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CHAPTER 11

An Evaluation of the Impact of Medical Services Provided by General Hospitals Compared with Services Aligned to a Social Model Perspective at a Spinal Cord Injury Centre in Bangladesh

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This chapter explores the differences arising from two distinctive approaches to supporting people with spinal cord lesion (SCL): first, those services offered by general hospitals that operate exclusively within a medical model; and second, the services provided by the Centre for the Rehabilitation of the Paralysed (CRP), which draw on a social model perspective. It will be argued that the exclusive reliance on a medical model that underpins general hospital provision too often results in health and rehabilitation problems and inadequate support services for people with SCL. In contrast, the combination of social and medical services at CRP delivered a range of support that produced better outcomes for people with SCL. On this evidence, the approach taken by CRP should be more widely adopted by government and non-government organisations in developing services for people with SCL.

Study Context

Bangladesh is one of the poorest countries in the world, with an estimated 45 per cent of the population living below the poverty line (ILO 2001). Poverty is defined here in terms of an individual's calorie intake, health care, educational opportunities, safe drinking water, sanitation and shelter. Approximately 60 per cent of the population does not have access to modern primary health care services beyond immunisation and family

planning (Abedin 1997, 2000), while only 25 per cent of pregnant women receive antenatal care, and a mere 14 per cent of births are attended by someone with formal training (World Bank 1999). Furthermore, only 44 per cent of the population uses a sanitary method of sewage disposal (BBS 1997). The life expectancy at birth is 60 years (BBS 2001a). However, sons are often preferred to daughters (Rahman and Davanzo 1993) and as a result, female children may be discriminated against in terms of the provision of food (Chen et al. 1981 cited in World Bank 1999) and medical and health care (Hossain and Glass 1988). Overall, 65 per cent of the adult population in Bangladesh is illiterate, but this figure rises to 78 per cent among females (World Bank 1993). The per capita income is US \$386 (Abedin 2000). Agriculture generates about one-third of the Gross Domestic Product (GDP), and provides employment for over 60 per cent of the labour force (NFOWD 1999).

In Bangladesh there is no specialist government hospital for the treatment and rehabilitation of people with SCL. Instead, there is a single non-government organisation (NGO), CRP, which has been working in this field for the last 25 years. Without a comprehensive government programme, the vast majority of people with SCL have not received any services and little attention has been given to how they cope in their respective communities. The incidence of people with SCL in Bangladesh has been estimated as six persons per million (Hoque 2002), although this is not a comprehensive study as many people with SCL do not survive after their injury, or do not (or cannot) access medical care. The World Health Organization (WHO) (1997) has suggested a much higher figure, between 20–40 persons per million, although it has been estimated that in Sri Lanka the equivalent rate is as high as 66.7 persons per million (Motivation 1999).

Conceptualising disability

The government of Bangladesh regards 'disability', including people with SCL, as solely a medical problem. In contrast, many people with SCL feel their condition is a curse from God because of their misdeeds, feelings that are reinforced by the negative attitudes of society towards disabled people (Momin 2003). This means that when people with SCL return to their communities they are not able to participate in everyday activities due to social and environmental barriers, ranging from overt discrimination to the lack of physical access in their locality.

Unlike some other 'low resource' countries Bangladesh has been slow to adopt a rights-based approach to providing services for disabled people.

There has been a widespread lack of community awareness of disability issues, although as a result of the United Nations (UN) initiative, the Bangladeshi government has begun to rethink its approach. It has agreed to implement the United Nations' 22 *Standard Rules on Equalisation of Opportunities for Persons with Disabilities* (UN 1993) and incorporated these within a national policy for the welfare of disabled people. However, there has been little action to advance the integration of people with SCL into community life. One of the reasons for this failure is the continuing perception that disability can only be tackled by medical and allied treatment services. Hence the importance of exploring a social model approach which highlights the attitudinal, institutional, and environmental discrimination against disabled people.

Though there are many issues surrounding the application of a social model approach in a non-western country (Stone 1999), it is useful to remember that the social model is an holistic approach that focuses on the entire disability experience. While it may be possible to distinguish between medical and social issues in the well-resourced countries of Europe and North America, it is not so easy in poor countries like Bangladesh where medical and rehabilitation services are extremely scarce. Again, a social model approach does not reject the significance of appropriate medical and rehabilitative interventions (Oliver 2004). Indeed, their denial is a political and human rights issue (Hurst 2001; WHO 2001). Hence, the value of a social model analysis of the support available to people with SCL in poor countries like Bangladesh.

Services for people with SCL in Bangladesh

Both specialised spinal cord lesion centres and general hospitals in Bangladesh provide services for people with SCL, although the level of medical care, rehabilitation and support services is generally regarded as inadequate and below the standards of similar services in India (Sinha 2000). Many people after sustaining a spinal injury are not immediately diagnosed or are mis-diagnosed, and a person acquiring a spinal cord injury will often be kept at home and seek support from a traditional healer. As a result, many people with SCL experience medical complications such as urine infections and bedsores.

As their condition deteriorates some are taken to *upazilla* or district hospitals. Those who are taken to the nearest *upazilla* health complex (a 31-50 bed government hospital staffed by, on average, eight qualified physicians) or to a nearby clinic, typically find that these institutions

provide them with little more than an initial assessment and basic treatment. Indeed, it may already be too late to save their lives. In other cases, the receiving hospital will refer the patient to a specialised hospital or medical college hospital or to CRP for further treatment (although there are no specialised government hospitals for the treatment and rehabilitation of people with SCL). However, transfer to a general hospital is dependent on the availability of beds and appropriate medical expertise in dealing with SCL. Given the widespread shortage of specialist skills at general hospitals, once their medical condition is stabilised, people with SCL are usually discharged even though therapeutic and support services in the community are inadequate.

Almost all people with SCL return to their own homes after being discharged, with only a few staying in specialist homes or rehabilitation centres for a short time. CRP receives 88 per cent of its users either as referrals from general hospitals, or when patients themselves decide to leave hospital in search of better care (CRP 2002). No matter what the source of the referral, many SCL patients experience severe pressure sores and other major complications. A significant number of those who do not receive specialist care die within two years, while most of those who do survive are dependent on their families for their personal care.

There is no standardised system of service provision in general hospitals in Bangladesh for people with SCL. Data collected as part of my study showed that on average people stay at these hospitals for 8 weeks after injury and then go back to their communities. Although hospital providers often declare an intention to 'cure' their patients, very few receive any treatment from therapists during their hospitalisation. Nor is there provision for any dialogue between patients and service providers. Therefore, when people with SCL are discharged from general hospitals, there is little or no follow-up treatment or advice, despite its obvious importance to their well-being. In comparison, India has significantly more hospital facilities for people with spinal cord injuries that include an established protocol of treatment (acute care) and rehabilitation (physical, emotional, social and economic) through to discharge into the community (Sinha 2000; Momin 2003).

In Bangladesh, general hospitals and clinics offer very little in the way of health education training programmes for people with SCL or their family members. The majority of people with SCL do not receive any mobility aids, even when such aids are essential. Very few are involved in self-care activities, continuing education or employment following their

hospitalisation. As a result they are often trapped within their homes with only their family to help them. Some hope that they will be 'cured' one day and return to a normal life, but when this does not happen they often lose confidence in themselves, and become fully dependent on their families for survival. This is a too-frequent outcome for ex-general hospital users because no training is provided to help them or their families adjust to their new life situation.

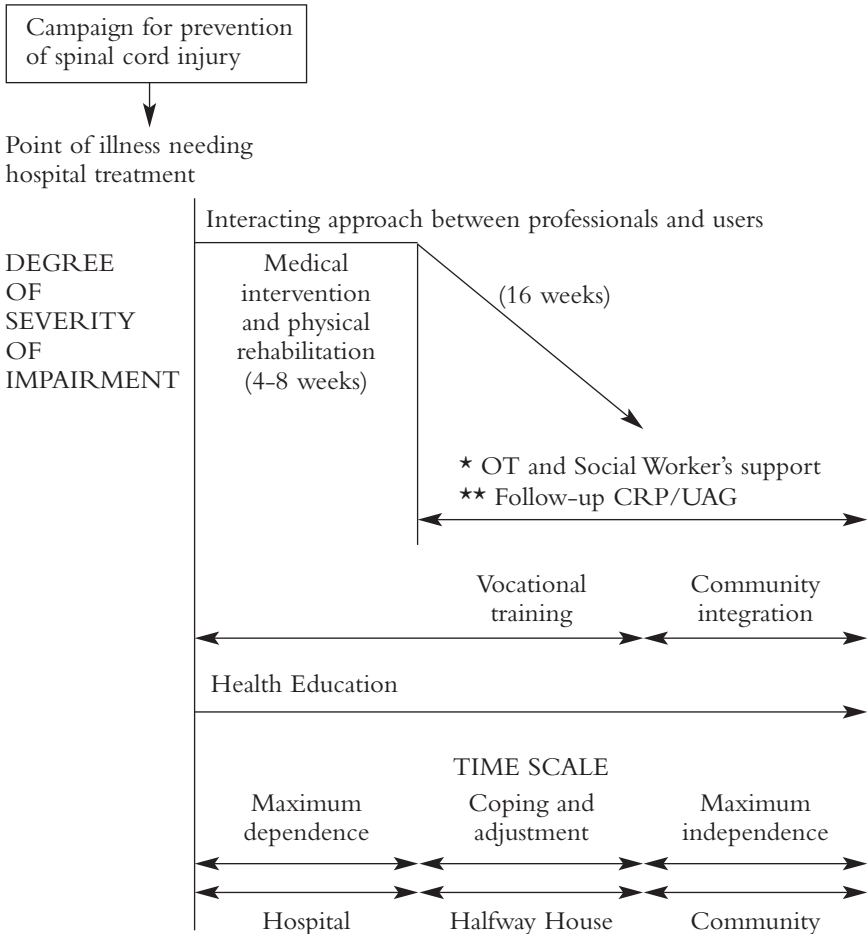
In contrast, CRP has developed a standard and comprehensive system to provide services for people with SCL, based on its existing resources. It has made a vital contribution to the rehabilitation of paralysed people, and the quality and importance of its work is widely recognised both in Bangladesh and elsewhere in South Asia. CRP has developed an approach that provides treatment and rehabilitation to the 'whole' person. It also campaigns for preventive measures and the avoidance of SCL through meetings, seminars, the electronic media and feature films.

Figure 1 summarises this process. In general, a person with SCL stays on average 16 weeks in the hospital under the care of a multidisciplinary team. During this time comprehensive medical intervention and physical rehabilitation support is provided. Once the medical condition is stabilised, attention is directed to the care of the skin, the bladder and the bowels, and the prevention of complications such as pressure sores, urinary infections and muscle contractions. This is done through the delivery of health education training to users and their carers/family members. Half-hourly turning and lifting takes place to prevent pressure sores, and intermittent catheterisation and bladder washouts are conducted as required.

At the same time the physical and social rehabilitation process is provided through the involvement of physiotherapists, occupational therapists and social workers. Health education and activities for daily living training are provided by ex-users who are mainly wheelchair users. Mobility aids are distributed along with instruction on their use and maintenance. If required, training of carers or family members also takes place. 'Active rehab' courses are provided to users to develop their self-confidence in the use of the wheelchair, within and outside the home environment. In addition, users are encouraged to share their ideas with the service providers (doctors, nurses, therapists and social workers).

The next stage is to refer users to a halfway house, where they usually stay for four to eight weeks while undertaking vocational training. The halfway house is modelled on a traditional Bangladeshi 'bari' (house). Its purpose is to build confidence in the person with SCL and their family

Figure 1: CRP service provision



Key: * Occupational Therapy;
** *Upazilla Action Group*, a forum for disabled people promoting community based rehabilitation

Source: Adapted from Finkelstein (1989: 8).

members so that when they return home they can manage themselves without support from professionals. There is no electricity supply and oil lamps are used for lighting the room, and no water supply so that a hand tube-well is used to provide water. In addition, there is no gas supply and firewood is used for cooking. There is a small vegetable plot, flower garden, and a small poultry/goat house. Users are responsible, on a rotational basis,

for undertaking important activities such as cooking and looking after the poultry.

Family members are encouraged to accompany people with SCL during their stay at the halfway house to familiarise them with the new environmental demands. All the facilities are accessible to wheelchair users who are encouraged to look after themselves and carry out their own activities of daily living. No personal assistance or nursing care is provided; instead, a member of the user's family is encouraged to give support. CRP's role is to facilitate a level of 'independent living' for users with the support of their family. If the individual is a tetraplegic, then a family member is supported to provide care, often by an ex-service wheelchair user. Furthermore, occupational therapy is available to the user when required. When people with SCL are in the halfway house, a CRP social worker visits their home to advise family members if any adaptations or modifications are required and to see if any professional advice is needed about what to do once the person with SCL returns. At the same time staff from the social welfare department discuss their plans for becoming self-reliant including, if required, specific work training.

After leaving the halfway house, people with SCL go back to their own communities. A social worker or a Community Based Rehabilitation (CBR) worker carries out a follow-up visit to a user's home to check if any physical, social, emotional or economic support is required in the community. The users will often be supported by members of the Upazilla Action Group Committee, so they are briefed about its functions and forms of assistance while they are at the Centre. Once back in the community, they are given an opportunity to share their experience with people with similar impairments, while CRP social workers or CBR workers make home visits to support them. The whole approach is designed to facilitate people with SCL in achieving a self-supported life.

In accordance with CRP's positive discrimination policy, women are given higher priority than men during service provision. In this way an attempt is made to redress the situation whereby women are deprived of available services by the traditional domination of males in Bangladeshi society. CRP aims to offer the fullest support to people with SC in order to assist their reintegration into community life.

Research study

The research findings reported here are based on fieldwork conducted as part of a PhD project undertaken by the author. The project adopted a

participatory approach based on the philosophy of emancipatory research (Oliver 1992; Barnes and Mercer 1997). People with spinal cord lesion played a key role in the research design, and it was considered vital that their views should be presented as accurately as possible.

In total, 64 individuals were recruited for face-to-face, semi-structured interviews. Half the sample came from CRP, selected through stratified random sampling, and the other half comprised general hospital patients identified by a process of quota sampling. The participants were aged between 10 and 59 years, and all had received services between 1994 and 1999. Data were analysed using the Statistical Package for the Social Sciences (SPSS). A detailed comparison was made of the views of CRP and general hospital users, and a chi-square test (with a 5 per cent level of significance) undertaken to assess the statistical significance of selected variables. In addition, more qualitative data have been used to present participants' views. All interviewees have been given pseudonyms to ensure their anonymity.

Health problems

Health problems for people with SCL are generated from poor medical treatment, nursing care and therapeutic services, received either at the institutional or community level. Eighteen common secondary problems related to medical services were identified from the review of the literature (e.g. Johnson et al. 1998). The interviews with users confirmed thirteen of these: superficial, deep and infected pressure sores, infections of respiratory tract, urinary tract or wound, bowel complications, regular and/or chronic pain in shoulder or abdomen; painful spasms, depression, relationship problems with partners, families or friends and psychological health.

Chi-square analysis was carried out to determine whether there was a significant difference between the percentage of CRP respondents and other respondents reporting secondary health problems. As illustrated in Table 1, the difference was significant ($p < .05$) for 11 of the 13 symptoms, with a lower percentage of CRP users reporting secondary problems. It is suggested that the care and service provided by CRP accounts for this pattern. The differences experienced by respondents are illustrated by comments from individual interviews. Thus, Rashida, a woman who received services in a general hospital and was suffering from pressure sores, said:

I developed my pressure sores at the hospital. No one told me why it happens or what to do about it. When they saw my physical condition was deteriorating they released me, saying it was not worth treating.

Rashida's comments reflect the experiences of the majority of general hospital users (72 per cent) who had developed their pressure sores when in hospital, and had not received advice about their prevention or treatment. Nafiza, a female CRP user who had earlier developed pressure sores at the general hospital, reported that:

When doctors at the general hospital saw that they were unable to manage the 'patients' in their own hospitals during the last stage, when their physical condition became unmanageable, then they referred them to CRP.

Table 1: Comparison health problems as between CRP users and general hospital users

Health problem	Percentage reporting			Statistical Significance
	CRP % (Number)	General hospital % (Number)	Total % (Number)	
Superficial pressure sores	16 (05)	59 (19)	38 (24)	p<.000
Deep pressure sores	19 (06)	50 (16)	34 (22)	p<.008
Infected pressure sores	03 (01)	44 (14)	23 (15)	p<.000
Respiratory tract infection	16 (05)	47 (15)	31 (20)	p<.007
Urinary tract infection	13 (04)	63 (20)	38 (24)	p<.000
Bowel complications	16 (05)	44 (14)	30 (19)	p<.000
Regular shoulder pain	47 (15)	69 (22)	58 (37)	p<.076
Regular abdominal pain	09 (03)	53 (17)	31 (20)	p<.000
Wound infection	03 (01)	44 (14)	23 (15)	p<.000
Painful spasm	44 (14)	59 (19)	53 (34)	p<.211
Depression	22 (07)	59 (19)	41 (26)	p<.002
Relationship with partner	09 (03)	28 (09)	19 (12)	p<.014
Relationship problems with family/friends	16 (05)	38 (12)	27 (17)	p<.048

This reflects the experience of 88 per cent of CRP users who were initially admitted to general hospitals. Moreover, there was a statistically significant relationship reported between 'severity of injury' and reports of 'superficial pressure sores' ($p < .000$), 'deep pressure sores' ($p < .001$), 'infected pressure sores' ($p < .004$), 'bowel complications' ($p < .000$), 'abdominal pain' ($p < .002$) and 'depression' ($p < .005$). Although respiratory tract infection itself does not demonstrate a statistical relationship to severity of injury, individuals have a greater chance of contracting respiratory tract infections if their injury prevents them from supporting themselves in a vertical position. As a rule, patients confined to their beds will be more prone to respiratory tract infection, as will those in poor health. There were no significant differences in the experiences of health problems of men and women.

Problems relating to rehabilitation services

Rehabilitation covers three different areas: physical, social and economic. Physical rehabilitation includes health education provided to users and their family members for prevention of further complications from spinal cord injury, such as pressure sores and urine infection. It has been found that of those participants and their family members who had received health education, very few reported health problems after being discharged from the hospital. Social rehabilitation was carried out through home visits to provide support to people with SCL in order to integrate them into family life, social activities, health care and education. Economic rehabilitation was provided through vocational training. When people with SCL are unable to return to their previous occupations, they require new skills to be able to take part in economic activities. CRP provides such rehabilitation, unlike most other SCL treatment centres.

Health education training for users

Health education training on the nature of SCL and the ways of managing and caring for associated health problems is crucial for people with SCL if they are to be kept fit, self-supportive and independent.

A statistically significant difference separated health education training between CRP users and general hospital users ($p < .000$). CRP encourages all its users, when they are ready, to join health education training so that they have appropriate basic self-care knowledge before they are discharged. This service is provided at CRP through peer group support with former users taking part in demonstrations and training. Many respondents

commented that they learn most when they can exchange experience with other people with SCL.

The general hospitals offered health education, but only 9 per cent actually received this service. Moreover, the training was partial and dependent on a user's determination to be shown some of the techniques of personal care during their hospital stay. Many general hospital users said they had some idea about self-care but this was mostly restricted to taking medicines and continuing exercise. This proved inadequate in community situations where the majority experienced pressure sores, urinary tract infections and bowel problems. Needless to say, such conditions made it difficult to continue with their everyday lives.

As an illustration, one general hospital user with a severe impairment, Akbar, reported that he had not received any training in bladder control and experienced severe infection:

I have no control of my bladder. I was asked to attend fortnightly checks at the doctor's clinic at hospital, which I did for the first few months. I no longer attend and still have persistent leaking of urine.

Akbar's wife complained that she had to take her husband to a doctor's clinic. Neither she nor her husband knew about the use of a catheter.

In contrast, the great majority of participants who received services from CRP said that they were able to control secondary complications such as pressure sores, urine infection and bowel complications. As Rajib, who was severely impaired, noted:

I have no bowel complications when I am regular but otherwise complications arise. I have learned at CRP how to manage my bowel and it is important that I follow CRP's advice to keep me fit.

No association was found between 'health education' and 'severity of injury' or 'gender'. This may be because all CRP users receive health education training.

Health education for family members

Family members of all CRP users were given health education training, unlike family members of general hospital users. Those people who attended CRP sessions were usually women, although males included the husband of a paraplegic user and some fathers and brothers of individuals with SCL. Health education training begins at CRP from the day the patient is transferred to the halfway hostel. There are two health educators, one male and one female, who are ex-patients of CRP and wheelchair

users. Their job is to deliver health education so that family members can help prevent medical complications. This training is provided in an informal setting, with practical demonstrations of lifting from the wheelchair to prevent bedsores, dressing of bedsores, use of the toilet and catheter, cleaning catheters, bowel training and the maintenance of technical aids and equipment.

Home visits

Home visits by social workers, rehabilitation workers, therapists and nurses proved to be very effective, especially given the absence of community nursing or other such services. CRP's policy is to visit all users once a year in their homes, and keep in touch with users every four months through a newsletter and a questionnaire to ascertain their physical, social, emotional and economic condition. Subsequent feedback is given by CRP staff, through home visits and associated support, or if necessary by re-admitting users. Conversely, general hospitals do not provide a home visit programme, and their staff do not know how their patients cope once discharged.

Users who are experiencing problems with adjusting to their new life in the community are visited by CRP staff more frequently. The majority of those receiving multiple visits were people with complete tetraplegia and paraplegia. It was felt by CRP users that home visits were successful in empowering those who were socially deprived or emotionally depressed. They have the added function of recognising service users as human beings and worthy of respect and support. No association was found between a home or follow-up visit and gender. Again this may be explained with reference to CRP's equal opportunities policy.

Vocational training

Vocational training offers an option to those who cannot return to their previous jobs with the opportunity to acquire new knowledge and skills. Fifty per cent of CRP users with tetraplegia, and 63 per cent of people with paraplegia received such training. For example, Hafiz, who was severely impaired, said:

When I was in ... hospital I felt that I was powerless and would soon die. Fortunately I was able to go to CRP where I accessed medical and rehabilitation services. As my physical impairment did not allow me to return to my previous occupation I also received vocational training in poultry keeping. I now have 300 ducks and am able to earn enough to maintain my family.

Hafiz's experience illustrates the usefulness of vocational training. CRP users who were unable to go back to their previous occupations received vocational training from CRP and as a consequence were able to maintain a self-supported lifestyle. Fifty per cent of CRP users, mostly mildly impaired, both men and women, felt no need for any vocational training, either because they were able to continue their previous occupations or because they found new occupations not requiring any training. Of those receiving vocational training, the great majority had either a severe or moderate impairment.

A few individuals receiving CRP services did not avail themselves of vocational training in the hope that they would be able to continue with their education or previous job, but others felt vocational training could help them to get paid work or run a business. One user commented that CRP should offer tailor-made training so that there would be no uncertainty about work. Another felt that because of his lack of confidence and insecurity about obtaining work, he did not wish to join the vocational training programme. General hospital patients generally regarded medical treatment as the priority, and few received vocational training, although several recognised the significance of becoming more self-reliant. There was no association between 'vocational training' and 'severity of injury' among CRP users, and no relationship between 'vocational training' and 'gender' – perhaps because a higher number of female users of CRP in the sample received vocational training.

Reported problems relating to support services

In this study, support services include provision of technical aids and appliances. The term aids covers mobility aids such as wheelchairs (fixed or folding, motorised or manual), trollies, crutches and walking frames. No participants had motorised wheelchairs, although CRP users had the choice of a fixed or folding manual wheelchair, whereas some general hospital were only offered a fixed wheelchair. In interview, one CRP user and two general hospital users made occasional use of crutches, but this lasted no more than six months. According to participants, when they left the hospital, doctors/therapists advised them to use crutches because of weakness in the lower limbs but over a period of time the lower limbs strengthened and crutches were discarded. Another three general hospital users reported that although it might have helped their movement, it was not suggested that they use crutches. Mannan, with a mild impairment, commented:

I took treatment from various hospitals. No one advised me to use a walking stick or crutches. After I received services at CRP I came to know the benefit of the use of crutches. Prior to that, I was homebound.

Table 2: Use of mobility aids (CRP and General Hospital users)

Mobility aids	Service providers		Total % (Number)
	CRP	General Hospital	
	% (Number)	% (Number)	
Don't require mobility aids	50 (16)	41 (13)	45 (29)
Required but didn't have mobility aids	06 (02)	53 (17)	30 (19)
Have mobility aids	44 (14)	06 (02)	25 (16)
Total	100 (32)	100 (32)	100 (64)

A statistically significant relationship was found between 'service provider' and 'user of mobility aids' ($p < .000$), and also between 'severity of injury' and 'use of mobility aids' ($p < .000$) (Table 2). A major weakness of general hospitals was that 50 per cent of people with tetraplegia and 31 per cent of people with paraplegia did not receive any mobility aids, which may be one of the reasons most of them depended on family members to carry them around. Fifty-three per cent of the general hospital users who were not using mobility aids believed that one day they could go back to their normal lives. In addition, their family members were reluctant to procure mobility aids even when they could afford to buy them. In contrast, only 6 percent of CRP users who said they needed them lacked mobility aids. One user's family believed that he would walk again, while another user felt that a wheelchair would make it more difficult to move around inside her house.

There was no statistically significant relationship between the 'user of mobility aids' and 'gender' – again perhaps because of CRP's priority support to female users. With one exception, all who required mobility aids received them. Moreover, CRP provides a free wheelchair to women if they are too poor to purchase one. It also has an on-site workshop that builds mobility aids for users. This is particularly important because there are very few places in Bangladesh where mobility aids are available. 'Appliances' include collars and splints, which directly or indirectly help in personal care. For example, a finger splint may enable someone to grasp a

pen for writing or typing, and at least six CRP participants were using splints, compared with none in the general hospital group.

Conclusion

The research fieldwork confirms that people with SCL are seldom a priority in Bangladesh. They do not receive adequate medical and support services in government hospitals which remain dominated by a medical approach. Present provision in the government and private sectors does not help people with SCL to survive or to become re-integrated into society. As a result many hospital patients lead an isolated life and experience higher levels of morbidity and a greater likelihood of premature death.

Conversely, the research demonstrates that people who go to CRP have fewer pressure sores, chest infections and less constipation than those who have sought help elsewhere. It also demonstrates that they suffer less pain and depression and experience a satisfactory level of support services, leading to better health. CRP services promote self-reliance rather than dependence on health and social services, with consequential cost savings. Nationwide availability of specialist CRP centres could revolutionise the health care outcomes and quality of life of people with SCL in Bangladesh – as has happened in Sri Lanka (Chappell 2001).

It is therefore recommended that the Government should re-think its exclusive support for medical and support services and establish a spinal unit modelled on CRP in each division of Bangladesh. This would help prevent people with SCL experiencing increasing morbidity and premature death. Greater collaboration between CRP and the general hospitals is necessary for the early transfer of people with SCL to CRP or similar spinal unit centres. It has been observed that those participants referred to CRP at an early stage required less time at the Centre than those admitted at a later stage. Moreover, the majority of clients admitted to CRP were referred from general hospitals with severe pressure sores. In the absence of standard protocols for treatment and rehabilitation of people with SCL they are often given the wrong diagnosis or inappropriate treatment which results in more suffering and may lead to death. Thus, protocols should be formulated to guide service development nationally in order to meet the continuing needs of people with SCL.

The Government has a long way to go to ensure that disabled people have access to high quality medical, rehabilitation and support services and facilities as a basic right, freely available to all people with impairment, regardless of the severity of injury, age, gender, race and sexual orientation.

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