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Brief Report

Strengthening rehabilitation capacity in Fiji through regional collaboration with Australian rehabilitation clinicians

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Rehabilitation services across many Pacific Island nations remain limited, constrained by workforce shortages of trained professionals, scarce resources, geographic isolation, and infrastructural challenges.[1] These systemic barriers continue to restrict equitable access to quality rehabilitation services and widen disability-related health disparities across the region.

Fiji faces a growing burden of non-communicable diseases (NCDs), which accounted for 77.1% of the national disease burden in 2019, up from 64.1% in 1990.[2] Also, NCDs contribute substantially to long-term impairment, disability, and premature mortality, with nearly 64% of NCD-related deaths occurring among adults aged 30 to 70 years in 2019.[2] The National Rehabilitation Medicine Hospital 2023-2024 Annual Report (Singh, 2023-2024, Rehab Annual Report, available on request) stated that 47.8% and 28.9% of inpatients were admitted secondary to spinal cord injury (SCI) and stroke respectively. In addition, 65.3% of outpatient cases were reported to be lower limb amputations. The increase in uncontrolled diabetes has led to a notable increase in the number of amputations with the overall five-year prevalence of diabetic foot amputation (DFA) was 106.6 per 1,000 diabetic patients (10.6%) between 2017 and 2021 which has impacted the already stretched manpower and funding resources.[3-6] The growing burden of disability, coupled with limited workforce and resources, has created an urgent need to strengthen rehabilitation services in Fiji. Within this context, Fiji has emerged as a regional leader through the development of its "National Disability Inclusive Health and Rehabilitation Action Plan 2023-2027".[7] Championed by the Fiji rehabilitation physician, this "Action Plan" provides a strategic framework for advancing inclusive, coordinated, and sustainable rehabilitation services at a national level.

This article describes the April 2025 Fiji Rehabilitation Workshop, building on the inaugural workshop held in March 2024, and identifies key lessons to inform future rehabilitation capacity-building efforts, including a planned workshop in May 2026.

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Workshop Delivery

The three-day workshop was delivered in Suva by six Australian clinicians (four rehabilitation physicians, one occupational therapist, and one speech pathologist) working alongside the local Fijian rehabilitation team. A broad range of clinical topics was selected by the Fijian rehabilitation team, including stroke, SCI, lower limb amputation, cerebral palsy (CP) in young adults, and rehabilitation in older adults. These were delivered over seven sessions across three days, with varying numbers of participants, as local clinicians joined sessions relevant to their clinical practice.

Teaching methods included interactive lectures, case-based discussions, and facilitated breakout groups, alongside hands-on, in-person skills sessions covering post-stroke cognitive and functional assessment, pressure-injury prevention and management, and amputee rehabilitation using real patients. A hybrid virtual/in-person speech pathology component was delivered in partnership with an Australian speech pathology provider and a local non-governmental organization (NGO). Daily reinforcement quizzes helped consolidate practical learning and reinforce key concepts throughout the sessions.

Local prosthetists joined the amputation rehabilitation session, sharing real trans-tibial and trans-femoral case discussions and locally relevant skills suited to the region's climate and landscape.

Participant Demographics

Demographic questions were collected only once, at the start of the stroke session (Session 1), and were completed by 32 of the participants present at that session. According to profession, respondents were predominantly nurses (n = 19, 59.4%), followed by physicians (n = 7, 22%), physiotherapists (n = 5, 15.6%), and one patient experience coordinator (3.1%). According to years of professional experience (n = 31/32 respondents): six (19.4%) had one to two years, seven (22.6%) had three to five years, five (16.1%) had six to 10 years, seven (22.6%) had 11 to 15 years, and six (19.4%) had more than 15 years.

Feedback

All participants were invited to complete an online feedback survey in REDcap after each of clinical topic sessions. Each survey asked participants to rate five domains on a 1 to 10 scale (1 = poor, 10 = excellent) clarity of information, engagement (activities and discussion), relevance of content, how well the slides supported understanding, and confidence to apply what was learned with space for free-text comments.

A total of 237 session-level survey submissions were received across the seven sessions (32 in Stroke, 40 in SCI, 36 in Amputee Rehabilitation, 31 in Geriatrics, 45 in Cognitive Impairment, 23 in CP, and 30 in Swallowing). Rating was overwhelmingly positive across all seven sessions (n = 23-45 per session), with median scores reaching ceiling (10/10, and interquartile ranges [IQR]: 7 to 10) on nearly every domain. The sole exception being the Stroke session, where two domains (engagement and confidence-to-apply-learning) had a median of 9 (IQR: 8 to 10).

These positive ratings were supported by free-text comments from participants. Participants valued the practical, case-based teaching style, describing sessions as a "good practical session," "fun," and "easy to apply," and praised facilitators' expertise and delivery as "very knowledgeable" and "clear and easy to understand." The main suggestion for improvement was to extend the session duration, allowing more time for discussion, reflection, and hands-on practice. This feedback, together with the strong engagement scores, suggests that participants valued the existing content and format and would benefit from greater time allocation rather than a change in approach.

DISCUSSION

Although the action plan offers a strategic framework, implementation is challenging for an already under-resourced workforce, making international collaboration essential. This initiative partnered with regional experts to upskill clinicians and foster multidisciplinary learning, aligning with the World Health Organization (WHO) Rehabilitation 2030

and International Society of Physical and Rehabilitation Medicine's (ISPRM) call to scale up rehabilitation in under-resourced countries, showing how context-specific collaboration can support service development.[8]

Current limitations, lessons learnt, and future planning:

1. Australian clinicians self-funded travel to attend workshops in Fiji, limiting the long-term sustainability of face-to-face collaboration.
2. Despite ongoing efforts by the local rehabilitation team and the Fijian government, stretched local resources continued to be a barrier to attendance for local participants.
3. Developing an appropriate education model was challenging given the program's context-specific nature and the absence of comparable models elsewhere. Rehabilitation physicians, therefore, worked with local partners to develop and contextualize a workshop-based model, informed by a needs assessment and local preferences.
4. It remains unclear whether participants have sustained their learning or changed clinical practice, as evaluation to date has focused on perceptions rather than objective outcomes. A follow-up survey at three months post-workshop is planned to capture reflections, applied learning, and impact, and virtual mentoring has already been offered to support ongoing application and connection.
5. Local capacity to use health information and clinical data needs strengthening. Strengthening local data collection and evaluation is a likely next step to assess capacity-building effectiveness from a local perspective.

In conclusion, Fiji's experience indicates how national leadership and international partnership can strengthen workforce capacity, interdisciplinary learning, and equitable access to rehabilitation. Future programs should add robust evaluation, including pre- and post-assessments, three-month follow-up surveys, and structured mentoring, to track practice change and patient outcomes. Scaling this model could benefit other Pacific and similarly resourced nations.

Declaration of Conflicting Interests

The authors declare that there are no conflicts of interest with respect to the research, authorship, and/or publication of this article.

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Author Contributions

S.G.: Conceived the study concept and developed the initial study design, took the lead in drafting the initial versions of the manuscript; S.G., Y.W., N.G., P.S.: Developed the feedback survey and analysed the data. All authors conducted the literature review. All authors critically reviewed and contributed to the manuscript and approved the final version.

Data Availability

The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

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AI Disclosure

The authors declare that artificial intelligence (AI) tools were not used, or were used solely for language editing, and had no role in data analysis, interpretation, or the formulation of conclusions. All scientific content, data interpretation, and conclusions are the sole responsibility of the authors. The authors further confirm that AI tools were not used to generate, fabricate, or 'hallucinate' references, and that all references have been carefully verified for accuracy.

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