World Health Organization
Western Pacific Region

REHABILITATION AND DISABILITY IN THE WESTERN PACIFIC

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CONTENTS

Acknowledgements	**iii**
Abbreviations and country codes	**iv**
Executive summary	**v**
Introduction	**1**
Methods	**5**
— Questionnaire	5
— Data collection	6
— Analysis of the survey data	7
— Development of country profiles	8
— Limitations	8
Results	**11**
— Part 1: Removing barriers and improving access to health care	11
— Part 2: Rehabilitation services, community-based rehabilitation and assistive technology	18
— Part 3: Information about people with disability	38
Report highlights and discussion	**41**
— Capacity to deliver disability-inclusive health care	41
— Capacity to deliver rehabilitation, assistive technology and community-based rehabilitation	43
— Availability of disability data	46
Conclusions and priority areas for action for the WHO Western Pacific Region	**47**
Annex	**53**
— **Country profiles**	54

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ABBREVIATIONS

CBR community-based rehabilitation
DPO disabled people's organization
ICF International Classification of Functioning, Disability and Health
INGO international nongovernmental organization
NGO nongovernmental organization
UN United Nations
WHO World Health Organization

COUNTRY CODES

AUS Australia
BRN Brunei Darussalam
CHN China
FJI Fiji
FSM Micronesia, Federated States of
JPN Japan
KHM Cambodia
KIR Kiribati
KOR Republic of Korea
LAO Lao People's Democratic Republic
MHL Marshall Islands
MNG Mongolia
MYS Malaysia
NEZ New Zealand
PHL Philippines
PLW Palau
PNG Papua New Guinea
SGP Singapore
SLB Solomon Islands
TON Tonga
TUV Tuvalu
VUT Vanuatu
VNM Viet Nam
WSM Samoa

EXECUTIVE SUMMARY

The *World Report on Disability* estimates there are more than 1 billion people with disability worldwide, about 15% of the global population. People with disability face widespread barriers to accessing services. They experience poorer health outcomes, lower educational achievement, less economic participation and higher rates of poverty than people without disability. The World Health Organization (WHO) recognizes disability as a global public health concern, a human rights issue and a development priority. Linked to this, the *WHO Global Disability Action Plan 2014–2021: Better Health for All People with Disability* aims to contribute to improving health, well-being and human rights for people with disability.

In 2015, the WHO Regional Office for the Western Pacific conducted a survey on the status of rehabilitation and disability in the Western Pacific Region. It is the first survey of its kind in the Region, intending to provide information on the status of national capacity to provide disability-inclusive health care, rehabilitation, assistive technology, community-based rehabilitation and disability data in the Western Pacific Region. An 80-item questionnaire was developed with three parts to reflect the objectives of the WHO Global Disability Action Plan:

1. Inclusion of people with disability in health care services and health facilities;
2. Rehabilitation services, community-based rehabilitation and assistive technology; and
3. Information and data about people with disability.

In all, 24 out of 27 countries (89%) in the Western Pacific Region responded to the survey. This report reflects the information provided by countries as of December 2015. The key findings are reflected against the background of progress of countries towards the three objectives of the Global Disability Action Plan.

Removing barriers and improving access to health services and programmes

Governments in the Region are increasingly echoing international commitments. National health legislation and policies regularly include persons with disabilities. Seven countries have taken steps to eliminate discrimination of persons with disabilities by health insurance agencies.

It is encouraging to see that governments are slowly developing leadership and governance structures for disability-inclusive health, mostly through utilizing the structure and mechanisms of national disability coordinating bodies. Most governments have undertaken some actions that will assist in making regular health care affordable through social protection mechanisms and health financing mechanisms.

Some countries have initiated making regular health care accessible through adopting national accessibility standards, communication of information through appropriate formats and supporting mechanisms to improve continuum of care by development of referral pathways.

Strengthening and extending rehabilitation, assistive technology, and community-based rehabilitation

Rehabilitation sector planning is needed, and positive progress has occurred with recent drafting of national rehabilitation strategies in some countries. Coordination between government agencies involved in delivery of rehabilitation services at both the highest planning level and the community service provision level needs attention.

Most high-income countries have comprehensive rehabilitation services available from primary to tertiary-level health care. However, most rehabilitation services in lower and upper middle-income countries are limited to physical therapy offered mostly in tertiary-level health care facilities.

Existing funding not adequate to meet the large unmet rehabilitation needs including assistive technology

Stark limitations in the rehabilitation workforce across lower and upper middle-income countries exist and have a significant impact on availability and quality of rehabilitation services. Rehabilitation services are part of a comprehensive health system that benefits all people experiencing functional limitations. Weak workforce capacity not only impacts on people with disability, but reaches across the population to all people recovering from illness or injury or managing chronic illnesses.

Increasingly, community-based rehabilitation is being adopted as a strategy to support inclusion of people with disability into local services and community. Increasingly, countries are addressing the need for assistive technology, albeit limited in scope and range. However, there remains limited availability of appropriate assistive technologies and inadequate standards for provision of good-quality, safe and affordable technologies.

Strengthening collection of relevant and internationally comparable data on disability and support research on disability and related services

Increasingly, governments in the Region are initiating activities for deepening understanding of the extent of disability in their countries. Governments are allocating research funding to disability-related studies, but these are limited to mostly high-income countries.

The survey highlighted that comprehensive and internationally comparable data on disability are limited as methods of measurement and monitoring approaches differ. Countries that have initiated steps towards identifying prevalence of disability have reported 2–3% prevalence rates; this is far from the 15% prevalence reported in the *World Report on Disability.*

Key conclusions and priority areas for action

1. Ministries of health are on the way to fully identifying and addressing barriers experienced by persons with disabilities when accessing general health services; a more systematic and strategic approach is encouraged.

2. There is very limited rehabilitation available in most lower and upper middle-income countries even though it is an essential health strategy; it is suggested that rehabilitation requires more significant planning and investment by ministries of health.

3. Provision of assistive technology is inadequate; stronger leadership, financing and development of comprehensive programmes that include a wide range of technology are encouraged.

4. Community-based rehabilitation remains an important strategy for increasing access to services in lower and upper middle-income countries, yet programme management and evaluation requires development; governments are encouraged to increasingly fund and support programmes with a strong community focus.

5. The Pacific island countries experience particularly large deficits in rehabilitation services and many governments are experiencing ongoing challenges to respond; political prioritization and collective action at national and Regional levels are suggested to strengthen both central and community-based services.

6. The rehabilitation workforce is limited and can be weak, contributing to the slow development of rehabilitation services; greater knowledge, attention and action to address the specific challenges of the rehabilitation workforce are suggested.

7. Good-quality, comparable disability data are limited and often under-utilized; knowledge, planning and better utilization of disability data are suggested.

8. People with disability play an important role in change; increased engagement of people with disability and their representative organizations in health planning and delivery is required.

INTRODUCTION

In May 2014, the Sixty-seventh World Health Assembly adopted a resolution endorsing the *WHO Global Disability Action Plan 2014–2021: Better Health for All People with Disability*. The vision of the WHO Global Disability Action Plan is a world in which all people with disability and their families live in dignity, with equal rights and opportunities, and are able to achieve their full potential. The World Health Organization (WHO) recognizes disability as a global public health issue, human rights issue and a development priority. It is a public health issue because people with disability face barriers to health and experience poorer health outcomes than people without disability. It is a human rights issue because people with disability experience discrimination and health inequalities. It is a development priority because disability prevalence is higher in low-income countries, and disability and poverty reinforce each other.

The *World Report on Disability* (2011) estimates that 15% of the global adult population experiences disability and 2–4% experience very significant difficulties in functioning. In the Western Pacific Region, this equates to 270 million people experiencing disability and 36–73 million people experiencing significant disability, respectively. The Western Pacific Region has an ageing population and is experiencing increases in noncommunicable diseases and in some countries injuries. These are all associated with disability, and as a result, disability prevalence is increasing.

Persons with disabilities have the right to the highest attainable standard of health as enshrined in the Convention on the Rights of Persons with Disabilities. While some health conditions associated with disability result in extensive health care needs, others do not. All persons with disabilities have the same general health care needs as everybody else and hence require access to mainstream services. Barriers to health care are often experienced by all people,

especially in low- and middle-income countries; however, persons with disabilities experience them even more. Barriers may be institutional, financial, physical and attitudinal. Addressing these barriers and ensuring health is accessible and inclusive of people with disability is an important role of ministries of health.

Rehabilitation can help reduce the impact of a broad range of health conditions. Rehabilitation can also assist those who experience or are likely to experience disability to achieve and maintain optimal functioning. Rehabilitation is an essential health strategy and core component of universal health coverage, along with health promotion, prevention, treatment and palliation. Rehabilitation services are primarily composed of rehabilitation medicine, therapy and assistive device provision and the health personnel required to deliver these come from broad professional categories. Rehabilitation takes place within multiple levels of health services, from primary through to tertiary settings, and utilizes models of care such as inpatient, outpatient, community outreach and mobile clinics. In all populations, there is a need for rehabilitation services, and the need is growing due to health trends. However, in most countries of the Western Pacific Region, there is currently a large unmet need for rehabilitation. Access to rehabilitation services is often a prerequisite for many people recovering from illness or injury, those managing chronic illness, older people and in particular people with disability, to be able to work, participate in community life and obtain an education.

The understanding of disability has evolved over time. In 2001, the World Health Assembly endorsed the International Classification of Functioning, Disability and Health (ICF), and in 2006, the United Nations adopted the Convention on the Rights of Persons with Disabilities. Both of these define disability as the functional outcome of the interaction between someone with impairment (as a result of a health condition) and their environment. This definition has had significant implications for measurement of disability. Disability data are limited and are often not comparable across countries. Good-quality data and research on disability is an essential basis for policy and programmes and the efficient allocation of resources. Currently, however, there is insufficient rigorous and comparable data and limited research available on disability and health.

The WHO Global Disability Action Plan 2014–2021 proposes actions across three broad areas: 1) to ensure access for persons with disabilities to all health care services; 2) to strengthen and extend rehabilitation, habilitation and assistive devices; and 3) to improve disability data collection, analysis and research. In line with this, the WHO Regional Office for the Western Pacific undertook a survey to collect information on the status of national capacity to provide disability-inclusive health care, rehabilitation services, assistive technology, community-based rehabilitation and disability data.

This report summarizes the results of the national capacity survey conducted in 2015. It provides a baseline to inform the status of countries in the Western Pacific Region against the actions and indicators outlined in the WHO Global Disability Action Plan. The report allows for inter-country comparisons and provides evidence of the Regional situation.

WHO Global Disability Action Plan 2014–2021

Vision

The vision of the action plan is a world in which all persons with disabilities and their families live in dignity, with equal rights and opportunities, and are able to achieve their full potential.

Goal

The overall goal is to contribute to achieving optimal health, functioning, well-being and human rights for all persons with disabilities.

Objectives

The action plan has the following three objectives:

1. to remove barriers and improve access to health services and programmes;
2. to strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation; and
3. to strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services.

METHODS

Questionnaire

This is the first multi-country survey undertaken by WHO on national capacity to provide disability-inclusive health care. The WHO Global Disability Action Plan 2014–2021 guided selection of items on the questionnaire. The 80-item questionnaire was developed with input from technical experts and piloted within selected countries from the Western Pacific Region. The survey questionnaire was divided into three parts to reflect the objectives of the WHO Global Disability Action Plan. The focus of questions is outlined below.

Objective 1

To remove barriers and improve access to health services and programmes.

Given that multiple factors limit access to health care for persons with disabilities, the questions in the first part of the survey reflected actions towards identifying and removing barriers to health care and promoting inclusion of people with disability in regular health care services with a focus on meeting their general health needs. The first part of the survey included sections on governance and leadership, service delivery and health workforce. The section on governance included questions relating to legislation, policy and regulation that support disability-inclusive health care services and health facilities. The service delivery section included questions relating to accessibility and affordability of regular health care services for people with disability. The last section on health workforce included questions on the capacity of the health workforce to work effectively with people with disability.

Objective 2

To strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation.

Rehabilitation is an integral part of health services yet remains limited in many countries. The questions sought to identify the capacity of the rehabilitation, assistive technology and community-based rehabilitation sectors. Questions explored how countries deliver and strengthen rehabilitation services in the context of the WHO health system building blocks. The building blocks are: leadership and governance; financing; workforce; products and technologies; information and research; and service delivery. There were many questions addressing service delivery, seeking information on the availability, coverage and quality of services.

Objective 3

To strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services.

The last part of the survey included questions on the availability and use of disability data. This included questions on the availability of disability data and their adequacy for policy and programme decision-making.

Data collection

The survey questionnaire was sent to the disability focal points or designated colleagues within the ministry (or department) of health or equivalent office within the 27 countries of the WHO Western Pacific Region. The questionnaire was designed to be completed by senior ministry of health personnel and, where needed, by other relevant senior personnel, in particular from the ministry of social affairs. In some countries, the ministry of social affairs plays a significant role in provision of rehabilitation, community-based rehabilitation and assistive technology. It was recommended that the survey be discussed and completed collectively by relevant senior personnel, and that additional information be sought prior to final completion, for example from disabled persons organizations (DPOs). The survey took place from May to October 2015.

Upon receipt of the completed surveys, the Disability and Rehabilitation Unit within the WHO Regional Office for the Western Pacific carried out additional validation and where needed corresponded with government ministries. If required, technical experts with experience in working within the disability and rehabilitation sector in the Region were consulted for validation of information provided by countries. In the Pacific region, there was an opportunity to conduct face-to-face interviews with country representatives during the 2nd Pacific Community-based Rehabilitation Forum in Nadi, Fiji in September 2015. Consultations involved senior representatives of ministries and representatives of DPOs. A final validation of country responses was undertaken by the WHO Technical Lead on Disability and Rehabilitation in 2015 for consistency of responses based on knowledge of rehabilitation, community-based rehabilitation and assistive technology programmes in the Western Pacific Region.

Analysis of the survey data

Twenty-four of the 27 countries in the Region participated in the survey. Three Pacific countries– Cook Islands, Nauru and Niue – were unable to respond to the survey in the allotted time frame. Data were extracted from the country questionnaires, compiled within Microsoft Excel, and then cleaned to ensure consistency between items and responses.

In the analysis, countries were categorized according to income group using the World Bank classification on estimates of gross national income per capita: high, upper middle, lower middle and low. For analysis, the one country that belonged to the low-income group (Cambodia) was placed into the lower middle-income group. The classification is as follows:

High income

1. Australia
2. Brunei Darussalam
3. Japan
4. New Zealand
5. Republic of Korea
6. Singapore

Upper middle income

1. China
2. Fiji
3. Malaysia
4. Marshall Islands
5. Mongolia
6. Palau
7. Tonga
8. Tuvalu

Lower middle income

1. Cambodia
2. Federated States of Micronesia
3. Kiribati
4. Lao People's Democratic Republic
5. Papua New Guinea
6. Philippines
7. Samoa
8. Solomon Islands
9. Vanuatu
10. Viet Nam

During the analysis, there are also times when the Pacific island countries are grouped together and all other non-Pacific countries are grouped together. These groupings are referred to as Pacific and Asian countries in tables, noting that Australia and New Zealand are placed in the Asian (non-Pacific) category.

Development of country profiles

Country profiles were created and reflect responses from countries. The profiles include both direct responses to questions from countries as well as a selection of composite indicators. The composite indicators were developed to reflect status across an area that cannot be easily represented through the response to only one question. These composite indicators reflect a broader area of action, and multiple survey questions captured information to reflect them. For example, the composite indicator "*Extent of reasonable accommodation measures to access mainstream health services*" reflects a compilation of four related questions from the survey, these being: government programmes/initiatives that target the inclusion of people with disability in regular health care services; government-led health promotion campaigns and publications with efforts to reach people with disability using different communication formats; alternative communication formats/guidelines/services to make regular health care services information accessible to people with disability; and transportation costs to regular health care services or facilities covered (full/partial) for people with disability. The responses to these related questions were given a total score that was used to determine if a country's capacity was emerging, established or expanded. The individual country profiles and marking rubric were shared with countries for approval before publication.

Limitations

Twenty-four out of 27 countries within the Western Pacific Region returned the completed survey. The response rate was good, but the three countries that did not reply were all Pacific island countries, namely Cook Islands, Nauru and Niue.

Some countries did not have data for some questions and therefore did not answer all of them. Important data such as workforce numbers were sometimes unavailable. Efforts were made to ensure that data representing the physical therapy and rehabilitation medicine workforce were included as a minimum so that a comparison across the Region could be made.

The survey questionnaire included working definitions of most key items. There were, however, some problems with interpretation in some areas. For example, the definition of "community-based rehabilitation" was broad. Some countries considered all community-focused rehabilitation programmes, while others limited the definition to dedicated community-based rehabilitation programmes only.

The questionnaires were mostly filled out by government personnel. They may have consulted nongovernmental organizations and DPOs, but it was not compulsory to do this. Having government as the primary responder may mean that the views of other agencies were not fully taken into account.

It should be clearly understood that the survey is designed to measure the countries' capacity to deliver disability-inclusive health and rehabilitation and not delivery itself. The countries' capacity to deliver is reflected by tangible and verifiable means, for example existence of policies, legislation, regulatory mechanism, financing, workforce numbers and service availability. The ''capacity to deliver'' may or may not reflect actual delivery; capacity is not delivery or performance and it cannot capture the impact of delivery. One of the only ways to identify the impact of services is through population surveys that are inclusive of disability, which many countries do not undertake. The WHO Model Disability Survey is an example of such a survey.

RESULTS

PART 1: REMOVING BARRIERS AND IMPROVING ACCESS TO HEALTH CARE

Key results

- Eighteen of 24 countries had ratified the Convention on the Rights of Persons with Disabilities.
- About 58% of the countries in the Region reported their national health legislation specifically mentions access to regular health services for persons with disability.
- Seven of 24 countries have legislation prohibiting health insurance agencies from discriminating against persons with disabilities.
- Five of 24 countries have evidence on affordability of health care for people with disability.
- About 58% of countries reported having initiatives to make health promotion accessible to persons with disabilities.
- Lower and upper middle-income countries reported poor accessibility of health facilities and limited enforcement of accessibility standards.
- Only two of 24 countries reported an extensive integration of disability into undergraduate training of health professionals.
- Half of the countries reported people with disability and their representative organizations participate in health planning processes “most of the time”.

Signed international or regional disability-related commitments

All of the countries in the Western Pacific Region have either signed or endorsed one or more international disability-related commitments such as the United Nations Convention on the Rights of Persons with Disabilities, the WHO Global Disability Action Plan as well as regional disability frameworks such as the Incheon Strategy to "Make the Right Real" for Persons with Disabilities in Asia and the Pacific, and the Pacific Regional Strategy on Disability.

However, at the time of the survey, six (Brunei Darussalam, Fiji, Tonga, Samoa, Solomon Islands and Federated States of Micronesia) of the 24 countries had not yet ratified the Convention on the Rights of Persons with Disabilities.

Access to regular health care services specifically mentioned in health legislation, health policy and/or disability legislation

About 58% of the countries in the Region reported that their national health legislation specifically mentions access to regular health care services and facilities for persons with disability. Around 58% of countries reported that this is reflected in a national health policy or strategy, and 46% of countries reported that their national disability legislation includes this. When combining the health and disability policy and legislation, 67% of countries demonstrate support for disability inclusion in health.

By income grouping, four (67%) high-income countries; one (13%) upper middle-income country; and six (60%) lower middle-income countries specifically mention disability access in their national health legislation. All five Pacific island countries in the upper middle-income category do not mention persons with disabilities having access to regular health services in their national health legislation, with some countries not having legislation.

Some countries such as Malaysia and Cambodia reported not having national health legislation inclusive of disability, but rather national disability legislation that specifically mentions access for persons with disability to regular health services. Of the Pacific island countries, Fiji and Vanuatu reported that their national disability legislation specifically mentions access to regular health services for persons with disabilities. Solomon Islands reported that this is reflected in their national health policy. Some countries such as Kiribati have yet to develop their national health and disability legislation and policy.

Prohibiting health insurers from discriminating against pre-existing disability

Only three (13%) countries (Australia, Japan and Republic of Korea) in the Region reported that their national health legislation prohibits insurers from discrimination against pre-existing disability. However, when disability legislation is taken into account, an additional two countries (Lao People's Democratic Republic and Viet Nam) reported their legislation addresses this issue.

National disability coordination and role of the ministry of health

All except one country in the Region reported having a national disability coordination body or council. Typically, the ministry of social affairs plays a lead role in disability and convenes and acts as secretariat to national disability councils. Countries described the ministry of health playing various roles within the national disability coordination body. These included chair, vice-chair, core member of council, chair of a working committee or directly responsible for the operation of programmes of the council relating to health services. In China, the vice-minister for health is the chairperson of the China Disabled Persons' Federation, and in Malaysia, the director-general of health is a permanent member of the disability council. Overall, health ministries were engaged with these bodies.

The national disability coordinating bodies had slightly differing roles, but most oversaw implementation of an overarching national disability strategy or policy. The specificity of roles is due to the specific national programmes and settings, for example the Australian Government's Disability Reform Council oversees the implementation of the National Disability Insurance Scheme and the National Disability Agreement which outlines the role of government agencies in funding and delivering a range of disability support services. In New Zealand, the Ministerial Committee on Disability Issues provides leadership, coordination and accountability for implementing the New Zealand Disability Strategy and the Convention on the Rights of Persons with Disabilities. In the Republic of Korea, the prime minister and minister of health and welfare are the chair and vice-chair, respectively, of the Policy Coordination Committee for Disabled Persons. The committee coordinates the multiple disability-related polices across ministries and is accountable for ensuring access to health care services and facilities including rehabilitation services and medical support for persons with disabilities.

Within ministries of health, the focal points for disability are located either in a specific disability unit or within a wider department, most commonly departments of preventive medicine or noncommunicable disease. WHO's experience with these focal points has revealed that they often are not specialists in disability, they undertake other programme roles, and they do not have a dedicated unit. The role of the focal point is commonly limited to periodic activities, but they can have strategic influence within the ministry and overall health system. Nineteen of 24 countries in the Region reported that there is a person or unit within the ministry of health responsible for addressing disability issues.

Accessible health infrastructure and information

Physical accessibility

Over 79% of the countries in the Region reported having national standards, guidelines or building codes that support physical accessibility of regular health care facilities. Many of these standards are national and apply to all public buildings, including health facilities. All of the high-income countries have such standards. In lower and upper middle-income countries, the

codes may exist. Regarding application of codes, many countries reported limited application and enforcement and/or application only to new buildings.

Access to health promotion information

Fourteen (58%) of the countries in the Region reported that within government-led health promotion campaigns there are efforts to reach persons with disabilities using different communication formats or targeted messages for persons with disabilities.

By income groups, five of the six high-income countries reported extensive methods to ensure health promotion and information was accessible to persons with disabilities. Countries provided examples of multiple communications formats such as radio services, closed captioning and easy read format. High-income countries were advanced in this area compared with lower and upper middle-income countries, where limited examples were given.

Upper middle-income countries reported a variety of initiatives, including using different formats (print, electronic, sign language and audio-based devices) in health promotion (Malaysia); targeted collaboration with specific disability groups to promote better health (Mongolia); designating days when programmes actively recruit/promote health services for target populations through radio announcements or outreach programmes (Palau); and through health-awareness programmes coordinated with DPOs (Tuvalu).

The lower middle-income countries reported examples to promote accessible information by utilizing mobile teams for information dissemination at the community level (Lao People's Democratic Republic); television, radio and print (Philippines); braille (Viet Nam); leaflets (Papua New Guinea); and sign language (Samoa). The extent of these programmes was not specifically requested, but many described the programmes as small scale with limited coverage.

Alternative communication formats in health care services

Countries were asked about availability of alternative communication formats/guidelines/services within general health care services. Ten (42%) countries in the Region reported initiatives to make regular health care services more accessible to people with disability.

By income groups, four of the six high-income countries reported using alternative communication formats. People with disability have access to sign language interpreters and easy read format in New Zealand; sign language interpreters and braille/audio formats in the Republic of Korea; and sign language interpreters, easy read format and braille/audio formats in Australia and Japan.

Five of the eight upper middle-income countries reported using alternative communication formats in health care services, such as sign language interpreters in China, easy read format in Malaysia and braille/audio formats in Mongolia. Again, the coverage and extent of these alternative communication formats was often limited, but positive progress is being reported.

In the lower middle-income category, only Viet Nam reported using sign language interpreters and braille/audio formats to make some information on health care services accessible to people with disability. Most Pacific island countries reported very limited activities in this area.

Inclusion of disability into health professional training

Countries were asked whether disability was included in medical, nursing and allied health training and given domains of training, these being: content on people with disability and their health care needs; content on effective communication with people with disability; content on sensitivity towards people with disability; and disability-focused clinical attachments/rotations. Countries were given a response category of none, some and full. Out of 24 countries, only two reported disability inclusion in health professional training across all domains; these countries were New Zealand and Samoa. All countries with health personnel training programmes reported some degree of inclusion across limited domains, while few reported none.

Initiatives for affordable health care services

Government exemptions/waivers or reductions for health care costs

Countries were asked questions about the affordability of health services and mechanisms that reduce the costs for people with disability. Countries were initially asked if they had knowledge or evidence of the affordability of health care for people with disability in their country. Only five countries reported available information.

Twenty-one (88%) of the countries in the Region reported having some mechanisms in place for government exemptions, waivers or reductions for health care costs for some or all people with disability in their country. In high-income countries, reductions or waivers are linked to eligibility for a variety of different schemes, including: a community services card or covered by Accident Compensation Corporation (New Zealand); by financial classification and basic livelihood pensions (Republic of Korea); recipients of Disability Support Pension and Health Care Cards (Australia); and classification of disability (Japan).

Upper middle-income countries also reported a variety of schemes, some of which are for all people with disability and some for people with disability who are also poor. China, Mongolia and Malaysia all have an identification process for people with disability who are provided with a card that can be used to attain reductions in health care costs. Reductions varied from hospital fee exemptions/reductions, reduced costs for assistive technology to reduced pharmaceutical costs.

In the lower middle-income group, Pacific island countries such as Papua New Guinea and Solomon Islands provide free health care services and, when available, free assistive devices. Samoa waives overnight inpatient department fees and general administrative fees for persons with disability; Vanuatu reports that it waives hospital fees for children with disability, older people and those with obvious physical disability. Pacific island countries do not have disability identification cards, and so they rely on health care staff to identify obvious disability.

In Viet Nam, persons with disabilities with identification cards were automatically part of the national health insurance scheme and received subsidized cost for medical services, and in the Philippines, reductions in hospital fees and pharmaceuticals are linked to their national disability identification card system.

Funding to cover rehabilitation costs within government health insurance scheme

Eight (33%) countries in the Region reported having a government-led national health insurance scheme, and all except Singapore reported that the scheme includes packages to cover rehabilitation costs. Most other countries in the Region have a health financing system that directly funds health services, without a third party. Many Pacific island countries such as Papua New Guinea and Tuvalu offer free health care including rehabilitation to all people.

Subsidized transport cost to regular health care services

Since transport costs to health services are commonly reported as a barrier, countries were asked what mechanisms are in place to reduce transport costs for people with disability. Sixteen (67%) countries in the Region reported that “some” of the transportation costs to the regular health care services or facilities are covered or reduced for people with disability through mechanisms such as: disability identification cards on public transport; local government initiatives; taxi cards; and utilizing nongovernmental organization networks. The seemingly positive result is countered by comments about the limited availability of local government resources and the inadequate national coverage of nongovernmental organizations. The Pacific island countries had few mechanisms available; Fiji, Papua New Guinea, Samoa and Palau reported some government-funded follow-up and referrals. Fiji has free bus transport and 20% off taxi fares for people with disability.

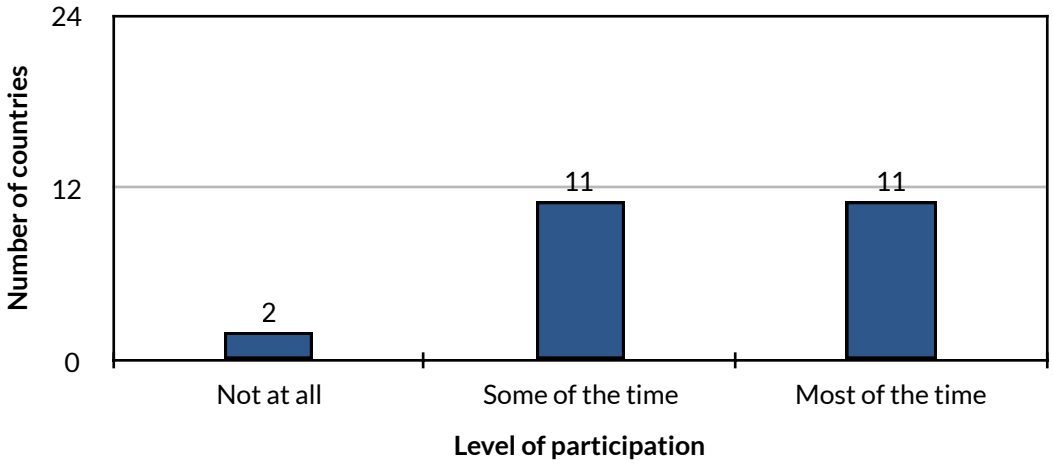
Participation of people with disability or their representative organizations (DPOs) in planning of health care services

92% of the countries in the Region reported engaging people with disability or their representative organizations to some degree in the planning of health care services (Figure 1). Countries responded by reporting not at all, some of the time or most of the time. Forty six per cent of countries reported that “most of the time" people with disability and their representative organizations participated in health planning. In high-income countries, examples of participation of people with disability portray a comprehensive involvement through established systems and mechanisms of policy consultation, programme development and user feedback linked to provision of services. Four of the six high-income countries reported participation of people with disability "most of the time”.

In upper middle-income countries, five out of eight reported they consulted people with disability or their representative organizations “some of the time”, while the other three reported they include them “most of the time". Examples included DPOs being included in consultations for drafting policies and ordinances, development of training manuals for disability awareness aimed at health personnel, and assessment of accessibility of health facilities.

In lower middle-income countries, examples of participation were more activity based such as invitations to attend consultative meetings for policy development and involvement in a pilot or demonstration project. Five out of ten countries reported sometimes consulting, while four reported “most of the time”.

Figure 1. Participation of persons with disability or DPOs in health care services



PART 2: REHABILITATION SERVICES, COMMUNITY-BASED REHABILITATION AND ASSISTIVE TECHNOLOGY

Key results

- Four out of 24 countries have a stand-alone rehabilitation strategy.
- Government budget is the primary source of rehabilitation funding in 21 out of 24 countries.
- Forty-six per cent of ministries of health have integrated rehabilitation services into wider health service standards and packages of care.
- Fifty per cent of countries report rehabilitation service regulation mechanisms exist.
- Lower middle-income countries have extremely limited rehabilitation services at the community level. Physical therapy is the only available therapy at this level.
- High-income countries have approximately 100 times more physical therapists than some lower middle-income countries per 10 000 population. Physical therapy is the most commonly available rehabilitation service.
- In 70% of countries in the Western Pacific Region, speech and occupational therapy is not available in the majority of their tertiary hospitals.
- No country in the Region reported rehabilitation professional as being a very attractive career choice.
- Six out of 24 countries have an agreed list of assistive technology.
- Seventy per cent of countries estimate they provide less than half of the assistive technology needed by people with disability.

National governance mechanisms for rehabilitation

National rehabilitation strategy or plan

Countries were asked about rehabilitation planning. Eleven countries (46%) in the Region reported having a national rehabilitation strategy or plan; however, only four have a dedicated document reflecting this. The other seven countries reported rehabilitation plans being embedded in a variety of health and social sector plans. Rehabilitation planning is commonly reflected within wider sectoral plans, such as plans for health, older persons, early childhood intervention and social services. Four of the six high-income countries reported having a strategy, with only one of these having a stand-alone plan. The Pacific island countries had little information regarding rehabilitation planning (neither separate plans nor integration into health strategies), while some included it in disability policies or plans.

The most common primary reason reported by countries for not having a national rehabilitation strategy or plan was because of other competing health priorities.

Mechanism for coordination in rehabilitation policy and planning

Seventy-nine per cent of countries in the Region reported having a mechanism for rehabilitation coordination that supports national rehabilitation policy and planning, and most reported that it included nongovernmental organizations and DPOs. Most countries described the existing national disability coordination bodies providing this coordination role. Some countries have a rehabilitation committee or working group under the national disability coordination body.

Regulatory mechanisms to ensure standards of rehabilitation care

Fifty per cent of countries in the Region reported that regulatory mechanisms for rehabilitation services exist, and the same 50% reported that this occurs through a variety of facility standards or accreditation schemes. All high-income countries, except Brunei Darussalam, reported wider health care monitoring systems that include rehabilitation care.

In line with regulatory mechanisms, only 50% of countries in the Region regularly monitor rehabilitation services to ensure high standards of care. Countries such as Australia, China, Japan, Malaysia, New Zealand, the Philippines and the Republic of Korea have established mechanisms for regular monitoring conducted by insurance corporations/third-party payers, ministry of health, and welfare and accrediting agencies. Monitoring is done either yearly, every three years or every four years. No Pacific island country reported monitoring of rehabilitation services.

Focal point for rehabilitation within government

Twenty-one countries described having a unit or person responsible for rehabilitation within the ministry of health, and 14 had focal points within the ministry of social affairs as well. In high-income countries, the focal points are described as being spread through different layers of government, managing diverse aspects of rehabilitation. In contrast, lower and upper middle-income countries described a medical services development division or a medical officer in charge of rehabilitation within a national hospital. Eleven of the 24 countries reported their ministry's rehabilitation focal person was situated in a hospital outside of the ministry of health bureaucracy and were rehabilitation practitioners (doctors or physiotherapists). In the Asian countries, they were within national rehabilitation centres, and in the Pacific island countries, they were mostly in national hospitals.

Rehabilitation service standards across health services

A total of 11 countries (46%) reported having health sector standards/guidelines that outline the recommended availability of rehabilitation personnel/services at various levels of health service. These are described differently and are known as packages of care at different levels.

By income group, four of the six high-income countries reported availability of guidelines such as service contracts with providers, service specifications, clinical guidelines, operational guidelines

as set by the ministry of health, and standards and guidelines implemented and monitored by states and territories and through medical colleges. In Australia, the Government works with the Royal Australasian College of Physicians to set standards for the provision of rehabilitation services in public and private hospitals including staffing.

Among the eight upper middle-income countries, three countries reported having guidelines or standards on availability of rehabilitation personnel; none of the five Pacific island countries had standards in place. The three countries with standards in place reported that the ministry of health issued these guidelines according to the level of care at each facility. Similarly, in the lower middle-income category, four of the 10 countries reported that standards exist and are reflected on circulars from the ministry of health or within the ministry of health classification of hospitals according to their functional capacity.

Financing of rehabilitation services

Rehabilitation budget

Seventeen (71%) countries reported that rehabilitation is included in either national budgets for health or social welfare. However, very few countries were able to provide more information about the amount or its proportion in relation to the annual health budget. Most high-income countries report that the budget for rehabilitation is dispersed across different agency accounts and is embedded in various service lines. The Republic of Korea described that from the annual health and welfare budget, 0.12% is earmarked for rehabilitation programmes.

Other countries in the Region described different scenarios of funding for rehabilitation. Malaysia stated various policies that support allocation of budget that can be utilized for specific programmes. For example, funding for community-based rehabilitation centres can be identified separately within Malaysia's Department of Social Welfare. Fiji specifically earmarks funding for the Ministry of Health and Medical Services community-based rehabilitation programme, but it cannot report on costs of the physiotherapists and other rehabilitation services within health. Tuvalu receives a budget specifically to cover supplies used by the physiotherapy department in the national hospital, which is the main provider of rehabilitation for the country. Papua New Guinea stated its rehabilitation budget is approximately 1% of the total health budget. Solomon Islands described that physiotherapy and rehabilitation made up 0.31% of the health budget between 2011 and 2015.

Within the social affairs budget, support for rehabilitation varied among countries. Some supported community-based rehabilitation activities or included rehabilitation for people with disability in their social assistance budget. Some budgeted for a national rehabilitation centre (often focused on vocational training) and/or specific support for operations and activities of the disability desk in the country. Multiple countries reported that the budget allocated to rehabilitation each year was insufficient for operating rehabilitation services.

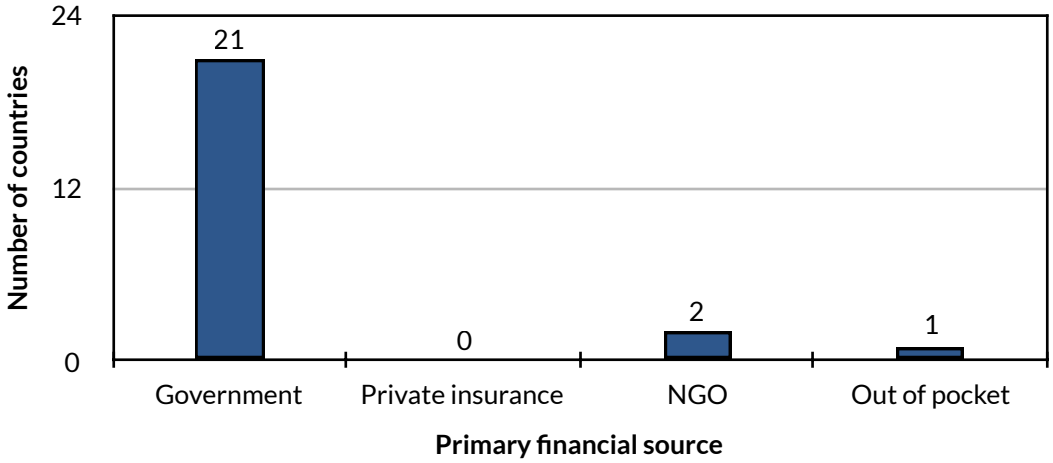
Sources of rehabilitation financing

In the survey, countries were asked to identify the primary sources of rehabilitation financing: government, private insurance, nongovernmental organizations and clients (out-of-pocket) (Figure 2).

All the high- and upper middle-income countries identified government as the primary financial source for rehabilitation in the country. Government was also identified as the sole funding source for rehabilitation in New Zealand, the Republic of Korea and a few Pacific island countries.

In the lower middle-income category, some countries such as Cambodia and the Federated States of Micronesia reported that nongovernmental organizations contribute the most financial resources for rehabilitation. The Philippines stated that the biggest contributor to funding for rehabilitation in the country is out-of-pocket payments by clients.

Figure 2. Primary contributors of financial resources for rehabilitation in the Western Pacific Region



Sixty-seven per cent of the countries in the Region reported the existence of social protection mechanisms such as a disability allowances, an income support system, cash transfers and allowances for living costs that can be used by clients to support their rehabilitation costs. These mechanisms are often for people with and without disability and eligibility is linked to economic status. In lower and upper middle-income countries, the social protection mechanisms were mostly utilized for additional living costs, and not specifically towards rehabilitation costs such as assistive technology.

High-income countries described a complex system of social protection mechanisms for people with disability. Eligibility is mostly linked to socioeconomic situation. New Zealand, for example, has various social protection mechanisms such as Child Disability Allowance, Supported Living Payment, Disability Allowance, Special Disability Allowance, Modification Grant and home health

financial assistance. The Republic of Korea provides Disability Pension and cash transfers, and the amounts vary based on level of disability.

The upper middle-income countries had a variety of schemes, with eight out of 10 having some sort of disability identification card that makes persons eligible for financial assistance and/or reductions in costs. For example, Malaysia described schemes and incentives for people with disability who are working, financial assistance for those who are incapable of work, financial assistance for purchase of assistive technology, and financial assistance to carers of those who have significant chronic illness. Mongolia reported various financial schemes such as social insurance allowance and pension, and social protection pension and allowance. Other countries in the upper middle-income group described a simpler system of disability welfare, where people with disability and their families receive a monthly allowance ranging from US$ 5 to US$ 120 (maximum per family).

In the lower middle-income countries, even fewer programmes were reported. Most Pacific island countries do not have social protection schemes; however, health and rehabilitation services are often free. The Philippines described active inclusion of people with disability in conditional cash transfer programmes and reductions in other costs including health.

Government contracting nongovernmental organizations to deliver rehabilitation services

Only 33% of countries in the Region reported that governments contract and fund nongovernmental organizations to deliver rehabilitation services. By income grouping, 50% of the high-income countries, namely Australia, New Zealand and Singapore, reported government contracting nongovernmental organizations to deliver rehabilitation services. These countries described a competitive bidding process with strict procurement and contracting rules. The rehabilitation services described were quite broad, including early intervention services and day activity centres.

Only four (18%) lower and upper middle-income countries reported governments contracting nongovernmental organizations. Rehabilitation services were described as having a focus on community-based rehabilitation, awareness-raising activities and physical rehabilitation services.

Data collection specific to rehabilitation

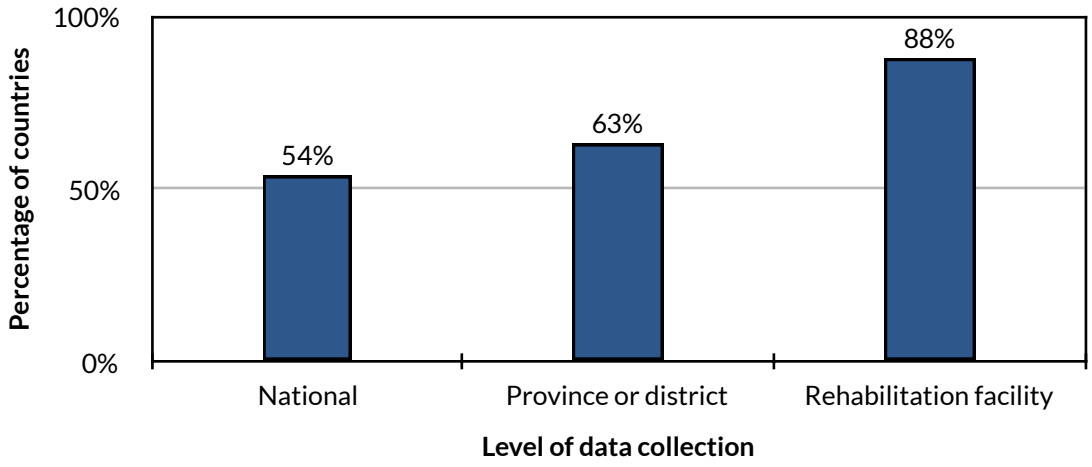
Countries were asked questions on mechanisms for data collection specific to rehabilitation at various levels: national, provincial, rehabilitation facility and regular health care. Parallel to this, countries were also asked whether the data are utilized in rehabilitation planning.

The collection of rehabilitation data in the Region is most common at the rehabilitation facility level (Figure 3). Eighty-eight per cent of the countries in the Region reported collecting data at the facility level, and 50% said facility-level data were used in national rehabilitation sector planning. Countries were asked if they had data on the rehabilitation needs (met or unmet), and 38% of countries reported some data on this.

Countries were asked whether information regarding disability status was collected at general health care facilities, and 46% of countries reported that some information is collected.

The actual description of this information suggests variability, and no country routinely collects information on disability status at all health facilities. Examples of the collection of disability data in health services were linked to eligibility of disability identification cards (Philippines), hospital/clinic facilities having data for local use (Solomon Islands) and national hospital physiotherapy department collecting data (Vanuatu).

Figure 3. Rehabilitation data collection



Rehabilitation service delivery

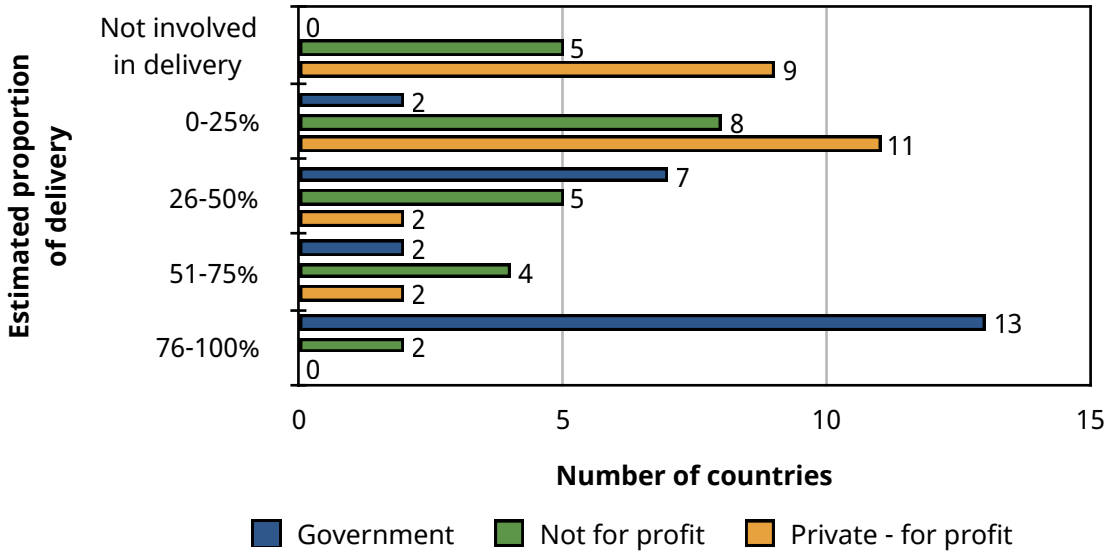
Agencies providing rehabilitation services

Most countries would find it difficult to provide precise data on provision of rehabilitation services by agency. Countries were asked to estimate (within a range) the proportion of services delivered by different agencies (Figure 4). Thirteen out of 24 countries reported that government was the main provider of rehabilitation services, providing 76–100% of rehabilitation services. Most countries identified government as their largest or second-largest provider, and all countries said government was engaged to some degree. Overall, nongovernmental organizations were the second-largest provider, and private for-profit providers were third. The Pacific subregion has very few private providers, so none of the Pacific island countries reported their involvement.

Availability of rehabilitation services at tertiary-level hospitals

Countries were given a list of common rehabilitation specialties and asked to identify which rehabilitation services were available in over 50% of tertiary-level hospitals in the country.

Figure 4. Agencies in rehabilitation service delivery



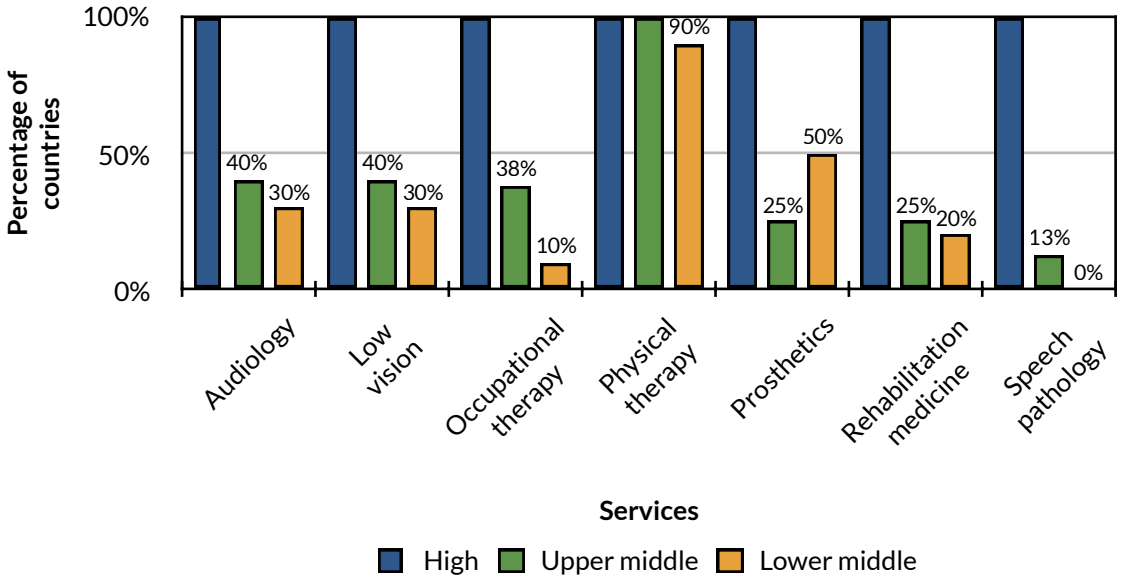
All six of the high-income countries reported that common rehabilitation services (audiology, low vision, occupational therapy, physiotherapy, prosthetics, rehabilitation medicine and speech pathology) were available in over 50% of tertiary hospitals in the country (Figure 5). The most common rehabilitation service offered in the Region is physical therapy. Physical therapy was reported to be available in over 50% of the tertiary hospitals in 100% of the high- and upper middle-income countries and in 90% of lower middle-income countries.

Excluding physical therapy, there is a very large drop in availability of rehabilitation specialties between the high-income group and upper middle-income group, let alone the lower middle-income group. While 100% of countries in the high-income group reported availability of rehabilitation specialties, only 40% of upper middle-income countries reported availability of specialties.

Availability of rehabilitation services decreased across the income groups, with prosthetic services being the only service that did not follow this pattern exactly. This is because of well-established prosthetic services in the post-conflict, land-mined countries of Cambodia, the Lao People's Democratic Republic and Viet Nam. Occupational therapy and speech pathology are extremely limited in the lower middle-income countries and almost nonexistent in the Pacific island countries.

When segregating the data by subregion, that is, between Pacific island countries and non-Pacific island countries (including Asia, Australia and New Zealand), an even more significant drop in services is revealed. Around 70% of non-Pacific island countries have most rehabilitation services across tertiary hospitals, while in the Pacific, the percentage of countries providing specific rehabilitation services ranged from 0% to 36%, except for physical therapy (Figure 6).

Figure 5. Rehabilitation services available in over 50% of tertiary hospitals by income group



Physical therapy is the most commonly available rehabilitation service in the Pacific. Prosthetics, audiology and low vision services are reported to be available in less than 50% of the Pacific island countries. In Pacific island countries, occupational therapy, rehabilitation medicine and speech pathology are not available in over 50% of tertiary hospitals. The Pacific island countries reported that some rehabilitation services are sometimes provided by "fly-in missions" from high-income countries and international volunteers, but not in substantial numbers.

Figure 6. Rehabilitation services available in over 50% of tertiary hospitals by subregion

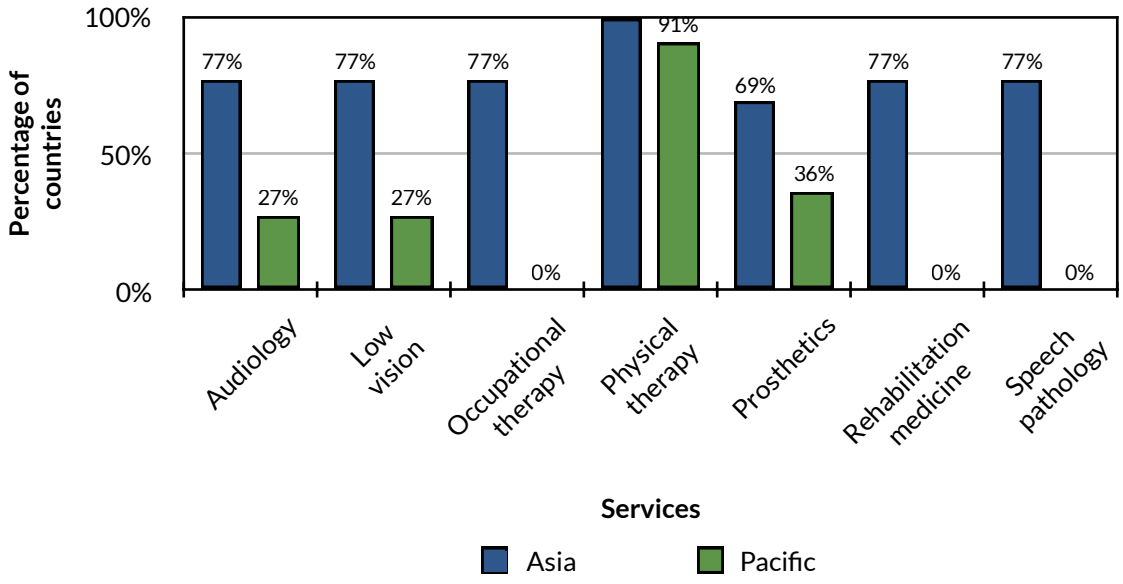
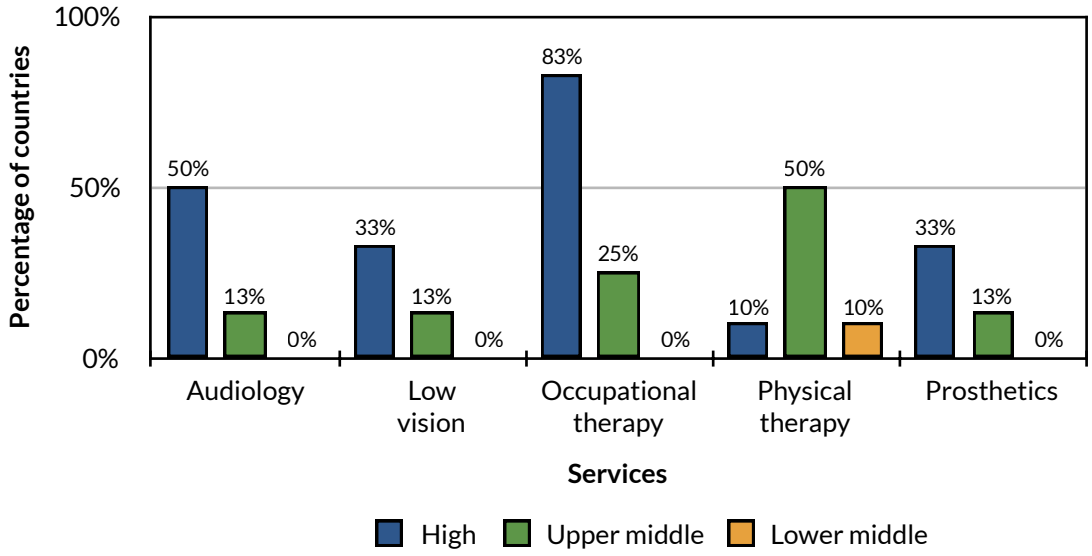


Figure 7. Rehabilitation services available at primary health care level by income group



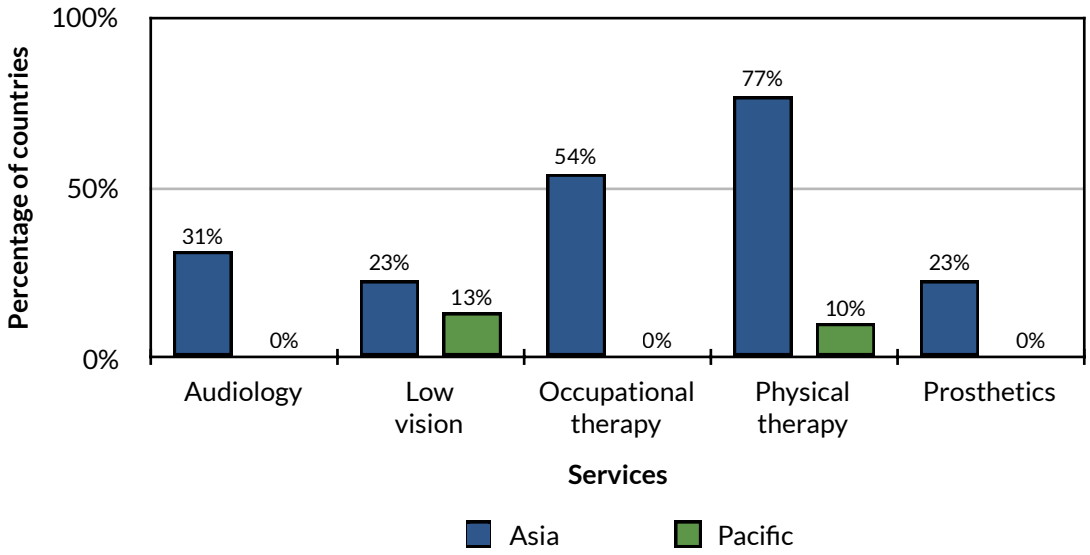
Availability of rehabilitation services at primary health care level

Countries were given a list of common rehabilitation specialties and asked to identify which ones were available at the primary health care level (Figure 7). Not all the services were the same as those expected in tertiary hospitals. Compared with availability of services at the tertiary level, there was a significant drop across all countries except Australia, New Zealand and Singapore.

In 75% of countries in the Western Pacific Region, extremely limited rehabilitation services are available at the community level. Physical therapy is again the most available service, and if it is removed, the result is even more dramatic between the high-income countries and the upper and lower middle-income countries.

When presenting the same data on availability of rehabilitation services at the community level, and comparing Pacific island countries and non-Pacific island countries, a similar significant drop occurs (Figure 8). The Pacific island countries have very limited available rehabilitation personnel and services. Physical therapy is the only rehabilitation service available at the primary care level in the Pacific subregion, and only in 10% of countries. Otherwise, there are no specialty rehabilitation services. It is, however, noteworthy and important to acknowledge that ministries of health in Fiji and Solomon Islands support community-based rehabilitation programmes that undertake some of the work of these specialties. In Papua New Guinea and Samoa, there are also dedicated community-based rehabilitation workers who are supported by nongovernmental organizations and who undertake some of the specialty rehabilitation work.

Figure 8. Rehabilitation services available at primary health care level by subregion



Practices in rehabilitation service delivery

Countries were asked about good practices in rehabilitation service delivery (Figure 9). Questions addressed the following good practices: multidisciplinary teamwork, assessment, goal setting, discharge planning, empowerment and training of rehabilitation users and their family members, and workplace or education setting modifications.

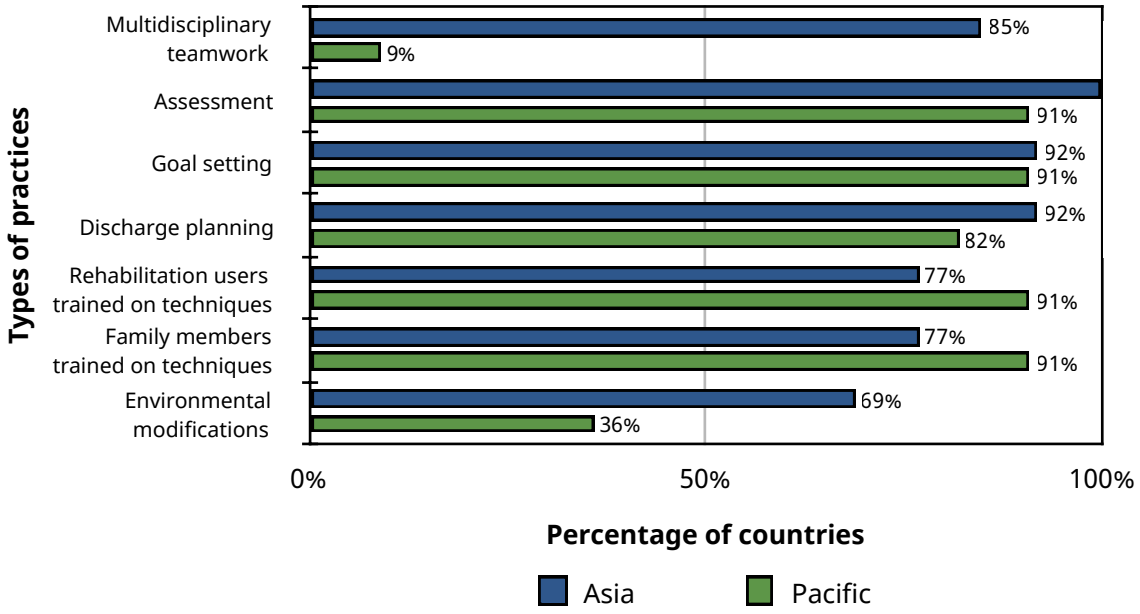
Responses revealed a direct link to the availability of specialized rehabilitation personnel in countries with multidisciplinary teamwork models. While 85% of the Asian countries reported multidisciplinary teamwork, only 9% of Pacific island countries (Fiji) reported multidisciplinary teamwork.

Goal setting is almost equally practised in both regions: 92% of Asian countries and 91% of Pacific island countries. Discharge planning is practised in 92% of Asian countries, but in only 82% of Pacific island countries. In contrast, there is a reverse trend on practising empowerment and training of rehabilitation users and engaging family members in rehabilitation techniques, suggesting the Pacific is stronger in this practice.

In relation to environmental modifications, 69% of Asian countries and only 36% of Pacific island countries provide advice on home, workplace or education setting modifications as part of rehabilitation service delivery.

While countries reported many good practices, they also commented on the limited application of these practices.

Figure 9. Common practices in rehabilitation service delivery



Mechanisms for referral pathways

Fourteen of the 24 countries (58%) reported having established referral systems in place. High-income countries were strongest at this, and only three out of 10 lower middle-income countries reported having systems in place.

High-income countries described extensive clinical referral pathways and service directories organized at multiple levels. In New Zealand, this mechanism is organized through professional groups (i.e. Paediatric Society of New Zealand); national groups (i.e. Parent to Parent New Zealand) which supports families, provides community information and is a resource network; between hospitals and community, through local authorities (each local council with community directory); and across government agencies. Singapore has established customer touchpoints in hospitals and community agencies who can refer clients to one-stop centres for disability information and for further referral to the schemes and services available. Australia's National Disability Insurance Agency provides information and referrals to existing mainstream and community services, and local coordinators help with information, linkage and referral activities.

Upper middle-income countries described various forms of rehabilitation referral mechanisms, such as: rehabilitation referral incorporated into the National Health Referral System (Malaysia); referral system from tertiary to secondary to primary and community and vice versa (Mongolia); public health officer responsible for onward referrals from the community to medical or rehabilitation services (Marshall Islands); and inclusion of children who require rehabilitation services in administrative systems for follow-up and referral to related services if required (Palau).

Simpler forms for referral systems are described by countries in the lower middle-income country category: health facilities refer people to other services required (Viet Nam); posters/ flowcharts displayed in service centres provide information for referrals (Samoa); doctors refer clients to physiotherapy services or people themselves fill in referral forms and request for services (Solomon Islands).

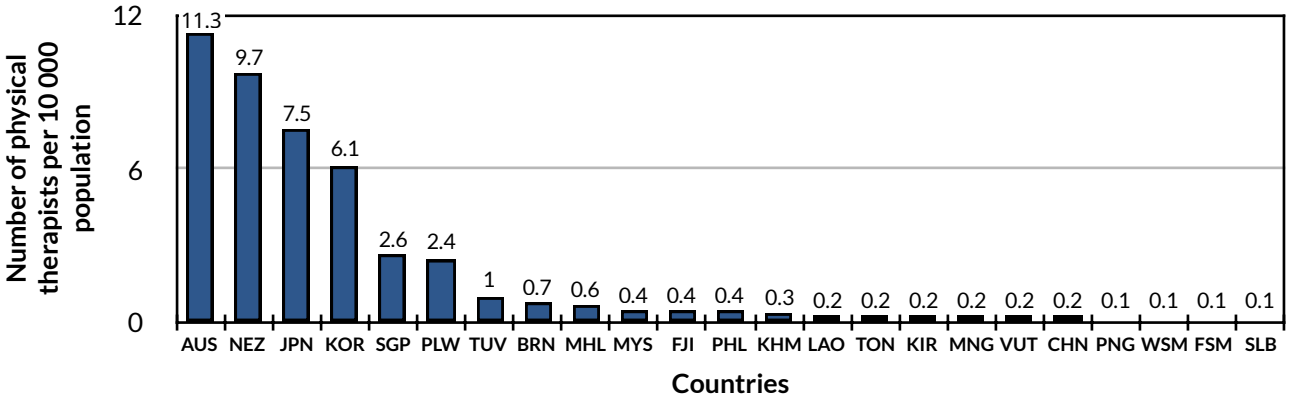
Rehabilitation workforce

Available workforce

In this survey, countries were asked to report the number of rehabilitation workers available according to occupational category, such as specialist medical practitioner, rehabilitation nurse, therapist, health technicians and community-based rehabilitation worker. While most countries had some data and provided numbers, there were also gaps across the professions and often the rehabilitation workforce specialties were not counted separately within health systems. For the purpose of the survey, all the therapist categories are considered rehabilitation personnel. However, it is important to acknowledge that many therapists engage in health interventions that are within a health promotion, prevention and treatment paradigm, not just rehabilitation. For the survey analysis, there is an assumption that a correlation exists between available therapy workforce and available rehabilitation workforce.

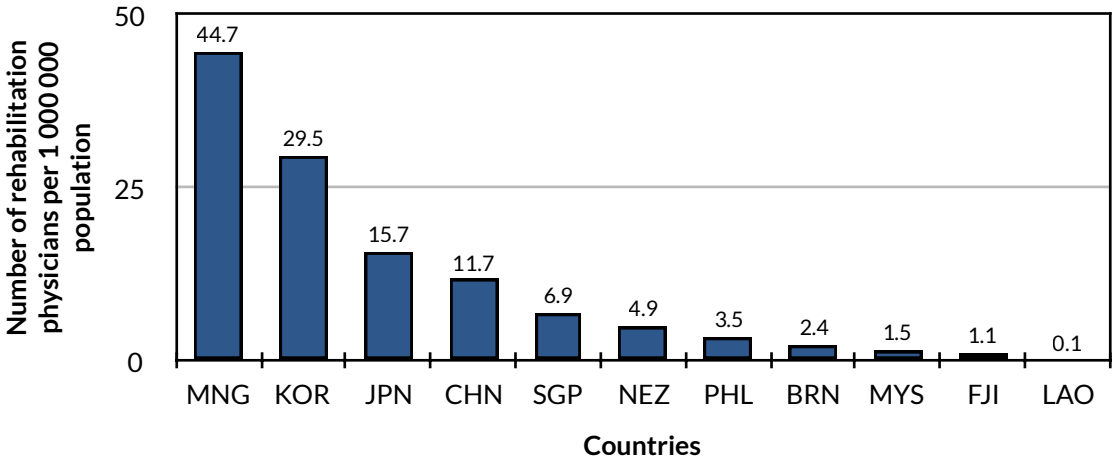
Physical therapists are the most available rehabilitation workforce across all countries except for Mongolia, which has a larger number of rehabilitation physicians. The number of physical therapists per 10 000 population was calculated across all countries that provided the information. In the high-income group, the number of physical therapists per 10 000 population ranged from 0.69 to 11.26, with Singapore and Brunei Darussalam having quite low rates. This number is seen to decrease dramatically in the other income groups. In the upper middle-income group, this ranged from 0.15 (China) to 2.37 (Palau). In the lower middle-income category, the ratio ranges from 0.07 (Solomon Islands) to 0.4 (Philippines). Figure 10 highlights the significant drop in physical therapists outside of the high-income country group.

Figure 10. Comparison of number of physical therapists



While Papua New Guinea has the largest number of physical therapists of all Pacific Island countries, when per capita ratio is considered, the reality of a weak physical therapy workforce becomes apparent.

Figure 11. Comparison of number of rehabilitation physicians



Similar to physical therapist data, the number of rehabilitation physicians per 1 000 000 population was calculated across all populations (Figure 11). The trend is not quite the same, with some northern Asian countries having higher numbers of rehabilitation physicians than, for example, New Zealand.

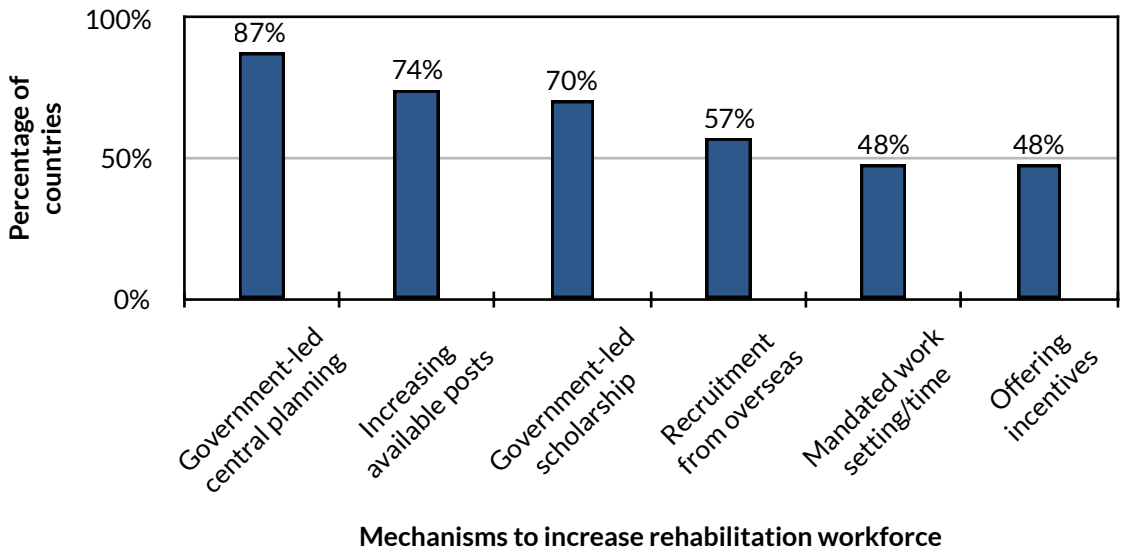
Mechanism for increasing rehabilitation workforce

Eighty-seven per cent of countries in the Region reported their governments have taken the lead role in planning for increasing the rehabilitation workforce (Figure 12). While 74% of countries reported that increasing the number of available posts in place is the key mechanism for increasing the rehabilitation workforce, 70% of countries reported having government scholarships for rehabilitation personnel training, and as many as 57% recruit rehabilitation professionals from other countries. Forty-eight per cent of countries (excluding Australia) in the Region have introduced mandated work setting or service time after graduation and offer incentives to retain rehabilitation professionals in the workforce.

Rehabilitation as a career

Countries were asked if a career as a rehabilitation professional was considered attractive and were given four possible responses: not at all, partially attractive, attractive, very attractive. None of the countries across the Region considered rehabilitation professional to be a very attractive career. Ten out of 24 countries considered it to be “attractive” (six high-income countries and Malaysia, Palau, Lao People’s Democratic Republic and Samoa), while the other 14 countries considered it only “partially attractive” or “not at all” attractive. The most common reasons for why countries responded “partially attractive” or “not at all” attractive were lack of financial incentive and limited career path.

Figure 12. Rehabilitation workforce development



Professional associations for rehabilitation professionals

Sixty-three per cent of countries in the Region reported having associations for rehabilitation professionals. All high-income countries have professional associations for a wide range of rehabilitation professionals. In both lower and upper middle-income countries, only 50% of the countries in each income category report having professional associations.

In high-income countries, the professional associations include a comprehensive list of rehabilitation professionals covering specialist medical practitioners (i.e. specialist rehabilitation physicians, neuro-rehabilitation), rehabilitation nurses and a variety of therapy professionals. In both the lower and upper middle-income countries, the number of countries with multiple professional associations drops off dramatically. Across both these two groups of 18 countries, only five report more than one professional association (Cambodia, China, Kiribati, Malaysia and the Philippines). This reflects the significant drop in rehabilitation personnel across many of these countries.

Community services and community-based rehabilitation (CBR)

Countries were asked questions about community-based rehabilitation. The term was broadly defined to reflect a multisectoral approach that empowers people with disability to access and participate in programmes across education, employment, health and social sectors. The questions reflected the WHO *CBR Guidelines* by referring to the five components of the CBR Matrix: health, education, livelihood, social and empowerment. Country responses to questions portrayed varied understandings, which is not surprising since there is a great variety of programmes within countries and there are many programmes that reflect CBR but are not locally identified as such.

National CBR policy, strategy, action plan and coordinating mechanism

Overall, 19 countries in the Region reported having CBR programmes, and 12 (50%) countries in the Region reported having a national CBR policy or action plan. Three (38%) upper and five (50%) lower middle-income countries reported having a national CBR plan. Six Pacific island countries reported having a CBR plan in draft form awaiting ministerial approval. Five countries in the Region reported not having any CBR programme in place: Brunei Darussalam, the Marshall Islands, Palau, Tonga and Tuvalu.

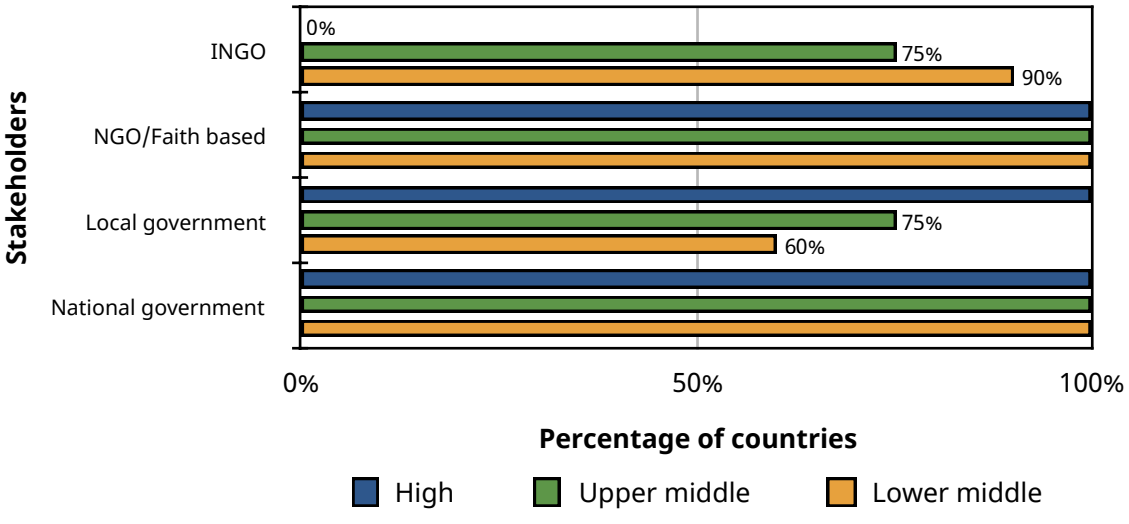
High-income countries described a wide range of CBR services and an integrated coordinating mechanism embedded into their extensive networks of rehabilitation and disability service systems. In contrast, lower middle-income countries identified the presence of a technical CBR working group, a CBR network and a partnership between ministries and services for referrals as mechanisms for coordination of CBR in the country. In many countries, the ministry of social affairs plays a key role in CBR, but responses suggested that both the ministry of social affairs and the health ministry financially contributed to a variety of CBR programmes.

Stakeholders and funding in CBR

In the survey, countries were asked which stakeholders regularly engage in CBR (Figure 13). Responses found that both government (national and local) and nongovernmental organizations (faith based/charity) are most regularly engaged. In lower and upper middle-income countries, the international nongovernmental organizations (INGOs) and development organizations also played a role.

In lower and upper middle-income countries, CBR is evolving and the ministry of social affairs is slightly more engaged than the ministry of health, although both often play a role. In upper middle-income countries, varying roles of government engagement were described, from national government funding and leadership to minimal levels of support and oversight. All countries reported the national government was engaged to some degree, but local governments were engaged in only 13 countries.

Figure 13. Engagement of stakeholders in CBR



In lower middle-income countries, a similar trend of decreased engagement of local government was found. Local nongovernmental organizations and INGOs play a larger role in CBR programmes in these countries. INGO engagement was reported more frequently in lower middle-income countries compared to upper middle-income countries.

Focus of CBR

Of the countries in the Region that are implementing CBR programmes, 14 (74%) reported that their country's CBR programme focused on all the components of the CBR Matrix: health, education, livelihood, social and empowerment. Four (21%) countries reported a primary focus on health (Federated States of Micronesia, Lao People's Democratic Republic, Republic of Korea and Solomon Islands) and one country (Kiribati) reported a primary focus on the social component.

Assistive technology

Countries were asked a broad set of questions that focused on the regulation, provision and affordability of assistive technology.

Legislation and regulation governing assistive technology

High-income countries reported having regulatory agencies and legislation (e.g. Act on Welfare of Persons with Disabilities in the Republic of Korea, Therapeutic Goods Regulations 2002 in Australia, New Zealand Public Health and Disability Act 2000) governing the prescription of assistive technology. Few countries in the Region reported other specific assistive technology standards. Some lower and upper middle-income countries described legal documents referring to assistive technology. For example, the Philippines pointed to the Law on Social Protection of People with Disabilities, Republic Act 7277 Rule V.

Six countries reported having an agreed list of essential assistive technology, namely Australia, China, Mongolia, New Zealand, Papua New Guinea and Viet Nam, leaving 18 countries without one. High-income countries appear to have more complex service provider systems to meet the wide range of assistive technology needed by persons with disabilities.

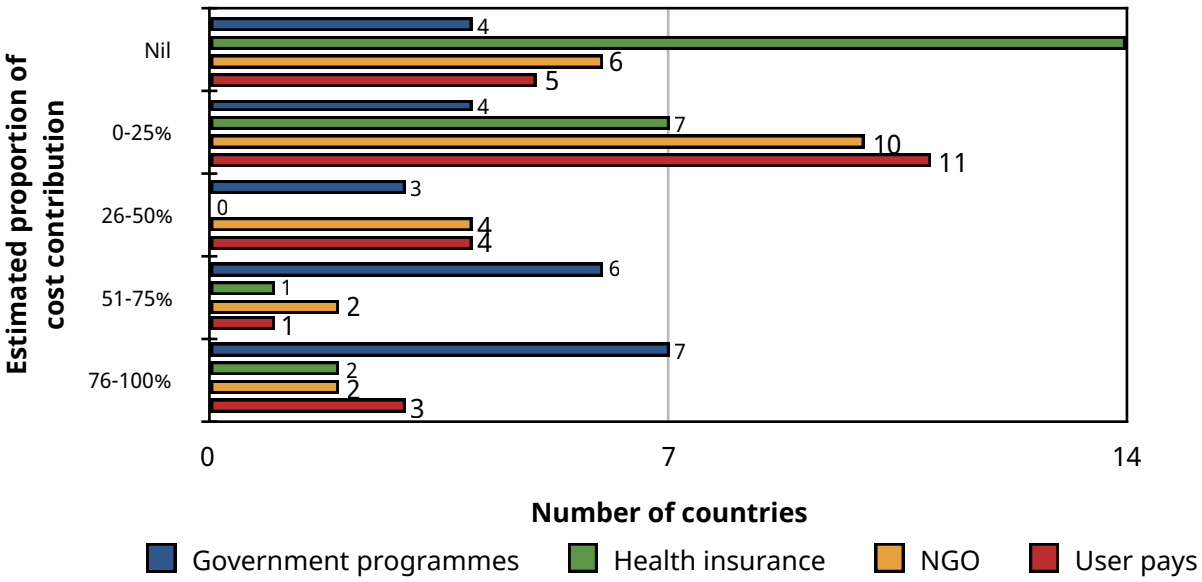
Funding for assistive technology

Precise data regarding overall cost contributions to assistive technology was difficult to attain. It was assumed that countries would not be able to reliably provide this information. Therefore, countries were asked to estimate the proportion of assistive technology funding from four sources and were given percentage ranges to choose for each (Figure 14).

High-income countries reported that government was the largest contributor to assistive technology costs, and that mechanisms are in place to cap the level of their contribution. In New Zealand, essential assistive technology is funded for people who have the greatest ability to benefit from it. Some equipment, such as artificial eyes, wigs, breast prostheses, hearing aids and children's spectacles for low-income families, is partly subsidized, with the user expected to

pay some of the cost. In Australia, the user's contribution cost is dependent on whether the device is in scope of government-funded programmes such as the National Disability Insurance Scheme or eligible for a benefits scheme at the jurisdictional level. Similarly, in Singapore, the contribution varies according to the income level of the user and needs of the individual.

Figure 14. Funding of assistive technology



Nongovernmental organizations play varied roles in the Region. In New Zealand, they provide or hire equipment in some circumstances. In Pacific island countries such as Fiji, the Federated States of Micronesia, Kiribati and the Marshall Islands, assistive devices (new and used) are donated by INGOs and faith-based organizations and provided free of charge through either government or nongovernmental programmes. In many Pacific island countries, these donations are intermittent, and when they run out, people who need assistive technology are responsible for sourcing and paying for it themselves or go without.

Mechanisms for affordability of assistive technology

Countries were also asked about government exemptions, reductions or waivers for people with disability for assistive technology.

Eighteen (75%) countries in the Region reported the existence of some form of government exemptions, waivers or reductions for assistive technology. By income group, 100% of the high-income countries reported government exemptions and/or reductions. Fifty per cent of the upper middle-income countries and 80% of the lower middle-income countries have government exemptions and/or reductions for assistive technology.

In high-income countries, the exemption or government subsidy is linked to income level of the person, and therefore low-income families can access a higher level of government support. In upper middle-income countries, the process varies. For example, in Malaysia, the reported reductions are for all people with disability registered with the Department of Social Welfare. In Mongolia, all persons with disabilities are eligible for cost-reduced and/or subsidized assistive technology.

In the lower middle-income category, some countries provide reductions or exemptions for specific devices such as prosthetics, orthotics, wheelchairs and crutches. Viet Nam reported government exemptions for assistive technology under a special programme related to Agent Orange victims and veterans. Papua New Guinea and Solomon Islands reported that all persons with disabilities are provided assistive technology free of charge, but the availability is often limited.

Linked to the provision of assistive technology is the need for environmental modifications to maximize its use and improve a user's functioning. Countries were asked whether home, workplace or education setting modifications (e.g. ramps, wheelchair-accessible toilets) are commonly funded by the government.

All the high-income countries reported that government funding is used to modify the environment of people with disability using assistive technology. In Brunei Darussalam, the government funds installation of ramps and wheelchair-accessible toilets in schools. In New Zealand, the government funds home modifications for people with long-term disability who meet income and asset criteria. The Republic of Korea and Japan implement programmes that install convenient equipment or redesign houses for persons with disabilities. In Australia, the National Disability Insurance Scheme includes provision for government funding of a range of home modifications for people with disability who are eligible for it, but this scheme does not cover all people who require these services.

In the upper middle-income category, three (38%) countries reported government funding for environmental modifications. Funded environmental modifications are only for public areas such as the workplace, schools and other public facilities. For the lower middle-income countries, only Solomon Islands reported funding for some basic home modifications.

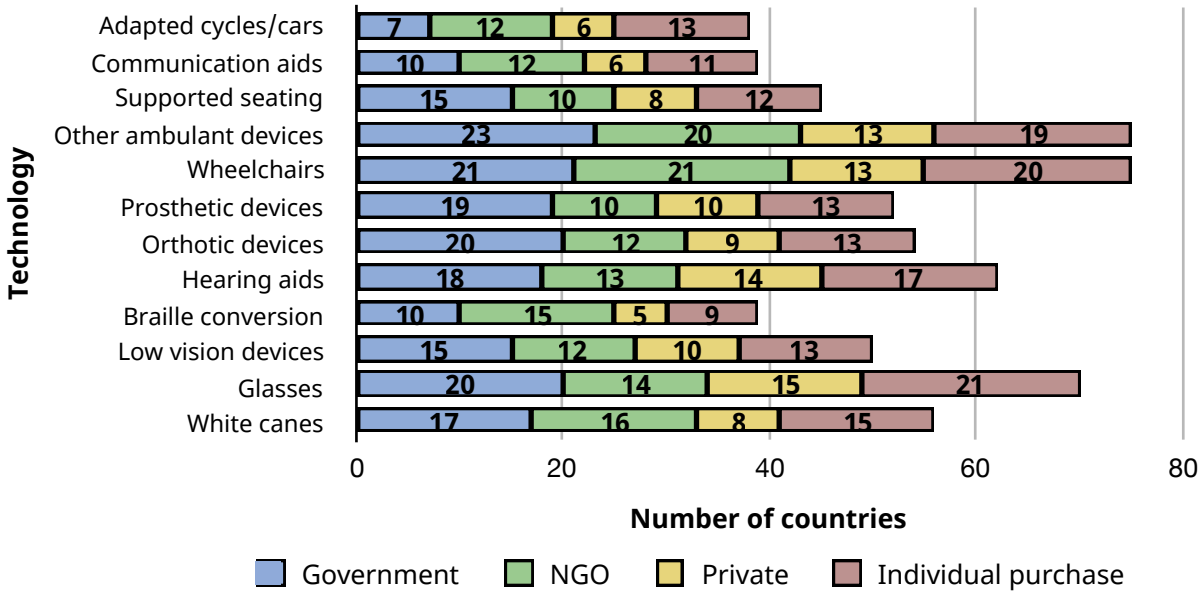
Commonly provided assistive technology

Countries were asked to identify which assistive technologies are commonly provided by different agencies, namely government, nongovernmental organizations, private clinics/ practitioners or purchased individually by users (Figure 15).

The four assistive technologies most commonly provided by governments in the Region are ambulant devices (e.g. crutches, walking frames), wheelchairs, glasses and orthotic devices. Similarly, nongovernmental organizations most frequently provide wheelchairs, ambulant devices, white canes and braille conversions. Private practitioners commonly provide glasses, hearing aids, ambulant devices and wheelchairs. Assistive technology purchased most frequently by users was reported to be glasses, wheelchairs and other ambulant devices.

Assistive technologies least likely to be provided by governments in the Region are adapted cycles/scooters/cars, braille conversion, communication aids and supported seating.

Figure 15. Assistive technologies as provided by different agencies in the Region



Estimate of population receiving assistive technology

Countries were asked to estimate the percentage of population of people with disability that receive the assistive technology that they need (Figure 16). Ten (42%) countries in the Region reported that 26–50% of the population requiring assistive technology is receiving what they need.

By income category, five (83%) of the high-income countries reported that 76–100% of the people with disability requiring assistive technology are receiving what they need. In contrast, four (50%) of the upper middle-income countries and five of the lower middle-income countries reported that 26–50% of people with disability are receiving the assistive technology that they need.

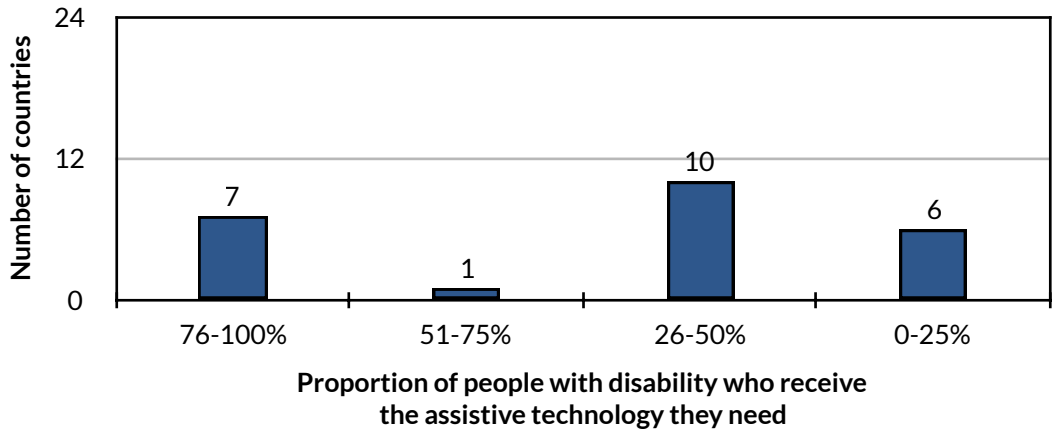
Services for assistive technology

Countries were also asked whether services are available to maintain assistive technology in good order including repair and replacement.

All six high-income countries reported the availability of services to maintain, repair and replace a range of assistive technologies. Six (75%) upper middle-income countries reported varying levels of services available. Most countries have services available for modifications and repairs of wheelchairs and mobility devices. In lower middle-income countries, eight (80%) countries reported availability of services for assistive technology. These are limited to repairs and maintenance of wheelchairs, prosthetics and orthotics, and mobility devices. Only Cambodia,

the Lao People's Democratic Republic and the Philippines reported additional services, such as services for hearing aids, low vision devices and braille conversion.

Figure 16. Assistive technology provision



In high-income countries, services for maintaining assistive technologies are mainly provided by the government, or by service providers/suppliers contracted by the government, as in the case of Australia, New Zealand and the Republic of Korea. In upper middle-income countries, these services are primarily available in hospitals that provided the assistive devices. In lower middle-income countries, aside from the government and hospitals, CBR workers and nongovernmental organizations play a role in repair and maintenance services of selected assistive technologies (mostly wheelchairs or mobility device repairs and prosthetic and orthotic services).

PART 3: INFORMATION ABOUT PEOPLE WITH DISABILITY

Key results

- Sixty-four per cent of countries reported disability questions had been included in a recent census.
- Thirty-eight per cent of countries reported a national disability survey had occurred.
- Thirty-eight per cent reported having a national registry of people with disability.
- Seventy-one per cent reported that data on children with disability could be obtained from the ministry of education.
- All six high-income countries reported disability research grants, but only three out of 18 upper and lower middle-income countries reported research grants.
- Reported disability prevalence ranged from 2% to 24%, suggesting there is still limited comparability of data across the Region.
- Seventy-one per cent of countries reported limited available disability data.

Countries were asked questions regarding availability of disability data. Questions addressed disability data across censuses, surveys and administrative data systems. Countries were asked what disability data existed, whether they considered their disability data adequate and if government funded disability research.

Disability questions in census and surveys

Fifteen (63%) countries in the Region reported that disability questions had been included in a recent census. Ten (42%) countries in the Region reported a national disability survey had occurred in their country. China and the Republic of Korea had undertaken disability surveys and therefore did not include questions in censuses, and Singapore had included disability questions in a survey but not a census. Twelve (50%) countries reported that disability questions had been included in other recent surveys.

High-income countries reported extensive availability of data on people with disability. Pacific island countries and most of the lower middle-income countries reported limited available data on disability.

Administrative systems and disability identification cards

Countries were asked whether there is a national registry for people with disability and whether the ministry of education collects data on children with disability. Nine (38%) countries in the Region reported that a national registry of persons with disability exists in their country, and 17 (71%) countries in the Region reported data on children with disability available from the ministry of education.

Thirteen (54%) countries in the Region issue some form of disability identification card to people with disability. The purpose of this card varies significantly. In Australia and New Zealand, the card was linked to disability parking permits. In Japan and the Republic of Korea, where financial benefit increases with severity of impairment, the card was involved in assessing disability severity. In China, the Philippines and Viet Nam, there was a link between the disability identification card and discounts on health care costs. Some countries such as Fiji, the Philippines and Singapore mentioned discounts on public transportation linked to a card. Not all countries that have a disability identification card have it linked to a national registry, although the majority do.

Other sources of disability data

When asked about other sources of data about people with disability, 10 (42%) countries in the Region reported that other sources were available. For example, New Zealand collected data after the Canterbury Earthquake, and the Philippines collected data after Typhoon Haiyan. In Australia, there is an annual survey of people with disability accessing government-funded disability services, and in Mongolia there is annual monitoring of progress towards moderate prosperity of people with disability.

Some countries reported having registries of people with disability accessing various services such as wheelchairs or physiotherapy services. Palau reported that children born with disability are automatically registered with the Office of Planning and Statistics. In Cambodia, the Mine Action and Victim Assistance Authority provides data on people with physical impairment. Some countries included population surveys that have focused on particular impairment groups, including mental health, vision and hearing surveys. Some countries have registries that keep track of number of traffic crashes and serious injuries, but they are not linked specifically to ongoing disability.

Disability research grants

The last question on the survey related to the provision of grants to support disability-related research. All six high-income countries reported making grants available for disability-related research, in contrast to only five (China, Malaysia, the Philippines, Palau and Viet Nam) out of 18 countries in the lower and upper middle-income categories.

High-income countries described how the funding for disability research helps to support evidence-based planning for policies, implementation and improvement of service delivery for people with disability and to measure outcomes of improvement in the lives of people with disability. New Zealand reported grant amounts available through various mechanisms. The research institute within the National Rehabilitation Center in the Republic of Korea has a budget of 40 billion Korean won, while the Korean Disabled People’s Development Institute is funded with 52 billion Korean won for research and development in disability.

Disability prevalence

Differences in measurement approaches to disability have a large impact on actual prevalence identified. Comparison of disability prevalence across countries remains difficult due to variable measurement approaches. The range of disability prevalence in the Region was reported from a low of 2% (National Population and Housing Census, Tuvalu) to a top level of 24% (Disability Survey, New Zealand). Where census data were used to report on disability, such as for Cambodia, the Philippines, Tonga and Tuvalu, the prevalence came in under 3%. When national disability surveys were used to report disability prevalence, it was significantly higher.

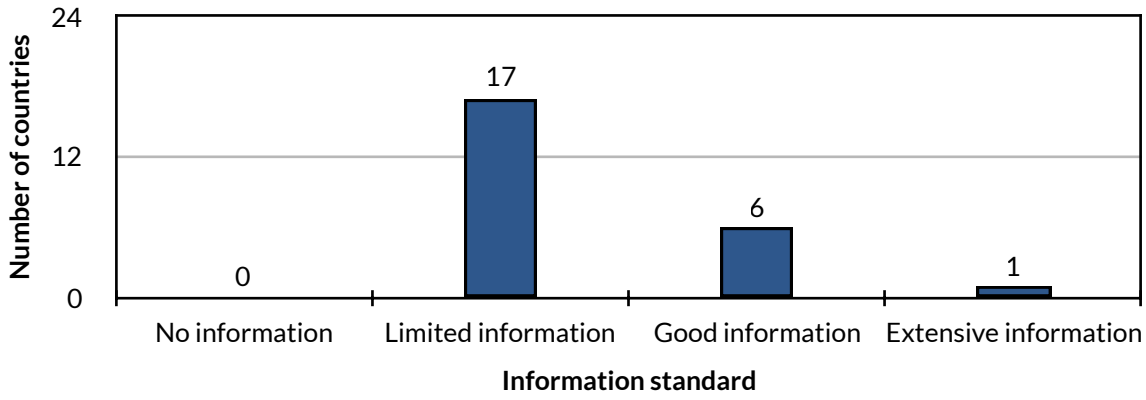
High-income countries such as Australia and New Zealand share similar measurement approaches and reported similar prevalence, close to 20% of the national population. Japan and Singapore reported a lower level, under 10% with their reported prevalence linked sometimes to their national disability identification card.

Adequacy of data

Countries were asked to rate the availability of disability data in their country. The high-income countries generally rated availability as good and extensive, while most of the lower and upper middle-income countries rated it as limited (Figure 17). Singapore and Brunei Darussalam, both high-income countries, also rated availability as limited. Seventy-one per cent of countries reported that data were limited, but no country reported that there was no information.

When countries were asked whether they considered their disability data to be adequate, four of the high-income countries (Australia, Japan, New Zealand and the Republic of Korea) reported good to extensive information, while China, Mongolia and Solomon Islands reported only good information. Countries that undertake national disability surveys report better availability of disability data, and Japan and Mongolia have national databases linked to their national disability identification card.

Figure 17. Disability data availability



REPORT HIGHLIGHTS AND DISCUSSION

The survey results reveal the status of countries' capacity to deliver disability-inclusive health and rehabilitation services for people with disability in the WHO Western Pacific Region. As the first such report globally, it provides governments with clear information about their current status and how it compares to other countries in the Region. This report sheds light on the similarities and differences experienced by countries and where patterns and trends exist between them. This report provides valuable information to assist our understanding of the regional and global situation.

The discussion reflects key findings across the areas of questions within the survey. It draws upon survey results as well as regional knowledge and information attained by WHO through their extensive engagement within countries across the Region.

Capacity to deliver disability-inclusive health care

In line with global and regional commitments

While 100% of countries have endorsed global and regional disability commitments, 75% have ratified the Convention on the Rights of Persons with Disabilities. This suggests ongoing support is required for realization of the Convention on the Rights of Persons with Disabilities, given just 29% of countries have legislation prohibiting discrimination against persons with disabilities by health insurance agencies.

It is encouraging to see that ministries of health are being positively influenced by international, regional and national disability commitments, and there is increasing awareness and action regarding the health needs and rights of persons with disabilities. Several countries have addressed disability in health legislation and policy and the Region is on track to full realization of global and regional commitments.

Leadership and governance for disability within health

Ministries of health are engaged in the high-level national disability coordination mechanisms, and 58% of countries reported their national health policy specifically mentions people with disability. Opportunities exist to encourage ministries in remaining countries to have dedicated disability personnel or units, as it has been reported that some ministries encounter challenges in supporting disability among many other priorities.

Addressing barriers to general health services for people with disability and prioritizing rehabilitation are challenges for many ministries of health, and in most lower and upper middle-income countries there is much still to do. Leadership and governance for disability within health still faces challenges (compared with many other issues within the health sector), and this is evident in ministries' internal disability capacity/focal points. However, while the actions are limited, there is increasing knowledge of what they should do and guidance to support this. There are many opportunities to increase disability leadership within health, particularly through the important (but crowded) health equity and universal health coverage agendas. Resourcing health ministries with knowledgeable staff in disability would be an important step forward in driving this agenda and realizing the action they know they should take.

Affordable health care

Five countries reported available evidence on the affordability of health care for people with disability, and 88% countries have undertaken action to reduce some health costs for people with disability.

It appears most ministries of health recognize that people with disability experience greater health care expenditure than people without disability, with 88% of countries undertaking some form of action in this area. This result has been positive. However, the limited availability of information about the affordability of health care means that the current range of reductions may not be tailored appropriately to different needs. Affordability of health care for people with disability is essential, and good evidence is a key tool for governments to design the most appropriate systems.

Inclusive health programmes, services and facilities

Fifty-eight per cent of the countries undertook actions to ensure health promotion campaigns were more accessible to persons with disability; with two out of 24 countries thoroughly embedding disability into health training curricula. Seventy-nine per cent of countries reported that accessibility standards existed and were applied to health but that implementation was limited.

Efforts to address barriers for 0.48 with disability across health programmes, services and facilities would appear to have room for development. Beyond most high-income countries, a need remains for ministries of health to make health services inclusive. Most countries, including all lower and upper middle-income countries, reported ad hoc efforts to increase accessibility of health information and programmes with limited extent and coverage. Countries reported challenges due to limitations in the availability of sign language interpreters, information in varied formats and disability awareness raising with health practitioners. Only a few ministries of health had strategic plans and programmes that systematically addressed the barriers to health care for persons with disability.

Physical accessibility of health services remains a large issue for most lower and upper middle-income countries. While it is positive that most countries reported national accessibility standards, the implementation and enforcement of these was reported as weak, and has been observed as weak. Retroactive efforts to improve physical accessibility do not progress rapidly, especially in the lower and upper middle-income countries.

Engaging people with disability in health planning

Fifty per cent of countries reported that people with disability participated "most of the time" in health planning, and no country reported "not at all".

It is very encouraging that ministries of health are aware of the need to work with people with disability and are regularly doing so. In high-income countries, a more extensive, mature engagement with disability groups was described. Positively, all countries reported some engagement, suggesting ministries of health are aware of the importance of consulting with people with disability and that their representative organizations are advocating and undertaking this role.

Capacity to deliver rehabilitation, assistive technology and community-based rehabilitation

National rehabilitation planning

Four out of 24 countries have stand-alone rehabilitation strategies, and four more have integrated rehabilitation into broader sector plans, leaving 66% of countries demonstrating limited rehabilitation sector planning.

Increasingly, countries have created or are drafting national rehabilitation strategies and action plans. This is most common in the lower and upper middle-income countries. The high-income countries commonly report rehabilitation strategic planning embedded into health planning at its different levels, suggesting that once it is well embedded, a less targeted approach is warranted. The increased attention to rehabilitation planning in lower middle-income countries is needed, as this area within health is often under-prioritized and neglected. In the Asian countries of the Western Pacific Region, the provision of rehabilitation commonly straddles two ministries, health and social affairs, which means interministerial collaboration in rehabilitation

is required. Unfortunately, many countries across multiple sectors find interministerial collaboration to be challenging. The need for both of these ministries to come together and regularly plan for improved rehabilitation is paramount. Rehabilitation sector planning is generally not strong across the Region, but recent progress suggests WHO's support is making a difference.

Financing rehabilitation

Government is the key agency financing rehabilitation in 21 out of 24 countries, but identification of precise rehabilitation budget within health funding is very challenging as it is embedded into a range of budget lines.

The key agency financing rehabilitation is government, and this is expected and needed. Precise data regarding rehabilitation financing were not available in most countries, and this is not surprising as it appropriately reflects the extensive degree in which rehabilitation is embedded into health service systems. Only lower middle-income countries had any significant financial contribution from an international organization. Of the eight countries that reported a national health insurance scheme, seven included funding for rehabilitation packages. Rehabilitation financing is integrated into broad health sector financing mechanisms; however, it is often reported as inadequate in order to meet the population's rehabilitation needs.

Availability of rehabilitation services

It would appear that availability of rehabilitation services is more limited in the lower and upper middle-income countries than in most high-income countries. Rehabilitation services are very limited in most lower and upper middle-income countries and are almost nonexistent at the community level.

High-income countries have a wide range of rehabilitation services available from primary to tertiary-level health care that caters to different age groups and health conditions, but this dramatically drops off in the lower and upper middle-income countries. The drop in rehabilitation services across country income groups is noticeable. In lower and upper middle-income countries, rehabilitation services are mostly available in tertiary hospitals albeit with limited specialties, and then almost not at all at the primary health care level. Physical therapy is the most available rehabilitation service in most countries, but lower and upper middle-income countries are still challenged to make it available at the primary health care level.

Adequacy of rehabilitation workforce

There are very large deficiencies in both the number and specialties of rehabilitation personnel across all lower and upper middle-income countries. High-income countries have approximately 100 times more physical therapists per 10 000 population than some of the lower middle-income countries, and no country ranked rehabilitation professional as a "very attractive" career.

The drop in workforce per capita ratios and skills outside of the high-income country group is concerning. It is an indicator of the need for further investment in rehabilitation services in lower and upper middle-income countries. It is positive to have countries report initiatives

under way to address rehabilitation workforce weaknesses, and a challenge to address will be to ensure efforts address the current workforce limitations. The large drop in rehabilitation personnel for lower and upper middle-income countries reflects the significant drop in service availability as noted.

Rehabilitation in the Pacific subregion

Pacific island countries have small rehabilitation workforces and very limited specialties.

With the increase in disability related to noncommunicable diseases, the limited rehabilitation workforce in the Pacific is a major concern. While some Pacific island countries have community-based rehabilitation programmes, they cannot provide all the specialized skills and services that rehabilitation therapists and doctors provide. The Pacific has very limited rehabilitation services at the tertiary hospital and community level. Attention must be given to both levels to increase access to quality services in the Region.

Assistive technology provision

Sixty per cent of countries reported that the provision of assistive technology is meeting less than 50% of the population needs.

Provision of assistive technology is increasing albeit with limits to scope and range. Recent international attention to assistive technology by the disability movement is attracting increased engagement by ministries of health and social affairs. Recent progress in countries is positive, and there remains room to develop standards, regulation and comprehensive planning of service systems. A much more comprehensive and planned approach to the provision of assistive technology could be considered to ensure devices are appropriate, safe and affordable. Effort must be made to ensure provision meets the broad needs of people with functional limitations and to balance the current provision focus on people with mobility difficulties.

Community-based rehabilitation

Sixty-seven per cent of countries undertake community-based rehabilitation (CBR) planning.

CBR remains widespread in the Region, and most countries report programmes with increasing government ownership, particularly by the ministry of social affairs. Both government and nongovernmental organizations undertake the majority of CBR leadership, financing and provision. CBR remains a key strategy for facilitating service provision for people with disability at the community level. It is most prominent in the lower and upper middle-income countries, and new CBR plans are being drafted across the Pacific.

Availability of disability data

Availability of disability data

Sixty-six per cent of countries provided disability prevalence figures, 29% reported good or extensive disability information was available.

It is encouraging that governments have undertaken action for increasing disability data and deepening their understanding of the situation of people with disability. Countries are doing this through the use of disability data in censuses, surveys and administrative data sets. Some countries were able to report disability prevalence across two to three data sets, for example in a census, a survey and education data systems, though the majority provided it through only one source. Many countries, especially lower and upper middle-income countries do not have specialists in disability data. As such, there is often limited capacity in disability measurement approaches. It is positive to see that countries that undertake national disability surveys have better disability data capacity and report very good levels of disability information. On the whole, disability data remain an area with much development required.

Comparability of disability data

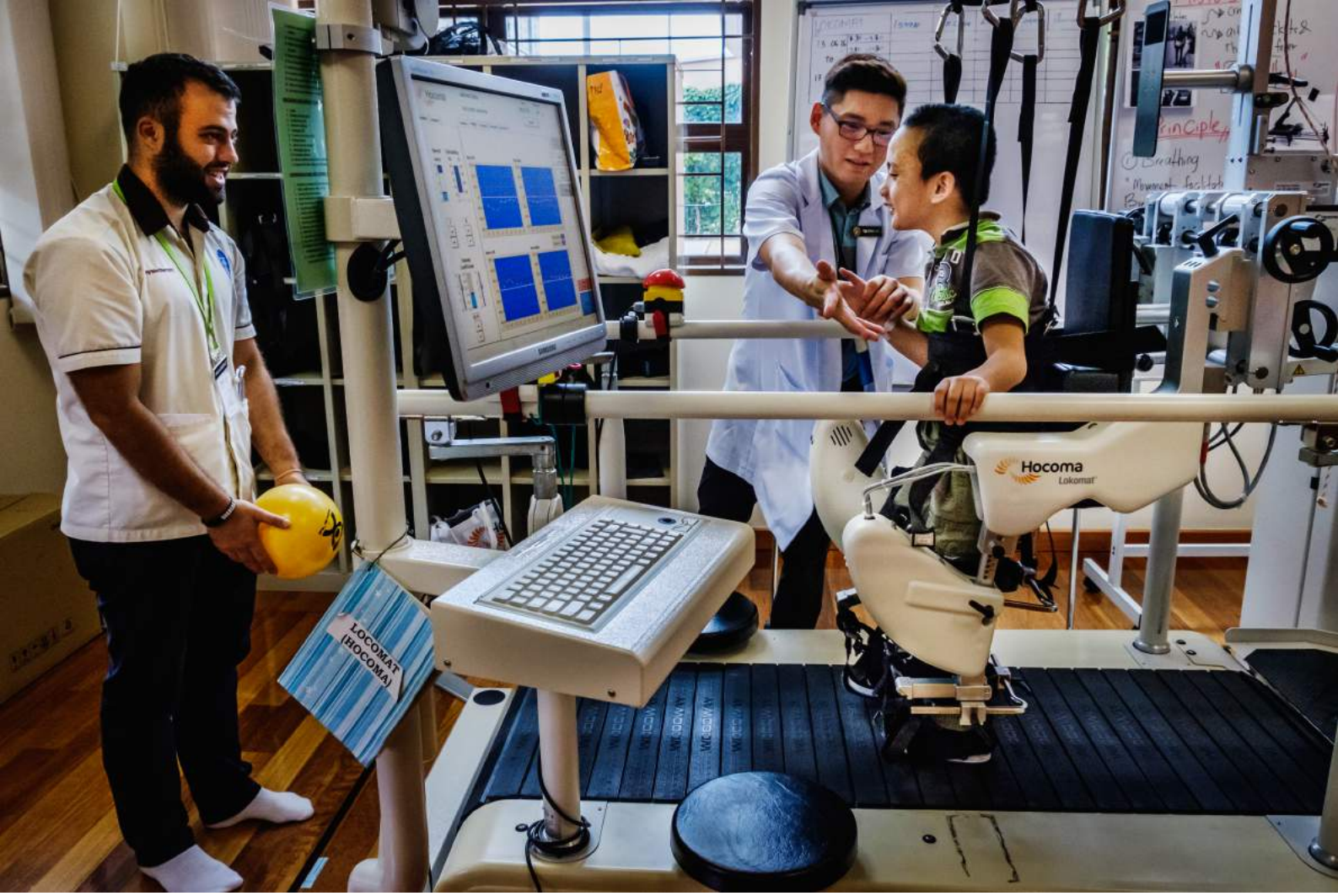
Disability prevalence provided by countries ranged from 2% (Tuvalu National Population and Housing Survey) to 24% (New Zealand Disability Survey, 2013), reflecting the differences in measurement approaches.

The survey highlighted that internationally comparable data on disability are still limited as measurement approaches differ. Even measurement approaches between high-income countries vary, with New Zealand and Australia reflecting similar approaches and prevalence levels (close to 20% of population), while China, Japan and the Republic of Korea have similar levels (close to 6% of population).

Disability research

Ten out of 24 countries provide grants for disability-related research. Five of these are the high-income countries.

High-income country governments are allocating research funding for disability-related studies, with 27% of the lower and upper middle-income countries reporting this. Unfortunately, it is often these countries where knowledge of the situation of people with disability is very limited and new research is most needed.



CONCLUSIONS AND PRIORITY AREAS FOR ACTION FOR THE WHO WESTERN PACIFIC REGION

Overall, the 2015 survey revealed extensive information on the status of country capacity to deliver disability-inclusive health, rehabilitation, community-based rehabilitation, assistive technology and disability data. Results suggest countries are gradually progressing towards realizing the objectives of the WHO Global Disability Action Plan 2014–2021, and maintaining momentum should be encouraged.

The survey results revealed progress and challenges across all countries and the need for all countries to continue efforts to increase disability-inclusive health and rehabilitation service provision. Through analysis of survey results, and contextualizing these within WHO country engagement, the following eight conclusions and priority areas for action have been identified.

1. **Ministries of health are on the way to fully identifying and addressing barriers experienced by persons with disabilities when accessing general health services; and a more systematic and strategic approach is encouraged.**

The ministries of health have limited information on the barriers experienced by people with disability when accessing health services and experience challenges in prioritizing this issue. In some lower and upper middle-income countries, the ministries of health have expressed a need to better understand their role in addressing disability. This situation in some countries may have resulted because government leadership for disability transferred from health to social affairs agencies. It is positive to see that ministries of health have been undertaking a range of ad hoc and intermittent activities in this area, with some having planned and comprehensive approaches to improving the health of people with disability. Many ministries of health are at the early stages of addressing this issue. A more informed, planned and systematic approach is needed.

- ***Ministries of health are encouraged to identify and resource units within their structure so as to undertake a planned and systematic approach to addressing barriers to health care for people with disability.***

- ***Ministries of health could build their capacity and undertake studies to increase country-specific knowledge of the barriers experienced by people with disability when accessing health care. They are urged to prioritize, plan and implement multiple actions, and collaborate with DPOs throughout the process.***

- ***Ministries of health are encouraged to link disability inclusion efforts with the broad universal health care, health equity and person-centred integrated health care agendas.***

2. **There is very limited rehabilitation available in most lower and upper middle-income countries even though it is an essential health strategy; it is suggested that rehabilitation requires more significant planning and investment by ministries of health.**

The large gap in rehabilitation availability observed between the high-income countries and all other countries is a serious concern and suggests under-prioritization of rehabilitation by the ministries of health in lower and upper middle-income groups. Such a large disparity between country income groups cannot simply be explained by income alone, as not all economic differences are commensurate with service gaps. Rehabilitation is a key health strategy, and considering ageing populations and increases in noncommunicable diseases and their corresponding rehabilitation needs, ministries of health are encouraged to urgently prioritize rehabilitation in the Western Pacific Region. Rehabilitation is an integral part of health services. It will take many decades to build the workforces and services that countries need.

- ***Ministries of health are urged to further prioritize rehabilitation services. A clearer understanding of the rehabilitation situation within countries as well as a planned and strategic approach is advised. In lower and upper middle-income countries attention to strengthening services at both tertiary and community levels is still needed, acknowledging some countries could consider a focus more on the community level.***

- ***Where both ministries of health and social affairs are engaged in rehabilitation services, a more planned and coordinated approach between them is suggested, given the resources available.***

3. **Provision of assistive technology is inadequate; stronger leadership, financing and development of comprehensive programmes that include a wide range of technology are encouraged.**

   The need for assistive technology is largely unmet in the Western Pacific Region, and it is growing significantly due to population ageing and increases in noncommunicable diseases. The extent of need, met or not, is unknown in most countries. However, even without good data, 66% of countries estimate they are meeting less than 50% of need. Assistive technology is a powerful tool for increasing the functioning and health in older people and people with disability. It is truly an investment in human capital that has many returns for society.

   - ***Ministries of health and social affairs are encouraged to work together to assess, plan and implement comprehensive programmes for assistive technology provision across multiple service sectors. Countries are advised to adopt an essential list of assistive devices, in line with WHO's essential assistive products list, to ensure the provision of appropriate, quality and affordable products.***

4. **CBR remains an important strategy for increasing access to services in lower and upper middle-income countries, yet programme management and evaluation requires development; governments are encouraged to increasingly fund and support programmes with a strong community focus.**

   CBR programmes that focus on multisectoral areas are an efficient approach for lower and upper middle-income countries. They are very often the only programmes that reach people with disability in their local community. Often, ministries of health and social affairs engage in CBR programmes, and this is consistent with the multisectoral approach promoted by WHO. Nongovernmental organizations are a primary delivery mechanism for CBR in lower and upper middle-income countries; however, the work they undertake should ultimately be resourced through government.

   - ***Ministries of health and social affairs are advised to work together, to support CBR. A more planned and programmatic approach to CBR is suggested. Ultimately, government is encouraged to fund CBR programmes, but they may or may not actually deliver them noting the strong, effective and flexible role nongovernmental organizations play. Stronger programme management and evaluation practices are suggested across this sector and supported by government.***

5. **The Pacific island countries experience particularly large deficits in rehabilitation services and many governments are experiencing ongoing challenges to respond; political prioritization and collective action at national and regional levels are suggested to strengthen both central and community-based services.**

   The Pacific subregion presents unique geographical features that challenge the provision of all health and social services. The population is widely dispersed with varying language and cultural groups and separated by great distances that involve costly travel. Rehabilitation is particularly limited with most countries reporting availability of rehabilitation at the national hospital only and weak to nonexistent outreach and community services. The specialist skills within the rehabilitation workforce are limited, and personnel often work alone and isolated from professional colleagues. Financial barriers to health care are less of an issue as services are often free, but specific funding is often required for assistive devices. CBR is an efficient multisectoral approach that can provide people with basic rehabilitation in the community and referral to specialists if needed. A coordinated, efficient and tailored approach is suggested in countries.

   - ***Ministries of health in the Pacific are encouraged to prioritize rehabilitation service development and take practical, long-term, context-specific steps to address the challenges in the rehabilitation workforce. CBR programmes are an important approach for facilitating access to services and promoting inclusion in community life. Both the ministry of health and ministry of social affairs have important roles to play in building access to a range of services.***

6. **The rehabilitation workforce is limited and can be weak, contributing to the slow development of rehabilitation services; greater knowledge, attention and action to address the specific challenges of the rehabilitation workforce are suggested.**

   The rehabilitation workforce experiences similar challenges as the health workforce, but evidence suggests this workforce faces additional challenges. The rehabilitation workforce numbers are often comparatively smaller than other areas of health, making it difficult to promote their own development. Additionally, in resource-constrained health ministries, the prioritization of preventative and curative health care reduces support for rehabilitation services and the rehabilitation workforce. Finally, the profession is often viewed to be less financially and socially attractive, making it particularly difficult to attract and retain competent rehabilitation professionals.

   - ***Ministries of health are encouraged to recognize the specific challenges faced by the rehabilitation workforce and address these with affirmative action that increases the training and subsequent attainment and retention in the workforce. The rehabilitation workforce requires prioritization to increase its numbers, specialties and quality of graduates.***

7. **Good-quality and comparable disability data are limited and often underutilized; knowledge, planning and better utilization of disability data are suggested.**

   Purpose-specific approaches are needed to measure disability data. Ideally, comprehensive disability data would be available, meaning measurement approaches would identify functioning difficulties in the population, and result in percentages closer to WHO's global estimate of 15% prevalence. There are currently variable understandings of disability in countries with correspondingly varied measurement approaches being applied, resulting in a lack of comparability. Government agencies need to understand the complexity of disability measurement. Many countries have very low capacity in disability data and are not utilizing the data they have.

   - ***Ministries of social affairs, health and others are suggested to increase their technical capacity in disability data and work together to develop planned approaches to national disability data collection. Where resources are available, ministries are encouraged to undertake national disability surveys.***

8. **People with disability play an important role in change; increased engagement of people with disability and their representative organizations, including rehabilitation users groups in health planning and delivery is required.**

   The engagement of people with disability and other rehabilitation users is essential in order to identify and address the barriers to health care often experienced by them. This engagement has begun and it has been suggested to strengthen it, particularly to generate evidence and understanding, build capacity and undertake evaluation of health services.

   - ***Ministries of health are advised to reach out to and collaborate with DPOs and rehabilitation user groups as they share a similar vision for inclusive, equitable and rights-based health services. Both suggested to build specific knowledge regarding the barriers experienced by people with disability and identify and systematically plan actions to address these barriers.***

ANNEX

Country profiles

National capacity to provide disability-inclusive health care, rehabilitation, assistive technology, community-based rehabilitation and disability data

Australia

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**Yes**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**No**
Defined standards for assistive technology provision	**Yes**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY

	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	●
Coverage and range of rehabilitation services	●
Mechanisms to support quality rehabilitation practices	●
Availability of rehabilitation services at community level	■
Availability of rehabilitation services in tertiary health care	●
Appropriate assistive technologies are available and affordable	●

WORKFORCE

	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	●
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	●

FINANCING

	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	●

	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION

	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**Yes**
Government grants for disability research	**Yes**

Disability Data | **Disability prevalence:** 18.5% | **Source:** Survey of Disability Ageing and Carers | **Year:** 2012

Brunei Darussalam

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**No**
Health policy explicitly mentions access to health care services for people with disabilities	**No**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**No**
National rehabilitation policy, strategy or plan	**No**
Defined standards for assistive technology provision	**No**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY	
	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	■
Mechanisms to support quality rehabilitation practices	■
Availability of rehabilitation services at community level	■
Availability of rehabilitation services in tertiary health care	■
Appropriate assistive technologies are available and affordable	▲

WORKFORCE	
	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	■

FINANCING	
	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	■
	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**–**

INFORMATION	
	Yes/No
Disability included in recent national census	**No**
Dedicated disability surveys	**No**
Government grants for disability research	**Yes**

Disability Data	**Disability prevalence: –**	**Source: –**	**Year: –**

Cambodia

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	Yes
Health policy explicitly mentions access to health care services for people with disabilities	Yes
Legislation prohibits health insurers from discriminating against pre-existing disability	No
Mechanisms for leadership and governance for disability-inclusive health	Yes
Engagement of people with disabilities in health planning	Yes
National rehabilitation policy, strategy or plan	No
Defined standards for assistive technology provision	Yes
National physical accessibility standards of public buildings including health facilities	No

SERVICE DELIVERY

	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	■
Mechanisms to support quality rehabilitation practices	▲
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	■
Appropriate assistive technologies are available and affordable	▲

WORKFORCE

	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	▲

FINANCING

	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	▲
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	▲

	Yes/No
Government is largest financial contributor to rehabilitation services	No
Government is largest financial contributor to assistive technology services	No
Significant government contribution to community-based rehabilitation services	No

INFORMATION

	Yes/No
Disability included in recent national census	Yes
Dedicated disability surveys	No
Government grants for disability research	No

Disability Data	Disability prevalence: 4%	Source: Socio-Economic Survey	Year: 2013

China

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**Yes**
Defined standards for assistive technology provision	**Yes**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY	
	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	■
Mechanisms to support quality rehabilitation practices	●
Availability of rehabilitation services at community level	■
Availability of rehabilitation services in tertiary health care	■
Appropriate assistive technologies are available and affordable	●

WORKFORCE	
	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	●

FINANCING	
	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	■
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	●
	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION	
	Yes/No
Disability included in recent national census	**No**
Dedicated disability surveys	**Yes**
Government grants for disability research	**Yes**

Disability Data	**Disability prevalence:** 6.35%	**Source:** Second National Sample Survey on Disability	**Year:** 2006

Fiji

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	–
Health policy explicitly mentions access to health care services for people with disabilities	No
Legislation prohibits health insurers from discriminating against pre-existing disability	No
Mechanisms for leadership and governance for disability-inclusive health	Yes
Engagement of people with disabilities in health planning	Yes
National rehabilitation policy, strategy or plan	No
Defined standards for assistive technology provision	No
National physical accessibility standards of public buildings including health facilities	Yes

SERVICE DELIVERY

	Emerging ▲	Established ■	Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services		▲	
Coverage and range of rehabilitation services		▲	
Mechanisms to support quality rehabilitation practices		■	
Availability of rehabilitation services at community level		▲	
Availability of rehabilitation services in tertiary health care		■	
Appropriate assistive technologies are available and affordable		▲	

WORKFORCE

	Emerging ▲	Established ■	Expanding ●
Adequacy of rehabilitation workforce		▲	
Integration of disability into relevant undergraduate health curricula	▲		
Government planning for increased rehabilitation personnel		▲	

FINANCING

	Emerging ▲	Established ■	Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services		▲	
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services		▲	

	Yes/No
Government is largest financial contributor to rehabilitation services	Yes
Government is largest financial contributor to assistive technology services	Yes
Significant government contribution to community-based rehabilitation services	Yes

INFORMATION

	Yes/No
Disability included in recent national census	Yes
Dedicated disability surveys	Yes
Government grants for disability research	No

Disability Data **Disability prevalence:** 10% | **Source:** Making Women with Disabilities Visible | **Year:** 2010

Japan

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**Yes**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**Yes**
Defined standards for assistive technology provision	**Yes**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY

	Emerging ▲	Established ■	Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services			●
Coverage and range of rehabilitation services			●
Mechanisms to support quality rehabilitation practices			●
Availability of rehabilitation services at community level	▲		
Availability of rehabilitation services in tertiary health care			●
Appropriate assistive technologies are available and affordable			●

WORKFORCE

	Emerging ▲	Established ■	Expanding ●
Adequacy of rehabilitation workforce			●
Integration of disability into relevant undergraduate health curricula		▲	
Government planning for increased rehabilitation personnel		■	

FINANCING

	Emerging ▲	Established ■	Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services			●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services			●

	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION

	Yes/No
Disability included in recent national census	**No**
Dedicated disability surveys	**Yes**
Government grants for disability research	**Yes**

Disability Data	**Disability prevalence:** 4.8 million people with disability identified	**Source:** Survey on People with Difficulties in Living	**Year:** 2011

Kiribati

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	Yes
Health policy explicitly mentions access to health care services for people with disabilities	No
Legislation prohibits health insurers from discriminating against pre-existing disability	No
Mechanisms for leadership and governance for disability-inclusive health	Yes
Engagement of people with disabilities in health planning	Yes
National rehabilitation policy, strategy or plan	No
Defined standards for assistive technology provision	No
National physical accessibility standards of public buildings including health facilities	Yes

SERVICE DELIVERY

	Emerging ▲	Established ■	Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services		▲	
Coverage and range of rehabilitation services		▲	
Mechanisms to support quality rehabilitation practices		▲	
Availability of rehabilitation services at community level		▲	
Availability of rehabilitation services in tertiary health care		▲	
Appropriate assistive technologies are available and affordable		▲	

WORKFORCE

	Emerging ▲	Established ■	Expanding ●
Adequacy of rehabilitation workforce		▲	
Integration of disability into relevant undergraduate health curricula	▲		
Government planning for increased rehabilitation personnel		▲	

FINANCING

	Emerging ▲	Established ■	Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services		■	
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services		■	

	Yes/No
Government is largest financial contributor to rehabilitation services	Yes
Government is largest financial contributor to assistive technology services	Yes
Significant government contribution to community-based rehabilitation services	Yes

INFORMATION

	Yes/No
Disability included in recent national census	No
Dedicated disability surveys	Yes
Government grants for disability research	No

Disability Data **Disability prevalence:** 4.1% | **Source:** UNESCAP Disability at a Glance | **Year:** 2015

Lao People's Democratic Republic

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**Yes**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**No**
Defined standards for assistive technology provision	**No**
National physical accessibility standards of public buildings including health facilities	**No**

SERVICE DELIVERY	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	▲
Mechanisms to support quality rehabilitation practices	▲
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	▲
Appropriate assistive technologies are available and affordable	▲

WORKFORCE	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	▲

FINANCING	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	▲
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	▲

	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**No**
Significant government contribution to community-based rehabilitation services	**No**

INFORMATION	
	Yes/No
Disability included in recent national census	**No**
Dedicated disability surveys	**No**
Government grants for disability research	**No**

Disability Data	**Disability prevalence:** –	**Source:** –	**Year:** –

Malaysia

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	Yes
Health policy explicitly mentions access to health care services for people with disabilities	Yes
Legislation prohibits health insurers from discriminating against pre-existing disability	No
Mechanisms for leadership and governance for disability-inclusive health	Yes
Engagement of people with disabilities in health planning	Yes
National rehabilitation policy, strategy or plan	Yes
Defined standards for assistive technology provision	No
National physical accessibility standards of public buildings including health facilities	Yes

SERVICE DELIVERY

	Emerging ▲	Established ■	Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services		■	
Coverage and range of rehabilitation services		■	
Mechanisms to support quality rehabilitation practices			●
Availability of rehabilitation services at community level		■	
Availability of rehabilitation services in tertiary health care		■	
Appropriate assistive technologies are available and affordable		■	

WORKFORCE

	Emerging ▲	Established ■	Expanding ●
Adequacy of rehabilitation workforce	▲		
Integration of disability into relevant undergraduate health curricula	▲		
Government planning for increased rehabilitation personnel		■	

FINANCING

	Emerging ▲	Established ■	Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services		■	
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services		■	

	Yes/No
Government is largest financial contributor to rehabilitation services	Yes
Government is largest financial contributor to assistive technology services	Yes
Significant government contribution to community-based rehabilitation services	Yes

INFORMATION

	Yes/No
Disability included in recent national census	No
Dedicated disability surveys	No
Government grants for disability research	Yes

Disability Data	Disability prevalence: –	Source: –	Year: –

Marshall Islands

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**No**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**No**
Defined standards for assistive technology provision	**Yes**
National physical accessibility standards of public buildings including health facilities	**No**

SERVICE DELIVERY

	Emerging ▲	Established ■	Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲		
Coverage and range of rehabilitation services	▲		
Mechanisms to support quality rehabilitation practices	▲		
Availability of rehabilitation services at community level	▲		
Availability of rehabilitation services in tertiary health care	▲		
Appropriate assistive technologies are available and affordable	▲		

WORKFORCE

	Emerging ▲	Established ■	Expanding ●
Adequacy of rehabilitation workforce	▲		
Integration of disability into relevant undergraduate health curricula	-		
Government planning for increased rehabilitation personnel	▲		

FINANCING

	Emerging ▲	Established ■	Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	▲		
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	▲		

	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**No**
Significant government contribution to community-based rehabilitation services	**No**

INFORMATION

	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**No**
Government grants for disability research	**No**

Disability Data **Disability prevalence:** 11.7% | **Source:** UNESCAP Disability at a Glance | **Year:** 2015

Micronesia, Federated States of

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	No
Health policy explicitly mentions access to health care services for people with disabilities	No
Legislation prohibits health insurers from discriminating against pre-existing disability	No
Mechanisms for leadership and governance for disability-inclusive health	Yes
Engagement of people with disabilities in health planning	No
National rehabilitation policy, strategy or plan	No
Defined standards for assistive technology provision	No
National physical accessibility standards of public buildings including health facilities	No

SERVICE DELIVERY

	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	▲
Mechanisms to support quality rehabilitation practices	▲
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	▲
Appropriate assistive technologies are available and affordable	▲

WORKFORCE

	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	–
Government planning for increased rehabilitation personnel	▲

FINANCING

	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	▲
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	▲

	Yes/No
Government is largest financial contributor to rehabilitation services	No
Government is largest financial contributor to assistive technology services	No
Significant government contribution to community-based rehabilitation services	No

INFORMATION

	Yes/No
Disability included in recent national census	Yes
Dedicated disability surveys	No
Government grants for disability research	No

Disability Data **Disability prevalence:** 11.0% **Source:** UNESCAP Disability at a Glance **Year:** 2015

Mongolia

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**Yes**
Defined standards for assistive technology provision	**Yes**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY	
	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	■
Coverage and range of rehabilitation services	■
Mechanisms to support quality rehabilitation practices	■
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	■
Appropriate assistive technologies are available and affordable	■

WORKFORCE	
	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	■

FINANCING	
	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	■
	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION	
	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**No**
Government grants for disability research	**No**

Disability Data	**Disability prevalence:** 3.9%	**Source:** UNESCAP Disability at a Glance	**Year:** 2015

New Zealand

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**Yes**
Defined standards for assistive technology provision	**Yes**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY			
	Emerging ▲	**Established** ■	**Expanding** ●
Extent of reasonable accommodation measures to accessing mainstream health services			●
Coverage and range of rehabilitation services			●
Mechanisms to support quality rehabilitation practices			●
Availability of rehabilitation services at community level			●
Availability of rehabilitation services in tertiary health care			●
Appropriate assistive technologies are available and affordable			●

WORKFORCE			
	Emerging ▲	**Established** ■	**Expanding** ●
Adequacy of rehabilitation workforce			●
Integration of disability into relevant undergraduate health curricula			●
Government planning for increased rehabilitation personnel			●

FINANCING			
	Emerging ▲	**Established** ■	**Expanding** ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services			●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services			●
	Yes/No		
Government is largest financial contributor to rehabilitation services	**Yes**		
Government is largest financial contributor to assistive technology services	**Yes**		
Significant government contribution to community-based rehabilitation services	**Yes**		

INFORMATION	
	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**Yes**
Government grants for disability research	**Yes**

Disability Data	**Disability prevalence:** 24%	**Source:** Disability Survey	**Year:** 2013

Palau

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**No**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**No**
Defined standards for assistive technology provision	**No**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY	
	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	■
Coverage and range of rehabilitation services	■
Mechanisms to support quality rehabilitation practices	■
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	▲
Appropriate assistive technologies are available and affordable	▲

WORKFORCE	
	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	■
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	■

FINANCING	
	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	■
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	■
	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION	
	Yes/No
Disability included in recent national census	**No**
Dedicated disability surveys	**Yes**
Government grants for disability research	**Yes**

Disability Data	**Disability prevalence:** –	**Source:** –	**Year:** –

Papua New Guinea

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	Yes
Health policy explicitly mentions access to health care services for people with disabilities	Yes
Legislation prohibits health insurers from discriminating against pre-existing disability	No
Mechanisms for leadership and governance for disability-inclusive health	Yes
Engagement of people with disabilities in health planning	Yes
National rehabilitation policy, strategy or plan	Yes
Defined standards for assistive technology provision	No
National physical accessibility standards of public buildings including health facilities	Yes

SERVICE DELIVERY

	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	▲
Mechanisms to support quality rehabilitation practices	▲
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	■
Appropriate assistive technologies are available and affordable	■

WORKFORCE

	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	▲

FINANCING

	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	■
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	■

	Yes/No
Government is largest financial contributor to rehabilitation services	Yes
Government is largest financial contributor to assistive technology services	Yes
Significant government contribution to community-based rehabilitation services	Yes

INFORMATION

	Yes/No
Disability included in recent national census	Yes
Dedicated disability surveys	No
Government grants for disability research	No

Disability Data **Disability prevalence:** 13.4% | **Source:** UNESCAP Disability at a Glance | **Year:** 2015

Philippines

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**Yes**
Defined standards for assistive technology provision	**Yes**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY	
	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	■
Coverage and range of rehabilitation services	■
Mechanisms to support quality rehabilitation practices	■
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	▲
Appropriate assistive technologies are available and affordable	▲

WORKFORCE	
	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	▲

FINANCING	
	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	■
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	▲
	Yes/No
Government is largest financial contributor to rehabilitation services	**No**
Government is largest financial contributor to assistive technology services	**No**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION	
	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**No**
Government grants for disability research	**Yes**

Disability Data	**Disability prevalence:** 1.6%	**Source:** UNESCAP Disability at a Glance	**Year:** 2015

Republic of Korea

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**Yes**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**Yes**
Defined standards for assistive technology provision	**Yes**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY

	Emerging ▲	Established ■	Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services			●
Coverage and range of rehabilitation services		■	
Mechanisms to support quality rehabilitation practices		■	
Availability of rehabilitation services at community level		■	
Availability of rehabilitation services in tertiary health care			●
Appropriate assistive technologies are available and affordable			●

WORKFORCE

	Emerging ▲	Established ■	Expanding ●
Adequacy of rehabilitation workforce			●
Integration of disability into relevant undergraduate health curricula		■	
Government planning for increased rehabilitation personnel		■	

FINANCING

	Emerging ▲	Established ■	Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services			●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services			●

	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION

	Yes/No
Disability included in recent national census	**No**
Dedicated disability surveys	**Yes**
Government grants for disability research	**Yes**

Disability Data **Disability prevalence:** 5.59% | **Source:** National Survey on Disability | **Year:** 2014

Samoa

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**No**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**No**
Defined standards for assistive technology provision	**No**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY	
	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	▲
Mechanisms to support quality rehabilitation practices	■
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	▲
Appropriate assistive technologies are available and affordable	■

WORKFORCE	
	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	■
Government planning for increased rehabilitation personnel	■

FINANCING	
	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	■
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	▲
	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**No**
Significant government contribution to community-based rehabilitation services	**No**

INFORMATION	
	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**No**
Government grants for disability research	**No**

Disability Data	**Disability prevalence:** 5.9%	**Source:** UNESCAP Disability at a Glance	**Year:** 2015

Singapore

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**No**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**Yes**
Defined standards for assistive technology provision	**Yes**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY	
	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	■
Coverage and range of rehabilitation services	■
Mechanisms to support quality rehabilitation practices	●
Availability of rehabilitation services at community level	■
Availability of rehabilitation services in tertiary health care	●
Appropriate assistive technologies are available and affordable	●

WORKFORCE	
	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	■
Integration of disability into relevant undergraduate health curricula	■
Government planning for increased rehabilitation personnel	■

FINANCING	
	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	●
	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION	
	Yes/No
Disability included in recent national census	**No**
Dedicated disability surveys	**No**
Government grants for disability research	**Yes**

Disability Data	**Disability prevalence:** 3	**Source:** –	**Year:** –

Solomon Islands

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**No**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**No**
Defined standards for assistive technology provision	**No**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY

	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	▲
Mechanisms to support quality rehabilitation practices	■
Availability of rehabilitation services at community level	■
Availability of rehabilitation services in tertiary health care	▲
Appropriate assistive technologies are available and affordable	■

WORKFORCE

	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	●

FINANCING

	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	■

	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION

	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**Yes**
Government grants for disability research	**No**

Disability Data **Disability prevalence:** 14.0% | **Source:** UNESCAP Disability at a Glance | **Year:** 2015

Tonga

LEADERSHIP AND GOVERNANCE

	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**No**
Health policy explicitly mentions access to health care services for people with disabilities	**No**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**No**
Defined standards for assistive technology provision	**No**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY

	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	▲
Mechanisms to support quality rehabilitation practices	▲
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	▲
Appropriate assistive technologies are available and affordable	▲

WORKFORCE

	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	▲

FINANCING

	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	▲
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	▲

	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**No**
Significant government contribution to community-based rehabilitation services	**No**

INFORMATION

	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**No**
Government grants for disability research	**No**

Disability Data **Disability prevalence:** 2.8% | **Source:** UNESCAP Disability at a Glance | **Year:** 2015

Tuvalu

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**No**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**No**
Defined standards for assistive technology provision	**No**
National physical accessibility standards of public buildings including health facilities	**No**

SERVICE DELIVERY	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	▲
Mechanisms to support quality rehabilitation practices	▲
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	▲
Appropriate assistive technologies are available and affordable	▲

WORKFORCE	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	■

FINANCING	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	●
	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**No**

INFORMATION	
	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**No**
Government grants for disability research	**No**

Disability Data	**Disability prevalence:** 1.9%	**Source:** UNESCAP Disability at a Glance	**Year:** 2015

Vanuatu

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**No**
Legislation prohibits health insurers from discriminating against pre-existing disability	**No**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**Yes**
Defined standards for assistive technology provision	**No**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY	
	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	▲
Coverage and range of rehabilitation services	▲
Mechanisms to support quality rehabilitation practices	▲
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	▲
Appropriate assistive technologies are available and affordable	▲

WORKFORCE	
	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	▲
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	▲

FINANCING	
	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	▲
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	▲
	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**No**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION	
	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**Yes**
Government grants for disability research	**No**

Disability Data	**Disability prevalence:** 12%	**Source:** UNESCAP Disability at a Glance	**Year:** 2015

Viet Nam

LEADERSHIP AND GOVERNANCE	
	Yes/No
Ratified Convention on the Rights of Persons with Disabilites	**Yes**
Health policy explicitly mentions access to health care services for people with disabilities	**Yes**
Legislation prohibits health insurers from discriminating against pre-existing disability	**Yes**
Mechanisms for leadership and governance for disability-inclusive health	**Yes**
Engagement of people with disabilities in health planning	**Yes**
National rehabilitation policy, strategy or plan	**Yes**
Defined standards for assistive technology provision	**Yes**
National physical accessibility standards of public buildings including health facilities	**Yes**

SERVICE DELIVERY	
	Emerging ▲ Established ■ Expanding ●
Extent of reasonable accommodation measures to accessing mainstream health services	■
Coverage and range of rehabilitation services	▲
Mechanisms to support quality rehabilitation practices	■
Availability of rehabilitation services at community level	▲
Availability of rehabilitation services in tertiary health care	■
Appropriate assistive technologies are available and affordable	■

WORKFORCE	
	Emerging ▲ Established ■ Expanding ●
Adequacy of rehabilitation workforce	–
Integration of disability into relevant undergraduate health curricula	▲
Government planning for increased rehabilitation personnel	●

FINANCING	
	Emerging ▲ Established ■ Expanding ●
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing mainstream health services	■
Mechanisms to reduce out-of-pocket payment for people with disabilities accessing rehabilitation services	■
	Yes/No
Government is largest financial contributor to rehabilitation services	**Yes**
Government is largest financial contributor to assistive technology services	**Yes**
Significant government contribution to community-based rehabilitation services	**Yes**

INFORMATION	
	Yes/No
Disability included in recent national census	**Yes**
Dedicated disability surveys	**No**
Government grants for disability research	**Yes**

Disability Data	**Disability prevalence:** 7.80%	**Source:** National Census	**Year:** –

World Health Organization

Western Pacific Region