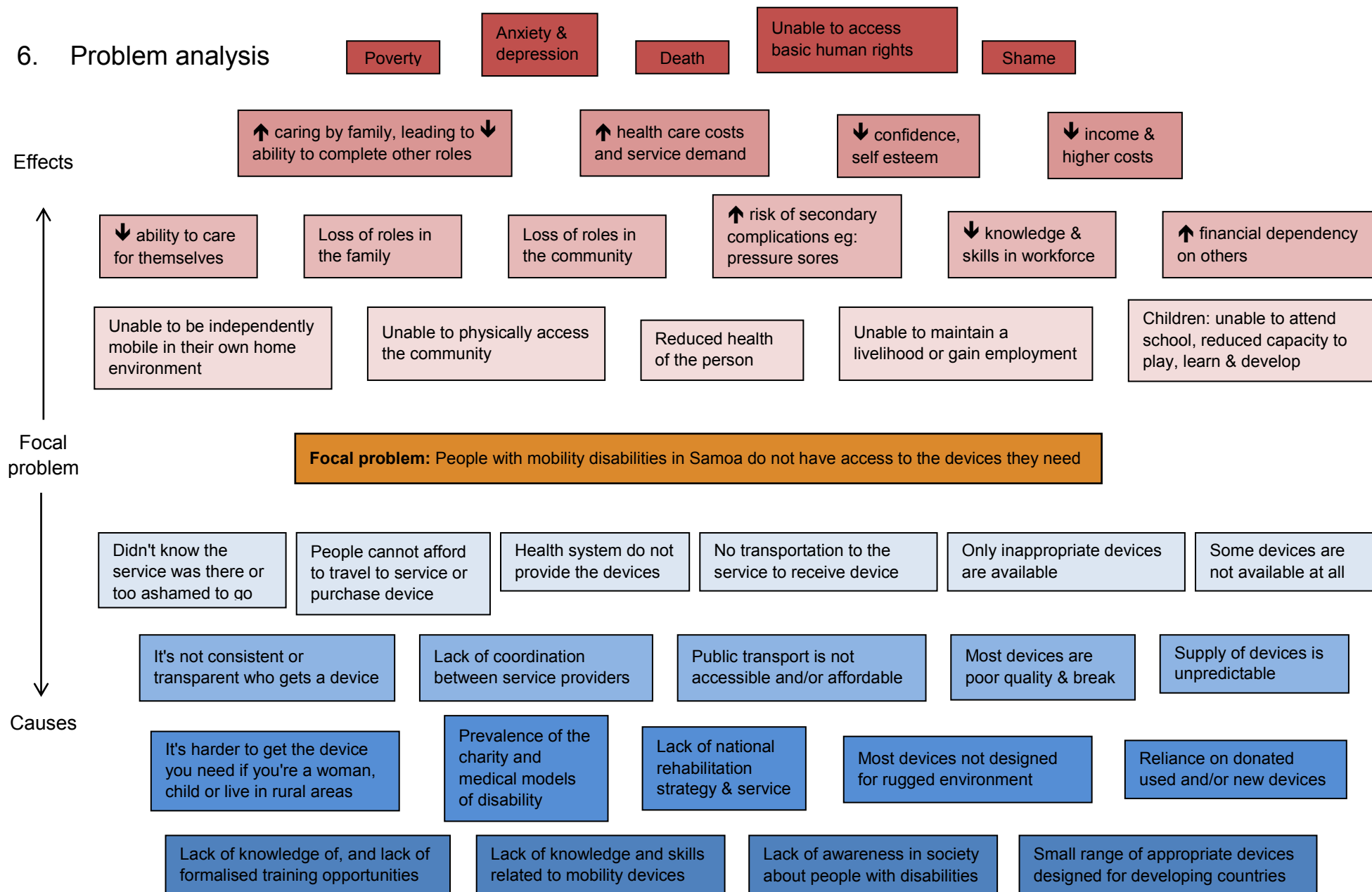
The Accident Compensation Commission (ACC) has provided wheelchairs for approximately 30 clients through the rehabilitation and devices compensation payments (following a work related or Road Traffic Accident). These wheelchairs have predominantly been purchased from Invacare New Zealand.

#### **5.3.3. *Current mobility device provision issues - from the consultation workshop***

Participants of the workshop held during the consultations listed a range of key issues with current mobility device provision. Overall, participants noted that provision is currently in-equitable, the majority of products that are donated are of poor quality, there is a lack of coordination between service providers, most service providers do not have sufficient technical knowledge to be able to judge what may be an 'appropriate product', the standards of service delivery vary, there is limited training for users of mobility devices, there is no accountability, and any training received to date by service provider personnel or volunteers is informal/not accredited or recognised.



## 6. Problem analysis



## 7. Programme design

### 7.1. SDP objective

- The overall programme goal of the SDP is "Disability-inclusive policy and implementation across Government, DPO and service provider organisations".
- Outcome 3(i) of the SDP is: "Increased accessibility of mobility device services."

### 7.2. SIMDES project purpose

To create consistent, equitable and sustainable access to appropriate mobility device provision for women, men, girls and boys with a mobility disability in Samoa.

### 7.3. Objectives

1. **Centre-based service** – Establish a comprehensive, mobility device service at the main hospital in Apia providing basic wheelchair, intermediate wheelchair, Prosthetics & Orthotics (P&O) services and other mobility devices by the end of year four.
2. **Community-based services** – Increase community-based mobility device service provision by GOs and NGOs (for those aspects of mobility device service provision that can be provided effectively in the community through personnel with less training and without workshop facilities).
3. **Sustainable training** – Improve the quality and sustainability of national training in mobility device service delivery; and increase the quantity of clinicians and technicians trained in mobility device provision.
4. **Equitable access to services** – Increase awareness of and equity of access to appropriate mobility device service provision for women, children and people from rural areas (centre-based and community-based).

### 7.4. Outputs

The project chart shown in section 13 shows how the following outputs relate to the four objectives:

1. **Training & mentoring for NHS team** - NHS MDS team trained & mentored to provide and manage basic wheelchair, intermediate wheelchair, Prosthetics & Orthotics (P&O) services and other devices, in both the centre-based and outreach setting,
2. **Outdoor mobility skills area** – designed & constructed with a range of surfaces and obstacles for mobility skills training at TTM Hospital.
3. **Community service provider training** - At least ten personnel from GO and NGO service providers trained to carry out those aspects of mobility device service provision that can be provided effectively in the community through personnel with less training and without workshop facilities (with support and coordination from the MDS team),
4. **Sector coordination group** – Sector coordination group established and representatives from GO and NGO stakeholder groups coordinating mobility device provision activities with the NHS MDS team,
5. **Tools & equipment** – Tools & equipment for the NHS (workshop, clinic and office) and community service provision (hand tools) sourced and procured,
6. **Materials and products** – sourced and procured 1,080<sup>13</sup> low cost, quality, appropriate mobility devices across a range of different models. Supplier information and procurement process handed over to NHS.

<sup>13</sup> 430 in project budget, with a further 650 devices provided as part of a partnership with the LDS church. Bringing the total to 1,290.

7. **SOP manual** - Standard Operating Procedure (SOP) manual created for the four mobility device service areas (including client pathways and technical resource management), for both centre and community based service settings,
8. **Training course development (clinical)** – 400 learning hours certificate course (competency assessed) for clinicians in mobility device service delivery developed.
9. **Training course development (technical)** – 400 learning hours certificate course (competency assessed) for technicians in mobility device service delivery developed.
10. **Course recognition & continuation** – clinical and technical mobility device service delivery certificate courses recognised by an accredited body and future delivery by an educational institution planned,
11. **Awareness raising** - Awareness raised amongst community organisations, personnel and volunteers about the different types of mobility device services available in Samoa and how to access them,
12. **Community referral network training** – At least 50 personnel from government and non-government organisations trained in identification of people with a mobility disability, referral to the most appropriate mobility device service site (NHS / community based), follow-up and support of people with mobility devices in the community.
13. **Gender equity strategy** - Strategy for gender equity in relation to mobility device service provision written in collaboration with NOLA, NHS, MWCSO and other stakeholders,
14. **Draft national guidelines** – Draft national guidelines related to different aspects of mobility device service provision written in collaboration with NOLA, NHS, MWCSO and other stakeholders (under the Samoa National Policy for People with Disabilities),

### 7.5. Key strategies

The following key implementation strategies have been identified:

1. **Scheduling of technical assistance** – The project implementation plan schedules a higher level of technical assistance in the earlier years of the project, tapering off this input in year three and setting aside year four for the technical partner to support full service delivery by the national personnel. This is intended to reduce the risk of a post-project drop in performance and quality (sometimes seen after shorter projects), reduce the overall budget and increase the sustainability by focusing on building the ability of the national personnel to run the new service without external technical assistance.
2. **Certificate training course** – The continuation after the project period; and accreditation of training was consistently raised by stakeholders during the consultations.

The most appropriate pathway towards accreditation in Samoa was identified as the SQA; who have advised that the minimum learning hours for a certificate course is 400 (or 40 credits). This fits well with potential candidates in Samoa for training in mobility device provision – who are likely to require training input to prepare them to undertake the core content of the WHO wheelchair service delivery training and additional modules on provision of other mobility devices. The MDS project should therefore develop a 400 hour certificate level course for clinicians and technicians; which will provide the training necessary to initiate comprehensive mobility device provision in Samoa; and is replicable for future training delivery.

The MDS project should also explore opportunities for continuation of this course after the project period. This requires identification of an educational institution to take over the delivery of the certificate course. At present there are no Samoan educational institutions offering courses with clinical allied health content. Also due to the niche nature of the subject, there may not be sufficient number of students to make the course viable in future years for a Samoan educational institution. A Regional solution may be more appropriate;

and a strong potential candidate is therefore the Fiji National University (FNU) in Suva (which runs the region's main Physiotherapy degree course). This strategy could create significant long term benefits for the whole sector in the region.

3. **MDS principal / counterpart** – There is an identified lack of allied health professionals in Samoa, and the timeframe of the MDS project is such that Samoan students who receive scholarships to study Physiotherapy at FNU in Fiji would not return during the project period. There is however the potential to recruit one of two Samoan allied health professionals, currently living overseas but looking to return to Samoa; identified through consultations with SENESE. This strategy would be beneficial for a number of reasons: attracting a graduate back to the sector in Samoa, having local project staff with good communication skills in English, and reducing the need for an in-country expatriate project manager (and therefore reducing the budget). It is envisaged that the recruited therapist would start as the in-country project officer and transition to become the Principal of the MDS (see organisation chart in Appendix A). This would create a focus for management, service systems and counterpart capacity building. This strategy was endorsed by the NHS Allied Health Manager during the project design visit.
4. **Management training** – Training and capacity building service personnel can be undermined and not translate into consistent service delivery, if the management & decision makers in the organisation lack understanding of what Mobility Device Service provision consists of. The MDS project should therefore include an appropriate level of capacity building managers of GO and NGO services engaged in mobility device provision. The strategy to run a short management level training course, before training service personnel, builds on learning from previous projects in the region. Training content will be based on the WHO Wheelchair Service Training Package Management module (due to be launched late 2013) with additional content added by the technical partner for other mobility devices. Management from community service providers as well as the NHS would be invited to attend; and would be a pre-requisite for any organisation wishing to access training for their personnel in mobility device provision through the MDS project.
5. **Volunteer Prosthetist Orthotist (PO)** – Due to the length of the training needed to qualify as a Category II PO at CSPO<sup>14</sup>, the current graduate (who commenced training at CSPO in October 2013) will not return until the end of year three of the project. In order to utilise the new purpose-built facility and start some P&O services as soon as possible, it is recommended that a volunteer expatriate Category I PO be recruited through the Australian Volunteer Programme. A Category I PO would be able to provide necessary on the job training for the two existing younger NHS orthotic personnel, preparing them in their role as bench technicians and enabling them to begin fabricating simple orthotic devices in the project's second year. Overlapping the volunteer PO with the returning graduate will provide some initial support for the new graduate and a smooth transition between personnel for continual service delivery. A requirement of the volunteer position is that they be familiar with the ICRC lower limb prosthesis technology which will be introduced to Samoa through this project, and which the CSPO graduate will learn at CSPO as part of their training in Cambodia. Not all Australian trained PO professionals have been introduced to this technology; and therefore provision has been made in the budget to equip the volunteer with this knowledge through a short course run by the ICRC in Ethiopia.

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<sup>14</sup> The Cambodian School of Prosthetics and Orthotics. <http://cspo.org.kh>

## 8. Implementation schedule

	Year 1		Year 2		Year 3		Year 4	
Key activities	Jan - Jun	Jul - Dec	Jan - Jun	Jul - Dec	Jan - Jun	Jul - Dec	Jan - Jun	Jul - Dec
Project establishment								
Training material development								
Outdoor mobility skills training area								
Referral network training and awareness								
Service manager training								
Basic wheelchair service start								
Other devices service start								
Establish services in new building								
Intermediate service start								
Lower limb orthotics service start								
Intermediate service mentoring								
Lower limb prosthetics service start								
Graduate PO return from CSPO								
Supporting full service delivery								
Monitoring & project management								

## 9. Programme implementation

The implementation of this project should be guided by the principles outlined in the PDD (p48) and ultimately those of the CRPD.

### 9.1. *Implementation arrangements*

The MDS project encompasses a diverse range of inputs in order to achieve the desired objectives, including human resource planning, training and capacity building through a range of in-country and external training courses; exploring opportunities for accreditation for in-country training; community awareness activities; establishment of a technical workshop; identification, procurement of a range of **appropriate** mobility devices and exploration of the possibility of establishing minimum standards of equipment.

Given this diversity, in the context of the current capacity of the NHS and NGO service providers at this time, it is recommended that the MDS project is implemented through the engagement of a specialist technical partner that works closely with the NHS and NOLA (as the peak representative body of people with a disability); and at the same time engages with the MWCSD.

In addition to these key agencies, it is proposed that a Sector Coordination Group is formed, coordinated by the NHS MDS Principal (with support by the technical partner) and consisting of representatives from the GO and NGO community service providers and NOLA. The Sector Coordination Group will initially ensure two-way communication between the MDS project implementing team, the NHS and other partners; and will lead towards greater cooperation, coordination and accountability between all agencies working in the mobility device provision sector.

### 9.2. *Project partners*

**Technical partner** - The MDS project plan encompasses a diverse range of specialist inputs in order to achieve the desired objectives. Given this diversity, in the context of the current capacity of the NHS and NGO service providers at this time, it is recommended that the MDS project is implemented through the engagement of a specialist technical partner that works closely with the NHS, NOLA (as the peak representative body of people with a disability) and engages with the MWCSD.

**The National Health Service (NHS)** - is responsible for the delivery of health services on behalf of the Government of Samoa. Prior to the SDP, the NHS has been actively seeking solutions to increase mobility device provision in Samoa. Inclusion of the building of an 'orthotics workshop' (now to become the MDS building) in the current SWAP was initiated by the NHS; and the NHS have sought assistance through other donors to establish a prosthetics service in Samoa. The MDS will be housed in a new purpose built building (planned and funded under the Samoa SWAP) in the grounds of the old section of Tupua Tamasese Meaole hospital (TTM) in Apia; and the personnel staffing the new service will be NHS employees. Establishing and building the capacity of the centre-based service in the hospital as well as developing enhanced coordination of mobility device provision as a whole is the responsibility of the NHS; and therefore the NHS is the primary partner for this project. Interaction between the NHS and technical partner will be on a day-to-day basis through capacity building activities and regular meetings.

**NOLA (Nuanua O Le Alofa)** - is the National DPO (Disabled People's Organisation) and the civil society focal point for people with disabilities. NOLA facilitated the first feasibility study carried out in Samoa to investigate the needs of people with a mobility disability (in partnership with Motivation Australia); and has been a strong advocate of the inclusion of the

MDS in the overall SDP. NOLA is a member of Disabled Peoples International (DPI), and an active member of PDF (Pacific Disability Forum).

Working in collaboration with NOLA throughout the project period should ensure that quality outcomes for people with mobility disabilities remain at the forefront of consideration by all partners. Interaction with NOLA should be through Faatino Masunu Utumap on an activity basis, seeking advice and ensuring inclusion in all relevant activities.

**The Ministry of Women, Community and Social Development (MWCSD)** - are the coordinating Ministry and focal point for disability for the Government of Samoa (GoS), and therefore have ownership of the wider SDP. Their network of village level women's representatives will be a valuable resource for the project to reach people with mobility disabilities and their families in the community. In addition, links with the MWCSD on key activities such as gender equity and monitoring and evaluation will be important. Interaction with the MWCSD and their networks should be coordinated through Elizabeth Ah Poe.

The proposed roles and responsibilities of stakeholders are summarised in the table below.

### 9.3. Roles and responsibilities of key stakeholders

**Table 3: Project roles & responsibilities**

Stakeholder	Project roles & responsibilities
MWCSD	<ul style="list-style-type: none"> <li>Ensuring that the SIMDES project contributes the desired outcomes to the broader SDP,</li> <li>Coordinating gender equity activities,</li> <li>Assisting the project implementation team to work effectively with the women's representatives at village level,</li> <li>Coordinating monitoring and evaluation activities.</li> </ul>
NOLA	<ul style="list-style-type: none"> <li>Ensuring that quality outcomes for people with mobility disabilities remain at the forefront of the project's activities,</li> <li>Utilising its networks in the community to promote the project and mobility device services to its members,</li> <li>Continuing to advocate for accessible and affordable transportation to services for people with mobility disabilities,</li> <li>Collaborating with the project team on awareness raising activities in the community,</li> <li>Assisting the project team to identify people with mobility disabilities to participate in practical training sessions,</li> <li>Representation on the Sector Coordination Group.</li> </ul>
NHS	<ul style="list-style-type: none"> <li>NHS have the central and coordinating role in both centre and community based mobility device service provision,</li> <li>Responsible for managing and securing NHS facilities applied to the project including an interim service location, the new MDS building and warehousing for stock,</li> <li>All functions of human resource and line management of MDS NHS personnel,</li> <li>Funding the salaries of MDS personnel from the beginning of year four of the project.</li> </ul>

Community service providers	<ul style="list-style-type: none"> <li>• Identifying personnel to attend management, clinical and technical training,</li> <li>• Utilising their networks in the community to promote the project and mobility device services to its members,</li> <li>• Representation on the Sector Coordination meetings,</li> <li>• Mobility device service delivery in accordance with training provided,</li> <li>• Provision of quantitative and qualitative data to support both monitoring and evaluation of the project and increased service delivery accountability and quality.</li> </ul>
Technical partner	<ul style="list-style-type: none"> <li>• The central and coordinating role in managing the project implementation in cooperation with the NHS and NOLA as primary partners,</li> <li>• Promote participation, coordination and community linkages as envisaged by the PDD,</li> <li>• Capacity building and technical assistance for the MDS services, ensuring that all inputs are based on sound development practises and meet WHO and ISPO (International Society of Prosthetics &amp; Orthotics) requirements for developing countries,</li> <li>• Assistance in recruitment of NHS MDS personnel including preparation of job descriptions, participation in interviews and formulating recommendations to the NHS Allied Health Manager,</li> <li>• Ensure product procurement decisions are based on technical knowledge, and the technical resources (tools &amp; equipment, materials, components and mobility devices) are acquired from specialist suppliers at the best possible value for money (taking into account principles of fit for purpose, durability and ease of repair) for the NHS and ultimately the government of Australia,</li> <li>• Build the NHS capacity to take a progressive, coordinating role in delivering both centre-based and community-based mobility device services including developing strong linkages with community organisations and other GoS departments.</li> <li>• Develop and deliver short training courses in Samoa utilising WHO training materials and working with the SQA to achieve recognition of training as a certificate level course.</li> <li>• Working with stakeholders – aim to progress system wide issues highlighted by the stakeholder workshop (which directly relate to mobility device provision) in collaboration and cooperation with other stakeholders, and within the scope of the programme, such as: <ul style="list-style-type: none"> <li>○ the lack of affordable and accessible transportation for people with disabilities,</li> <li>○ collaborating with NOLA to raise awareness of a <i>rights based approach</i> to disability (in contrast to the <i>charitable</i> and <i>medical</i> models),</li> <li>○ the promotion of sporting activities for people with disabilities to increase participation and social inclusion, in cooperation with NOLA (as contemplated by outcome 2 of the PDD).</li> </ul> </li> </ul>



## 10. Monitoring & evaluation (M&E)

### 10.1. *M&E links within the Samoa Disability Programme*

As the MDS project is one element within the overall Samoa Disability Programme, it is important that M&E is considered within the broader context of the whole programme. It is also important to note that there is a well-documented need for the provision of appropriate mobility devices throughout the Pacific Region – and as such, this project is an opportunity to increase learning for other small island Pacific Nations, DFAT and other stakeholders re cost effective ways to meet this need.

The PDD indicates the early engagement of an M&E specialist, who will assist all stakeholders in the development of an overall MEL framework. It is also recommended in the PDD that work is carried out to establish base line data to assist with evaluating the overall programme impacts. Given the above context, the following specific recommendations are made for the implementation of effective M&E for the MDS project:

- The MDS project partners input via the Samoa Disability Programme M&E specialist to detailed planning to be carried out in the first year to develop an overall MEL framework. The MDS project partners can help to identify base line questions that will help to measure the impact of mobility device provision as the project progresses; and work with the M&E specialist to confirm M&E methodology including the scope and method of data collection.
- The monitoring and evaluation methodology for the MDS project enable collection of data to effectively monitor and evaluate the MDS project **and** its contribution to the overall Samoa Disability Programme (ie - outcomes 1-4). Table 4 below indicates the potential alignment between Samoa Disability Programme objectives and MDS related indicators.
- The Samoa Disability Programme mid-term and end-of-term evaluations encompass the MDS project; and a consultant with a sound understanding of rehabilitation/service delivery in a less resourced setting is a member of the evaluation team.
- The MDS project establish an MDS data base, to collect statistical data of all service delivery carried out as a result of this project (via the NHS centre based service and NGO/GO community service providers), which will be used to assist in monitoring and evaluation of the MDS project. As a minimum this data should include gender, age, location of those accessing the service, service site accessed, details of the device provided and follow up data as it becomes available through routine follow up appointments.
- Pending further discussions with the M&E specialist; a strategy is identified to ensure that recipients of a mobility device through this project are followed up in sufficient numbers and detail to measure the impact of the project on the lives of these people.

## **10.2. Resources required for M&E**

Resources required for M&E will depend upon the final methodology; however the primary requirements are for the database to be developed, a computer (including the relevant software) for the NHS to maintain the database; human resources and travel to enable follow up of MDS recipients. Two computers have been included in the MDS project budget; however there is no provision for human resources and travel. This needs to be considered in the broader SDP planning.

## **10.3. Reporting**

The following recommendations are made regarding the MDS project reporting and communication:

- The MDS project partners develop a quarterly reporting format for communication between implementing partners including NHS senior management. The quarterly report should provide a summary of project achievements against planned activities and objectives and outlines activities for the next quarter. Any issues of concern should be identified within this report; and actions taken or planned to mitigate concerns noted.
- The MDS project report to the MWCSO and DFAT on a six monthly basis. The reporting format should be agreed with the MWCSO and DFAT; and include reference to key indicators as per a finalised M&E framework.
- Given the level of interest in the MDS project from Samoan stakeholders; it is recommended that a summary update be provided on a quarterly basis; and circulated via the proposed sector coordination group.

#### 10.4. Draft M&E framework

Table 4: Draft M&E framework for the MDS project, aligned with the overall Samoa Disability Programme and DFAT Development for All Strategy (outcome one).

DFAT Development for All Strategy	Samoa Disability Programme (SDP)	Samoa Integrated Mobility Device Services (SIMDES)
Core outcome one	Outcome statements (from Annex 9 of PDD)	M&E recommendations and suggested indicators
Improved quality of life for people with disability	<b>Outcome 1:</b> GoS assisted to achieve compliance with the CRPD.	Specifically, this progress will support the GoS's capacity to meet its obligations under Article 20 – Personal Mobility.  Indicators as per outcome 3.
	<b>Outcome 2:</b> Increased community awareness of, and support for, the rights of women, men, boys and girls with disability and their increased inclusion in society.	The WHO recognise that the provision of an appropriate mobility device is for many people with a significant mobility disability a prerequisite for inclusion in society.  Project partners (technical specialist, NOLA, MWCSD, NHS) to work with the M&E specialist to identify methods to track how the Mobility Device Service project contributes to achievement of outcome two; including inclusion in base line study of questions relating to awareness of rights to mobility, how to access a mobility device and how to support someone with a mobility disability in the community. Possible indicators:  <ul style="list-style-type: none"> <li>• Increase referral rates to mobility device service.</li> <li>• Case study evidence of awareness impact (if any) as a result of provision of an appropriate mobility device.</li> <li>• Case study evidence of inclusion impact (if any) as a result of provision of an appropriate mobility device.</li> </ul>

DFAT Development for All Strategy	Samoa Disability Programme	Samoa Integrated Mobility Device Services (SIMDES)
Core outcome one	Outcome statements (from Annex 9 of PDD)	M&E recommendations and suggested high level indicators
Improved quality of life for people with disability	<b>Outcome 3:</b> Improved access by people with disability to services, goods and information, <b>as well as provision of disability-specific services for people with disability.</b>	<p>Improved access to mainstream services:</p> <ul style="list-style-type: none"> <li>Project partners (technical specialist, NOLA, MWCSD, NHS) to work with the M&amp;E specialist to identify methods to track how the Mobility Device Service project contributes to increased access by people with mobility disabilities to mainstream services as a result of the provision of an appropriate mobility device, including inclusion of base line questions related to access barriers for people with a mobility disability.</li> </ul> <p>Provision of mobility device service (disability specific service) indicators:</p> <ul style="list-style-type: none"> <li>Capacity created for up to 800 women, men, girls and boys (by year four) to access appropriate mobility devices per annum through trained personnel from centre and community-based services.</li> <li>Women, children and people with mobility disabilities living in rural areas access the service.</li> <li>NHS commitment to fund mobility devices and services, and to provide them to end users without charge (by year four).</li> <li>Methodology: <ul style="list-style-type: none"> <li>NHS mobility device service client database (to be established as part of this programme); providing aggregated data regarding recipients of mobility devices through the services. Key categories to include: gender, age, service site (centre/community), distance from service site, mobility device received, follow up data.</li> <li>Qualitative feedback (most significant change) from women, men, girls and boys accessing services in order to identify the impact of provision of an appropriate mobility device<sup>15</sup>.</li> </ul> </li> </ul>

<sup>15</sup> The amount of qualitative feedback will depend on available funds to carry out M&E activities to follow up those people who receive a mobility device as a result of this programme.

DFAT Development for All Strategy	Samoa Disability Programme	Samoa Integrated Mobility Device Services (SIMDES)
Core outcome one	Outcome statements (from Annex 9 of PDD)	M&E recommendations and suggested high level indicators
Improved quality of life for people with disability	<b>Outcome 4:</b> Increased access to livelihoods and economic participation by women and men with disability.	<p>Project partners (technical specialist, NOLA, MWCSD, NHS) to work with the M&amp;E specialist to identify methods to track how the Mobility Device Service project contributes to achievement of outcome four; including ensuring that M&amp;E methodology includes a breakdown of different disabilities and collects data on services received by respondents.</p> <p>Possible indicators:</p> <ul style="list-style-type: none"> <li>• Changes in employment status of people with a mobility disability who have been provided with a mobility device through the MDS (requires effective follow up);</li> <li>• Case study evidence of employment impact (if any) as a result of provision of an appropriate mobility device.</li> </ul>

## 11. Cross cutting issues

### 11.1. Gender Equity

A formal gender analysis was outside of the scope of this project design; however participants of the stakeholder workshop indicated that *'it is harder for women to access services in Samoa than men'*. The 2009 UNDP study<sup>16</sup> quoted in the PDD highlighted the multiple and compounding forms of discrimination faced by women and girls with a disability; and the Samoa National Policy for Persons with Disabilities (NPPD) acknowledges that women and girls with disabilities face discrimination in Samoa.

Motivation Australia is currently engaged in research in Papua New Guinea (funded by DFAT: SPSN) aimed at identifying the key barriers and facilitators that affect access to services; with a specific focus on women, children and people who live remote from service sites. Early results from this research indicate that there is significant difference between the barriers faced by men and women.

This PNG research and the Samoan experience reflected in the NPPD demonstrate the importance of deep consideration of strategies to ensure that the MDS project addresses gender equity. As gender equity is also explicitly addressed within the Samoa Disability Programme PDD, it is recommended that the MDS project partners develop in collaboration with MWCSO and other stakeholders (see output 12) a Gender Equity Strategy for mobility device service delivery. This strategy should include the following measures, and others that may be identified as the project progresses:

- Analysis of barriers and facilitators affecting access to mainstream and disability services – in order to inform a detailed Gender Equity Strategy,
- Ensure MDS data collection is disaggregated by gender in order to track the percentage of service users that are women or girls,
- Seek to have equal representation of female and male personnel involved in mobility device service delivery,
- Seek to have equal representation of female and male people with disabilities participating in mobility device clinics as part of the training of national personnel;
- Seek to have equal representation of female and male people with disabilities on any material promoting the MDS,
- Take opportunities to advocate with national stakeholders regarding the rights of women and girls for equitable access to services.

### 11.2. Child Protection

The MDS project will involve working directly with children through the provision of mobility device services. Children with a disability can be particularly vulnerable to abuse because a child with a disability may: be more dependent on other people for their care including dressing, eating, toileting and general mobility; sometimes do not understand that they are being abused; may not have the opportunity to tell people what is happening; may have difficulties with communication which can make it hard to tell another person what is happening to them.

As such, it is essential that the MDS project partners carry out a Child Protection Risk Assessment in the early stages of the project and prior to the delivery of training or

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<sup>16</sup> UNDP Pacific Centre (2009)

commencement of services. Specific strategies that are likely to be identified in a Child Protection Risk Assessment include:

- Training of GO and NGO personnel in mobility device service delivery to include a review of child safe best practises, in line with the Government of Samoa's Child Protection Policy and taking into account the need to safely assess children to effectively provide a mobility device,
- The SOP manual to be developed within the MDS project include a *Child Safe Code of Conduct* for personnel working with children including clear guidance regarding the use of images depicting children,
- All NGO service providers have, or are supported to develop a Child Protection Policy,
- All Australian consultants/volunteers engaged on the project to provide technical assistance should be familiar with Child Protection principles; have signed a relevant Child Protection Policy; and have been cleared through an Australian Federal police check.

### **11.3. Counter-terrorism**

The Australian Federal Government has not identified any of the proposed project partners as terrorist organisations.

### **11.4. Environment**

The potential impacts of the MDS project on the environment are through the flights used to transport technical partner personnel to and from Samoa, the procurement and shipping of technical resources (products, materials, tools & equipment) from overseas and any waste produced by the MDS.

Recommended strategies for minimising environmental damage in these identified areas are:

- Wherever possible when booking flights paying the carbon offset fee to airlines,
- Seeking assurances from suppliers of technical resources that their businesses are managed responsibly,
- Choosing to procure mobility devices which are more durable in rugged environments. For example: some of the best products available come from The Motivation Charitable Trust (UK based development organisation) and are manufactured in China. Motivation's Chinese supplier has been assessed against criteria that reflects the intention of Social Accountability International's SA8000 standard. This includes quality control, factory standards, environmental impact and child labour.
- Used appropriate wheelchairs (originally procured by the service) which are returned damaged to the MDS can be disassembled and kept for spare parts (rather than disposed of). Examples of this strategy being effective at reducing waste from wheelchair services can be seen in The Solomon Islands, Papua New Guinea, Fiji and East Timor.
- Importing goods creates packaging waste. Most of the mobility devices to be procured through this project are normally delivered in 40' shipping containers packed in cardboard cartons. Opportunities should be identified to work with the NHS and other service partners to ensure that the cardboard boxes are re-used or recycled responsibly.
- Fabricating P&O devices creates small scraps of Polypropylene (PP). PP is a thermoplastic which can be easily recycled even in a developing country context and there is potential to provide the NHS with advice on the necessary machinery.

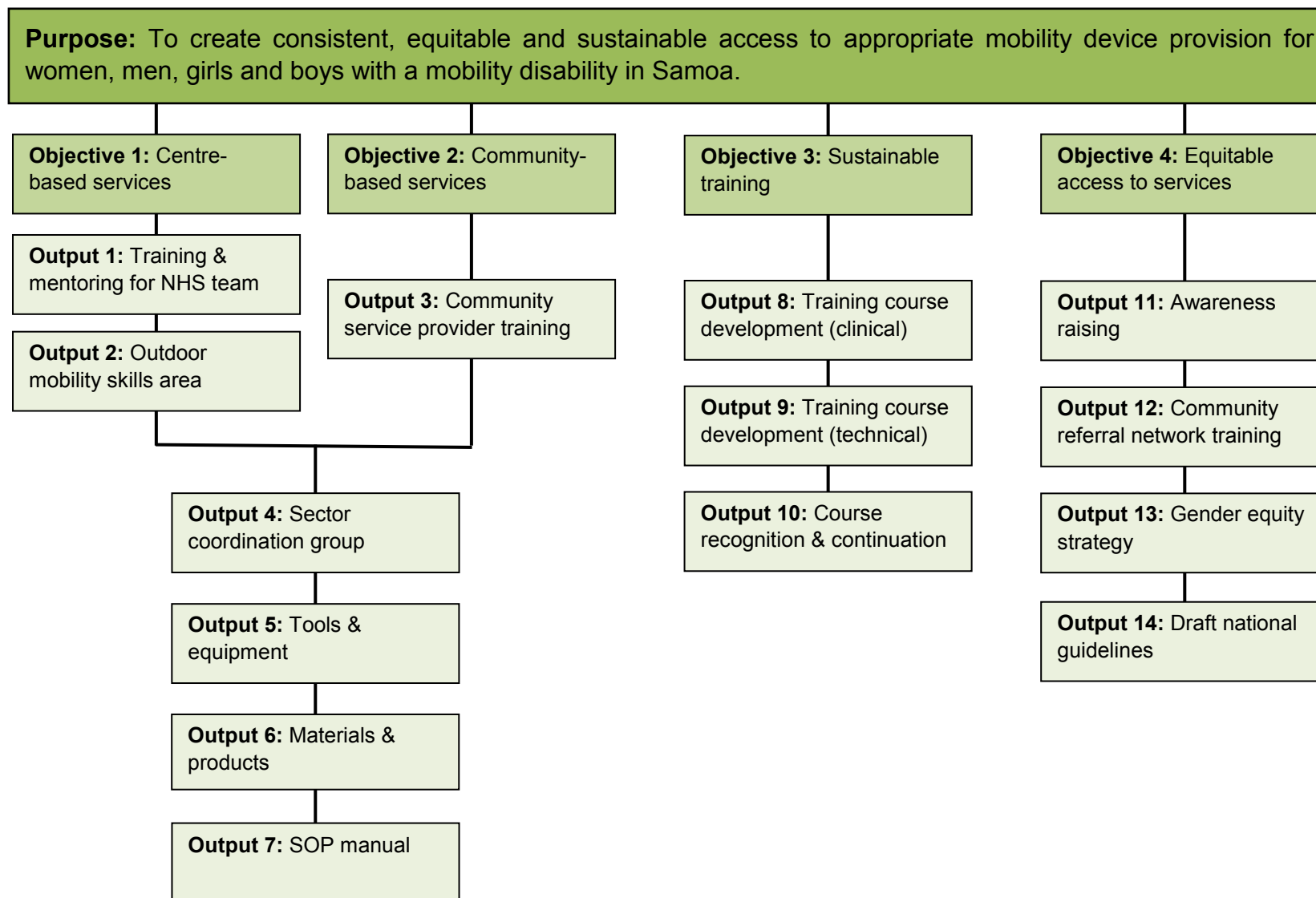
## 12. Budget

No.	Description	Funding source		Total	Comment
		DFAT	LDS Church		
	<b>Capital costs</b>	328,474.54			
	Two mixed containers of mobility devices		130,000.00		Donation by LDS Church - TBC
	<b>Subtotal capital costs</b>			<b>458,474.54</b>	
	<b>Operational costs</b>	212,350.00			
	<b>Subtotal operational costs</b>			<b>212,350.00</b>	
	<b>Human resources</b>				
	Technical partner salaries	554,900.08			
	NHS salaries	257,788.10			
	<b>Subtotal human resources</b>			<b>812,688.18</b>	
	<b>Staff travel</b>	171,040.00			
	<b>Subtotal staff travel</b>			<b>171,040.00</b>	
	<b>Subtotal</b>	<b>1,524,552.72</b>	<b>130,000.00</b>	<b>1,654,552.72</b>	
	Contingency at 3%	45,896.75			
	Inflation at 3%	46,604.20			
	Indirect cost recovery (administration, auditing & accountability) <sup>17</sup>	182,946.33			
	<b>Grand total</b>	<b>1,800,000.00</b>	<b>130,000.00</b>	<b>1,930,000.00</b>	

<sup>17</sup> Indirect Cost Recovery at 12% supports Technical Partner costs associated with: administration; fund raising; programme management, evaluation and dissemination; ongoing liaison with partners before and after programme implementation as part of a longer term commitment; donor reporting; Australian auditing and accountability requirements.



### 13. Project chart



## 14. Logical framework

Project purpose	Indicators	Means of verification	Risks & assumptions
To create consistent, equitable and sustainable access to appropriate mobility device provision for women, men, girls and boys with a mobility disability in Samoa.	<p>Capacity created for the centre and community-based services to provide 745 individually fitted, appropriate mobility devices to women, men, girls and boys per annum through trained personnel (see Table 1).</p> <p>Approximately 430 women, men, girls and boys receive a mobility device from the materials &amp; products included in the project budget.</p> <p>A further 650 women and men receive mobility devices through partnership between the MDS and the LDS<sup>18</sup>.</p> <p>Women, children and people with mobility disabilities living in rural areas access the service.</p> <p>NHS funding MDS personnel by year four of the programme; and formal commitment to fund mobility devices and services, and to provide them to end users without charge.</p>	<p>NHS MDS client database records; analysis and bi-annual reports</p> <p>NHS HR records show recommended personnel employed [See Appendix A: MDS organisation chart].</p> <p>Qualitative feedback collected (most significant change) from women, men, girls and boys accessing services.</p>	<p>The capacity building of NHS personnel, in combination with the creation of systems and procedures, is sufficient to create an organisational culture which fosters equity and consistency of service.</p> <p>That the NHS maintain the level of staffing proposed in the design upon which all figures based, and take up the payment of salaries after year 3.</p> <p>That the estimates of how many clients the MDS personnel can see on average per year prove to be accurate.</p> <p>Activities undertaken through the project to increase the equity of access are successful.</p> <p>Sustaining senior level support within the NHS &amp; MWCS is critical to the project meeting its objectives.</p> <p>Transportation to services is successfully addressed as part of the wider Samoa Disability Programme.</p> <p>The LDS commit to funding two 40' mixed containers of devices (approx. 650 devices) as discussed.</p>

<sup>18</sup> Church of the Jesus Christ of the Latter Day Saints.

Project objectives	Indicators	Means of verification	Risks & assumptions
<p>1. <b>Centre-based service</b> – Establish a comprehensive, mobility device service at the main hospital in Apia providing basic wheelchair, intermediate wheelchair, Prosthetics &amp; Orthotics (P&amp;O) services and other devices by the end of year four.</p>	<p>The MDS is operational with trained staff, competent to provide a full range of mobility devices<sup>19</sup>.</p> <p>The technical resources needed to run the MDS are in place.</p> <p>Stock of materials and products in storage at the new facility and other warehouse locations.</p> <p>Personnel providing services based on their training, the MDS standard operating procedures (SOP) and mentoring from the technical partner.</p> <p>An outdoor mobility training area is constructed.</p>	<p>Competency assessment and certificate for each training participant.</p> <p>Project progress documented in quarterly monitoring reports.</p> <p>Receipts for purchases made by the project.</p> <p>NHS client database records.</p> <p>MDS standard operating procedures (SOP).</p> <p>An outdoor mobility skills training area and records of use.</p>	<p>The building is constructed and tools &amp; equipment are procured and installed on time by the NHS &amp; SWAP programme.</p> <p>Buildings and facilities are safe and fit for purpose at both the interim and final location in the new building.</p> <p>That the personnel trained by the project remain with the service for at least two years after training.</p>
<p>2. <b>Community-based services</b> – Increase community-based mobility device service provision by GOs and NGOs (for those aspects of mobility device service provision that can be provided effectively in the community through personnel with less training and without workshop facilities).</p>	<p>People with mobility disabilities able to access mobility devices appropriate to their needs without needing to visit TTM hospital in Apia<sup>21</sup>.</p> <p>NGOs providing mobility device services in the community<sup>20</sup>.</p> <p>Service providers in the community have the technical resources they need.</p> <p>Community service provision is being coordinated with the MDS in Apia through a Sector Coordination Group.</p>	<p>NHS client database records showing who carried out the assessment and prescription.</p> <p>MDS records of how many of which devices were provided to whom and where.</p> <p>Competency assessment and certificate for each training participant.</p> <p>Project progress documented in monitoring reports.</p>	<p>The leaders of the NGO service providers continue to support the project, cooperate and work collaboratively with the NHS through the Sector Coordination Group.</p> <p>The community service providers store the tools needed for mobility device service provision securely.</p>

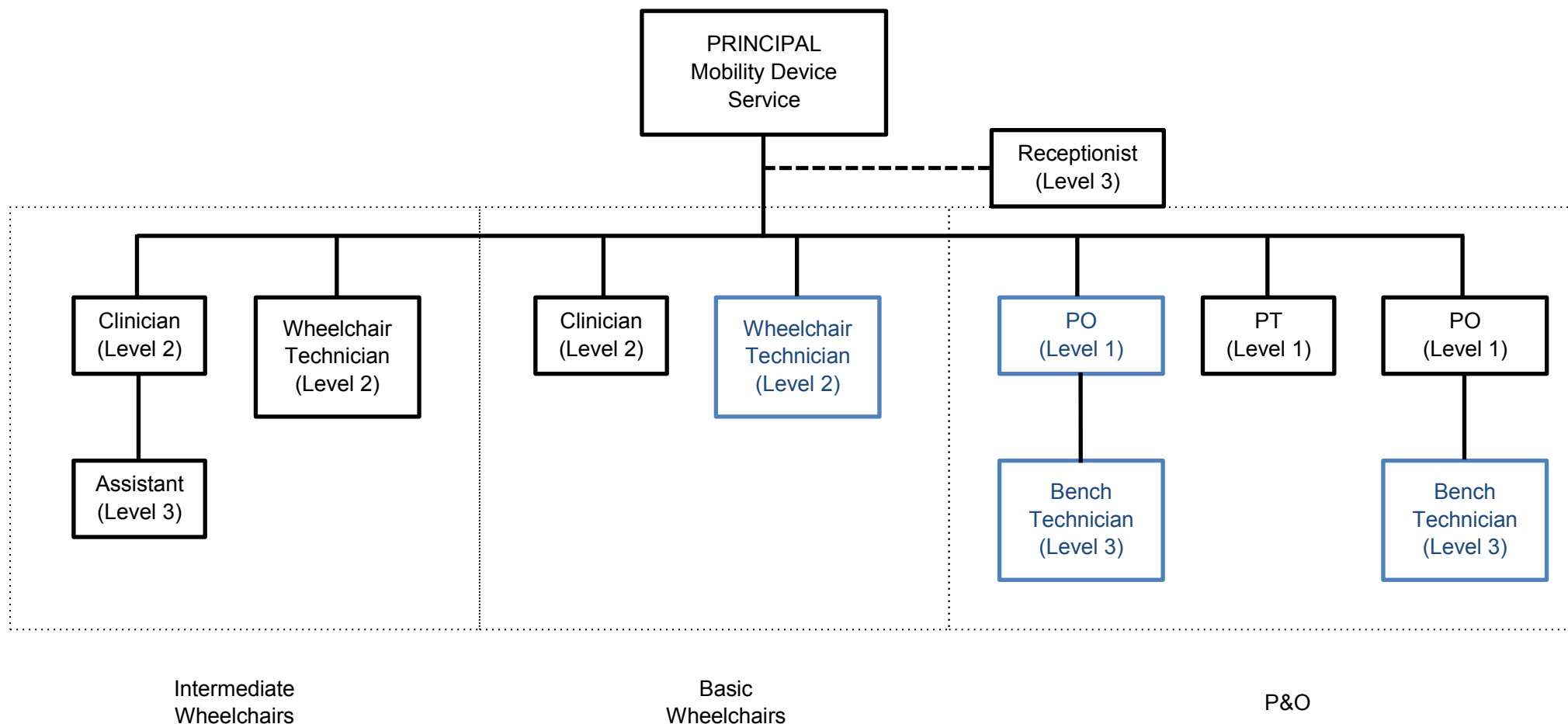
<sup>19</sup> Basic wheelchairs, intermediate wheelchairs, Prosthetics & Orthotics (P&O) services and other devices

<sup>20</sup> For those aspects of mobility device service provision that can be provided effectively in the community through personnel with less training and without workshop facilities

Project objectives	Indicators	Means of verification	Risks & assumptions
3. <b>Sustainable training</b> – Improve the quality and sustainability of training; and increase the quantity of clinicians and technicians trained in mobility device service provision.	<p>Training curriculum developed in mobility device service provision for clinicians.</p> <p>Training curriculum developed in mobility device service provision for technicians.</p> <p>Training recognised or accredited by a Samoan institution.</p> <p>A training institution in the region offer the course to students.</p>	<p>Training course materials.</p> <p>Documentation for accreditation as formal or informal training.</p> <p>Correspondence with an educational institution confirming that they will offer the course.</p>	<p>That the training curriculum developed meet the requirements of SQA (Samoan Quality Assurance) to be accredited as either formal or informal training.</p> <p>That there are sufficient numbers of potential students for either an educational institution in Samoa, Fiji National University (FNU), University of the South Pacific (USP) or another training institution in the region to offer the course.</p>
4. <b>Equitable access to services</b> – Increase awareness of and equity of access to appropriate mobility device service provision for women, children and people from rural areas (centre-based and community-based).	<p>Events to raise the awareness about the different types of mobility device services available in Samoa and how to access them are held.</p> <p>Personnel from potential referral sources for the MDS participate in workshops to learn about identification, referral and follow-up.</p> <p>A gender equity strategy is drafted to promote equality of access to mobility device services.</p> <p>National guidelines on aspects of mobility device provision are drafted.</p>	<p>Attendance records at awareness raising and referral network events.</p> <p>Draft gender equity strategy documents.</p> <p>Draft national guideline documents.</p> <p>Correspondence and records of meetings with government and non-government stakeholders.</p>	<p>A gender equity strategy is drafted which has GoS support and is practical enough to make a significant difference for women accessing services.</p> <p>The GoS is open to adopting the national guidelines on mobility device provision drafted by the project partners.</p>

## Appendix A: Proposed Mobility Device Service organisation chart

Proposed staffing structure for year four, when three separate teams can be engaged to provide: Basic Wheelchairs, Intermediate Wheelchairs and P&O services respectively. It is envisaged that other mobility devices (such as crutches, walkers, walking sticks, etc) would be provided by the Basic Wheelchair team. Existing NHS budgeted positions are shown in blue.



## Appendix B: Risk matrix

Risk	Likelihood	Impact	Risk level	Is this level of risk acceptable?	Proposed mitigating action
The lack of affordable and accessible transportation remains a significant barrier to PWDs being able to access the service.	Very likely	Major	4.Extreme	No	Discuss vehicle purchase with NHS & DFAT. Research private sector models. Highlight the issue in the detailed design document as a significant challenge. Explore cost of an accessible vehicle to inform discussions.
That the flow of donated, inappropriate equipment continues outside of the service and puts users' health at risk.	Very likely	Major	4.Extreme	No	Continue to advocate for appropriate devices, engage and raise awareness amongst organisations, utilise LDS as a model of improved donation, advocate for minimum standards, create educational material about the risks.
The one PO training at CSPO does not return to work in the service for whatever reason.	Likely	Major	3.High	No	Train at least one other PO.
There are not enough people with a clinical skills / aptitude to train to fill all of the clinical positions.	Likely	Moderate	2.Medium	No	Identify and enrol clinical staff of the MDS in shorter training courses (one year or less) as soon as possible.
That the NGO community remains fragmented / uncoordinated with each group continuing to do their own thing. May not affect the MDS at the hospital, but could affect reach into the community.	Likely	Moderate	2.Medium	No	Initiate a regular coordination meeting with NGOs at the MDS run by the Principal. Include personnel from the NGOs in first year training activities.
The LDS do not commit to funding two 40' mixed containers of devices (approx. 650 devices) as discussed	Unlikely	Moderate	1.Low	No	Budgeted for approximately 640 mobility devices. Partnership agreement to be sought with LDS. Further funding would need to be sought.

[TABLE REDACTED: Commercial in confidence]

## Appendix C: List of people involved in consultations

Sorted alphabetically by organisation

Name	Organisation	Email	Mobile / Landline
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Nofovaleane Mapusua	NOLA		21147 / 25243
Sa Utailesolo	NOLA		21147 / 25243
Ueni(Wayne) Siilata	NOLA		21147 / 25243
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Elenoa	Samoa Victim Support		
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## Appendix D: Definitions

For the purpose of this document, the following terms are defined as:

- **Appropriate prosthetic or orthotic technology:** A system providing fit and alignment which suits the needs of the individual and can be sustained by the country at the most economical price. Proper fit and alignment should be based on sound biomechanical principles<sup>21</sup>.
- **Appropriate wheelchair:** A wheelchair that meets the user's needs and environmental conditions; provides proper fit and postural support; is safe and durable; is available in the country; and can be obtained and maintained, and services sustained in the country at the most economical and affordable price<sup>22</sup>.
- **Basic level service:** A basic level wheelchair service is able to provide a wheelchair and cushion to girls, boys, women and men who have a mobility impairment, but who can sit upright without additional postural support.
- **Integrated mobility device services:** Within this document, this term is used to refer to the provision of wheelchairs, Prosthetics and Orthotics (P&O) and supportive seating (and other mobility devices such as walking frames, crutches) within one integrated service.
- **Intermediate level service:** An intermediate level wheelchair service is able to provide wheelchairs to girls, boys, women and men who have a mobility disability, and need additional postural support in their wheelchair to help them to sit upright.
- **ISPO Category I Prosthetist Orthotist:** responsible for all aspects of prosthetic and orthotic client care and management of service as well as research and development initiatives.
- **ISPO Category II Prosthetist Orthotist:** responsible for all aspects of prosthetic and orthotic client care and is not trained in research and development.
- **ISPO Category III Bench Technician:** Responsible for supporting Prosthetist/Orthotist in fabricating and repairing prostheses and orthoses as requested and directed by clinical staff, as well as maintaining the workshop tools and equipment. The bench technician does not provide direct client care.
- **Mobility devices:** Mobility devices are designed to facilitate or enhance a user's personal mobility. Common examples include crutches, walking frames, wheelchairs, tricycles, orthoses such as callipers and prostheses such as artificial legs<sup>23</sup>.
- **Orthosis:** An orthopaedic device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. Lower limb orthoses may be used to enhance mobility.
- **Prosthesis:** An artificial device used to replace a missing body part. In this document, the terms 'prosthesis' or 'prosthetic limb' are used primarily to describe a lower limb prosthesis.
- **Supportive seating:** A type of wheelchair for people who cannot sit upright without support. Providing a higher level of individually prescribed postural support than a standard appropriate wheelchair, and supporting the wheelchair user in a functional upright sitting posture.
- **Wheelchair:** A device providing wheeled mobility and seating support for a person with difficulty in walking or moving around. In this document, a wheelchair refers to a manual wheelchair.

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<sup>21</sup>World Health Organization (2005) *Guidelines for training personnel in developing countries for Prosthetics and Orthotics services*; World Health Organization: Geneva

<sup>22</sup>World Health Organization (2008) *The provision of manual wheelchairs in less resourced settings*; World Health Organization: Geneva

<sup>23</sup>World Health Organization (2011) *Joint position paper on the provision of mobility devices in less resourced settings*, World Health Organization: Geneva