

The UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities:

government responses to the
implementation of the rules on
medical care, rehabilitation, support services
and personnel training

Regional Report WPRO



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The present report was prepared on the basis of information made available by governments and nongovernmental organizations responding to the questionnaire sent out by WHO in May 1999. This questionnaire, developed at the request of the Special Rapporteur on Disability of the UN Commission for Social Development, was designed for the purpose of monitoring the implementation of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, in accordance with the United Nations General Assembly resolution 48/96. Some of the results have already been published in February 2000 in the report of the UN Special Rapporteur to the UN Commission for Social Development.

Dr Dimitris Michailakis, assistant professor in sociology at the University of Uppsala, Sweden, has compiled this report, including the preparation of the tables and layout. His advice has been important to WHO's endeavours assessing the implementation of the Standard Rules. However, the views expressed in this report are those of the author and do not necessarily reflect the views of the WHO.

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PART I
Summary

Preface

The present report presents information collected in 1999 by means of a questionnaire sent to all governments of Member States of the WHO and to 600 nongovernmental organizations (NGOs) working in the disability field in the Member States of the WHO. The information focuses on issues related to four of the 22 Standard Rules on the Equalization of Opportunities for Persons with Disabilities: Rule 2 on Medical Care, Rule 3 on Rehabilitation, Rule 4 on Support Services and Rule 19 on Personnel Training. WHO has collected the information contained in this report from the governments and NGOs listed in Annexes II, III and IV herein.

The questionnaire was finalized in April 1999 and distributed.¹ It was pointed out to the respondents that the objective of the study was twofold:

- To identify various government policies regarding medical care, rehabilitation, support services and personnel training
- To identify various strategies adopted and problems encountered when working in the field of medical care and rehabilitation of persons with disabilities

Respondents were asked to complete this questionnaire in order to help WHO identify the official policy of the country. For this purpose respondents were not asked to give their personal opinion but to quote the official opinion.

In view of the increasing demand for information of this nature and the need of reflecting on trends and developments in this domain, WHO has undertaken the present survey. A total of 191 Member States were initially contacted to contribute to this exercise and 104 responded, which must be deemed a very satisfactory result.² A classification according to socio-economic criteria of the governments responding to the questionnaire is presented in Table A.³

Table A

Socio-economic classification of government responses	No. of responses
Developed market-economy countries	18
Developing countries. Least developed countries	24
Developing countries. Other developing countries. (excluding least developed countries)	53
Economies in transition	9
Total	104

Eighteen developed market-economy countries, 24 least developed countries, 53 other developing countries (excluding least developed countries) and 9 countries with economies in transition responded.

¹ The selected NGOs belong to the international organizations represented in the Panel of Experts, i.e., Disabled Persons International (DPI), Inclusion International (ILSMH), Rehabilitation International (RI), World Blind Union (WBU), World Federation of the Deaf (WFD), World Network of Users and Survivors of Psychiatry (WNUSP),

² Eleven additional responses were received during September-November, 4-6 months after the deadline for replies: Australia, Barbados, Democratic Republic of the Congo, Federated States of Micronesia, Gabon, Greece, Guinea-Bissau, Kazakhstan, Malawi, Nigeria and the former Yugoslav Republic of Macedonia. These responses are not counted in the tables since they arrived after the tables and figures had been prepared.

³ The classifications used in this report are based on the classification of 1 May 1998 used by the United Nations. This classification is an update of the classifications used by the United Nations in the *World Economic and Social Survey 1997*. The groupings are employed for analytical purposes only and do not have any official status.

Replies were received from countries representing the different world regions (Table B): 27 from African Region; 17 from the Region of Americas; 4 from the South_East Asian Region; 25 from the European Region; 11 from the Eastern Mediterranean Region; and 20 from the Western Pacific Region. The percentages are counted on the basis of the regional distribution of Member States. Thus, in the Regional Office for the Americas there are 36 Member States. From that region 17 responses were received, which means that 47% from this region responded to the questionnaire.

Table B

Regional distribution of Member States	No. of responses	No. of Member States in each region	Percentage
African Region	27	46	59
Region of the Americas	17	36	47
Eastern Mediterranean Region	11	22	50
European Region	25	51	49
South East Asian Region	4	10	40
Western Pacific Region	20	28	71
Total	104	193	55

One hundred and fifteen responses came from NGOs.⁴ The total number of countries covered by the responses from governments in the Member States and NGOs in these Member States is 130 (see Annex III).⁵ A classification of the NGO responses received according to socio-economic criteria may be given as follows: 25 NGO responses (21.7%) came from developed market-economy countries; 21 NGO responses (18.3%) from the least developed countries; 47 NGO responses (40.9%) from other developing countries (excluding least developed countries); and 20 NGO responses (19.1%) from countries with economies in transition (see table B in Part III of this report).

A classification of NGO responses according to regions is as follows: 22 NGO responses (19.1%) came from the African region; 21 NGO responses (18.3%) from the Region of the Americas; 6 NGO responses (5.2%) from the South-East Asian Region; 42 NGO responses (36.5%) from the European Region; 10 NGO responses (8.7%) from the eastern Mediterranean Region; and 14 NGO responses (12.2%) from the Western Pacific Region (see table C in Part III of this report).

A classification of NGOs responses according to the international disabled persons organizations to which they belong is as follows. 18 responses (15.7%) were received from NGO member organizations of Disabled Persons International (DPI); 28 responses (24.3%) were received from NGOs member organizations of Inclusion International (ILSMH); 24 responses (20.9%) from NGO member organizations of Rehabilitation International (RI); 23 NGO responses (20.0%) from member organizations of the World Blind Union (WBU); 14

⁴ During October-November three more replies were received from NGOs in the Central African Republic and Nigeria. These responses are not counted in the tables on NGO responses since they arrived after the tables and figures had been prepared.

⁵ The survey conducted by the Special Rapporteur's office at 1997 had elicited 83 responses from governments, 163 responses from NGOs. The total number of countries covered by the replies from governments in Member States and NGOs in these Member States was 126.

responses (12.2%) from NGOs member organizations of the World Federation of the Deaf (WFD), and eight responses (6.7%) from NGO member organizations of World Network of Users and Survivors of Psychiatry (WNUSP) (see Table A in Part III of this report).⁶

The information was collected by means of a questionnaire (Annex I) which has been completed by the division or unit within the ministry responsible for medical care, rehabilitation and support services to persons with disabilities (usually the Ministry of Health and Social Affairs). Notwithstanding the constraints imposed by this method of compiling information - it presupposes that it will be answered by the most well informed official within the field, or that the official takes the time to find answers elsewhere when he/she is unable to answer - the survey represents a unique distillation of information on practice world-wide. It can be of assistance to policy-makers, administrators and rehabilitation specialists. The survey should be seen as part of WHO's contribution to the monitoring of the implementation of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities with respect to medical care, rehabilitation, support services to persons with disabilities and personnel training. The study is carried out in cooperation with the office of the United Nations Special Rapporteur on Disability, in its continuous monitoring of the implementation of the Standard Rules.

The Standard Rules establish that solutions must be sought not only in the individual sphere, but also in those spheres of society that hinder real participation (barriers in the physical environment, legislation, education, etc.). The policy should aim at enabling persons with disabilities to be included in society, as well as adapting the environment to the needs of persons with disabilities. In the attempt to set a standard for measures that will maximize the opportunities for disabled people to participate in society, the Standard Rules try to establish a balance between support to the individual and removal of barriers in the environment. In order to reach the objective of equalization of opportunities some basic preconditions must be fulfilled: for instance provision of qualified medical care, provision of rehabilitation services where necessary, as well as elimination of discrimination of persons with disabilities.

Part I provides a summary and analysis of the information received and highlights present trends. While this part illustrates the present situation with respect to the level of implementation of the four Standard Rules studied here, it also provides indications for future planning. In order to facilitate comparisons the data are tabulated. The tables correspond to different questions in the questionnaire; the number of the question in the questionnaire is marked. The reader who wishes a general overview might consult only Part I. Still, analysis requires reference to the actual cases and these can be found in Part II. Here, the information is presented in a detailed form in order to make known the answers of the responding Member States. Part II, thus, consists of a summary of all the replies presented in a uniform way corresponding as closely as possible with that of part I. The results of the NGO responses are tabulated in Part III. A complementary study is needed in order to compare and interpret the differences between the NGO and government responses.

Methodological considerations

The global perspective implied by the WHO presents special challenges for research. Several questions concerning definitions and classifications immediately arise. Methodologies must be applicable to widely different social and cultural conditions, demanding an analysis of the concepts used in the questionnaire broad enough to encompass the diversity of meanings

⁶ In a forthcoming report the replies of the NGOs will be analysed and published by the WHO.

ascribed to them. The economic, social and cultural setting of the countries responding to the questionnaire varies considerably. One issue to be resolved in a global cross-national survey is that of interpretation. Many interpretative difficulties derive not only from the nature of the information itself since basic concepts, such as the medical care system, prevention of impairment and rehabilitation services, have widely different meanings in different countries, but also from the differing significance attached to policy statements.

To collect information within a group of countries with a basic homogeneity, at least in some respect, is relatively easy. Collating information from countries worldwide is a challenging task. Interpreting this information within a common framework is even more challenging. How can we know, for instance, that the term "medical care" in one country is also considered "medical care" in another country? There are key concepts in this study that are very complex owing to the widely differing organisation of societies. In some cases one can detect injustices, inadequate service, and so on. There are also cases where the response does not *necessarily reflect* a good or bad provision of services, but *one* possible way of organising such a provision. Results indicating that municipalities do not take an active part in rehabilitation could be interpreted as a lack of service. However, this conclusion may not be justified. Whether medical care and rehabilitation programmes/services provided by a government or municipality are equally good, or whether the one or the other constitutes a better alternative, is a topic for another study, although not within the framework of WHO. The services relating to the four rules on disability studied here are organized differently according to each country and this must be respected: determining factors include not only the country's socio-economic level of development, but also its history.

There is always a risk that an explanation valid for a certain system may be unquestionably and uncritically applied to other social arrangements. One way of validating the received information is to compare it with prior or subsequent information, searching for patterns and tendencies in the whole population. In global cross-national studies the focus does not lie on some specific country, but on groups of countries or whole populations in different respects. Knowledge is sought on specific issues - the present level of rehabilitation for persons with disabilities, the medical care provided – within the global population.

Despite the difficulties, the effort to interpret all the collected data from various sources is nonetheless worthwhile since it enables countries to make useful comparisons and to share information on policy and practice. Such data are needed to plan both general socio-political measures to optimise the environment for persons with disabilities and more individual support services.

This study aims primarily to identify tendencies and patterns. However, the cross-national character of this study is limiting, i.e. the study gives only an approximate picture of the present conditions worldwide for persons with disabilities. Any tendencies and patterns – old and new – will indicate the trend.

When the need for change is recognized the survey can act as a powerful stimulus towards reform and its support. The previous survey was widely used and generated a great deal of positive feedback.⁷

⁷ *Government Action on Disability Policy*. Office of the United Nations' Special Rapporteur on Disability. Stockholm, 1997. This survey concentrated on four other Rules, namely, Rule 15 on Legislation, Rule 5 on Accessibility, Rule 18 on Organizations of Persons with Disabilities and Rule 17 on Coordination of Work. Therefore, an overall comparison between these two studies cannot easily be done.

MEDICAL CARE

Most countries provided information on the questions about the medical care system, the professionals involved in the provision of medical care, exclusion/inclusion of persons with disabilities in regular medical care services, finance of medical care and percentage of the population covered by social insurance schemes.

The first question on medical care was whether the medical care system provides services to persons with disabilities. According to the opening paragraph in the Rule on Medical Care: “States should ensure the provision of effective medical care to persons with disabilities.” The first question indicates the extent to which states comply with this recommendation. As Table 1 shows, an overwhelming majority do provide services to persons with disabilities. The five countries that do not (out of 104 responding to this report) are developing countries.

Table 1 Question 1a

Countries with a medical care system that provides services to persons with disabilities

Services to persons with disabilities	Frequency	Percentage
Provided	99	95.2
Not provided	5	4.8
Total	104	100.0

According to paragraph 3 in the Rule on Medical Care, states should ensure “that persons with disabilities, particularly infants and children, are provided with the same level of medical care *within the same system as other members of society*”. As Table 2 shows, of those 95 countries that provide medical care to persons with disabilities there are 46 countries in which there is a tendency to treat certain groups of disabled people outside the medical care services, which is high frequency. This tendency is against the spirit of Rule 2 on Medical Care and the whole idea of non-discrimination against persons with disabilities, which is a cornerstone in the Standard Rules. This tendency must be regarded as an unjustifiable form of discrimination of certain groups of disabled people. It is also a remarkable fact that this tendency is so widespread (48.4%). The results of the responses here reaffirm a relation, which has been pointed out by WHO many times: “Not all people have benefited equally from world-wide improvements in health status, health coverage and access to health services. The socio-economic-health gap between nations and within them is widening daily.” This trend is more pronounced with regard to disabled and non-disabled persons.

Table 2 Question 1b

Countries according to treatment given

Treatment of persons with disabilities	Frequency	Percentage
Outside	46	48.4
Inside	49	51.6
Total	95	100.0

According to the first paragraph in the Rule on Medical Care: “States should work towards the provision of programmes for early detection, assessment and treatment of impairment. This could prevent, reduce or eliminate disabling effects.” In Table 3 the programmes

included in the medical care system are presented. In six of the countries providing information on this issue there are no programmes for treatment of impairment. In 11 countries there are no programmes for prevention of impairment. In 15 countries there are no programmes for early detection and diagnosis of impairment. In 12 countries there are no programmes for rehabilitation techniques. In 13 countries there are no programmes for necessary referrals and in 20 countries counselling for parents does not exist. A total of 102 countries responded this question.

The great majority of responding countries include treatment of impairment, prevention of impairment and rehabilitation techniques in the medical care system and other programmes. Less usual are programmes for counselling of parents and early detection and diagnosis. As many as 15 countries do not include programmes for early detection and diagnosis, which is regrettable since early detection/diagnosis is of great value for the subsequent rehabilitation.

Table 3 Question 2

Programmes included in the medical care system⁸

Programmes	Frequency		Percentage	
	Included	Not included	Included	Not included
Prevention of impairment	89	11	87.3	10.8
Early detection and diagnosis	85	15	83.3	14.7
Treatment of impairment	96	6	94.1	5.9
Rehabilitation techniques	88	12	86.3	11.8
Necessary referrals	81	13	79.4	12.7
Counselling for parents	77	20	75.5	19.6
Total=102				

According to the first paragraph in the Rule on Medical Care the provision of programmes for early detection, assessment and treatment of impairment “should ensure the full participation of persons with disabilities and their families at the individual level, and of organizations of persons with disabilities at the planning and evaluation level”. Table 4 summarizes the degree of involvement of organizations of persons with disabilities in planning and evaluation of these programmes included in the medical care system. In only three countries of 103 providing information on this issue are the organizations of persons with disabilities always involved, whereas in 12 countries the organizations of disabled people are never involved in planning and evaluation of disability programmes. In 32 countries the organizations are often or always involved. In the majority of the countries providing information on this issue the organizations of disabled people are only sometimes involved, i.e., involvement of organizations of disabled people in programmes related to their specific situation within the medical care system is not systematic; and is usually infrequent.

⁸ In some questions several alternatives were given to the respondents with the indication “Mark all that apply”. In these questions the respondents have indicated more than one alternative and, thus, the total counted in percent sums to more than 100%.

Table 4 Question 3*Involvement of organizations in planning and evaluation of these programmes*

Degree of involvement	Frequency	Percentage
Always	3	2.9
Often	29	28.2
Sometimes	59	57.3
Never	12	11.6
Total	103	100.0

Table 5 summarizes the responses to the question of whether there are early detection methods for children with disabilities and, if they exist, at what age they are performed. From the 104 countries replying to this question, 80 countries responded that early detection methods are performed when the infants are less than six months old. For older infants these methods are carried out more rarely. Thus, between six months and three years of age, early detection methods are performed only in 55 countries. The fact that early detection methods for children with disabilities are not an established practice in all countries indicates that infants in almost 25% of the countries responding to the questionnaire are left with no professional assistance. In addition, these methods are used more rarely as the infants become children. Since many of the disabilities manifest themselves before the child is four years old, this decrease in testing is understandable. However, if one takes into account the fact that a great part of the developing world's children are not provided with more than a primary health care as infants, there must consequently be a great number of unrecorded disabilities of children at the age of four years (the difficulty in detecting many disabilities, for instance, hearing disability). Furthermore, the reading-writing disability (dyslexia) is not possible to detect earlier than at pre-school age. The fact that half of the countries do not have early detection methods in the 4-7 year age group must be considered a low proportion.

Table 5 Question 4*Early detection methods for children with disabilities*

Age	Frequency	Percentage
0-6 months	80	76.9
6 months-3 years	69	66.3
4-7 years	55	52.9
Total=104		

As mentioned above the paragraph 3 in Rule on Medical Care ensures that infants and children with disabilities are provided with the same level of medical care within the same system as other members of society. The aim in question 5 was twofold: to find whether infants and children with disabilities are provided medical care within the same system as other infants and children and, if not, to determine the reasons of exclusion. As Table 6 shows, there are 14 countries of 104 that responded to this question where infants and children with disabilities are not provided medical care within the same system as other infants and children. These countries are all developing countries. Compared with question 1

it is seen that children are to a much greater extent included in the general medical care system than persons with disabilities in general.

Table 6 Question 5a

Medical care for children with disabilities within the general medical care system

Medical care within the same system	Frequency	Percentage
Provided	90	86.5
Not provided	14	13.5
Total	104	100.0

The subsequent question suggested five reasons for not treating disabled children within the general medical care system. Table 7 summarizes the responses of the 14 governments that do not provide medical care to infants and children with disabilities within the same system as for other children. The most common reason given was the lack of resources and education in society (lack of specific programmes, lack of staff, lack of training), i.e. deficiencies at the societal level. The respondents stated as the second most common reason economic constraints in the family. Six countries also marked negative societal attitudes as a reason for not providing medical care to infants and children with disabilities, within the same system as other children. Infants and children are not only affected by lack of resources in society and in families, but also by the prejudices of the non-disabled. Prejudices are to a certain extent connected with economic constraints and lack of education. The task of raising public awareness befalls the governments according to the Standard Rules.⁹

Table 7 Question 5b

Reasons for not treating children with disabilities within the same system

Reasons	Frequency	Percentage
Lack of specific programmes	11	78.6
Lack of staff	10	71.4
Lack of training	8	57.1
Negative societal attitudes	6	42.9
Economic constraints in the family	9	64.3
Total=14		

As in the previous question the aim of question 6 was twofold: to find whether persons with disabilities are provided with regular medical treatment to preserve or improve their level of functioning and, in the countries where they are not, the reasons for lack of services. According to paragraph 6 of the Rule on Medical Care: “States should ensure that persons with disabilities are provided with any regular treatment and medicines they may need to preserve or improve their level of functioning.” As Table 8 shows, in 18 of the 103 countries responding to this question, persons with disabilities are not provided with regular medical treatment. These countries are mostly developing countries.

⁹ The opening paragraph of Rule 1 on Awareness-raising says that: “States should take action to raise awareness in society about persons with disabilities, their rights, their needs, their potential and their contribution.”

Table 8 Question 6a*Provision of regular medical treatment*

Regular treatment	Frequency	Percentage
Provided	85	82.5
Not provided	18	17.5
Total	103	100.0

Table 9 summarizes the responses to question 6b from the 18 countries not providing persons with disabilities with regular medical treatment. The pattern is the same as in question 5, namely, the most common reason concerns the lack of resources and education in society (lack of specific programmes, lack of staff, lack of training), i.e. deficiencies at the societal level. Next common reason is economic constraints in the family. Half of these countries also named negative societal attitudes as a reason for not providing regular medical treatment to persons with disabilities in order to preserve or improve their level of functioning. The first Rule on Awareness-raising in the Standard Rules, which is one of four preconditions for equal participation, has not been implemented successfully.

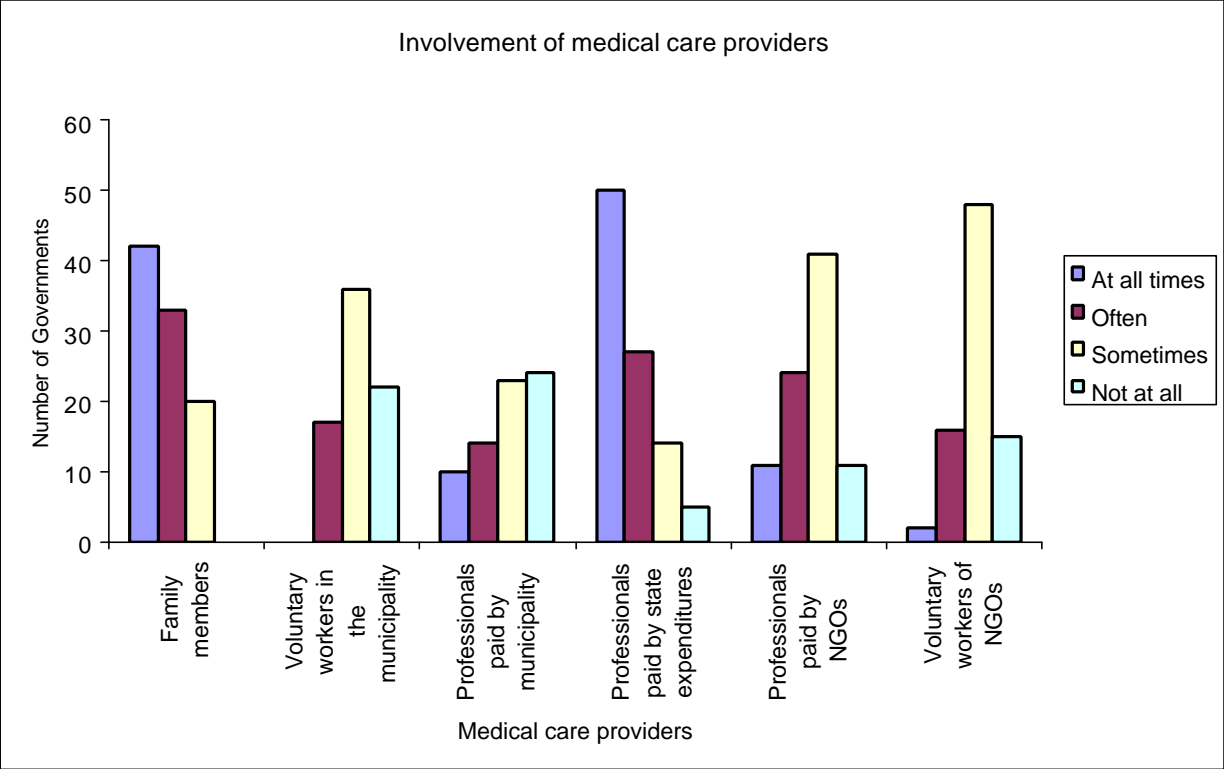
Table 9 Question 6b*Reasons for not providing regular medical treatment*

Reasons	Frequency	Percentage
Lack of specific programmes	16	88.9
Lack of staff	12	66.7
Lack of training	8	44.4
Negative societal attitudes	9	50.0
Economic constraints in the family	12	66.7
Total=18		

As mentioned above the first paragraph in the Rule on Medical Care states that multidisciplinary teams of professionals should run the provision of programmes and, furthermore, that such programmes should ensure the full participation of persons with disabilities and their families at the individual level, and of organizations of persons with disabilities at the planning and evaluation level. Figure 1 summarizes the responses concerning the frequency of involvement of different groups of medical care providers. One aim was to identify the groups in society with the responsibility of providing medical care. Another aim was to find whether society undertakes the economic responsibility of providing medical care to citizens with disabilities or whether this responsibility is laid upon civil society members (e.g. family, voluntary workers) and, as a consequence, whether medical care is provided by professionals. (Professionals are as a rule paid, while family members and voluntary workers are not). As seen from Figure 1, in 71 countries out of 104 responding to the questionnaire, provide at all times professionals paid by the municipality or state expenditures or NGOs. In 44 countries family members and voluntary workers of NGOs are involved at all times as medical care providers. Thus, the regular medical care is provided mainly on two levels (the state or the family), while the NGOs are occasional providers of regular medical care. It is noteworthy that the municipality (the close provider in a spatial

sense) is most frequently not involved at all, while the family (the close provider in an emotional sense) never abstains from providing medical care. What information does this figure provide – merely the distribution of the providers of medical care, irrespective of content and quality? What the high frequency of family involvement mean? What kind of regular medical care can the family provide? What level of regular medical care is actually provided? These questions raise many others. Which could be more closely investigated by WHO in another study.

Figure 1 Question 7



The aim of question 8 was to determine who finances medical care. Table 10 summarizes the responses from the 104 countries that responded to the questionnaire. In most countries government ministries provide it free of charge. The second most common arrangement is partial payment by the patient and partial payment by social insurance schemes. In almost one third of the countries it is paid fully by the patient, which is a remarkably high frequency. The question that arises is how persons with disabilities manage to pay for their medical care, since they are usually among the poorest in society and/or families with a disabled member are put under increased economic pressure (for instance, because the family plays such an active role in providing care). WHO points out that “the purpose of development is to improve all people’s quality of life, including their health”. There is much evidence that persons with disabilities suffer from lower status within the community and at the workplace, economic dependence, illiteracy and fewer opportunities for education, training and employment, all of which increase their vulnerability to diseases. The promotion and protection of disabled people’s rights empower them and hence improve their health. WHO also states: “On the other hand, it has become evident that the capacity to develop is itself

dependent on health. Health expenditures are a cost-effective investment in a nation's human capital, enhancing people's ability to contribute actively to overall economic and social development and enjoy a satisfactory quality of life."

Some countries have responded that medical care is both provided free of charge by government ministries partially paid by the patient and paid by social insurance schemes. This can be interpreted that different arrangements exist for different groups in society.

Table 10 Question 8

Medical care subsidies

Payment for medical care	Frequency	Percentage
Provided free of charge by government ministries	68	65.4
Paid by social insurance schemes	46	44.2
Paid fully by the patient	31	29.8
Paid partially by the patient	62	59.6
Total=104		

Table 11 summarizes the responses to the question of which groups are covered by social insurance schemes. Among the 46 countries where medical care is paid by social insurance schemes, almost all (41) cover children. In 32 countries the elderly are covered, in 27 countries all adults are covered and in 24 only working adults are covered. Thus, only 5 countries exclude children from the social insurance scheme, while 14 exclude elderly persons.

Table 11 Question 9

Groups covered by social insurance schemes

Groups	Frequency	Percentage
Children	41	89,1
All adults	27	58,7
Working adults only	24	52,2
Elderly	32	69,6
Total=46		

Table 12 summarizes the extent of the population covered by social insurance schemes in the 62 countries that responded to this question. There are 22 countries in which 20% or less of the population is covered by social insurance schemes. In 27 countries more than 80% of the population is covered by social insurance schemes. The discernible pattern is that when medical care is paid by social insurance schemes it is either for a small part of the population (up to 20%) or for almost everybody (81-100%). This indicates that social insurance schemes are either a solution for a small, privileged group (thus obtaining a better medical care) or they are a broad solution for the whole society.

Table 12 Question 10*Extent of the population covered by social insurance schemes*

Population covered (%)	Frequency	Percentage
0-20	22	35.5
21-40	6	9.7
41-60	3	4.8
61-80	4	6.5
81-100	27	43.5
Total	62	100.0

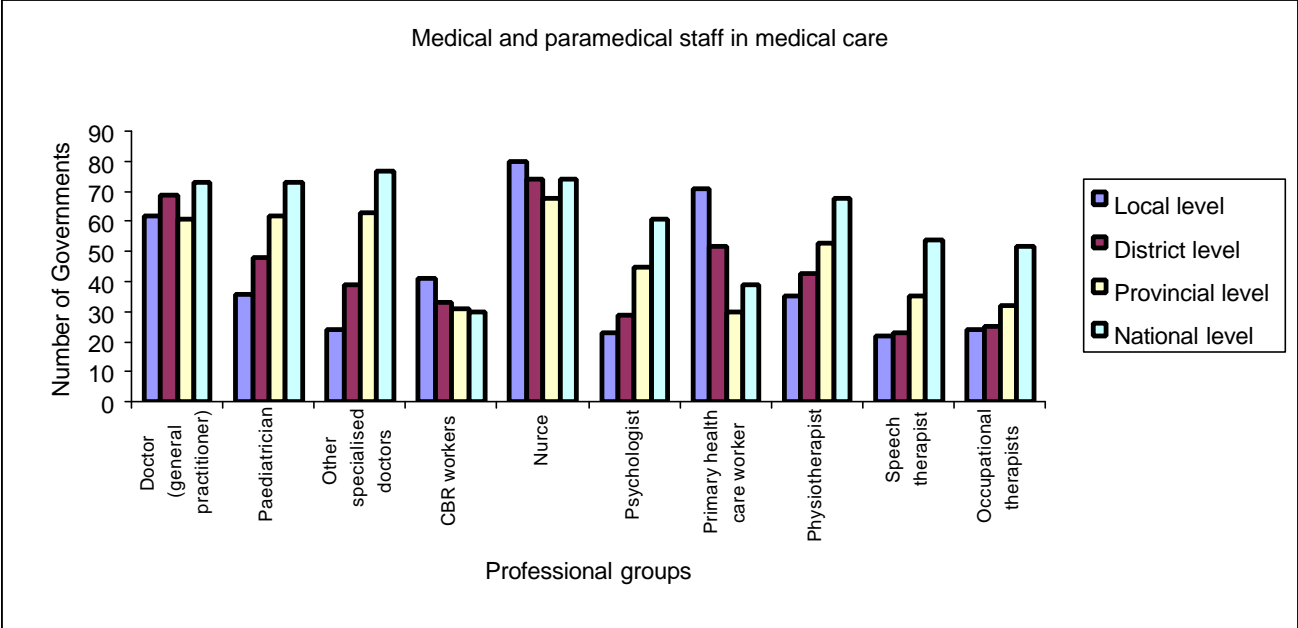
Two paragraphs in the Rule on Medical Care emphasize the importance of available and adequately trained and equipped medical and paramedical staff. According to paragraph 4: “States should ensure that all medical and paramedical personnel are adequately trained and equipped to give medical care to persons with disabilities and that they have access to relevant treatment methods and technology.” According to paragraph 5: “States should ensure that medical, paramedical and related personnel are adequately trained so that they do not give inappropriate advice to parents, thus restricting options for their children. This training should be an ongoing process and should be based on the latest information available.”

Respondents were asked to define medical and paramedical staff available at different levels in medical care. Figure 2 summarizes the responses of the countries. Doctors (general practitioners) and nurses are the professional groups that are available in most countries and equally frequently at all levels. No country reports that a doctor (general practitioner) is not included at any of the levels (local, district, provincial or national). In only one country is a nurse not included in any of the levels. Paediatricians and other specialised doctors are not so frequently available at the local and district levels. In many countries (all the developed market-economy countries) there are no community-based rehabilitation (CBR) workers. Psychologists, physiotherapists, speech therapists and occupational therapists are rarely available at the local and district levels; most often these professional groups are available at the national level. Primary health care workers are most frequently available at the local level. With the exception of CBR workers and primary health care workers, the availability of all other groups becomes more frequent moving from the local and district levels to the provincial and national levels (see question 7). Three kinds of patterns can be discerned in Figure 2: (1) a balanced presence irrespective of level, e.g. doctors who are general practitioners and nurses; (2) an increasing presence on moving away from the local level, e.g. specialized doctors and therapists; (3) a decreasing presence when moving away from the local level primary health care workers.

The question that arises is whether medical care can be provided when key personnel, i.e. specialists such as paediatricians and psychologists, are available only at a provincial or national level. According to the respondents this is the case in many countries. The problems may be appreciable for a person with a disability when his/her family lives in a rural area and when a consultation is needed with a specialist (psychologist or physiotherapist) at a provincial or even national level. There are economic and practical aspects of this unavailability. There is also the aspect of the frequency of therapy. A paediatrician receives his/her patients once or twice, making a diagnosis and deciding further treatment, but a physiotherapist or a psychologist must receive their patients over a long period of time in order to administer treatment. If the patient is inaccessible then treatment is also inaccessible.

Paediatricians, other specialized doctors, psychologists, physiotherapists, speech therapists and occupational therapists are only accessible at a local level in one-third of the countries providing information on this subject. At the district level the frequency increases for paediatricians, other specialized doctors and physiotherapists. It is the nurse who is most frequently available. However, nurses cannot themselves provide all medical care; nurses assist and complement doctors.

Figure 2 Question 11



According to the second paragraph in the rule on Medical Care: “Local community workers should be trained to participate in areas such as early detection of impairments, the provision of primary assistance and referral to appropriate services.” Table 13 shows that the majority of countries provide medical care services in poor and urban areas. Only five countries of 102 providing information on this issue report that services are not provided in poor and urban areas. These five countries are all developing countries.

Table 13 Question 12a
Medical care services in villages and in poor urban areas

Services in villages and in poor urban areas	Frequency	Percentage
Provided	97	95.1
Not provided	5	4.9
Total	102	100.0

The subsequent question was aimed to find the form of services provided in villages and in poor urban areas. Table 14 shows that the most frequent form is primary health care (88 countries 90.1%). Less than half of the countries responding (44 out of 97 countries) provide community-based rehabilitation in villages and poor urban areas.

Table 14 Question 12b*Services provided in villages and in poor urban areas*

Services provided	Frequency	Percentage
Primary health care	88	90.1
Community-based rehabilitation	44	45.4
Other	3	3.1
Total=97		

In question 13 respondents were asked to indicate the services provided to facilitate information and communication between persons with disabilities and staff in health care. It is obvious that without the provision of such services the knowledge of disabled persons about services and medical care becomes very restricted. Table 15 indicates that the most frequent service provided for that purpose is easy reading information, followed by sign language interpretation. In general, persons with intellectual disability lag behind other disability groups in services being provided, but in this case they head. One possible explanation is that easy reading information is not expensive to produce. Fifty countries of 104 providing information on this issue do provide sign language interpretation but only about one-third of the countries provide information in Braille or on tape. Thus, blind and deaf persons are disadvantaged in terms of receiving services facilitating information and communication.¹⁰ Half of these countries do not provide services to facilitate information to deaf persons and to blind persons. If persons with disabilities cannot receive services that facilitate information, be it in medical care or other areas, they remain isolated and may not be able to maintain their rights without the support of a family.

¹⁰ In the survey conducted by the UN Special Rapporteur in 1997 one of the reviewed rules was Rule 5 on Accessibility. One question was formulated: "Which of the following services are provided in order to facilitate information and communication between persons with disabilities and other persons?" The results from this study differ greatly (see Table 15a).

Table 15a

Services to facilitate information and communication	Frequency	Percent
Literature in Braille/tape	71	87.7
News magazines on tape/Braille	47	58.0
Sign language interpretation for any purpose	33	40.7
Sign language interpretation for major events	30	37.0
Easy readers for persons with mental disabilities	25	30.9
None	5	6.2

Total 81, No answer 4

The table shows that, deaf persons constitute a disadvantaged group in terms of services facilitating information and communication between deaf persons and others. In most developing countries deaf persons do not even have access to interpretation for major events. According to that survey, the most disadvantaged are the persons with mental disabilities, while deaf persons are in a slightly better situation. In the majority of the countries providing information, these services are not provided to these two groups of disabled persons.

Table 15 Question 13

Services to facilitate information and communication between persons with disabilities and others

Services provided	Frequency	Percentage
Information in Braille	33	31.7
Information on tape	37	35.6
Sign language interpretation	50	48.1
Easy reading information	62	59.6
Total=104		

REHABILITATION

“WHO estimates that more than 300 million people worldwide are disabled, over 70% of whom live in the developing countries. Only about 1% to 2% of disabled persons in the developing world have access to rehabilitation and the majority of them are relegated to the margins of society. Over the past decade, WHO has been promoting community-based rehabilitation as a way to increase access to rehabilitation and promoting equalization of opportunities for the social integration of disabled persons into the community and society. This approach employs resources within the family and community, along with support from the referral services.”

The opening paragraph in Rule 3 on Rehabilitation says that “states should ensure the provision of rehabilitation services to persons with disabilities in order for them to reach and sustain their optimum level of independence and functioning”. Table 14 showed that community-based rehabilitation was not so frequent in villages and in poor urban areas. Less than half of the countries provide community-based rehabilitation in these areas, which include a great part of the world’s population. The aim of question 14 was to find the extent of national rehabilitation programmes in Member States of the WHO (Table 16). A total of 102 countries responded to this question. In almost 30% of the countries responding to the questionnaire national rehabilitation programmes do not exist. This is a disappointingly high percentage.

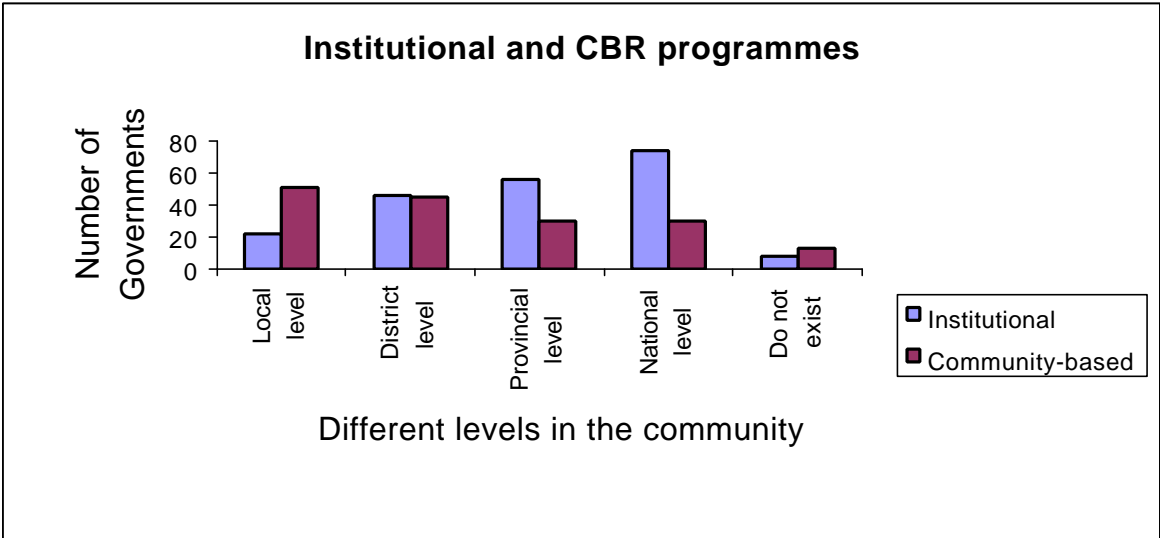
Table 16 Question 14

Countries with national rehabilitation programmes

Rehabilitation programmes	Frequency	Percentage
Exist	73	71.6
Do not exist	29	28.4
Total	102	100.0

According to paragraph 5 in Rule 3 on Rehabilitation: “All rehabilitation services should be available in the local community where the person with disabilities lives. However, in some instances, in order to attain a certain training objective, special time limited rehabilitation courses may be organized, where appropriate, in residential form.” In question 15 respondents were asked to indicate at what levels institutional and community-based rehabilitation programmes exist. The availability of institutional rehabilitation becomes more frequent when moving from the local to the national level (Figure 3). The reverse relation applies for community-based rehabilitation, which is most frequent at the local level and least frequent at the national level. It is noteworthy that 51 countries provide community-based rehabilitation programmes at a local level, and nearly as many provide it at a district level. Institutional rehabilitation programmes are as frequent as the community-based programmes at the district level.

Figure 3 Question 15



Question 16 aimed to find the percentage of the population receiving rehabilitation in each country (Table 17). Only 90 countries responded to this question, which may indicate that statistics are not available in 14 countries. The results are not encouraging. Only 12 countries provide the great part of the population (more than 80%) with rehabilitation when needed. In almost half the countries 20% or less of the population receive rehabilitation services. In 55 countries less than 40% receives rehabilitation, which must be considered very low.

Table 17 Question 16

Percentage of the population receiving rehabilitation

Population receiving rehabilitation (%)	Frequency	Percentage
0-5	19	21.1
6-20	23	25.6
21-40	13	14.4
41-60	13	14.4
61-80	10	11.1
81-100	12	13.4
Total	90	100.0

According to Rule 3 on Rehabilitation no group of disabled people should be excluded from rehabilitation services. “All persons with disabilities, including persons with severe and/or multiple disabilities, who require rehabilitation should have access to it.” As table 18 indicates, rehabilitation services, when they exist, are provided mainly to persons with mobility impairments and least frequently to persons with learning difficulties. In 99 countries of the 104 responding to this question rehabilitation is provided to persons with mobility impairments. In 90 countries it is provided to persons with hearing impairments; in 84 countries to deaf people; in 89 to persons with severe sight impairment; in 86 countries to persons with intellectual disabilities; in 69 countries to persons with learning difficulties; in

74 countries to persons with chronic diseases and to persons who are mentally ill; in 73 countries to persons with multiple/severe disabilities. Thus, it is only in five countries that persons with mobility impairments do not receive rehabilitation services, only in 14 countries where persons with hearing impairments do not receive such services, and only in 15 countries where persons with sight impairments do not receive rehabilitation services, for example.

Compared with the results from the previous question there is a striking difference. It seems that the provision of rehabilitation services is very good, but that there is a great gulf between these services and the percentage of the population receiving rehabilitation in a great many countries. It is noteworthy that even for learning difficulties rehabilitation services are provided in 69 countries. There are rehabilitation services in as many as 74 countries for persons with mental illness, otherwise the most disregarded disability group of all. If this provision were matched with a high frequency of rehabilitation being received it would imply a great step forward.

Table 18 Question 17

Rehabilitation services to different groups

Groups	Frequency	Percentage
Persons with mobility impairments	99	95.2
Persons with hearing impairments	90	86.5
Deaf people	84	80.1
Persons with severe sight impairment	89	86.6
Persons with intellectual disabilities	86	82.7
Persons with learning difficulties	69	66.3
Persons with disabilities owing to chronic diseases	74	71.2
Persons with disabilities owing to mental illness	74	71.2
Persons with multiple/severe disabilities	73	70.2
Total=104		

When in paragraph 3 in the Rule on Rehabilitation states that all persons with disabilities should have access to rehabilitation it also means that nobody should be excluded because of old age. Table 19 shows the responses to the question on whether all age groups are included in rehabilitation services. From the 98 countries that provided information on this issue there are eight that do not include all age groups in rehabilitation services, nearly all of them being developing countries.

Table 19 Question 18

Countries including all age groups in rehabilitation services

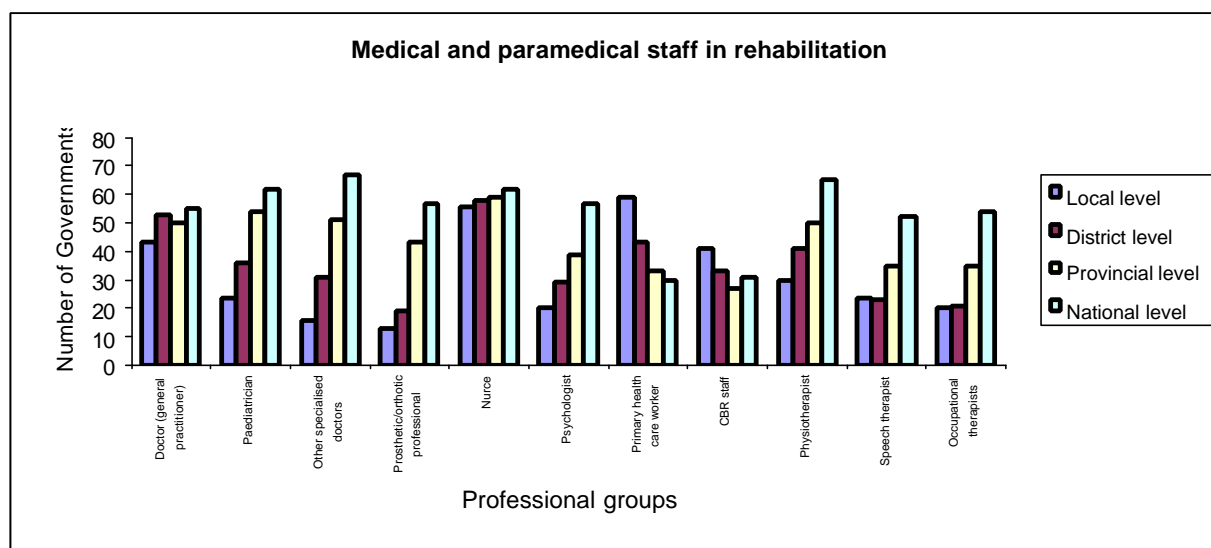
All age groups	Frequency	Percentage
Included	90	91.8
Not included	8	8.2
Total	98	100.0

The aim of question 19 was to identify the professional groups involved in rehabilitation services. Ninety-eight countries responded to this question. The patterns that emerge resemble the distributions in Figure 2 concerning the availability of medical and paramedical staff in medical care. As in medical care, doctors (general practitioners) and nurses are the professional groups that predominate and are equally frequent at all levels, but at a slightly lower frequency (about 50–60% in comparison with 60–70% in medical care). Paediatricians and other specialized doctors are not so often available at the local and district levels. In many countries — all the developed market-economy countries — CBR workers are not found. As in medical care, psychologists, physiotherapists, speech therapists and occupational therapists are rarely available at the local and district levels; most often these professional groups are only available at the national level. Primary health care workers on the contrary are most frequently available at the local level. With the exception of CBR workers and primary health care workers, the availability of all other groups becomes more frequent on moving from the local and district levels to the provincial and national levels. On the average, nurses constitute the principal professional group in rehabilitation and not specialists or rehabilitation professions (such as physiotherapists, occupational therapists). This may indicate that the level of rehabilitation in practice still lies at the level of basic health care in a majority of countries.

Comparison with the results in question 11 clearly shows that there are fewer medical and paramedical staff available in rehabilitation than in medical care. This is one essential indication concerning the quality of rehabilitation worldwide. As in medical care, key personnel, such as psychologists, speech therapists and orthotic professionals, are rarely available in rehabilitation at local and district levels in many countries. In about half of the countries general practitioners, nurses and primary health care workers are present at local and district levels. In order to visit a paediatrician, other specialized doctor or therapist, in half of the countries the patient must move to a provincial or even national level. As with medical care, the problems may be appreciable for a person with a disability when his/her family lives in a rural area and when a consultation with a specialist (psychologist or speech therapist) is needed at a provincial or even national level. Rehabilitation often implies that treatment and service are given over a long period. This indicates an inadequate rehabilitation service worldwide.

The low availability of almost every other professional staff except primary health care workers and nurses at local and district levels reveals that a more specialized rehabilitation is not available in practice in the majority of countries. As in medical care, nurses predominate rehabilitation in their equal frequency at all levels, with the exception that primary health care workers are slightly more frequent at the local level. There are many disabilities and many different forms of rehabilitation, yet the fact that nurses play such a key role in rehabilitation reveals some information about the standard of rehabilitation.

Figure 4 Question 19



As stated above paragraph 5 in the Rule on Rehabilitation requires that “All rehabilitation services should be available in the local community where the person with disabilities lives.” The aim of question 20 was twofold: to find whether rehabilitation services are available at the community level and how these services are organized. Table 20 indicates that among the 99 countries responding to this question 84 provide rehabilitation services. In 15 countries rehabilitation services at the community level do not exist. Many of them are developing countries, but not all.¹¹

Table 20 Question 20a

Rehabilitation services at community level

Rehabilitation services	Frequency	Percentage
Exist	84	84.8
Do not exist	15	15.2
Total	99	100.0

The subsequent question was to determine how rehabilitation services at the community level are organized. Table 21 indicates that among the 84 countries where rehabilitation services exist at the community level, it is equally frequent that these services are organized through primary health care as through community-based rehabilitation and/or by NGOs. WHO

¹¹ The result from this question is strikingly positive. A possible interpretation is that the responses include provision of services by governments, NGOs or the private sector at community level and do not refer to actual community involvement. This interpretation is plausible since the question did not ask specifically for community involvement, which could be community based, so responses may refer generally to the presence of services at the community level.

stresses the great importance of primary health care as the “central function and main focus of the country’s health system”. One may question whether primary health care has the resources and adequate staff to organize also the rehabilitation services, as is the case in half of the countries.

Table 21 Question 20b

Organization of rehabilitation services at community level

Organization of rehabilitation services through:	Frequency	Percentage
Primary health care	55	65.5
Community-based rehabilitation	54	64.3
NGOs	57	67.9
Total=84		

There are three paragraphs in Rule 3 on Rehabilitation, which state the importance of participation of persons with disabilities, their families and their organizations in the provision of rehabilitation:

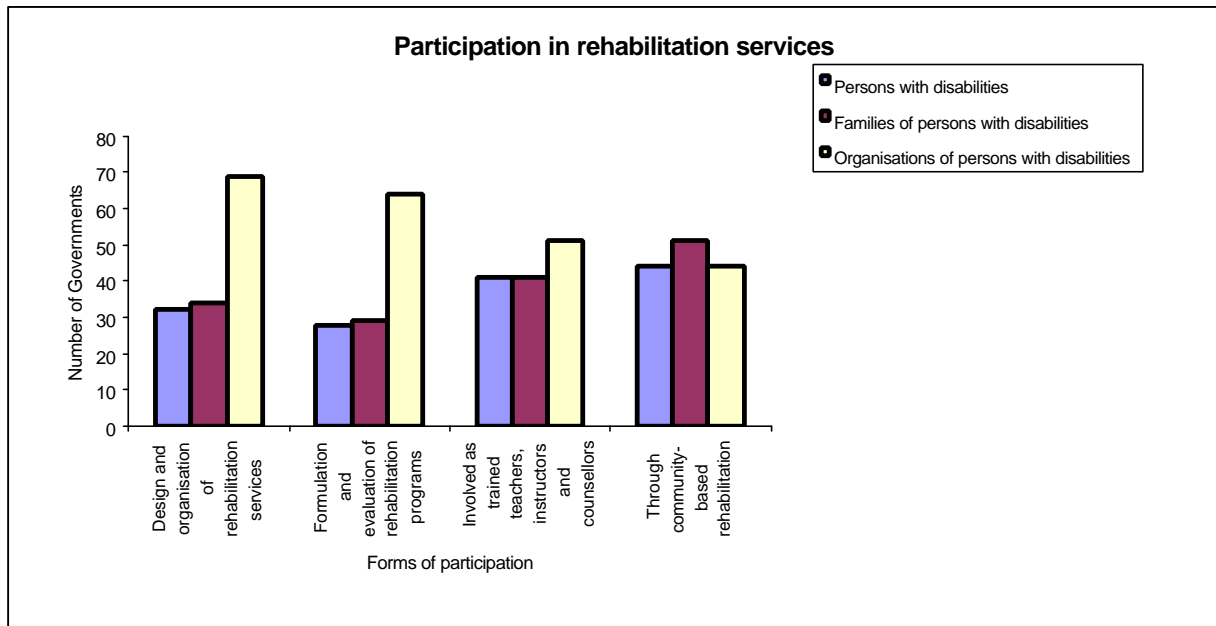
- “Persons with disabilities and their families should be able to participate in the design and organization of rehabilitation services concerning themselves.”
- “Persons with disabilities and their families should be encouraged to involve themselves in rehabilitation, for instance as trained teachers, instructors or counsellors.”
- “States should draw upon the expertise of organizations of persons with disabilities when formulating or evaluating rehabilitation programmes.”

Question 21 aims to find how persons with disabilities, their families and their organizations are involved in rehabilitation services. Figure 5 shows that persons with disabilities are most often involved through community-based rehabilitation and as trained teachers, instructors and counsellors. Least involved are persons with disabilities in formulation and evaluation of rehabilitation programmes. The same pattern is found for the families of persons with disabilities, though families are more frequently involved in the above-mentioned activities than persons with disabilities themselves. The reverse pattern emerges for the organizations of persons with disabilities, namely, that organizations are most frequently involved in the design and organization of rehabilitation services and in the formulation and evaluation of rehabilitation programmes. Organizations are also most involved as trained teachers, instructors and counsellors. It must be noted that in a great number of countries organizations are not involved at all. This is also the case and even to a greater extent for persons with disabilities and their families. For community-based rehabilitation the organizations are as equally concerned as persons with disabilities; they participate in 44 countries.

The stress that is laid upon the involvement of persons with disabilities in the design of rehabilitation services in Rule 3 is not reflected in more than one-third of the countries. Instead, it is the organizations of persons with disabilities that in 69 countries participate in the design of services. States should look for more participation by disabled persons when formulating and evaluating programmes, but it is common that the organizations at the same time participate in the design. One may question this practice. Those most suitable to help in designing the services are unquestionably the persons with disabilities themselves. Much remains in order to activate persons with disabilities and families of persons with disabilities.

The absence of these key participants is another indication that the quality of rehabilitation in many countries is lacking.

Figure 5 Question 21



SUPPORT SERVICES

According to the fourth paragraph of the Rule on Support Services: “States should recognize that all persons with disabilities who need assistive devices should have access to them as appropriate, including financial accessibility. This may mean that assistive devices and equipment should be provided free of charge or at such a low price that persons with disabilities or their families can afford to buy them.” Table 22 shows how the financing of assistive devices and equipment is arranged. The most common arrangement is shared responsibility between government ministries and persons with disabilities who pay by themselves. In 28 countries of 104 which responded to this question government ministries or municipalities pay fully. In nine countries assistive devices and equipment are paid fully by social insurance schemes, in 18 countries they are paid fully by persons with disabilities themselves and in 13 countries the NGOs pay fully. It is remarkable that in 32 countries government ministries or municipalities do not pay at all for the provision of assistive devices and equipment for persons with disabilities. Compared with question 8 there are more people that are provided with assistive devices/equipment than persons receiving medical care. Is the provision of medical care more resource demanding, or does it mean that the provision of assistive devices/equipment is of an elementary form? These are questions that can be followed up in a subsequent study.

Table 22 Question 22

Arrangements for financing assistive devices and equipment

Source of finance	Fully	Partially	Not at all
Government Ministries	23	67	6
Municipalities	5	31	26
Social insurance schemes	9	40	16
Persons with disabilities	18	67	7
NGOs	13	56	10
Total=104			

The aim of question 23 was to find the extent of coverage of certain groups by social insurance schemes. Table 23 indicates that children are covered in 41 of 49 countries where assistive devices and equipment are fully or partially financed by social insurance schemes. In 28 countries all adults are covered and in 25 only working adults are covered when assistive devices and equipment are financed by social insurance schemes. It is possible that working adults are covered by insurance linked to their work. In only 29 countries are the elderly covered when assistive devices and equipment are financed by social insurance schemes. This result is worrying, especially as different devices and equipment are often needed in old age.

Table 23 Question 23*Groups covered by social insurance schemes for provision of assistive devices*

Groups	Frequency	Percentage
Children	41	83.7
All adults	28	57.1
Working adults only	25	51.0
Elderly	29	59.2
Total=49		

According to paragraph 2 of the Rule on Support Services: “States should support the development, production, distribution and servicing of assistive devices and equipment and the dissemination of knowledge about them.” The aim of question 24 was to determine government involvement in the provision of assistive devices. Table 24 shows that in 87 countries of 96 responding on this issue, governments are involved in the provision of assistive devices. The great majority of countries have taken up this task, which is encouraging.

Table 24 Question 24a*Government involvement in the provision of assistive devices*

Government involvement	Frequency	Percentage
Exists	87	90.6
Does not exist	9	9.4
Total	96	100.0

The subsequent question was to determine how the governments contribute to the provision of assistive devices. Table 25 summarizes the responses to this question. In 59 countries the government provides information about the availability of assistive devices; in 58 countries the Government is involved in the distribution of assistive devices; in 51 countries the Government is involved in maintenance and repair of assistive devices; and in 49 countries the government is involved in development and production of assistive devices.

Table 25 Question 24b*Government provision of assistive devices*

Government provision	Frequency	Percentage
Development and production	49	56.3
Distribution	58	66.7
Maintenance and repair	51	58.6
Information about availability	59	67.8
Total=87		

According to the first paragraph of Rule 4 on Support Services: “States should ensure the provision of assistive devices and equipment, personal assistance and interpreter services, according to the needs of persons with disabilities, as important measures to achieve the equalization of opportunities.” Being disabled can be expensive. Access to assistive devices and personal assistance can mitigate its effects and overcome social barriers. Table 26 summarizes responses to the question on the kinds of assistive devices and equipment provided by the Government. Crutches are the most frequent equipment provided, i.e. 87 of the 104 countries responding to the questionnaire. In 83 countries prostheses/orthoses are provided; in 77 countries wheelchairs are provided. In 64 countries hearing devices are provided, in 62 countries visual devices are provided, in 48 countries devices for daily living are provided and only in 23 countries computers are provided. Foremost, it is equipment for people with mobility impairments that is provided by the government, followed by equipment for persons with hearing or sight impairments. Unquestionably there is a cost element in this provision. Computers, which are expensive, are only rarely provided. Devices for daily living – usually uncomplicated but useful devices - are not provided by more than half of the countries. Generally, the frequencies in Table 26 are high, indicating, as mentioned above, that a majority of governments have accomplished much in the provision of devices and equipment.

Table 26 Question 25

Assistive devices and equipment provided by the government

Assistive devices/equipment	Frequency	Percentage
Prostheses/orthoses	83	79.8
Wheelchairs	77	74.0
Crutches	87	83.7
Hearing devices	64	61.5
Visual devices	62	59.6
Devices for daily living	48	46.2
Computers	23	22.1
Total=104		

According to paragraph 6 of the Rule on Support Services: “States should support the development and provision of personal assistance programmes and interpretation services, especially for persons with severe and/or multiple disabilities. Such programmes would increase the level of participation of persons with disabilities in everyday life at home, at work, in school and during leisure-time activities.” The aim of question 26 was to find whether personal assistance is provided and for which services in society. Table 27 shows that personal assistance is provided in 76 of the 101 countries giving information on this issue. This is an unexpectedly high frequency, since personal assistance programmes are usually resource demanding. Most likely the definition of “personal assistance” is not the same in all countries.

Table 27 Question 26a*Provision of personal assistance*

Personal assistance	Frequency	Percentage
Provided	76	75.2
Not provided	25	24.8
Total	101	100.0

Table 28 summarizes the responses to the subsequent question on where personal assistance is provided. In 61 countries personal assistance is provided at the health service; in 58 countries at the social service; in 53 countries at home; in 52 countries at school; in 38 countries at work; in 31 countries during leisure; and in 20 countries at other services in society. Provision of personal assistance at the health service is the most frequent case, i.e., in 80% of the countries. About 70% of countries provide assistance at the social services, at school and at home, but only half of the countries provide it at work. This may not only reflect the employment situation of the disabled, but also constitute a real hindrance to finding employment. How persons with severe or multiple disabilities in 40 countries are able to visit a doctor remains an open question.

Table 28 Question 26b*Localities/activities where personal assistance is provided*

Localities/activities	Frequency	Percentage
Home	53	69.7
School	52	68.4
Work	38	50.0
During leisure	31	40.8
Health service	61	80.3
Social service	58	76.3
Other services in society	20	26.3
Total=76		

Table 29 summarizes the responses to the question concerning the arrangements for financing personal assistance. A frequent pattern is the shared responsibility among government ministries, persons with disabilities and/or NGOs. In 29 of 104 countries responding to this question government ministries or municipalities pay fully for personal assistance. In 19 countries persons with disabilities pay fully for their personal assistance, and in eight countries personal assistance is paid fully by social insurance schemes and by NGOs. Personal assistance is partially financed in 47 countries by NGOs, in 45 countries by persons with disabilities, in 37 countries by government ministries, in 25 countries by municipalities and in 23 countries by social insurance schemes. It is remarkable that in 45 countries government ministries and/or municipalities are not involved at all in the financing of personal assistance. There are only 11 countries where persons with disabilities do not pay at all for personal assistance.

The most frequent arrangement is the shared financing, followed by not paying at all, i.e., it is very unusual that the government or municipalities pay fully for personal assistance. It is

notable that NGOs and persons with disabilities partially finance personal assistance in almost half of the countries. Even more notable is that on summarizing the frequencies of the full and partial contributions, persons with disabilities are the greatest financiers of the personal assistant.

Table 29 Question 27

Arrangements for financing personal assistance

Source of finance	Fully	Partially	Not at all
Government ministries	25	37	20
Municipalities	4	25	25
Social insurance schemes	8	23	25
Persons with disabilities	19	45	11
NGOs	8	47	13
Total=104			

The aim of question 28 was to find whether support to families with children with disabilities is provided and how it is financed. Seventy-eight of 96 countries providing information on this issue responded that support to families is provided (Table 30). In as many as 18 countries support to families with children with disabilities is not provided.

Table 30 Question 28a

Support to families with children with disabilities

Support	Frequency	Percentage
Provided	78	81.3
Not provided	18	18.7
Total	96	100.0

A number of patterns emerged from the arrangements for financing support to families (Table 31). A common pattern is shared finance by government ministries or municipalities and persons with disabilities. In only 18 countries is support to families fully paid by government ministries or municipalities; in 10 countries it is fully financed by social insurance schemes; in four countries by persons with disabilities and by NGOs. In 75 countries it is partially financed by government ministries and/or municipalities; in 51 countries by NGOs; in 43 countries by persons with disabilities; and in 22 countries by social insurance schemes. It should be observed that in 20 countries, government ministries and/or municipalities give no financial support to families with children with disabilities.

Table 31 Question 28b*Arrangements for financing support to the families*

Source of finance	Fully	Partially	Not at all
Government Ministries	16	50	5
Municipalities	2	25	15
Social insurance schemes	10	22	13
Persons with disabilities pay by themselves	4	43	8
NGOs	4	51	5
Total=78			

The aim of question 29 was to find whether interpreter service is provided and for which services. Sixty-seven of 100 countries providing information on this issue responded that interpreter service is provided (Table 32). Thus, in as many as 33 countries interpreter service is not provided.

Table 32 Question 29a*Provision of interpreter service*

Interpreter service	Frequency	Percentage
Provided	67	67.0
Not provided	33	33.0
Total	100	100.0

Table 33 summarizes the responses to the question on where interpreter service is provided. In 51 countries interpreter service is provided at school; in 31 countries at the social services; in 29 countries at the health service; in 26 countries at work; in 19 countries during leisure; in 18 countries at other services in society; and in 17 countries at home. It is remarkable that many countries do not provide an interpreter for such an essential services as health care. Since a doctor always needs to communicate with the patient in order to make a correct diagnosis, it is questionable whether deaf persons in these countries can receive adequate health care.

Table 33 Question 29b*Localities/activities where interpreter service provided*

Localities/activities	Frequency	Percentage
Home	17	25.4
School	51	76.1
Work	26	38.8
During leisure	19	27.9
Health service	29	43.3
Social service	31	46.3
Other services in society	18	26.7
Total=67		

Table 34 summarizes the arrangements for financing interpreter service. The most common pattern seems to be a shared responsibility between government ministries and NGOs and between persons with disabilities and municipalities. In 23 countries interpreter service is fully financed by government ministries; in 12 countries by NGOs; in seven countries by persons with disabilities paying for themselves and in five countries by municipalities. In only one country is it fully financed by social insurance schemes. In as many as 30 countries NGOs partially finance interpreter service, followed by 28 countries where government ministries partially finance it. In 19 countries it is partially financed by persons with disabilities; in 14 countries by municipalities; and in nine countries by social insurance schemes. The major financiers are thus government ministries and NGOs who wholly or partially finance the service. However, there is a notable proportion of persons with disabilities who pay for themselves in order to receive an interpreter service.

Table 34 Question 30

Arrangements for financing interpreter service

Source of finance	Fully	Partially	Not at all
Government ministries	23	28	14
Municipalities	5	14	17
Social insurance schemes	1	9	20
Persons with disabilities	7	19	11
NGOs	12	30	7
Total=67			

The aim of question 31 was to determine whether persons with disabilities and/or their organizations are involved in the planning of support services (Table 35). In almost one-third of the countries responding to the question, persons with disabilities and/or their organizations are not involved in the planning of support services. In 68 of 99 countries providing information on this issue persons with disabilities are involved in the planning of support services. Many countries could achieve a greater involvement than this: to include persons with disabilities and their organizations in the planning of support services is neither resource demanding nor overwhelmingly difficult.

Table 35 Question 31

Involvement of persons with disabilities and/or their organizations in the planning of support services

Planning of support services	Frequency	Percentage
Involved	68	68.7
Not involved	31	31.3
Total	99	100.0

PERSONNEL TRAINING

For the WHO personnel training is an issue of the highest priority to ensure that there are sufficient numbers of properly trained health personnel to carry out national health programmes: “Over the years, this priority has been refined and expanded. It now includes not only human resource planning but also consideration of the optimal mix of different categories of health professionals to deliver the most effective service of an acceptable quality. WHO has also successfully promoted the incorporation of sound educational principles to ensure relevant training curricula and effective learning.”

According to the first paragraph of the Rule on Personnel Training: “States should ensure that all authorities providing services in the disability field give adequate training to their personnel.” The aim of question 32 was to find whether government ministries ensure that all authorities/agencies providing services in the disability field give training to their personnel. Ninety-six countries provided information on this issue. Table 36 shows that one third of the countries do not ensure that authorities/agencies providing services in the disability field give training to their personnel. Thus, there is a high percentage of personnel in the disability field who do not have professional training. Neither the effectiveness nor the quality can be ensured when unskilled personnel provide the services. This implies that resources given to the disability field may not yield optimal services. It is very regrettable if the measures taken, the programmes decided and the services planned for persons with disabilities fail at the point of implementation because of this lack of training.

Table 36 Question 32a

Training ensured to professionals in the disability field

Training	Frequency	Percentage
Ensured	64	66.7
Not ensured	32	33.3
Total	96	100.0

The subsequent question was to determine how different forms of training are expressed in countries where government ministries ensure that training is given to personnel in the disability field. In 49 countries governments ensure that training is given through supervision of the training curriculum for medical and paramedical staff (Table 37). In 46 countries it is expressed through policy adopted by government ministries.

Table 37 Question 32b

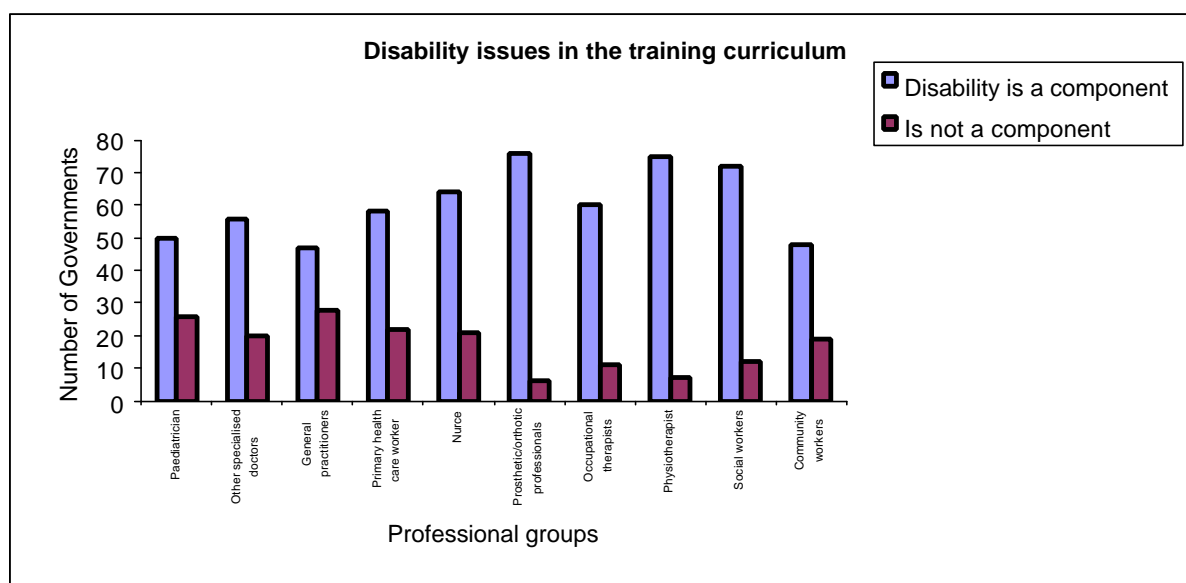
Forms of training to professionals

Training	Frequency	Percentage
Policy adopted by government ministries	46	71.9
Supervision of training curriculum	49	76.6
Total=64		

According to the second paragraph of the Rule on Personnel Training: “In the training of professionals in the disability field, as well as in the provision of information on disability in general training programmes, the principle of full participation and equality should be appropriately reflected.” The aim of question 33 was to identify the professional groups, providing services to persons with disabilities, which include disability issues as a component in their training curriculum. Figure 6 summarizes the responses to this question. Disability issues are not a component in the curriculum of general practitioners in 28 countries; of paediatricians in 26 countries; of primary health care workers in 22 countries; of nurses in 21 countries; of other specialized doctors in 20 countries; of community workers in 19 countries; of social workers in 12 countries; of occupational therapists in 11 countries; of physiotherapists in seven countries; and of prosthetic/orthotic professionals in six countries.

Comparing the results from question 11, where it became evident that nurses are the most available profession in medical care at all levels, and the results from question 19 where the pattern is the same concerning rehabilitation, it is regrettable that this profession does not receive adequate education, if they receive education at all, in disability issues in 21 countries. It would have great impact on the medical care and rehabilitation provided to persons with disabilities if all countries would take the responsibility to ensure that nurses, at least, always have a disability component in their training curriculum. Other professions, in particular general practitioners, other specialized doctors and community workers, in many more countries should follow some formal training in disability issues in their training curriculum.

Figure 6 Question 33



According to the third paragraph of the Rule on Personnel Training: “States should develop training programmes in consultation with organizations of persons with disabilities, and persons with disabilities should be involved as teachers, instructors or advisers in staff training programmes.” The aim of question 34 was to find whether staff training programmes for persons with disabilities are developed in consultation with organizations of persons with disabilities. Table 38 summarizes government responses to this question. In 49 countries of 92 providing information on this issue the organizations of disabled people are not consulted when staff training programmes are being developed. This is a tangible objective and a very essential one. By involving persons with disabilities and their organizations in staff training programmes, the programmes will become more successful.¹²

¹² In the survey conducted by the UN Special Rapporteur in 1997 one of the reviewed rules was Rule 18 on Organizations of Persons with Disabilities. For the purpose of comparison with question 34 in this report there are two questions that are interesting:

- Are there legal provisions mandating the representatives of persons with disabilities to participate in policy-making and to work with Governmental institutions? No Yes
- When preparing laws, regulations and/or guidelines with a disability aspect, are the views of organizations of persons with disabilities taken into account? Never Sometimes Often Always

Regarding the existence of legal provisions mandating the representatives of persons with disabilities to participate in policy-making and to work with governmental institutions, the results were less encouraging. In 32 countries out of 81 providing information, there were no such legal provisions. In 49 countries there were legal provisions mandating the representatives of disabled persons to participate in policy making.

Participation in policy-making	Frequency	Percentage
Countries reporting participation	49	60,5
Countries reporting no participation	32	39,5
Total	81	100,0

Regarding the second question the results from that survey shows that in 37 countries out of 80 providing information on this issue, organizations are always consulted during the preparation of laws, regulations and/or guidelines with a disability aspect. In 24 countries their views are often taken into account, in 18 their views are sometimes taken into account, and in one country their views are never taken into account.

Table 38 Question 34*Training programmes developed in consultation with organizations*

Organizations	Frequency	Percentage
Consulted	43	46.7
Not consulted	49	53.3
Total	92	100.0

The aim of question 35 was to find whether persons with disabilities are involved in staff training programmes and, if so, their roles. Ninety-three countries responded to this question. In 50 countries (Table 39) persons with disabilities are involved in staff training programmes.

Table 39 Question 35a*Involvement in staff training programmes*

Organizations	Frequency	Percentage
Involved	50	53.8
Not involved	43	46.2
Total	93	100.0

Table 40 shows that when persons with disabilities are involved in staff training programmes they act most frequently as advisers, and less frequently as teachers and instructors. Thus, in 42 countries disabled people act as advisers in staff training programmes, in 29 countries they act as teachers and in 29 as instructors. It appears that there is still a great potential to involve persons with disabilities in staff training programmes.

Table 40 Question 35b*Roles of persons with disabilities in staff training programs*

Role	Frequency	Percentage
Teachers	29	58.0
Instructors	29	58.0
Advisers	42	84.0
Total=50		

Consultations with organizations of persons with disabilities	Frequency	Percentage
Never	1	1,3
Sometimes	18	22,5
Often	24	30,0
Always	37	46,3
Total	80	100,0

CONCLUSIONS

This study reveals that rehabilitation is provided in a majority of countries, but in a basic traditional form from a consideration of the services and professional personnel available in practice. One notable factor is that nurses predominate at all levels, in both medical care and rehabilitation. Another factor is that medical care is not fully provided everywhere; specialized doctors are not available in many countries at a local or district level. Thus, persons with disabilities may need to travel great distances from their homes to consult specialized medical staff. WHO stresses the need to provide medical care of high quality. It is doubtful whether this is possible in many of the countries responding to the questionnaire, not only on medical care and availability of professional staff but also on the provision of rehabilitation services (in general, the latter is needed in order to receive the former).

A noticeable pattern is that many countries do provide rehabilitation programmes, but there is a great gulf between these services and the percentage of the population receiving it. Discrimination – in the sense of avoiding the mixing of persons with disabilities with those without, owing to prejudice – is still practised in some countries.

Persons with disabilities still lag behind as a pressure group. This is reflected in the observation that there are many personnel working in the disability field who have received no relevant formal training.

The organization of rehabilitation programmes and services is still not well implemented, implying the waste of resources by not ensuring trained personnel in disability issues as well as the waste of not involving persons with disabilities, their families and their organizations in the planning of programmes and education. The quality aspect of medical care, of rehabilitation programmes and of services cannot be stressed enough.

Another pattern in this study is that the main participants within the field are, on the one hand, the state/government and, on the other, the families/persons with disabilities themselves. In some areas the NGOs play an important role. It is remarkable how families of the disabled and disabled persons can afford to take upon themselves so great a share since, in general, they are economically weak and need to spend much effort in managing their daily lives.

The objective of the Standard Rules concerning provision of assistive devices – crutches, hearing devices, etc. – has been implemented to a great extent. Governments are assuming their responsibility for provision.

From a consideration of age groups it is clear that children are best provided for in medical care and rehabilitation. However, there is a great risk of becoming disabled as an adult owing to war, famine, accidents at the work place, diseases or traffic accidents. During old age there is an increasing probability of becoming disabled. Therefore, it is regrettable to find that adults and the elderly are not supported to any great extent by medical care, rehabilitation programmes and services.

Nevertheless, the adequate provision of both medical care and rehabilitation services (for instance, at school) to children is in agreement with the spirit of the Standard Rules and the objectives of WHO.

PART II

Summaries of the Government responses

REGIONAL OFFICE FOR THE WESTERN PACIFIC

CHINA

Medical care

The medical care system in China provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members are *at all times* involved as medical care providers. Voluntary workers in the municipality, professionals paid by municipality, professionals paid by state expenditures, professionals paid by NGOs and voluntary workers of NGOs are *sometimes* involved as medical care providers.

Medical care is provided free of charge by Government Ministries, it is paid by social insurance schemes and partially paid by the patient.

Children and working adults are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: CBR workers and primary health care worker. At the *district level* are the following groups involved: paediatrician, other specialised doctors, CBR workers. At the *provincial level* paediatrician, other specialised doctors, psychologist, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* paediatrician, other specialised doctors, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and through CBR.

Information in Braille, information on tape, sign language interpretation and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in China. Institutional rehabilitation programs exist at the provincial and national level. Community-based rehabilitation exist at the local and district level.

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: doctor (general practitioner) and CBR staff. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, physiotherapist. At the *provincial level* paediatrician, other specialised doctors, psychologist, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* paediatrician, other specialised doctors, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Rehabilitation services are available at community level through CBR.

The organisations of persons with disabilities participate in the provision of rehabilitation services through CBR programs.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by Government Ministries and persons with disabilities.

The Government of China is involved in the provision of assistive devices through development and production and distribution of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices and visual devices.

Personal assistance is provided at home, social service and at other services in society.

Personal assistance is financed by the following actors: *fully* by Government Ministries and persons with disabilities.

Interpreter service (sign language and speech interpretation) is provided at other services in society.

Interpreter service is financed *fully* by Government Ministries and municipalities.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in China ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries and through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: specialised doctors, prosthetic/orthotic professionals, occupational therapists, physiotherapists.

The staff training programs are not developed in consultation with organisations of persons with disabilities.

COOK ISLANDS

Medical care

The medical care system in Cook Islands provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *often* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members and professionals paid by NGOs are *at all times* involved as medical care providers. Professionals paid by state expenditures are *often* involved as medical care providers. Voluntary workers of NGOs are *sometimes* involved as medical care providers.

The medical care system is provided free of charge by Government Ministries from the age of 0-15 years and 60 years and over in all other cases it is paid fully by the patient.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), CBR worker, nurse and primary health care worker. At the *district level* are the following groups involved: CBR worker, nurse and primary health care worker. At the *provincial level* paediatrician, CBR worker, nurse, primary health care worker and physiotherapist are involved. At the *national level* doctor (general practitioner), CBR worker, nurse and primary health care worker are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and in the form of CBR.

Information on tape and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Cook Islands. Institutional rehabilitation programs exist at the local, provincial and national level. Community-based rehabilitation programs exist at the local level.

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: primary health care worker and CBR staff. At the *district level* are the

following groups involved: specialised doctors, primary health care worker and CBR staff. At the *provincial level* doctor (general practitioner), other specialised doctors, primary health care worker, CBR staff and physiotherapist are involved. At the *national level* specialised doctors, primary health care worker and CBR staff are involved.

Rehabilitation services are available at community level through primary health care, community-based rehabilitation (CBR) and through NGOs.

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services, in the formulation and evaluation of rehabilitation programs and as trained teachers, instructors, counsellors and through CBR. The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services, in the formulation and evaluation of rehabilitation programs and as trained teachers, instructors, counsellors and through CBR. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services, in the formulation and evaluation of rehabilitation programs and as trained teachers, instructors, counsellors and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by NGOs; *partially* financed by Government Ministries.

The Government of the Cook Islands is involved in the provision of assistive devices through development and production, distribution, maintenance and repair and through information about availability.

Personal assistance is provided at home, school, work and health service.

Support is provided to families with children with disabilities. This support is financed *fully* by Government Ministries.

Interpreter service (sign language and speech interpretation) is not provided.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in the Cook Islands ensure that all authorities/agencies providing services in the disability field give training to their personnel through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: primary health care workers, nurses and community workers.

The staff training programs are developed in consultation with organisations of persons with disabilities.

Persons with disabilities are involved in staff training programs as teachers, instructors, and as advisers.

Medical care

The medical care system in Fiji provides services for persons with disabilities; there is, however a tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Professionals paid by state expenditures are *at all times* involved as medical care providers. Family members, professionals paid by municipality and professionals paid by NGOs are *often* involved as medical care providers. Voluntary workers in the municipality and voluntary workers of NGOs are *sometimes* involved as medical care providers.

Medical care is partially paid by the patient.

Children and only working adults are covered by social insurance schemes. Between 21-40 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), CBR workers, nurse, primary health care worker, physiotherapist and occupational therapist. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, CBR workers, nurse, psychologist, primary health care worker, physiotherapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors and speech therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and in the form of CBR.

Information in Braille, information on tape, sign language interpretation and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Fiji. Institutional rehabilitation programs exist at the district, provincial level. Community-based rehabilitation exists at the local and district level.

Less than 5 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: doctor (general practitioner), nurse, psychologist, primary health care

worker, CBR staff, physiotherapist and occupational therapist. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, Prosthetic/orthotic professional, nurse, psychologist, primary health care worker, physiotherapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, CBR staff, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional and speech therapist are involved.

Rehabilitation services are available at community level through primary health care, CBR and through NGOs.

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors and counsellors and through CBR. The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors and counsellors and through CBR. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs and as trained teachers, instructors, counsellors and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by Government Ministries, social insurance schemes, persons with disabilities and NGOs, *partially* financed by Government Ministries, municipalities, social insurance schemes, persons with disabilities and NGOs. Children and working adults are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Fiji is involved in the provision of assistive devices through distribution, maintenance and repair and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: wheelchairs, crutches, hearing devices, visual devices, devices for daily living.

Personal assistance is provided at home, school, work, health and social service.

Personal assistance is financed by the following actors: *fully* by social insurance schemes and NGOs, *partially* by Government Ministries, municipalities and persons with disabilities.

Support is provided to families with children with disabilities. This support is financed *partially* by Government Ministries, municipalities, social insurance schemes, persons with disabilities and NGOs.

Interpreter service (sign language and speech interpretation) is provided at home, school, work, during leisure, at health service.

Interpreter service is financed *partially* by Government Ministries, municipalities, social insurance schemes, persons with disabilities and NGOs.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in Fiji ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries and through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic/orthotic professionals, occupational therapists, physiotherapists, social workers and community workers.

The staff training programs are developed in consultation with organisations of persons with disabilities.

Persons with disabilities are involved in staff training programs as teachers, instructors and advisers.

JAPAN

Medical care

The medical care system in Japan provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members, professionals paid by the municipality and professionals paid by state expenditures are *sometimes* involved as medical care providers.

The medical care system is paid by social insurance schemes.

Children, all adults and the elderly are covered by social insurance schemes. Between 81-100 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, nurse, primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, CBR worker, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, CBR worker, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, CBR worker, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and CBR.

Information in Braille, information on tape, sign language interpretation and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Japan. Institutional rehabilitation programs exist at the local, district, provincial and national level. Community Based rehabilitation programs exist at the local, district, provincial and national level.

Between 81-100 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with

learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, primary health care worker, CBR staff, physiotherapist, speech therapist and occupational therapist. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, primary health care worker, CBR staff, physiotherapist, speech therapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, primary health care worker, CBR staff, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Rehabilitation services are available at community level through primary health care, through CBR and through NGOs.

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and as trained teachers, instructors and counsellors. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by social insurance schemes; *partially* financed by Government Ministries, municipalities and persons with disabilities.

Only working adults are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Japan is involved in the provision of assistive devices through development and production, distribution, maintenance and repair and information about availability.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices, visual devices and devices for daily living.

Personal assistance is provided at home, school, work, during leisure, health and social service and at other services in society.

Personal assistance is financed by the following actors: *partially* by Government Ministries, municipalities and persons with disabilities.

Support is provided to families with children with disabilities. This support is financed *partially* by Government Ministries and municipalities.

Interpreter service (sign language and speech interpretation) is provided at home, school, work, during leisure, at health and social service and at other services in society.

Interpreter service is financed *partially* by Government Ministries and municipalities.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in Japan ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries and through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic/orthotic professionals, occupational therapists, physiotherapists, social workers and community workers.

The staff training programs are developed in consultation with organisations of persons with disabilities.

Persons with disabilities are involved in staff training programs as advisers.

KIRIBATI

Medical care

The medical care system in Kiribati does not provide services for persons with disabilities.

The organisations of persons with disabilities are *never* involved in the planning and evaluation of the above mentioned programs.

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Professionals paid by state expenditures are *often* involved as medical care providers. Family members are *sometimes* involved as medical care providers.

Medical care provides free of charge by Government Ministries.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), nurse, primary health care worker and physiotherapist.

Medical care services reach villages and poor urban areas in the form of primary health care.

Rehabilitation

There is no national rehabilitation program for persons with disabilities in Kiribati. Community-based rehabilitation programs exist at the local.

Less than 5 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes) and persons with disabilities due to mental illness (e.g. schizophrenia).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: physiotherapist.

Rehabilitation services are available at community level through NGOs.

LAO PEOPLE'S DEMOCRATIC REPUBLIC

Medical care

The medical care system in Lao provides services for persons with disabilities; there is, however, a tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Family members are *at all times* involved as medical care providers. Professionals paid by municipality and professionals paid by state expenditures are *sometimes* involved as medical care providers.

Medical care is provided free of charge by Government Ministries, it is paid by social insurance schemes and partially paid by the patient.

Children, all adults and the elderly are covered by social insurance schemes. Between 0-20 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: CBR worker, nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, CBR worker, primary health care worker. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, physiotherapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and in the form of community-based rehabilitation.

Information in Braille, sign language interpretation are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Lao. Institutional rehabilitation programs exist at the provincial and national level. Community-based rehabilitation exists at the local and district level.

Between 41-60 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: nurse, primary health care worker and CBR staff. At the *district level* are the

following groups involved: paediatrician, nurse, primary health care worker, CBR staff. At the *provincial level* doctor (general practitioner), paediatrician, prosthetic/orthotic professional, physiotherapist are involved. At the *national level* doctor (general practitioner), paediatrician, prosthetic/orthotic professional, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Rehabilitation services are available at community level through primary health care, CBR and NGOs.

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through CBR programs. The families of persons with disabilities participate in the provision of rehabilitation services through CBR programs. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by NGOs, *partially* financed by Government Ministries, municipalities and social insurance schemes and persons with disabilities. Only working adults are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Lao is involved in the provision of assistive devices through development and production, distribution, maintenance and repair and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices, visual devices, devices for daily living.

Personal assistance is provided at home, school, work, during leisure, health and social service.

Personal assistance is financed by the following actors: *partially* by Government Ministries, social insurance schemes and persons with disabilities.

Interpreter service (sign language and speech interpretation) is provided at school and social service.

Interpreter service is financed *fully* by Government Ministries.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in Lao ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries and through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: specialised doctors, general practitioners, primary health care workers, nurses, prosthetic/orthotic professionals, occupational therapists, physiotherapists, community workers.

Persons with disabilities are involved in staff training programs as teachers and as instructors.

MALAYSIA

Medical care

The medical care system in Malaysia provides services for persons with disabilities; there is, however, a tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *always* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months).

Family members are *at all times* involved as medical care providers. Voluntary workers in the municipality, professionals paid by state expenditures, professionals paid by NGOs are *sometimes* involved as medical care providers.

Medical care is partially paid by the patient.

Between 0-20 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, primary health care worker, physiotherapist, speech therapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Information in Braille, information on tape, sign language interpretation and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Malaysia. Institutional rehabilitation programs exist at the district, provincial and national level. Community-based rehabilitation exists at the district, provincial and national level.

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: nurse, primary health care worker and CBR staff. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, nurse, primary health care worker, physiotherapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, primary health care worker, CBR staff, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, CBR staff, physiotherapist, speech therapist and occupational therapist are involved.

Rehabilitation services are available at community level through primary health care, CBR and through NGOs.

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors and counsellors and through CBR. The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors and counsellors and through CBR. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs and as trained teachers, instructors, counsellors and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *partially* financed by Government Ministries, social insurance schemes and NGOs.

The Government of Malaysia is involved in the provision of assistive devices through development and production, distribution and maintenance and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices, visual devices, devices for daily living and computers.

Personal assistance is provided at home, school, work, during leisure, health and social service and at other services in society.

Personal assistance is financed by the following actors: *partially* by Government Ministries, social insurance schemes, persons with disabilities and NGOs.

Support is provided to families with children with disabilities. This support is financed *partially* by Government Ministries, social insurance schemes, persons with disabilities and NGOs.

Interpreter service (sign language and speech interpretation) is provided at other services in society.

Interpreter service is financed *fully* by Government Ministries, *partially* by social insurance schemes, persons with disabilities and NGOs.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in Malaysia ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic/orthotic professionals, occupational therapists, physiotherapists, social workers and community workers.

The staff training programs are developed in consultation with organisations of persons with disabilities.

Persons with disabilities are involved in staff training programs as teachers, instructors and advisers.

MARSHALL ISLANDS

Medical care

The medical care system in the Republic of the Marshall Islands provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

The following groups of medical and paramedical staff are available in medical care at the *district level* are the following groups involved: primary health care worker. At the *provincial level* doctor (general practitioner), paediatrician, nurse are involved. At the *national level* physiotherapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Information on tape, sign language interpretation and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *district level* are the following groups involved: primary health care worker. At the *provincial level* doctor (general practitioner), paediatrician, nurse are involved. At the *national level* specialised doctors, physiotherapist are involved.

Rehabilitation services are available at community level through primary health care.

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs, and as trained teachers, instructors and counsellors. The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs and as trained teachers, instructors and counsellors.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by persons with disabilities themselves. Children and all adults are covered by social insurance schemes regarding the provision of assistive devices.

The Government of the Marshall Islands is involved in the provision of assistive devices through distribution and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: wheelchairs, crutches.

Personal assistance is financed by the following actors: *fully* by persons with disabilities.

MONGOLIA

Medical care

The medical care system in Mongolia provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members are *at all times* involved as medical care providers. Professionals paid by municipality and professionals paid by state expenditures are *often* involved as medical care providers. Voluntary workers in the municipality are *sometimes* involved as medical care providers.

Medical care is paid by social insurance schemes and partially paid by the patient.

Only working adults are covered by social insurance schemes. Between 81-100 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), CBR workers, nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), specialised doctors, CBR workers, nurse, primary health care worker and physiotherapist. At the *provincial level* doctor (general practitioner), specialised doctors, CBR workers, nurse, and primary health care worker are involved. At the *national level* doctor (general practitioner), specialised doctors, nurse, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and in the form of CBR.

Information on tape and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Mongolia. Institutional rehabilitation programs exist at the district, provincial and national level. Community-based rehabilitation programs exist at the local, district, provincial and national level.

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with

learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: nurse, primary health care worker and CBR staff. At the *district level* are the following groups involved: doctor (general practitioner), specialised doctors, nurse, primary health care worker and CBR staff. At the *provincial level* doctor (general practitioner), specialised doctors, prosthetic/orthotic professional, nurse, primary health care worker, CBR staff, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), specialised doctors, nurse, psychologist, primary health care worker, speech therapist and occupational therapist are involved.

Rehabilitation services are available at community level through primary health care, through CBR and through NGOs.

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through CBR programs. The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through CBR programs. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs and as trained teachers, instructors, counsellors and through CBR programs.

Support services

Assistive devices and equipment for persons with disabilities are *partially* financed by persons with disabilities. Only working adults are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Mongolia is involved in the provision of assistive devices through development and production, maintenance and repair and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs and crutches.

Personal assistance is provided at home, school, health and social service.

Personal assistance is financed by the following actors: *fully* by social insurance schemes, *partially* by municipalities and NGOs.

Support is provided to families with children with disabilities. This support is financed *fully* by Government Ministries, social insurance schemes, *partially* by municipalities.

Interpreter service (sign language and speech interpretation) is provided at school, work, at social service.

Interpreter service is financed *partially* by government Ministries and NGOs.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in Mongolia ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries and through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: general practitioners, primary health care workers, prosthetic/orthotic professionals, occupational therapists, physiotherapists, social workers.

The staff training programs are developed in consultation with organisations of persons with disabilities.

Persons with disabilities are involved in staff training programs as teachers and as advisers.

NAURU

Medical care

The medical care system in Nauru provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for early detection and diagnosis as well as for treatment of impairment. It includes also programs for necessary referrals.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members are *sometimes* involved as medical care providers.

Medical care is provided free of charge by Government Ministries.

Children, all adults and the elderly are covered by social insurance schemes. Between 81-100 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse.

Medical care services reach villages and poor urban areas.

Rehabilitation

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *national level* doctor (general practitioner), paediatrician, other specialised doctors.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by Government Ministries, *partially* by persons with disabilities. Children, all adults and the elderly are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Nauru is involved in the provision of assistive devices through maintenance and repair and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices, visual devices, devices for daily living.

Personal assistance is provided at home, work.

Personal assistance is financed by the following actors: *fully* by Government Ministries, *partially* by persons with disabilities.

Support is provided to families with children with disabilities. This support is financed *fully* by Government Ministries, *partially* by persons with disabilities.

Personnel training

The staff training programs are developed in consultation with organisations of persons with disabilities.

NEW CALEDONIA

Medical care

The medical care system in New Caledonia provides services for persons with disabilities; there is, however, a tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members, professionals paid by state expenditures are *at all times* involved as medical care providers. Professionals paid by municipality are *sometimes* involved as medical care providers.

Medical care is provided free of charge by Government Ministries, it is paid by social insurance schemes and partially paid by the patient.

Children, all adults and the elderly are covered by social insurance schemes. Between 81-100 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), nurse and primary health care worker. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Information on tape and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

Institutional rehabilitation programs exist at the provincial and national level.

Between 61-80 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: doctor (general practitioner), nurse, primary health care worker. At the *provincial level* paediatrician, other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* paediatrician, other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Rehabilitation services are available at community level through primary health care.

The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs.

Support services

Assistive devices and equipment for persons with disabilities are *partially* financed by municipalities, social insurance schemes and persons with disabilities. Children, all adults and the elderly are covered by social insurance schemes regarding the provision of assistive devices.

Personal assistance is provided at home, school, work, during leisure and social service.

Personal assistance is financed by the following actors: *partially* by municipalities, social insurance schemes and persons with disabilities.

Support is provided to families with children with disabilities. This support is financed *partially* by municipalities, social insurance schemes and persons with disabilities.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, nurses, prosthetic/orthotic professionals, occupational therapists, physiotherapists, social workers.

NEW ZEALAND

Medical care

The medical care system in New Zealand provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents. Rehabilitation techniques and counselling are provided but availability varies.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs. Organisations are *often* involved in the mental health area.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members, professionals paid by state expenditures are *at all times* involved as medical care providers. Voluntary workers in the municipality are *often* involved as medical care providers. Professionals paid by NGOs and voluntary workers of NGOs are *sometimes* involved as medical care providers.

Some medical care is provided free of charge by central government. Some people chose to privately pay for medical care (although general practitioner visits are available to all on subsidy. Other sources of payment or subsidy include: ACC (Accident Compensation Corporation, a government-owned statutory corporation responsible for accident injury compensation and from 1 July 1999 employers may also provide accident injury compensation for employees with similar benefits), and private medical insurance.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* paediatrician, other specialised doctors, nurse and psychologist are involved. (Provincial level is interpreted here and elsewhere as equating to regional level. Some services organise on a district basis or a district-equivalent basis e.g. HHS. I New Zealand there are no CBR workers as such.)

Medical care services reach villages and poor urban areas in the form of primary health care and community-based rehabilitation. There is community-based rehabilitation, without specific CBR workers as such. Other services include outreach services and access to other levels of services on referral.

Sign language interpretation is services provided in order to facilitate information and communication between persons with disabilities and staff in health care. Information in Braille and on tape is only available in one or two isolated instances, e.g. a Code of Health and Disability Services Consumers' Rights is available. Some people who are blind or have

visual impairments access health and disability information via the internet. Sign language interpretation and easy reading information, e.g. for Pacific peoples, are not always available.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in New Zealand. National rehabilitation/habilitation programs only exist in a few areas, e.g. spinal injury. There are no programs in other areas. Institutional rehabilitation programs exist at the district and national level. Community-based rehabilitation exists at the local and district level. There are a few institutional rehabilitation programs e.g. at 2 spinal units; 1-2 other medical/social rehabilitation programs based at larger hospitals e.g. for Head Injury; or programs funded by Education (e.g. there are two schools with outreach services for children; two schools for children and young people who are deaf). HFA funds programs for adults who are blind/have visual impairments. There are HFA-funded community based rehabilitation equivalent programs at a local or district level e.g. Child Development Teams.

Between 61-80 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities. Not all persons with learning disabilities, mental illness nor those with multiple/severe disabilities receive rehabilitation services.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: doctor (general practitioner), nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist. At the *district level* are the following groups involved: paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist. At the *provincial level* paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* paediatrician, other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved. Availability of medical/paramedical staff varies at the different levels, depending on how services are organised in different areas, e.g. in some areas there good rehabilitation services available at a local level (e.g. through coverage of a Child Development Teams. These teams are considered equivalent to CBR for this question); in some areas services are only available at a district/smaller HHS level; in other areas services are only available at a provincial/regional HHS level; in yet other areas both levels may lack rehabilitation services, or have both levels. Specialised habilitation/rehabilitation workers include neuro-developmental therapists (for children with developmental disabilities), and orientation and mobility trainers (for people with visual impairments). There are only one or two specialised national rehabilitation units employing these staff e.g. spinal units, the national secure unit for people with mental health illness who have come before the law.

Rehabilitation services are available at community level through primary health care, through CBR and through NGOs.

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services, through the formulation and evaluation of rehabilitation programs, and through CBR. The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of

rehabilitation services, through the formulation and evaluation of rehabilitation programs, and through CBR. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services, through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors, counsellors and through CBR. Persons with disabilities and families – some participate in design and organisation of services (mainly through NGOs), a few in formulation or evaluation, or through CBR equivalent programs. Organisations – some participate in design and organisation of services, a few in formulation or evaluation, or through CBR equivalent programs and some are involved as trained teachers etc.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by Government Ministries, persons with disabilities and NGOs; *partially* financed by Government Ministries. Government fully funds some devices (e.g. most manual wheelchairs) some on a targeted basis (e.g. communication equipment), and partially funds other equipment (e.g. there is a minimum \$37 on smaller items). Some people chose to pay for their own equipment, or the difference between a funded assessed product and the product of choice. NGOs now supply few devices. Other sources include: ACC, Lotery Grants Board (for mobility and communication equipment for those who do not otherwise qualify for assistance), and private medical insurance.

The New Zealand Government is involved in the provision of assistive devices through development and production, distribution, maintenance and repair and information about availability of assistive devices. One government-funded business company (NZ Disability Resource Centre) designs/develops a small number of one-off devices. Assessment, information and supply of equipment is purchased and managed by two Equipment Management Services, on contract to HFA. Other local disability resource centres have HFA contracts to provide equipment and other information.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices, visual devices, devices for daily living and computers. Computers are funded for children (by Education or HFA); and for some targeted adults, e.g. those in employment. Other targeted vehicle grants and modifications, home modifications.

Personal assistance is provided at home, school, work, during leisure, health and social service. Personal assistance is provided where the person requires it, although mostly home or work. It is more available to those under ACC (those injured by accident).

Personal assistance is financed by the following actors: *fully* by Government Ministries, persons with disabilities. Although Government via HFA may pay for some PA on a needs basis (there is a high threshold of need, though no income or asset test), the amount supplied is limited, and some people able to do so may supplement this by privately purchasing additional PA.

Support is provided to families with children with disabilities. This support is *fully* financed by: Government Ministries, persons with disabilities and NGOs. While support services such as respite care/caregiver support are provided on the basis of need, access to home support service (home help) takes into account the family income.

Interpreter service (sign language and speech interpretation) is provided at home, school, work, during leisure, at health and social service and at other services in society. Limited services are provided due to limited availability of interpreters/speech interpreters.

Interpreter service is financed *fully* by Government Ministries, and NGOs. HFA purchases some services for strictly defined purposes e.g. accessing health services. NGOs (e.g. Deaf

Association) fund interpreters for some occasions/individuals, supplementing what is available elsewhere. Employers may also fund some interpretation in some circumstances.

Persons with disabilities and/or their organisations are involved in the planning of support services. Involvement in planning varies, but if it occurs it is likely to occur through consultation, and in some instances as members of working groups.

Personnel training

Government Ministries in New Zealand ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries. Training is specified in most government service contracts, but the quality/amount delivered varies. The Education Qualification Authority oversees training curricula where courses are registered with this body (not all are).

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic/orthotic professionals, occupational therapists, physiotherapists, social workers and community workers. Most training curriculum have some disability/disability issues component, but the quality/amount varies.

The staff training programs are developed in consultation with organisations of persons with disabilities. Though consultation with disability organisation varies.

Persons with disabilities are involved in staff training programs as teachers, instructors and as advisers. Involvement of people with disabilities in the roles specified varies. In some cases, they manage programs.

A brief over view health and disability services, to aid understanding of some of the responses was added.

The New Zealand Central Government funds the Health Funding Authority (HFA), via vote: Health, to purchase a range of health and disability services for all New Zealanders, including people with disabilities.

The HFA purchases services from a range of public, private and voluntary service providers, on a prioritised needs basis. Most health and medical rehabilitation services are provided by Hospital and Health Services (HHS).

- Primary care services are mainly provided locally by privately employed General Practitioners (GPs) and other professionals. Most GPs are funded on a fee for service subsidy basis.
- Secondary services such as acute, elective surgery and rehabilitation services, are mainly provided by HHSs, with many HHS facilities being based in larger towns and cities. Tertiary and other more specialised services are increasingly located in a small number of major hospitals in larger urban areas such as Auckland. Some of these services have a national coverage.
- Disability Support Services (DSS) are funded by HFA on a ring fenced basis. HFA contracts a wide variety of DDS providers, most of whom are based in the community (rather than in hospitals or other institutions). Some DDS services are generic, e.g. home support, while other DSS are specialised, e.g. services for people with vision impairments. Many DSS services are provided by Non-Governmental Agencies (e.g. the royal New Zealand Foundation for the Blind) or private agencies (e.g. rest homes).

The New Zealand Central Government also funds some disability services through other votes, such as Vote Education. The Ministry of Education directly funds some support services for children and young people with disabilities, and contracts agencies such as Special Education Services for other support services.

New Zealand does not have:

- Dedicated Community Based Services (in the sense used in the questionnaire). It does have a range of rehabilitation and primary health community services funded by HFA and provided by primary or personal health agencies or disability support service agencies, or funded by Vote Education.
- Health or disability services based on local, provincial or national levels of government, in the sense of a range of health and disability responsibilities implied in this questionnaire. In New Zealand, local and district Government levels have few health (other than environmental public health) or disability service responsibilities. There is no provincial government layer, although some health and disability services are provided regionally (these regions generally equate to provinces, and some questions have been answered on this basis). Central or national government through HFA is the main funder/purchaser of services, although planning or individual access decisions may be made at other levels. Some services are provided nationally, generally through larger HHSs.

NORTHERN MARIANA ISLANDS

Medical care

The medical care system in Northern Mariana Islands provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Professionals paid by state expenditures are *at all times* involved as medical care providers. Family members are *often* involved as medical care providers. Voluntary workers in the municipality, professionals paid by municipality, professionals paid by NGOs and voluntary workers of NGOs are *sometimes* involved as medical care providers.

The medical care system is provided free of charge by Government Ministries, it is paid by social insurance schemes and partially paid by the patient.

Children, all adults and the elderly are covered by social insurance schemes. Between 81-100 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist.

Medical care services reach villages and poor urban areas.

Easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Northern Mariana Islands. Institutional rehabilitation and community based rehabilitation programs exist at the local level.

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, CBR

staff, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist.

Rehabilitation services are available at community level through primary health care, through community based rehabilitation and through Non-Governmental Organisations

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services, through the formulation and evaluation of rehabilitation programs and through CBR. The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs.

Support services

Assistive devices and equipment for persons with disabilities are *partially* financed by Government Ministries, municipalities, social insurance schemes, persons with disabilities and NGOs. Children, all adults and the elderly are covered by social insurance schemes regarding the provision of assistive devices.

The Government of the Northern Mariana Islands is involved in the provision of assistive devices through distribution, maintenance and repair and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices, visual devices and devices for daily living and computers.

Personal assistance is provided at home, school, work, during leisure, health and social service.

Personal assistance is financed by the following actors: *fully* by Government Ministries, social insurance schemes; *partially* by persons with disabilities.

Support is provided to families with children with disabilities. This support is financed *fully* by Government Ministries, social insurance schemes and NGOs.

Interpreter service is financed *fully* by Government Ministries.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in Northern Mariana Islands ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries and through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers and nurses.

The staff training programs are developed in consultation with organisations of persons with disabilities.

Persons with disabilities are involved in staff training programs as advisers and committee members.

PALAU

Medical care

The medical care system in Palau provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members are *at all times* involved as medical care providers. Professionals paid by municipality, professionals paid by state expenditures and professionals paid by NGOs are *sometimes* involved as medical care providers.

Medical care is partially paid by the patient.

Children, all adults and the elderly are covered by social insurance schemes. Between 81-100 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: primary health care worker. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Information on tape, sign language interpretation and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Palau. Institutional rehabilitation programs exist at the national level.

Less than 5 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: primary health care worker. At the *national level* specialised doctors, psychologist, physiotherapist and speech therapist are involved.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by persons with disabilities and NGOs, *partially* financed by Government Ministries and social insurance schemes. Children, all adults and the elderly are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Palau is involved in the provision of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches.

Support is provided to families with children with disabilities. This support is financed *fully* by Government Ministries, *partially* by social insurance schemes and NGOs.

Interpreter service (sign language and speech interpretation) is provided at school.

Interpreter service is financed *fully* by Government Ministries.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: primary health care workers, nurses, prosthetic/orthotic professionals and social workers.

PHILIPPINES

Medical care

The medical care system in Philippines provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are not provided medical care within the same system as other infants and children due to lack of staff, lack of training, due to societal attitudes and difficulties in the families due to economic constraints.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning depending on the financial status of the family of disabled persons.

Family members and voluntary workers of NGOs are *often* involved as medical care providers. Voluntary workers in the municipality and professionals paid by NGOs are *sometimes* involved as medical care providers.

Medical care is paid fully by the patient.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, CBR workers, nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse and primary health care worker. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and CBR.

Easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Philippines. Institutional rehabilitation programs exist at the national level. Community-base rehabilitation programs exist at the local, district, provincial and national level.

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, persons with severe sight impairment (blind), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: doctor (general practitioner), nurse, primary health care worker and CBR staff. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, nurse, primary health care worker and CBR staff. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, primary health care worker, CBR staff, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, CBR staff, physiotherapist, speech therapist and occupational therapist are involved.

Rehabilitation services are available at community level through primary health care, through CBR and through NGOs.

Persons with disabilities participate in the provision of rehabilitation services through CBR programs. The families of persons with disabilities participate in the provision of rehabilitation services as trained teachers, instructors, counsellors and through CBR programs. The organisations of persons with disabilities participate in the provision of rehabilitation services through as trained teachers, instructors, counsellors and through CBR programs.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by persons with disabilities; *partially* financed by municipalities and NGOs.

The Government of Philippines is involved in the provision of assistive devices through development and production, distribution, maintenance and repair and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices and devices for daily living.

Support is provided to families with children with disabilities. This support is financed *fully* by persons with disabilities; *partially* by NGOs.

Interpreter service (sign language and speech interpretation) is provided at school and at health service.

Interpreter service is financed *fully* by NGOs; *partially* by municipalities and persons with disabilities.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in Philippines ensure that all authorities/agencies providing services in the disability field give training to their personnel through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic/orthotic professionals, occupational therapists, physiotherapists, social workers and community workers.

The staff training programs are developed in consultation with organisations of persons with disabilities.

Persons with disabilities are involved in staff training programs as teachers, instructors and as advisers.

REPUBLIC OF KOREA

Medical care

The medical care system in The Republic of Korea provides services for persons with disabilities; there is, however, a tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

Organisations of persons with disabilities are *often* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members, professionals paid by state expenditures are *at all times* involved as medical care providers. Voluntary workers in the municipality and voluntary workers of NGOs are *often* involved as medical care providers.

Medical care is provided free of charge by Government Ministries.

Children, all adults and the elderly are covered by social insurance schemes. Between 81-100 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, physiotherapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Information in Braille and sign language interpretation are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in the Republic of Korea. Institutional rehabilitation programs exist at the district, provincial and national level.

Between 81-100 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes) and persons with disabilities due to mental illness (e.g. schizophrenia).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: doctor (general practitioner), paediatrician, nurse, primary health care worker and CBR staff. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, physiotherapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, physiotherapist and occupational therapist are involved.

Rehabilitation services are available at community level through primary health care.

The families of persons with disabilities participate in the provision of rehabilitation services as trained teachers, instructors, counsellors. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by Government Ministries and social insurance schemes. Children, all adults and the elderly are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Korea is involved in the provision of assistive devices through development and production, distribution, maintenance and repair and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices and visual devices.

Personal assistance is provided at home, school, work, health and social service and at other services in society.

Personal assistance is financed by the following actors: *fully* by Government Ministries and social insurance schemes.

Support is provided to families with children with disabilities. This support is financed *fully* by Government Ministries and social insurance schemes.

Interpreter service (sign language and speech interpretation) is provided at school.

Interpreter service is financed *fully* by Government Ministries.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in the Republic of Korea ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic/orthotic professionals and community workers.

The staff training programs are developed in consultation with organisations of persons with disabilities.

Persons with disabilities are involved in staff training programs as teachers, instructors and as advisers.

SINGAPORE

Medical care

The medical care system in Singapore provides services for persons with disabilities; there is, however, a tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members and professionals paid by state expenditures are *often* involved as medical care providers. Professionals paid by NGOs and voluntary workers of NGOs are *sometimes* involved as medical care providers.

Medical care is partially paid by the patient.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, CBR staff, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, CBR staff, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved.

Information on tape and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Singapore. Institutional and community based rehabilitation programs exist at the national level.

Between 61-80 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, CBR staff, physiotherapist, speech therapist and occupational therapist.

Rehabilitation services are available at community level through primary health care, through CBR and through NGOs.

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services, through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors, counsellors and through CBR. (This is only relevant for certain disability groups and age groups. Adults with disabilities are mainly involved in planning and decision making.) The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors, counsellors and through CBR. (where possible, parents are also involved. For e.g. parents of autistic children may be involved as teachers, trainers in services for autistic children.) The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs and as trained teachers, instructors, counsellors, and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by Government Ministries, persons with disabilities and NGOs; *partially* financed by Government Ministries, persons with disabilities and NGOs. (The Government may finance fully or partially on a case-by-case basis, depending on the financial circumstances of the client. Likewise, NGOs may also finance fully or partially, as in the case of them providing subsidies to clients. Both the Government and NGOs may also subsidise partially depending on clients needs and on a case-by-case basis.

The Government of Singapore is involved in the provision of assistive devices through information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, crutches, visual devices and devices for daily living.

Personal assistance is provided at home, school, work, during leisure, health and social service and at other services in society.

Personal assistance is financed by the following actors: *fully* by Government Ministries, persons with disabilities and NGOs; *partially* by Government Ministries, persons with disabilities and NGOs.

Support is provided to families with children with disabilities. This support is *fully* financed by Government Ministries, persons with disabilities and NGOs; *partially* by Government Ministries, persons with disabilities and NGOs.

Interpreter service (sign language and speech interpretation) is provided at school, work, at health and social service.

Interpreter service is financed *fully* by Government Ministries, persons with disabilities and NGOs.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in Singapore ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries and through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic/orthotic professionals, occupational therapists, physiotherapists, social workers and community workers.

The staff training programs are developed in consultation with organisations of persons with disabilities.

Persons with disabilities are involved in staff training programs as teachers, instructors and as advisers.

TAHITI FRENCH POLYNESIA

Medical care

The medical care system in Tahiti provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques.

The organisations of persons with disabilities are *often* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members, professionals paid by state expenditures are *at all times* involved as medical care providers. Professionals paid by municipality are *often* involved as medical care providers. Voluntary workers in the municipality, professionals paid by NGOs are *sometimes* involved as medical care providers.

Medical care is paid by social insurance schemes and partially paid by the patient.

Children and all adults and are covered by social insurance schemes. Between 81-100 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), CBR workers, nurse, psychologist. At the *district level* are the following groups involved: doctor (general practitioner), CBR workers, nurse, psychologist, physiotherapist, speech therapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), other specialised doctors, CBR workers are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

Institutional rehabilitation programs exist at the provincial and national level. Community-based rehabilitation exist at the local, district and provincial level.

Between 41-60 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, nurse, prosthetic/orthotic professional, psychologist, physiotherapist, speech therapist and occupational therapist. At the *national level* doctor (general practitioner) are involved.

Rehabilitation services are available at community level through primary health care.

The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs.

Support services

Assistive devices and equipment for persons with disabilities are *partially* financed by social insurance schemes and persons with disabilities. Children and all adults are covered by social insurance schemes regarding the provision of assistive devices.

Personal assistance is provided at home, school, health and social service.

Personal assistance is financed by the following actors: *partially* by Government Ministries, social insurance schemes and persons with disabilities.

Support is provided to families with children with disabilities. This support is financed *fully* by Government Ministries and social insurance schemes.

Interpreter service (sign language and speech interpretation) is provided at school.

Interpreter service is financed *fully* by Government Ministries.

Personnel training

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: prosthetic/orthotic professionals, occupational therapists, physiotherapists.

The staff training programs are developed in consultation with organisations of persons with disabilities.

TONGA

Medical care

The medical care system in Tonga provides services for persons with disabilities; there is, however, a tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, treatment of impairment. It includes also programs for rehabilitation techniques and necessary referrals.

The organisations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Professionals paid by state expenditures, professionals paid by NGOs and voluntary workers of NGOs are *at all times* involved as medical care providers. Family members, and voluntary workers in the municipality are *often* involved as medical care providers.

Medical care is provided free of charge by Government Ministries.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, primary health care worker and physiotherapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and CBR.

Information in Braille, information on tape and easy reading information are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Tonga. Institutional rehabilitation programs exist at the national level. Community-base rehabilitation exists at the national level.

Between 21-40 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, primary health care worker, physiotherapist and speech therapist.

Rehabilitation services are available at community level through primary health care, through community-based rehabilitation and through NGOs.

The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *partially* financed by Government Ministries, social insurance schemes, persons with disabilities and NGOs.

The Government of Tonga is involved in the provision of assistive devices through development and production, distribution, maintenance and repair and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, visual devices, devices for daily living.

Personal assistance is provided at home, school, health and social service.

Personal assistance is financed by the following actors: *partially* by persons with disabilities and NGOs.

Support is provided to families with children with disabilities. This support is financed *partially* by Government Ministries, persons with disabilities and NGOs.

Interpreter service (sign language and speech interpretation) is provided at health and social service.

Interpreter service is financed *partially* by NGOs.

Personnel training

Government Ministries in Tonga ensure that all authorities/agencies providing services in the disability field give training to their personnel through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, occupational therapists, physiotherapists, social workers and community workers.

The staff training programs are developed in consultation with organisations of persons with disabilities.

VIETNAM

Medical care

The medical care system in Vietnam provides services for persons with disabilities; there is, however, a tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organisations of persons with disabilities are *often* involved in the planning and evaluation of the above mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members, voluntary workers in the municipality, professionals paid by the municipality, professionals paid by state expenditures, professionals paid by NGOs and voluntary workers of NGOs are *sometimes* involved as medical care providers.

Medical care is provided free of charge by Government Ministries, it is paid by social insurance schemes and partially paid by the patient.

Only working adults are covered by social insurance schemes. Between 0-20 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), CBR worker and nurse. At the *district level* are the following groups involved: doctor (general practitioner), specialised doctors, nurse, primary health care worker and physiotherapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, physiotherapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and CBR.

Information in Braille and sign language interpretation are services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Vietnam. Institutional rehabilitation programs exist at the provincial and national level. Community-based rehabilitation exist at the local, district, provincial and national level.

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g.

epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level*: doctor (general practitioner), nurse, CBR staff. At the *district level* are the following groups involved: doctor (general practitioner), nurse. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, physiotherapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, physiotherapist are involved.

Rehabilitation services are available at community level through primary health care, CBR and through NGOs

Persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors, counsellors and through CBR. The families of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors, counsellors and through CBR. The organisations of persons with disabilities participate in the provision of rehabilitation services through the design and organisation of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors, counsellors and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *partially* financed by Government Ministries, municipalities, persons with disabilities and NGOs. Only working adults are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Vietnam is involved in the provision of assistive devices through development and production, distribution, maintenance and repair and information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices, visual devices, devices for daily living.

Personal assistance is provided at home, school, work.

Personal assistance is financed by the following actors: *partially* by Government Ministries, municipalities, social insurance schemes, persons with disabilities and NGOs.

Support is provided to families with children with disabilities. This support is financed *partially* by Government Ministries, municipalities, social insurance schemes, persons with disabilities and NGOs.

Interpreter service (sign language and speech interpretation) is provided at home, school, work.

Interpreter service is financed *partially* by Government Ministries, municipalities, social insurance schemes, persons with disabilities and NGOs.

Persons with disabilities and/or their organisations are involved in the planning of support services.

Personnel training

Government Ministries in Vietnam ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries and through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic/orthotic professionals, occupational therapists, physiotherapists, social workers and community workers.

The staff training programs are developed in consultation with organisations of persons with disabilities.

Persons with disabilities are involved in staff training programs as teachers, instructors and as advisers.

PART III

Survey of NGO responses

Introduction

This part of the report analyses the responses of the questionnaire sent to 600 Non-Governmental Organizations within the disability field. One hundred fifteen responded. No comparison between the views of NGOs and of governments is made in this part. Hopefully this study can be made later on.

The distribution of NGOs in different regions according to socio-economic criteria and according to geographical indicators and according to the International Disabled Persons Organizations (IDPOs) they belong to is presented in tables A, B and C below.

The distribution of NGOs according to the international organization to which they belong is as follows:

Table A

International Disabled Persons Organizations

IDPO's	Frequency	Percent
Disabled Persons International (DPI)	18	15,7
Inclusion International (ILSMH)	28	24,3
Rehabilitation International (RI)	24	20,9
World Blind Union (WBU)	23	20,0
World Federation of the Deaf (WFD)	14	12,2
World Network of Users and Survivors of Psychiatry (WNUSP)	8	6,7
Total	115	100,0

The distribution of NGOs according to socio-economic criteria is as follows.

Table B

Classification of NGOs according to socio-economic criteria

Regions	Frequency	Percent
Developed market-economy countries (DMEC)	25	21,7
Economies in transition (ET)	22	19,1
Least developed countries (LDC)	21	18,3
Other developing countries (excluding least developed countries) (ODC)	47	40,9
Total	115	100,0

The distribution of NGOs according to geographical criteria is as follows.

Table C

Classification of NGOs according to geographical criteria

Regions	Frequency	Percent
Africa (AFR)	22	19,1
America (AMR)	21	18,3
Eastern Mediterranean Region (EMR)	10	8,7
Europe (EUR)	42	36,5
South East Asian Region (SEAR)	6	5,2
Western Pacific Region (WPR)	14	12,2
Total	115	100,0

MEDICAL CARE

Table 1 Question 1a

Countries with a medical care system that provides services to persons with disabilities

Services to persons with disabilities	Frequency	Percent
Provide	109	94,8
Do not provide	6	5,2
<i>Total</i>	115	100.0

Table 2 Question 1b

A tendency to treat them inside or outside this system

Treatment of persons with disabilities	Frequency	Percent
Outside	56	52,3
Inside	51	47,7
<i>Total</i>	107	100,0

Table 3 Question 2

Programs included in the medical care system

Programs for:	Frequency		Percent	
	Included	Not included	Included	Not included
Prevention of impairment	83	26	72,2	22,6
Early detection and diagnosis	86	25	74,8	21,7
Treatment	100	13	87,0	11,3
Rehabilitation techniques	89	19	77,4	16,5
Necessary referrals	77	24	67,0	20,9
Counseling for parents	67	38	58,3	33,0
N=113				

Table 4 Question 3

Involvement of organizations in planning and evaluation of these programs

Degree of involvement	Frequency	Percent
Always	2	1,8
Often	19	16,8
Sometimes	64	56,6
Never	28	24,3
<i>Total</i>	113	100,0

Table 5 Question 4

Early detection methods for children with disabilities

Detection methods performed at:	Frequency	Percent
0-6 months	67	58,3
6 months - 3 years	68	59,1
4 - 7 years	59	51,3
N=115		

Table 6 Question 5a

Medical care for children with disabilities within the general medical care system

Within the same system as for other children	Frequency	Percent
Provided	79	71,8
Not provided	31	28,2
Total	110	100,0

Table 7 Question 5b

Reasons not treating them within the same system

Reasons:	Frequency	Percent
Lack of specific programs	26	83,9
Lack of staff	13	41,9
Lack of training	15	48,4
Negative societal attitudes	14	45,2
Economic constraints in the family	18	58,1
N=31		

Table 8 Question 6a

Provision of regular medical treatment

Regular treatment	Frequency	Percent
Provided	77	68,8
Not provided	35	31,3
Total	112	100,0

Table 9 Question 6b

Reasons not providing regular medical treatment

Reasons:	Frequency	Percent
Lack of specific programs	28	80,0
Lack of staff	14	40,0
Lack of training	14	40,0
Negative societal attitudes	14	40,0
Economic constraints in the family	23	65,7
N=35		

Table 10 Question 7

Involvement of medical care providers

Medical care providers	At all times	Often	Sometimes	Not at all
Family members	30	27	36	10
Voluntary workers in the municipality	4	11	37	40
Professionals paid by municipality	17	23	27	22
Professionals paid by state expenditures	38	31	24	7
Professionals paid by NGOs	12	22	44	17
Voluntary workers of NGOs	6	12	46	25
N=115				

Table 11 Question 8

Medical care subsidies

Who pays for medical care	Frequency	Percent
Government Ministries	42	36,5
Social insurance schemes	52	45,2
Paid fully by the patient	31	27,0
Paid partially by the patient	75	65,2
N=115		

Table 12 Question 9

Groups covered by social insurance schemes

Different groups	Frequency	Percent
Children	52	100,0
All adults	42	80,8
Only working adults	36	69,2
Elderly	48	92,3
N=53		

Table 13 Question 10

Extent of the population covered by social insurance schemes

Extent:	Frequency	Percent
0-20 percent	15	20,5
21-40 percent	16	21,9
41-60 percent	6	8,2
61-80 percent	7	9,6
81-100 percent	29	39,7
Total	73	100,0

Table 14 Question 11

Medical and paramedical staff available at different levels in medical care

Professional support in medical care	Local level	District level	Provincial level	National level	Not included
Doctor (general practitioner)	85	64	56	59	1
Paediatrician	55	50	55	60	1
Other specialised doctors	28	43	52	60	4
CBR workers	37	34	22	24	20
Nurse	87	66	62	60	1
Psychologist	32	37	40	56	7
Primary health care worker	74	56	32	36	7
Physiotherapist	36	50	47	57	3
Speech therapist	30	41	34	52	8
Occupational therapists	33	34	31	48	7
N=115					

Table 15 Question 12a

Medical care services in poor and urban areas

Services in poor and urban areas	Frequency	Percent
Providing	100	89,3
Not providing	12	10,7
Total	112	100,0

Table 16 Question 12b

Forms of services provided

Different forms	Frequency	Percent
Primary health care	85	85,0
Community-based rehabilitation	31	31,0
Other	0	0,0
N=100		

Table 17 Question 13

Services to facilitate information and communication between persons with disabilities and others

Different levels	Frequency	Percent
Information in Braille	37	32,2
Information on tape	30	26,1
Sign language interpretation	43	37,4
Easy reading information	46	40,0
N=115		

REHABILITATION

Table 18 Question 14

National rehabilitation programs

Countries with rehabilitation programs	Frequency	Percent
Programs exist	69	62,2
Programs do no exist	42	37,8
Total	111	100,0

Table 19 Question 15

Institutional and community-based rehabilitation programs

Programs	Local level	District Level	Provincial level	National Level	Do not exist
Institutional rehabilitation	38	45	51	63	5
Community-based rehabilitation	44	35	25	25	22
N=115					

Table 20 Question 16

Percent of the population receiving rehabilitation

Receive rehabilitation	Frequency	Percent
Less than 5 percent	31	33,3
6-20 percent	24	25,8
21-40 percent	13	14,0
41-60 percent	6	6,5
61-80 percent	9	9,7
81-100 percent	10	10,8
Total	93	100,0

Table 21 Question 17

Rehabilitation services to different groups

Different groups	Frequency	Percent
Persons with mobility impairments	99	86,1
Persons with hearing impairments	86	74,8
Deaf people	85	73,9
Persons with severe sight impairment	89	77,4
Persons with intellectual disabilities	87	75,7
Persons with learning difficulties	69	60,0
Persons with disabilities due to chronic diseases	70	60,9
Persons with disabilities due to mental illness	77	67,0
Persons with multiple/severe disabilities	70	60,9
N=115		

Table 22 Question 18

Countries including all age groups in rehabilitation services

All age groups	Frequency	Percent
Included	79	73,1
Do not included	29	26,9
Total	108	100,0

Table 23 Question 19

Medical and paramedical staff available in rehabilitation

Professional groups in rehabilitation	Local level	District level	Provincial level	National level	Not included
Doctor (general practitioner)	53	43	45	54	3
Paediatrician	31	47	45	54	3
Other specialised doctors	27	38	41	55	1
Prosthetic/orthotic professional	17	28	45	64	3
Nurse	57	51	52	58	2
Psychologist	29	38	38	54	7
Primary health care worker	59	46	35	36	9
CBR staff	36	27	23	22	18
Physiotherapist	28	48	44	53	2
Speech therapist	20	34	35	53	9
Occupational therapists	28	35	41	53	6
N=117					

Table 24 Question 20a

Rehabilitation services at community level

Rehabilitation services	Frequency	Percent
Services exist	84	75,7
Services do not exist	27	24,3
Total	111	100,0

Table 25 Question 20b

Organization of rehabilitation services at community level

Organization of rehabilitation services through:	Frequency	Percent
Primary health care	35	41,7
Community-based rehabilitation	37	44,0
Non-Governmental Organizations	55	65,5
N=84		

Table 26 Question 21

Participation in rehabilitation services

Forms of participation	Persons with disabilities	Families of persons with disabilities	Organizations of persons with disabilities
Design and organization of rehabilitation services	32	39	72
Formulation and evaluation of rehabilitation programs	29	28	64
Involved as trained teachers, instructors and counsellors	40	31	63
Through community-based rehabilitation	33	35	43
N=115			

SUPPORT SERVICES

Table 27 Question 22

Arrangements for the financing of assistive devices and equipment

Financed by:	Fully	Partially	Not at all
Government Ministries	9	71	12
Municipalities	3	40	25
Social insurance schemes	7	56	15
Persons with disabilities pay by themselves	24	64	7
NGOs	9	70	8
N=115			

Table 28 Question 23

Groups covered by social insurance schemes concerning assistive devices

Groups:	Frequency	Percent
Children	40	63,5
All adults	33	52,4
Only working adults	33	52,4
Elderly	33	52,4
N=63		

Table 29 Question 24a

Government involvement in the provision of assistive devices

Government involvement	Frequency	Percent
Exist	77	74,0
Do not exist	27	26,0
Total	104	100,0

Table 30 Question 24b

Forms of Government involvement in the provision of assistive devices

Different forms:	Frequency	Percent
Development and production	39	50,6
Distibution	42	54,5
Maintenance and repair	40	51,9
Information about availability	44	57,1
N=77		

Table 31 Question 25

Kinds of assistive devices and equipment provided by the Government

Assistive devices/equipment	Frequency	Percent
Prostheses/orthoses	69	60,0
Wheelchairs	65	56,5
Crutches	63	54,8
Hearing devices	60	52,2
Visual devices	51	44,3
Devices for daily living	33	28,7
Computers	18	15,7
N=115		

Table 32 Question 26a

Provision of personal assistance

Personal assistance:	Frequency	Percent
Provided	68	64,2
Do not provided	38	35,8
Total	106	100,0

Table 33 Question 26b

At what activities is personal assistance provided

Provided at:	Frequency	Percent
Home	45	66,2
School	46	67,6
Work	38	55,9
During leisure	18	26,5
Health service	42	61,8
Social service	41	60,3
Other services in society	14	20,6
N=68		

Table 34 Question 27

Arrangements for financing personal assistance

Arrangements:	Fully	Partially	Not at all
Government Ministries	10	50	20
Municipalities	4	27	26
Social insurance schemes	5	33	26
Persons with disabilities pay by themselves	22	47	11
NGOs	11	48	13
N=115			

Table 35 Question 28a

Support to families with children with disabilities

Support is:	Frequency	Percent
Provided	77	71,3
Not provided	31	28,7
Total	108	100,0

Table 36 Question 28b

Arrangements for financing support to the families

Financed by:	Fully	Partially	Not at all
Government Ministries	9	50	4
Municipalities	4	31	9
Social insurance schemes	4	24	10
Persons with disabilities pay by themselves	11	35	4
NGOs	13	37	7
N=77			

Table 37 Question 29a

Provision of interpreter service

Interpreter service is:	Frequency	Percent
Provided	69	65,7
Not provided	36	34,3
Total	105	100,0

Table 38 Question 29b

At what activities is interpreter service provided

Provided at:	Frequency	Percent
Home	10	14,5
School	56	81,2
Work	26	37,7
During leisure	19	27,5
Health service	20	29,0
Social service	32	46,4
Other services in society	19	27,5
N=69		

Table 39 Question 30

Arrangements for financing interpreter service

Financed by:	Fully	Partially	Not at all
Government Ministries	17	26	15
Municipalities	6	10	16
Social insurance schemes	0	5	20
Persons with disabilities pay by themselves	9	27	11
NGOs	12	26	14
N=115			

Table 40 Question 31

Involvement of persons with disabilities and/or their organizations in the planning of support services

Planning of support services	Frequency	Percent
Involved	61	58,7
Do not involved	43	41,3
Total	104	100,0

PERSONNEL TRAINING

Table 41 Question 32a

Training to professionals in the disability field

Training is:	Frequency	Percent
Ensured	56	52,8
Do not ensured	50	47,2
Total	106	100,0

Table 42 Question 32b

How different forms of training are expressed

Expressed through:	Frequency	Percent
Policy adopted by Government Ministries	41	73,2
Supervision of training curriculum	30	53,6
N=56		

Table 43 Question 33

Disability issues in the training curriculum of personnel providing services

Professional groups	Is a component	Is not a component
Paediatrician	44	36
Other specialised doctors	52	30
General practitioners	41	38
Primary health care worker	39	37
Nurse	53	31
Prosthetic/orthotic professionals	66	17
Occupational therapists	65	21
Physiotherapist	69	9
Social workers	67	20
Community workers	38	28
N=115		

Table 44 Question 34

Training programs are developed in *consultation with organizations*

Organizations are:	Frequency	Percent
Consulted	29	27,4
Not consulted	77	72,6
Total	106	100,0

Table 45 Question 35a

Involvement in staff training programs

Organizations are:	Frequency	Percent
Involved	44	42,7
Not involved	59	57,3
Total	103	100,0

Table 46 Question 35b

Involvement in staff training programs

Involved as	Frequency	Percent
Teachers	23	52,3
Instructors	20	45,5
Advisors	30	68,2
N=44		

ANNEX I Questionnaire



**QUESTIONNAIRE TO ALL GOVERNMENTS OF MEMBER
STATES OF THE WHO**

Country:

Name of Ministry:

Address:

Contact person:

Tel no:

Fax no:

E-mail:

**Questionnaire to be returned at latest 30th April to
WHO
Disability and Rehabilitation Team
Avenue Appia 20
CH-1211 Geneva 27
Switzerland
Fax no: 41 22 791 48 74**

Please read this before answering the questionnaire

In 1993, the General Assembly of the United Nations adopted the Standard Rules (Resolution 48/96 of 20 December 1993). The main purpose of the Standard Rules is to facilitate for Member States to adopt policies, programmes and measures in order to achieve Full Participation and Equality for Persons with Disabilities. One important feature of the Standard Rules is that the United Nations and the specialized agencies should actively monitor the implementation.

In 1997, the UN Special Rapporteur on Disability, Mr. Bengt Lindqvist, in consultation with his Panel of Experts, requested WHO to provide assistance to him. The World Health Organization is therefore presently monitoring the implementation of four rule areas of the UN Standard Rules. The objective of the study is twofold:

- to identify various government policies regarding medical care, rehabilitation, support services and personnel training for persons with disabilities
- to identify various strategies adopted and problems encountered when working in the field of medical care and rehabilitation of persons with disabilities

WHO will perform this task through collecting information based on the four rules Medical Care, Rehabilitation, Support Services and Personnel Training. For this purpose we have elaborated a questionnaire to be sent to all Member States.

You are kindly asked to answer this questionnaire in order to help us identify the official policy of your country. You are not asked to give your personal opinion but to quote the official opinion. In some instances interpretations of official documents and policies may be necessary so that the official policy can be clearly stated.

Since the Standard Rules stress the importance of the involvement of persons with disabilities, their families and their organizations in all matters that relate to them, the questionnaire will also be sent to International Disabled Peoples' Organizations (IDPOs). The selected IDPOs all belong to the international organizations represented in the above mentioned Panel of Experts. The same procedure has been utilized in previous surveys of the UN Special Rapporteur on Disability.

Results of the survey will be presented by the UN Special Rapporteur on Disability in his report to the UN Commission for Social Development as well as in a report from WHO at the end of this year. It is also the intention of the Special Rapporteur to publish guidelines concerning the above areas. Such guidelines have to be based on an accurate knowledge of the situation in a number of countries, since traditions and cultural values differ between countries in the WHO Member States.

We are aware of your interest in this field and are therefore asking for your assistance in our effort to identify the government policy in your country. We thank you in advance for your kind co-operation and trust that you will return this questionnaire as soon as possible and at the latest before 30h of April.

Definition of terms

With **Governments** is understood government ministries or bodies representing ministries on national, regional or local level (e.g. counties and municipalities).

The term “**disability**“ summarizes a great number of different functional limitations occurring in any population in any country of the world. People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness. Such impairments, conditions or illnesses may be permanent or transitory in nature.

The term “**handicap**“ means the loss or limitation of opportunities to take part in the life of the community on an equal level with others. It describes the encounter between the person with a disability and the environment. The purpose of this term is to emphasize the focus on the shortcomings in the environment and in many organized activities in society, for example, information, communication and education, which prevent persons with disabilities from participating on equal terms.

The term “**rehabilitation**“ refers to a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric and/or social functional levels, thus providing them with the tools to change their lives towards a higher level of independence. Rehabilitation may include measures to provide and/or restore functions, or compensate for the loss or absence of a function or for a functional limitation. It includes a wide range of measures and activities from more basic and general rehabilitation to goal-oriented activities, for instance vocational rehabilitation. The rehabilitation process does not, however, involve initial medical care.

The term “**equalization of opportunities**“ means the process through which the various systems of society and the environment, such as services, activities, information and documentation, are made available to all, particularly to persons with disabilities.

Community-Based Rehabilitation, CBR, is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services.

The term “**personal assistance**“ refers to assistance provided to a person (child, youth or adult) with multiple/severe disability according to his or her needs.

Rule 2. Medical care

States should ensure the provision of effective medical care to persons with disabilities.

Most questions can be answered by ticking the appropriate alternative. In some questions more than one answer may be ticked or there is an alternative to answer with your own words. Please read the instructions carefully and do not rush. It will only take a very limited amount of time to complete the questionnaire.

1. Does the medical care system in your country provide services for persons with disabilities?

- 1 Yes ——— If yes, ———> Is there a tendency to treat certain groups of persons with disabilities outside the general medical care services?
2 No
- 1 Yes
2 No

2. Does the medical care system include programs for:

MARK ALL THAT APPLY

- | | | |
|---------------------------------------------|--------------------------------|-------------------------------|
| Prevention of impairment | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| Early detection and diagnosis of impairment | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| Treatment of impairment | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| Rehabilitation techniques | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| Necessary referrals | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |
| Counseling for parents | 1 <input type="checkbox"/> Yes | 2 <input type="checkbox"/> No |

3. Are organizations of persons with disabilities involved in the planning and evaluation of the above mentioned programs?

- 1 Always
- 2 Often
- 3 Sometimes
- 4 Never

4. If there are early detection methods for children with disabilities at what stage are they performed?

- 1 When the child is born (0-6 months)
- 2 Mother and child health care (6 months - 3 years)
- 3 Health care in pre-school/school age (4-7 years)

5. Are infants and children with disabilities provided medical care within the same system as other infants and children?

1 Yes

2 No — If no, why? —>

MARK ALL THAT APPLY

- 1 Due to lack of specific programs
- 2 Due to lack of staff
- 3 Due to lack of training
- 4 Due to societal attitudes
- 5 Difficulties in the families due to economic constraints
- 6 Due to other reasons. Please specify:

6. Are persons with disabilities provided with regular medical treatment (e.g. for epilepsy or diabetes) to preserve or improve the level of functioning?

1 Yes

2 No — If no, why? —>

MARK ALL THAT APPLY

- 1 Due to lack of specific programs
- 2 Due to lack of staff
- 3 Due to lack of training
- 4 Due to societal attitudes
- 5 Difficulties in the families due to economic constraints
- 6 Due to other reasons. Please specify:

7. How often are the following medical care providers involved?

Care providers	At all times	Often	Some-times	Not at all
Family members	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Voluntary workers in the municipality	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Professionals paid by municipality	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Professionals paid by state expenditures	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Professionals paid by NGOs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
Voluntary workers of NGOs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

8. Is medical care subsidised in any way?

MARK ALL THAT APPLY

- It is provided free of charge by Government Ministries 1
- It is paid by social insurance schemes 2
- It is paid fully by the patient 3
- It is paid partially by the patient 4
- Other. Please specify: 5

9. Who are covered by social insurance schemes?

Please answer only if the health care in your country is paid by social insurance schemes.

MARK ALL THAT APPLY

- Children 1
- All adults 2
- Only working adults 3
- Elderly 4

10. What is the percentage of the population covered by social insurance schemes?

- 0-20 percent 1
- 21-40 percent 2
- 41-60 percent 3
- 61-80 percent 4
- 81-100 percent 5

11. What medical and paramedical staffs are available at different levels in the medical care of your country?

MARK ALL THAT APPLY

Professional support in medical care	Local level	District level	Provincial level	National level	Not included
Doctor (general practitioner)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Paediatrician	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Other specialised doctors	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
CBR workers	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Nurse	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Psychologist	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Primary health care worker	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Physiotherapist	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Speech therapist	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Occupational therapist	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Other. Please specify:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

12. Does medical care services reach villages and poor urban areas?

1 Yes _____ If yes, in what form? _____→

2 No

1

Primary health care

2

Community Based rehabilitation

3

Other. Please specify:

13. Which of the following services are provided in order to facilitate information and communication between persons with disabilities and staff in health care?

MARK ALL THAT APPLY

Information in Braille 1

Information on tape 2

Sign language interpretation 3

Easy reading information 4

Rule 3. Rehabilitation

States should ensure the provision of rehabilitation services to persons with disabilities in order for them to reach and sustain their optimum level of independence and functioning.

14. Is there a national rehabilitation program for persons with disabilities in your country?

- 1 Yes
2 No

15. At what levels do you have institutional and community-based rehabilitation programs in your country?

MARK ALL THAT APPLY

Programs	Local level	District level	Provincial level	National level	Do not exist
Institutional rehabilitation	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Community-based rehabilitation	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

16. What is the percentage of persons with disabilities receiving rehabilitation in your country?

- Less than 5 percent 1
6-20 percent 2
21- 40 percent 4

41- 60 percent 5
61 - 80 percent 6
81 - 100 percent 7

17. What groups of persons with disabilities receive rehabilitation services?

MARK ALL THAT APPLY

- Persons with mobility impairments 1
- Persons with hearing impairments 2
- Deaf people 3
- Persons with severe sight impairment (blind) 4
- Persons with intellectual disabilities (mental handicap) 5
- Persons with learning difficulties (e.g. dyslexia) 6
- Persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes) 7
- Persons with disabilities due to mental illness (e.g. schizophrenia) 8
- Persons with multiple/severe disabilities 9

18. Are all age groups included in rehabilitation services?

- 1 Yes
- 2 No _____ If no, please specify _____ →

19. What medical and paramedical staff are available at different levels in rehabilitation?

MARK ALL THAT APPLY

Professional support in rehabilitation	Local level	District level	Provincial level	National level	Not included
Doctor (general practitioner)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Paediatrician	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Other specialised doctors	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Prosthetic/orthotic professional	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Nurse	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Psychologist	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Primary health care worker	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
CBR staff	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Physiotherapist	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Occupational therapist	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Speech therapist	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
Other. Please specify:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

20. Are rehabilitation services available at community level?

1 Yes

2 No

If yes, how are they organized

1 Through primary health care (PHC)

2 Through community-based rehabilitation (CBR)

3 Through Non-Governmental Organizations

4 Other. Please specify:

21. How do persons with disabilities, their families and organizations of persons with disabilities participate in the provision of rehabilitation in your country?

MARK ALL THAT APPLY

	Persons with disabilities	Families of persons with disabilities	Organizations of persons with disabilities
They participate in the design and organization of rehabilitation services	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
They are involved in the formulation and evaluation of rehabilitation programs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
They are involved in rehabilitation as trained teachers, instructors, counselors	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
They participate through CBR	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other. Please specify:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

4. Support services

States should ensure the development and supply of support services, including assistive devices for persons with disabilities, to assist them to increase their level of independence in their daily living and to exercise their rights.

22. What arrangements exist for the financing of assistive devices and equipment for persons with disabilities?

Financing of assistive devices	Fully	Partially	Not at all
Government Ministries	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Municipalities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Social insurance schemes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Persons with disabilities pay by themselves	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
NGOs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other. Please specify:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

23. Who are covered, if the assistive devices are paid by social insurance schemes?

Please answer only if the health care in your country is paid by social insurance schemes.

- 1 Children
- 2 All adults
- 3 Only working adults

- 4 Elderly

24. Is your Government involved in the provision of assistive devices?

- 1 Yes _____ If yes, through _____ →
- 2 No → (If no, pass to q. 26)

MARK ALL THAT APPLY

- Development and production of assistive devices 1
- Distribution of assistive devices 2
- Maintenance and repair of assistive devices 3

- Information about availability of assistive devices 4
- Other. Please specify: 5

25. What kind of assistive devices/equipment does your Government provide?

MARK ALL THAT APPLY

- Prostheses/Orthoses 1
Wheelchairs 2
Crutches 3

Hearing devices 4
Visual devices 5
Devices for daily living 6

Computers 7
Other. Please specify: 8

26. Is personal assistance provided?

1 Yes _____ If yes, where? _____ →

2 No **MARK ALL THAT APPLY**

- At home 1
At school 2
At work 3

During leisure 4
At health service 5
At social service 6

At other services in society 7

27. What arrangements exist for the financing of personal assistance for persons with disabilities?

Financing of personal assistance	Fully	Partially	Not at all
Government Ministries	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Municipalities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Social insurance schemes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Persons with disabilities pay by themselves	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
NGOs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other. Please specify:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

28. Is support provided to families with children with disabilities?

1 Yes — If yes, —————> How is it financed?

1 No

MARK ALL THAT APPLY

	Fully	Partially	Not at all
Government Ministries	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Municipalities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Social insurance schemes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Persons with disabilities pay by themselves	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
NGOs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other. Please specify:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

29. Is interpreter service (sign language and speech interpretation) provided?

1 Yes ————— If yes, where? —————>

2 No

MARK ALL THAT APPLY

At home	1 <input type="checkbox"/>
At school	2 <input type="checkbox"/>
At work	3 <input type="checkbox"/>
During leisure	4 <input type="checkbox"/>
At health service	5 <input type="checkbox"/>
At social service	6 <input type="checkbox"/>
At other services in society	7 <input type="checkbox"/>

30. Who pays for interpreter service?

	Fully	Partially	Not at all
Government Ministries	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Municipalities	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Social insurance schemes	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Persons with disabilities pay by themselves	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
NGOs	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Other. Please specify:	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

31. Are persons with disabilities and/or their organizations involved in the planning of support services?

1 Yes

2 No

Rule 19. Personnel training

States are responsible for ensuring the adequate training of personnel, at all levels, involved in the planning and provision of programs and services concerning persons with disabilities.

32. Do Government Ministries in your country ensure that all authorities/agencies providing services in the disability field give training to their personnel?

1 Yes _____ If yes, how is it expressed? _____→

2 No

Through policy adopted by Government Ministries 1
Through supervision of training curriculum for medical and paramedical staff 2
Other. Please specify: 3

33. Are disability issues a component in the training curriculum of personnel providing services to persons with disabilities?

MARK ALL THAT APPLY

Professional groups	Yes	No
Paediatrician	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Other specialized doctors	1 <input type="checkbox"/>	2 <input type="checkbox"/>
General practitioners	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Primary health care workers	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Nurses	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Prosthetic and orthotic professionals	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Occupational therapists	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Physiotherapists	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Social workers	1 <input type="checkbox"/>	2 <input type="checkbox"/>
Community workers	1 <input type="checkbox"/>	2 <input type="checkbox"/>

34. Are the staffs training programs developed in consultation with organizations of persons with disabilities?

1 Yes

2 No

35. In what roles are persons with disabilities involved in staff training programs?

1 Yes _____ If yes, _____ → **MARK ALL THAT APPLY**

2 No

1 As teachers

2 As instructors

3 As advisers

4 Other. Please specify

ANNEX II Countries from which government responses received

Government responses were received from the following countries			
Algeria	Estonia	Mali	Republic of Korea
Armenia	Ethiopia	Malta	Rwanda
Austria	Fiji	Marshall Islands	Saint Kitts and Nevis
Bahamas	Finland	Mauritania	Saint Lucia
Bahrain	France	Mexico	Saudi Arabia
Belarus	Gambia	Mongolia	Seychelles
Belgium	Ghana	Morocco	Singapore
Belize	Grenada	Mozambique	Slovakia
Botswana	Honduras	Myanmar	South Africa
Bulgaria	Ireland	Namibia	Spain
Burkina Faso	Israel	Nauru	Sweden
Cameroon	Japan	Nepal	Switzerland
Chad	Jordan	Netherlands	Syrian Arab Republic
Chile	Kenya	New Caledonia	Tahiti French Polynesia
China	Kiribati	New Zealand	Tanzania
Comoros	Kuwait	Nicaragua	Thailand
Cook Islands	Laos	Niger	Togo
Costa Rica	Latvia	Northern Mariana Islands	Tonga
Côte d' Ivoire	Lebanon	Norway	Uganda
Cyprus	Lesotho	Oman	United Arab Emirates
Czech Republic	Liberia	Palau	United Kingdom
Denmark	Lithuania	Panama	United States of America
Djibouti	Luxembourg	Paraguay	Uruguay
Dominica	Madagascar	Philippines	Vietnam
Dominican Republic	Malaysia	Poland	Zambia
El Salvador	Maldives	Portugal	Zimbabwe

Total 104 country responses

ANNEX III Government and/or NGO responses

Table 1

Countries from which Government and/or NGOs responses received	Government response	Number of NGO responses received
Algeria	Yes	0
Angola	No	2
Antilles	No	1
Armenia	Yes	0
Austria	Yes	0
Azerbaijan	No	1
Bahamas	Yes	0
Bahrain	Yes	0
Bangladesh	No	1
Barbados	No	1
Belarus	Yes	1
Belgium	Yes	0
Belize	Yes	0
Benin	No	2
Bolivia	No	1
Botswana	Yes	0
Bulgaria	Yes	1
Burkina Faso	Yes	0
Cameroon	Yes	0
Canada	No	1
Cape Verde	No	1
Chad	Yes	0
Chile	Yes	2
China	Yes	4
Comoros	Yes	0
Cook Islands	Yes	0
Costa Rica	Yes	1
Côte d' Ivoire	Yes	0
Cyprus	Yes	0
Czech Republic	Yes	2
Denmark	Yes	2
Djibouti	Yes	0
Dominica	Yes	0
Dominican Republic	Yes	2
Egypt	No	1
El Salvador	Yes	3
Estonia	Yes	1
Ethiopia	Yes	1
Fiji	Yes	3
Finland	Yes	3
France	Yes	3
Gambia	Yes	0
Germany	No	1

Ghana	Yes	2
Greece	No	1
Grenada	Yes	0
Haiti	No	1
Honduras	Yes	1
Indonesia	No	1
Iran	No	2
Ireland	Yes	1
Israel	Yes	1
Jamaica	No	1
Japan	Yes	3
Jordan	Yes	0
Kenya	Yes	1
Kiribati	Yes	0
Kuwait	Yes	1
Laos	Yes	0
Latvia	Yes	0
Lebanon	Yes	1
Lesotho	Yes	2
Liberia	Yes	1
Lithuania	Yes	0
Luxembourg	Yes	0
Madagascar	Yes	2
Malaysia	Yes	1
Maldives	Yes	0
Mali	Yes	1
Malta	Yes	1
Marshall Islands	Yes	0
Mauritania	Yes	3
Mexico	Yes	1
Moldova	No	2
Mongolia	Yes	0
Morocco	Yes	1
Mozambique	Yes	1
Myanmar	Yes	0
Namibia	Yes	0
Nauru	Yes	0
Nepal	Yes	2
Netherlands	Yes	1
New Caledonia	Yes	0
New Zealand	Yes	1
Nicaragua	Yes	2
Niger	Yes	0
Nigeria	No	1
Northern Mariana Islands	Yes	0
Norway	Yes	1
Oman	Yes	0
Pakistan	No	2

Palau	Yes	0
Panama	Yes	1
Paraguay	Yes	1
Philippines	Yes	0
Poland	Yes	1
Portugal	Yes	0
Republic of Korea	Yes	2
Romania	No	3
Russian Federation	No	5
Rwanda	Yes	0
Saint Kitts and Nevis	Yes	0
Saint Lucia	Yes	0
Saudi Arabia	Yes	0
Senegal	No	1
Seychelles	Yes	0
Singapore	Yes	0
Slovakia	Yes	2
Slovenia	No	1
Somalia	No	1
South Africa	Yes	1
Spain	Yes	0
Sri Lanka	No	1
Sweden	Yes	3
Switzerland	Yes	0
Syrian Arab Republic	Yes	1
Tahiti French Polynesia	Yes	0
Tanzania	Yes	0
Thailand	Yes	1
The former Yugoslav Republic of Macedonia	No	2
Togo	Yes	0
Tonga	Yes	0
Uganda	Yes	0
United Arab Emirates	Yes	0
United kingdom	Yes	2
United States of America	Yes	1
Uruguay	Yes	0
Vietnam	Yes	0
Zambia	Yes	0
Zimbabwe	Yes	0

Total 115 responses from NGOs, which came from 74 countries. From 130 countries Government and/or NGO response was received. From 26 countries NGO response(s) were received but no Government response. From 56 countries no NGO response was received.

Table 2

Number of NGO responses	Number of countries
None NGO response	56
One NGO response	46
Two NGO responses	18
Three NGO responses	8
Four NGO responses	1
Five NGO responses	1

Table 3

Countries from which no Government response was received			
Angola	Canada	Iran	Senegal
Antilles	Cape Verde	Jamaica	Slovenia
Azerbaijan	Egypt	Moldova	Somalia
Bangladesh	Germany	Nigeria	Sri Lanka
Barbados	Greece	Pakistan	The former Yugoslav
Benin	Haiti	Romania	Republic of Macedonia
Bolivia	Indonesia	Russian Federation	
Total 26 countries			

Table 4

Countries from which no NGO response(s) received			
Algeria	Cyprus	Myanmar	Seychelles
Armenia	Djibouti	Namibia	Singapore
Austria	Dominica	Nauru	Spain
Bahamas	Gambia	New Caledonia	Switzerland
Bahrain	Grenada	Niger	Tahiti French Polynesia
Belgium	Jordan	Northern Mariana Islands	Tanzania
Belize	Kiribati	Oman	Togo
Botswana	Laos	Palau	Tonga
Burkina Faso	Latvia	Philippines	Uganda
Cameroon	Lithuania	Portugal	United Arab Emirates
Chad	Luxembourg	Rwanda	Uruguay
Comoros	Maldives	Saint Kitts and Nevis	Vietnam
Cook Islands	Marshall Islands	Saint Lucia	Zambia
Côte d' Ivoire	Mongolia	Saudi Arabia	Zimbabwe
Total 56 countries			

ANNEX IV Alphabetic order according to organization's name

Table 1

Name of Non-Governmental Organizations	IDPO's	Country
A.B.I.F.A.	DPI	Paraguay
ACOGIPRI		El Salvador
All Russian Society of the Deaf	WFD	Russian Federation
All Russian Society of Disabled People	DPI	Russian Federation
Alliance of Organizations of Disabled People in Slovakia	DPI	Slovakia
All-Russian Association of the Blind	WBU	Russian Federation
Asociación de padres de familia	ILSMH	Nicaragua
Asociation Boliviana de Padres y Amigos de Personas con Discapacidad Mental	ILSMH	Bolivia
Asociation de Pachs de Familia con Discapacidad	ILSMH	Nicaragua
Asociation Dominicana de Rehabilitation	RI	Dominican Republic
Asociation Dominicana de Rehabilitation	RI	Dominican Republic
Asociation National de Discapitados	DPI	Chile
Asociation Salvadorena de Sordos	WFD	El Salvador
Associacad National de Deficientes Angolauas	DPI	Angola
Associacados Deficientes Mozambicanos	DPI	Mozambique
Associagao Caboverdeana de Deficients	DPI	Cape Verde
Associo Nacional de Apoio aos Deficientes Visuals	WBU	Angola
Association Beninoise Pour Handicapes Mentaux	ILSMH	Benin
Association des Amis et Parents d'Enfants Handicapes Mentaux de Madagascar	ILSMH	Madagascar
Association Des Parents Et Amis D' Enfants Inadaptes	ILSMH	Morocco
Association Familiale Malgache pour l Aide aux Handicapes Mentaux	ILSMH	Madagascar
Association for the Physically Disabled of Kenya	RI	Kenya
Association Haitienne pour la rehabilitation des handicapes	RI	Haiti
Association Nationale des aveugles de Mauritanie	WBU	Mauritania
Association Nationale des Sourds du Senegal	WFD	Senegal
Association of parents and friends of persons with a mental disability	ILSMH	Antilles
Association of the Blind and Partially Sighted of Slovenia	WBU	Slovenia
Association of the Deaf and Hard of Hearing Persons of Macedonia	WFD	The former Yugoslav Republic of Macedonia
Association pour la Promotion et l' Integration Sociale des Aveugles et Ambyopes du Benin	WBU	Benin
ATHAREP	WNUSP	France
Azerbaijan Association of the Blind	WBU	Azerbaijan
Bancroft Neuro-Health	ILSMH	United States of America
Barbados Council for the Disabled	RI	Barbados
Belarusian Association of Assistance to Handicapped Children	ILSMH	Belarus
Brotherhood Link International	RI	Ghana
Canadian Council of the Blind	WBU	Canada

Center for Advice, Training, Studies on Mental Retardation	ILSMH	Egypt
Central Board of Moldavian Blind Union	WBU	Moldova
Centro National de rehabilitation	RI	Costa Rica
Christian Health Association of Lesotho	WNUSP	Lesotho
CLIMAX	WNUSP	Greece
Confederation Mexicana de organizaciones en Favor de la Persona con Discapacidad Intelectual, A.C.	ILSMH	Mexico
CUN	WNUSP	Netherlands
Dansk Blindesamfund	WBU	Denmark
Danske Döves Landsforbund	WFD	Denmark
Disabled Persons Federation	DPI	China
Estonian Mentally Disabled People Support Organization	ILSMH	Estonia
Ethiopians National Association of the Deaf	WFD	Ethiopia
Federation Malenne des Associations de Personnes Handikapees	DPI	Mali
Federation Salvadorena de Entidades de Padres y Amicos de Personas con Discapacidad	ILSMH	El Salvador
Fiji National Council for Disabled Persons	RI	Fiji
Finnish Association for Mental Health	ILSMH	Finland
Founds National de la Discapacidad	ILSMH	Chile
FUHRIL	WNUSP	Honduras
Ghana National Association of the Deaf	WFD	Ghana
Goodwill Industries of Thailand, National council on Social Welfare of Thailand	RI	Thailand
Groupement Francais des Personnes Handikapées	DPI	France
Handikappförbundens Samarbetsorgan	DPI	Sweden
Hong Chi Association	ILSMH	China
HUMANITAS	ILSMH	Moldova
ICH	ILSMH	New Zealand
Indonesian Society for the Care of Children	RI	Indonesia
Instituto Panameno de Habilitacion Especial	RI	Panama
Interessenvertretung Selbstbestimmt Leben	DPI	Germany
Interregional Union of Life Help for Mentally Handicapped persons	ILSMH	Russian Federation
Iran welfare Organization	RI	Iran
Jamaica Association for Persons with Mental Retardation	ILSMH	Jamaica
Japanese Society for Rehabilitation of Persons with Disabilities	RI	Japan
Joint Council for the Physically and mentally Disabled Hong Kong	RI	China
Korea Blind Union	WBU	Republic of Korea
Korean Society for Rehabilitation of Persons with Disabilities	RI	Republic of Korea
Kuwait Society for the Handicapped	RI	Kuwait
Lesotho Society for Mentally Handicapped Persons	ILSMH	Lesotho
Liberia Christian Association of the Blind	WBU	Liberia
Malaysian Leprosy Relief Association	RI	Malaysia
NAMHI	ILSMH	Ireland
National Association of the Disabled in Finland	RI	Finland
National Federation of the Blind	WBU	Bangladesh
National Federation of the Disabled	DPI	Nepal
National Rehabilitation Medicine Hospital	WNUSP	Fiji
Nepal Association of the Blind	WBU	Nepal
NGO (No name reported)	WNUSP	Japan

NGO (No name reported)	DPI	Malta
Nigeria Association of the Blind	WBU	Nigeria
Pakistan Association of the Deaf	WFD	Pakistan
Polish Association of the Blind	WBU	Poland
Rehab. Inv	RI	Mauritania
Republic Centre for Helping Persons with Mental Handicap	ILSMH	The former Yugoslav Republic of Macedonia
Romanian National Association of the Deaf	WFD	Romania
Royal National Institute for the Blind	WBU	United Kingdom
Slovak Union of the Deaf and Hard of Hearing	WFD	Slovak Republic
Societatea Romana Speranta	ILSMH	Romania
Somali Society of the Blind	WBU	Somalia
Sri Lanka Confederation of Organizations of the Handicapped People	DPI	Sri Lanka
Syrian Federation of Deaf and Mute Welfare Societies	WFD	Syria
The association of Disabled Persons	RI	Czech Republic
The Board of Representatives from the Organizations of Disabled People	RI	Czech Republic
The Centre for the Blind in Israel	WBU	Israel
The Finish Federation of the Visually Impaired	WBU	Finland
The Hong Kong Society of the Blind	WBU	China
The National Council for Persons with Physical Disabilities in South Africa	RI	South Africa
The National Organizations of Disabled People in Romania	DPI	Romania
The Norwegian Association of the Deaf	WFD	Norway
The Pakistan Society for the Rehabilitation of the Disabled	RI	Pakistan
The Swedish Association of the Visually Impaired	WBU	Sweden
The Swedish National Society for Persons with Mental Handicap	ILSMH	Sweden
UK Advocacy Network, Mental Health Service Users	WNUSP	United Kingdom
UNAPEI	ILSMH	France
Union Nationale des Handicapes de Mauritanie	DPI	Mauritania
Union of the Deaf in Bulgaria	WFD	Bulgaria
United Blind Persons of Fiji	WBU	Fiji
We to children	ILSMH	Russian Federation
Welfare Organization	RI	Iran
World Federation of the Deaf Regional Secretariat in Asia/Pacific	WFD	Japan
Youth Association of the Blind	WBU	Lebanon

Total 115

Alphabetic order according to country's name

Table 2

Name of Non-Governmental Organizations	IDPO's	Country
Associaçad National de Deficientes Angolauas	DPI	Angola
Associao Nacional de Apoio aos Deficientes Visuais	WBU	Angola
Association of parents and friends of persons with a mental disability	ILSMH	Antilles
Azerbaijan Association of the Blind	WBU	Azerbaijan
National Federation of the Blind	WBU	Bangladesh
Barbados Council for the Disabled	RI	Barbados
Belarusian Association of Assistance to Handicapped Children	ILSMH	Belarus
Association Beninoise Pour Handicapes Mentaux	ILSMH	Benin
Association pour la Promotion et l' Integration Sociale des Aveugles et Ambyopes du Benin	WBU	Benin
Asociation Boliviana de Padres y Amigos de Personas con Discapacidad Mental	ILSMH	Bolivia
Union of the Deaf in Bulgaria	WFD	Bulgaria
Canadian Council of the Blind	WBU	Canada
Associagao Caboverdeana de Deficientes	DPI	Cape Verde
Asociation Nacional de Discapacitados	DPI	Chile
Founds Nacional de la Discapacidad	ILSMH	Chile
Disabled Persons Federation	DPI	China
Hong Chi Association	ILSMH	China
Joint Council for the Physically and mentally Disabled Hong Kong	RI	China
The Hong Kong Society of the Blind	WBU	China
Centro Nacional de rehabilitation	RI	Costa Rica
The association of Disabled Persons	RI	Czech Republic
The Board of Representatives from the Organizations of Disabled People	RI	Czech Republic
Dansk Blindesamfund	WBU	Denmark
Danske Döves Landsforbund	WFD	Denmark
Asociation Dominicana de Rehabilitation	RI	Dominican Republic
Asociation Dominicana de Rehabilitation	RI	Dominican Republic
Center for Advice, Training, Studies on Mental Retardation	ILSMH	Egypt
ACOGIPRI		El Salvador
Asociation Salvadorena de Sordos	WFD	El Salvador
Federation Salvadorena de Entidades de Padres y Amicos de Personas con Discapacidad	ILSMH	El Salvador
Estonian Mentally Disabled People Support Organization	ILSMH	Estonia
Ethiopians National Association of the Deaf	WFD	Ethiopia
Fiji National Council for Disabled Persons	RI	Fiji
National Rehabilitation Medicine Hospital	WNUSP	Fiji
United Blind Persons of Fiji	WBU	Fiji
Finnish Association for Mental Health	ILSMH	Finland
National Association of the Disabled in Finland	RI	Finland
The Finish Federation of the Visually Impaired	WBU	Finland
ATHAREP	WNUSP	France
Groupement Francais des Personnes Handikapées	DPI	France
UNAPEI	ILSMH	France
Interessenvertretung Selbstbestimmt Leben	DPI	Germany
Brotherhood Link International	RI	Ghana

Ghana National Association of the Deaf	WFD	Ghana
CLIMAX	WNUSP	Greece
Association Haitienne pour la rehabilitation des handicapes	RI	Haiti
FUHRIL	WNUSP	Honduras
Indonesian Society for the Care of Children	RI	Indonesia
Iran welfare Organization	RI	Iran
Welfare Organization	RI	Iran
NAMHI	ILSMH	Ireland
The Centre for the Blind in Israel	WBU	Israel
Jamaica Association for Persons with Mental Retardation	ILSMH	Jamaica
Japanese Society for Rehabilitation of Persons with Disabilities	RI	Japan
NGO (No name reported)	WNUSP	Japan
World Federation of the Deaf Regional Secretariat in Asia/Pacific	WFD	Japan
Association for the Physically Disabled of Kenya	RI	Kenya
Kuwait Society for the Handicapped	RI	Kuwait
Youth Association of the Blind	WBU	Lebanon
Christian Health Association of Lesotho	WNUSP	Lesotho
Lesotho Society for Mentally Handicapped Persons	ILSMH	Lesotho
Liberia Christian Association of the Blind	WBU	Liberia
Association des Amis et Parents d'Enfants Handicapes Mentaux de Madagascar	ILSMH	Madagascar
Association Familiale Malgache pour l Aide aux Handicapes Mentaux	ILSMH	Madagascar
Malaysian Leprosy Relief Association	RI	Malaysia
Federation Malenne des Associations de Personnes Handikapees	DPI	Mali
NGO (No name reported)	DPI	Malta
Association Nationale des aveugles de Mauritanie	WBU	Mauritania
Rehab. Inv	RI	Mauritania
Union Nationale des Handicapes de Mauritanie	DPI	Mauritania
Confederation Mexicana de organizaciones en Favor de la Persona con Discapacidad Intelectual, A.C.	ILSMH	Mexico
Central Board of Moldavian Blind Union	WBU	Moldova
HUMANITAS	ILSMH	Moldova
Association Des Parents Et Amis D' Enfants Inadaptes	ILSMH	Morocco
Associacados Deficientes Mozambicanos	DPI	Mozambique
National Federation of the Disabled	DPI	Nepal
Nepal Association of the Blind	WBU	Nepal
CUN	WNUSP	Netherlands
ICH	ILSMH	New Zealand
Asociación de padres de familia	ILSMH	Nicaragua
Asociation de Pachs de Familia con Discapacidad	ILSMH	Nicaragua
Nigeria Association of the Blind	WBU	Nigeria
The Norwegian Association of the Deaf	WFD	Norway
Pakistan Association of the Deaf	WFD	Pakistan
The Pakistan Society for the Rehabilitation of the Disabled	RI	Pakistan
Instituto Panameno de Habilidadacion Especial	RI	Panama
A.B.I.F.A.	DPI	Paraguay
Polish Association of the Blind	WBU	Poland
Korea Blind Union	WBU	Republic of Korea
Korean Society for Rehabilitation of Persons with Disabilities	RI	Republic of Korea
Romanian National Association of the Deaf	WFD	Romania

Societatea Romana Speranta	ILSMH	Romania
The National Organizations of Disabled People in Romania	DPI	Romania
All – Russian Society of the Deaf	WFD	Russian Federation
All Russian Society of Disabled People	DPI	Russian Federation
All-Russian Association of the Blind	WBU	Russian Federation
Interregional Union of Life Help for Mentally Handicapped persons	ILSMH	Russian Federation
We to children	ILSMH	Russian Federation
Association Nationale des Sourds du Senegal	WFD	Senegal
Slovak Union of the Deaf and Hard of Hearing	WFD	Slovak Republic
Alliance of Organizations of Disabled People in Slovakia	DPI	Slovakia
Association of the Blind and Partially Sighted of Slovenia	WBU	Slovenia
Somali Society of the Blind	WBU	Somalia
The National Council for Persons with Physical Disabilities in South Africa	RI	South Africa
Sri Lanka Confederation of Organizations of the Handicapped People	DPI	Sri Lanka
Handikappförbundens Samarbetsorgan	DPI	Sweden
The Swedish Association of the Visually Impaired	WBU	Sweden
The Swedish National Society for Persons with Mental Handicap	ILSMH	Sweden
Syrian Federation of Deaf and Mute Welfare Societies	WFD	Syria
Goodwill Industries of Thailand, National council on Social Welfare of Thailand	RI	Thailand
Association of the Deaf and Hard of Hearing Persons of Macedonia	WFD	The former Yugoslav Republic of Macedonia
Republic Centre for Helping Persons with Mental Handicap	ILSMH	The former Yugoslav Republic of Macedonia
UK Advocacy Network, Mental Health Service Users	WNUSP	United Kingdom
Royal National Institute for the Blind	WBU	United Kingdom
Bancroft Neuro-Health	ILSMH	United States of America

Total 115

Alphabetic order according to IPDO's name

Table 3

Name of Non-Governmental Organizations	IDPO's	Country
Associacád National de Deficientes Angolauas	DPI	Angola
Associagáo Caboverdeana de Deficientes	DPI	Cape Verde
Asociation National de Discapitados	DPI	Chile
Disabled Persons Federation	DPI	China
ACOGIPRI	DPI	El Salvador
Groupement Francais des Personnes Handikapées	DPI	France
Interessenvertretung Selbstbestimmt Leben	DPI	Germany
Federation Malenne des Associations de Personnes Handikapees	DPI	Mali
NGO (No name reported)	DPI	Malta
Union Nationale des Handicapes de Mauritanie	DPI	Mauritania
Associacados Deficientes Mozambicianos	DPI	Mozambique
National Federation of the Disabled	DPI	Nepal
A.B.I.F.A.	DPI	Paraguay
The National Organizations of Disabled People in Romania	DPI	Romania
All Russian Society of Disabled People	DPI	Russian Federation
Alliance of Organizations of Disabled People in Slovakia	DPI	Slovakia
Sri Lanka Confederation of Organizations of the Handicapped People	DPI	Sri Lanka
Handikappförbundens Samarbetsorgan	DPI	Sweden
Association of parents and friends of persons with a mental disability	ILSMH	Antilles
Belarusian Association of Assistance to Handicapped Children	ILSMH	Belarus
Association Beninoise Pour Handicapes Mentaux	ILSMH	Benin
Asociation Boliviana de Padres y Amigos de Personas con Discapacidad Mental	ILSMH	Bolivia
Founds National de la Discapacidad	ILSMH	Chile
Hong Chi Association	ILSMH	China
Center for Advice, Training, Studies on Mental Retardation	ILSMH	Egypt
Federation Salvadorena de Entidades de Padres y Amigos de Personas con Discapacidad	ILSMH	El Salvador
Estonian Mentally Disabled People Support Organization	ILSMH	Estonia
Finnish Association for Mental Health	ILSMH	Finland
UNAPEI	ILSMH	France
NAMHI	ILSMH	Ireland
Jamaica Association for Persons with Mental Retardation	ILSMH	Jamaica
Lesotho Society for Mentally Handicapped Persons	ILSMH	Lesotho
Association des Amis et Parents d'Enfants Handicapes Mentaux de Madagascar	ILSMH	Madagascar
Association Familiale Malgache pour l Aide aux Handicapes Mentaux	ILSMH	Madagascar
Confederation Mexicana de organizaciones en Favor de la Persona con Discapacidad Intelectual, A.C.	ILSMH	Mexico
HUMANITAS	ILSMH	Moldova
Association Des Parents Et Amis D' Enfants Inadaptes	ILSMH	Morocco
ICH	ILSMH	New Zealand
Asociación de padres de familia	ILSMH	Nicaragua
Asociation de Pachs de Familia con Discapacidad	ILSMH	Nicaragua
Societatea Romana Speranta	ILSMH	Romania

Interregional Union of Life Help for Mentally Handicapped persons	ILSMH	Russian Federation
We to children	ILSMH	Russian Federation
The Swedish National Society for Persons with Mental Handicap	ILSMH	Sweden
Republic Centre for Helping Persons with Mental Handicap	ILSMH	The former Yugoslav Republic of Macedonia
Bancroft Neuro-Health	ILSMH	United States of America
Barbados Council for the Disabled	RI	Barbados
Joint Council for the Physically and mentally Disabled Hong Kong	RI	China
Centro Nacional de rehabilitation	RI	Costa Rica
The association of Disabled Persons	RI	Czech Republic
The Board of Representatives from the Organizations of Disabled People	RI	Czech Republic
Asociation Dominicana de Rehabilitation	RI	Dominican Republic
Asociation Dominicana de Rehabilitation	RI	Dominican Republic
Fiji National Council for Disabled Persons	RI	Fiji
National Association of the Disabled in Finland	RI	Finland
Brotherhood Link International	RI	Ghana
Association Haitienne pour la rehabilitation des handicapes	RI	Haiti
Indonesian Society for the Care of Children	RI	Indonesia
Iran welfare Organization	RI	Iran
Welfare Organization	RI	Iran
Japanese Society for Rehabilitation of Persons with Disabilities	RI	Japan
Association for the Physically Disabled of Kenya	RI	Kenya
Kuwait Society for the Handicapped	RI	Kuwait
Malaysian Leprosy Relief Association	RI	Malaysia
Rehab. Inv	RI	Mauritania
The Pakistan Society for the Rehabilitation of the Disabled	RI	Pakistan
Instituto Panameno de Habilidadacion Especial	RI	Panama
Korean Society for Rehabilitation of Persons with Disabilities	RI	Republic of Korea
The National Council for Persons with Physical Disabilities in South Africa	RI	South Africa
Goodwill Industries of Thailand, National council on Social Welfare of Thailand	RI	Thailand
Associao Nacional de Apoio aos Deficientes Visuais	WBU	Angola
Azerbaijan Association of the Blind	WBU	Azerbaijan
National Federation of the Blind	WBU	Bangladesh
Association pour la Promotion et l' Integration Sociale des Aveugles et Ambyopes du Benin	WBU	Benin
Canadian Council of the Blind	WBU	Canada
The Hong Kong Society of the Blind	WBU	China
Dansk Blindesamfund	WBU	Denmark
United Blind Persons of Fiji	WBU	Fiji
The Finish Federation of the Visually Impaired	WBU	Finland
The Centre for the Blind in Israel	WBU	Israel
Youth Association of the Blind	WBU	Lebanon

Liberia Christian Association of the Blind	WBU	Liberia
Association Nationale des aveugles de Mauritanie	WBU	Mauritania
Central Board of Moldavian Blind Union	WBU	Moldova
Nepal Association of the Blind	WBU	Nepal
Nigeria Association of the Blind	WBU	Nigeria
Polish Association of the Blind	WBU	Poland
Korea Blind Union	WBU	Republic of Korea
All-Russian Association of the Blind	WBU	Russian Federation
Association of the Blind and Partially Sighted of Slovenia	WBU	Slovenia
Somali Society of the Blind	WBU	Somalia
The Swedish Association of the Visually Impaired	WBU	Sweden
Royal National Institute for the Blind	WBU	United Kingdom
Union of the Deaf in Bulgaria	WFD	Bulgaria
Danske Döves Landsforbund	WFD	Denmark
Asociation Salvadorenna de Sordos	WFD	El Salvador
Ethiopians National Association of the Deaf	WFD	Ethiopia
Ghana National Association of the Deaf	WFD	Ghana
World Federation of the Deaf Regional Secretariat in Asia/Pacific	WFD	Japan
The Norwegian Association of the Deaf	WFD	Norway
Pakistan Association of the Deaf	WFD	Pakistan
Romanian National Association of the Deaf	WFD	Romania
All - Russian Society of the Deaf	WFD	Russian Federation
Association Nationale des Sourds du Senegal	WFD	Senegal
Slovak Union of the Deaf and Hard of Hearing	WFD	Slovak Republic
Syrian Federation of Deaf and Mute Welfare Societies	WFD	Syria
Association of the Deaf and Hard of Hearing Persons of Macedonia	WFD	The former Yugoslav Republic of Macedonia
National Rehabilitation Medicine Hospital	WNUSP	Fiji
ATHAREP	WNUSP	France
CLIMAX	WNUSP	Greece
FUHRIL	WNUSP	Honduras
NGO (No name reported)	WNUSP	Japan
Christian Health Association of Lesotho	WNUSP	Lesotho
CUN	WNUSP	Netherlands
UK Advocacy Network, Mental Health Service Users	WNUSP	United Kingdom

Total 115

Classification of NGO responses according to socio-economic criteria¹³

Table 4

Name of Non-Governmental Organizations	Grouping	Country
Canadian Council of the Blind	DMEC ¹⁴	Canada
Danske Döves Landsforbund	DMEC	Denmark
Dansk Blindesamfund	DMEC	Denmark
Finnish Association for Mental Health	DMEC	Finland
National Association of the Disabled in Finland	DMEC	Finland
The Finish Federation of the Visually Impaired	DMEC	Finland
ATHAREP	DMEC	France
Groupement Francais des Personnes Handikapées	DMEC	France
UNAPEI	DMEC	France
Interessenvertretung Selbstbestimmt Leben	DMEC	Germany
CLIMAX	DMEC	Greece
NAMHI	DMEC	Ireland
Japanese Society for Rehabilitation of Persons with Disabilities	DMEC	Japan
NGO (No name reported)	DMEC	Japan
World Federation of the Deaf Regional Secretariat in Asia/Pacific	DMEC	Japan
NGO (No name reported)	DMEC	Malta
CUN	DMEC	Netherlands
ICH	DMEC	New Zealand
The Norwegian Association of the Deaf	DMEC	Norway
Handikappförbundens Samarbetsorgan	DMEC	Sweden
The Swedish Association of the Visually Impaired	DMEC	Sweden
The Swedish National Society for Persons with Mental Handicap	DMEC	Sweden
UK Advocacy Network, Mental Health Service Users	DMEC	United Kingdom
Royal National Institute for the Blind	DMEC	United Kingdom
Bancroft Neuro-Health	DMEC	United States of America
Belarusian Association of Assistance to Handicapped Children	ET ¹⁵	Belarus
Union of the Deaf in Bulgaria	ET	Bulgaria
The association of Disabled Persons	ET	Czech Republic
The Board of Representatives from the Organizations of Disabled People	ET	Czech Republic
Estonian Mentally Disabled People Support Organization	ET	Estonia
Central Board of Moldavian Blind Union	ET	Moldova
HUMANITAS	ET	Moldova
Polish Association of the Blind	ET	Poland
Romanian National Association of the Deaf	ET	Romania
Societatea Romana Speranta	ET	Romania
The National Organizations of Disabled People in Romania	ET	Romania
All – Russian Society of the Deaf	ET	Russian Federation
All Russian Society of Disabled People	ET	Russian Federation

¹³ Based on the classifications used by the United Nations in the *World Economic and Social Survey 1997*. The above groupings are employed for analytical purposes only and do not have any official status.

¹⁴ DMEC: Developed market-economy countries.

¹⁵ ET: Economies in transition.

All-Russian Association of the Blind	ET	Russian Federation
Interregional Union of Life Help for Mentally Handicapped persons	ET	Russian Federation
We to children	ET	Russian Federation
Slovak Union of the Deaf and Hard of Hearing	ET	Slovak Republic
Alliance of Organizations of Disabled People in Slovakia	ET	Slovakia
Association of the Blind and Partially Sighted of Slovenia	ET	Slovenia
Association of the Deaf and Hard of Hearing Persons of Macedonia	ET	The former Yugoslav Republic of Macedonia
Republic Centre for Helping Persons with Mental Handicap	ET	The former Yugoslav Republic of Macedonia
Azerbaijan Association of the Blind	ET	Azerbaijan
Associao Nacional de Apoio aos Deficientes Visuais	LDC ¹⁶	Angola
National Federation of the Blind	LDC	Bangladesh
Association Beninoise Pour Handicapes Mentaux	LDC	Benin
Association pour la Promotion et l' Integration Sociale des Aveugles et Ambyopes du Benin	LDC	Benin
Associagao Caboverdeana de Deficientes	LDC	Cape Verde
Ethiopians National Association of the Deaf	LDC	Ethiopia
Association Haitienne pour la rehabilitation des handicapes	LDC	Haiti
Christian Health Association of Lesotho	LDC	Lesotho
Lesotho Society for Mentally Handicapped Persons	LDC	Lesotho
Liberia Christian Association of the Blind	LDC	Liberia
Association des Amis et Parents d'Enfants Handicapes Mentaux de Madagascar	LDC	Madagascar
Association Familiale Malgache pour l Aide aux Handicapes Mentaux	LDC	Madagascar
Federation Malenne des Associations de Personnes Handikapees	LDC	Mali
Association Nationale des aveugles de Mauritanie	LDC	Mauritania
Rehab. Inv	LDC	Mauritania
Union Nationale des Handicapes de Mauritanie	LDC	Mauritania
Associacados Deficientes Mozambicianos	LDC	Mozambique
National Federation of the Disabled	LDC	Nepal
Nepal Association of the Blind	LDC	Nepal
Somali Society of the Blind	LDC	Somalia
Associacad Nacional de Deficientes Angolauas	LDC	Angola
Barbados Council for the Disabled	ODC ¹⁷	Barbados
Asociation Boliviana de Padres y Amigos de Personas con Discapacidad Mental	ODC	Bolivia
Asociation Nacional de Discapitados	ODC	Chile
Founds National de la Discapacidad	ODC	Chile
Disabled Persons Federation	ODC	China
Hong Chi Association	ODC	China
Joint Council for the Physically and mentally Disabled Hong Kong	ODC	China

¹⁶ LDC: Least developed countries.

¹⁷ ODC: Other developing countries (excluding least developed countries).

The Hong Kong Society of the Blind	ODC	China
Centro Nacional de rehabilitation	ODC	Costa Rica
Asociation Dominicana de Rehabilitation	ODC	Dominican Republic
Asociation Dominicana de Rehabilitation	ODC	Dominican Republic
Center for Advice, Training, Studies on Mental Retardation	ODC	Egypt
ACOGIPRI	ODC	El Salvador
Asociation Salvadorena de Sordos	ODC	El Salvador
Federation Salvadorena de Entidades de Padres y Amicos de Personas con Discapacidad	ODC	El Salvador
Fiji National Council for Disabled Persons	ODC	Fiji
National Rehabilitation Medicine Hospital	ODC	Fiji
United Blind Persons of Fiji	ODC	Fiji
Brotherhood Link International	ODC	Ghana
Ghana National Association of the Deaf	ODC	Ghana
FUHRIL	ODC	Honduras
Indonesian Society for the Care of Children	ODC	Indonesia
Iran welfare Organization	ODC	Iran
Welfare Organization	ODC	Iran
The Centre for the Blind in Israel	ODC	Israel
Jamaica Association for Persons with Mental Retardation	ODC	Jamaica
Association for the Physically Disabled of Kenya	ODC	Kenya
Kuwait Society for the Handicapped	ODC	Kuwait
Youth Association of the Blind	ODC	Lebanon
Malaysian Leprosy Relief Association	ODC	Malaysia
Confederation Mexicana de organizaciones en Favor de la Persona con Discapacidad Intelectual, A.C.	ODC	Mexico
Association Des Parents Et Amis D' Enfants Inadaptes	ODC	Morocco
Asociación de padres de familia	ODC	Nicaragua
Asociation de Pachs de Familia con Discapacidad	ODC	Nicaragua
Nigeria Association of the Blind	ODC	Nigeria
Pakistan Association of the Deaf	ODC	Pakistan
The Pakistan Society for the Rehabilitation of the Disabled	ODC	Pakistan
Instituto Panameno de Habilitacion Especial	ODC	Panama
A.B.I.F.A.	ODC	Paraguay
Korea Blind Union	ODC	Republic of Korea
Korean Society for Rehabilitation of Persons with Disabilities	ODC	Republic of Korea
Association Nationale des Sourds du Senegal	ODC	Senegal
The National Council for Persons with Physical Disabilities in South Africa	ODC	South Africa
Sri Lanka Confederation of Organizations of the Handicapped People	ODC	Sri Lanka
Syrian Federation of Deaf and Mute Welfare Societies	ODC	Syria
Goodwill Industries of Thailand, National council on Social Welfare of Thailand	ODC	Thailand
Association of parents and friends of persons with a mental disability	ODC	Antilles

Total 115

Classification of NGO responses according to geographical criteria¹⁸

Table 5

Name of Non-Governmental Organizations	Grouping	Country
Associao Nacional de Apoio aos Deficientes Visuais	AFR ¹⁹	Angola
Association Beninoise Pour Handicapes Mentaux	AFR	Benin
Association pour la Promotion et l' Integration Sociale des Aveugles et Ambyopes du Benin	AFR	Benin
Associagao Caboverdeana de Deficientes	AFR	Cape Verde
Ethiopians National Association of the Deaf	AFR	Ethiopia
Brotherhood Link International	AFR	Ghana
Ghana National Association of the Deaf	AFR	Ghana
Association for the Physically Disabled of Kenya	AFR	Kenya
Christian Health Association of Lesotho	AFR	Lesotho
Lesotho Society for Mentally Handicapped Persons	AFR	Lesotho
Liberia Christian Association of the Blind	AFR	Liberia
Association des Amis et Parents d'Enfants Handicapes Mentaux de Madagascar	AFR	Madagascar
Association Familiale Malgache pour l Aide aux Handicapes Mentaux	AFR	Madagascar
Federation Malenne des Associations de Personnes Handikapees	AFR	Mali
Association Nationale des aveugles de Mauritanie	AFR	Mauritania
Rehab. Inv	AFR	Mauritania
Union Nationale des Handicapes de Mauritanie	AFR	Mauritania
Associacados Deficientes Mozambicianos	AFR	Mozambique
Nigeria Association of the Blind	AFR	Nigeria
Association Nationale des Sourds du Senegal	AFR	Senegal
The National Council for Persons with Physical Disabilities in South Africa	AFR	South Africa
Associacad National de Deficientes Angolauas	AFR	Angola
Barbados Council for the Disabled	AMR ²⁰	Barbados
Asociation Boliviana de Padres y Amigos de Personas con Discapacidad Mental	AMR	Bolivia
Canadian Council of the Blind	AMR	Canada
Asociation National de Discapitados	AMR	Chile
Founds National de la Discapacidad	AMR	Chile
Centro National de rehabilitation	AMR	Costa Rica
Asociation Dominicana de Rehabilitation	AMR	Dominican Republic
Asociation Dominicana de Rehabilitation	AMR	Dominican Republic
ACOGIPRI	AMR	El Salvador
Asociation Salvadorena de Sordos	AMR	El Salvador
Federation Salvadorena de Entidades de Padres y Amicos de Personas con Discapacidad	AMR	El Salvador
Association Haitienne pour la rehabilitation des handicapes	AMR	Haiti
FUHRIL	AMR	Honduras
Jamaica Association for Persons with Mental Retardation	AMR	Jamaica

¹⁸ Based on the classifications used by the United Nations in the *World Economic and Social Survey 1997*. The above groupings are employed for analytical purposes only and do not have any official status.

¹⁹ AFR: Africa.

²⁰ AMR: America.

Confederation Mexicana de organizaciones en Favor de la Persona con Discapacidad Intelectual, A.C.	AMR	Mexico
Asociación de padres de familia	AMR	Nicaragua
Asociation de Pachs de Familia con Discapacidad	AMR	Nicaragua
Instituto Panameno de Habilitacion Especial	AMR	Panama
A.B.I.F.A.	AMR	Paraguay
Bancroft Neuro-Health	AMR	United States of America
Association of parents and friends of persons with a mental disability	AMR	Antilles
Iran welfare Organization	EMR ²¹	Iran
Welfare Organization	EMR	Iran
Kuwait Society for the Handicapped	EMR	Kuwait
Youth Association of the Blind	EMR	Lebanon
Association Des Parents Et Amis D' Enfants Inadaptes	EMR	Morocco
Pakistan Association of the Deaf	EMR	Pakistan
The Pakistan Society for the Rehabilitation of the Disabled	EMR	Pakistan
Somali Society of the Blind	EMR	Somalia
Syrian Federation of Deaf and Mute Welfare Societies	EMR	Syria
Center for Advice, Training, Studies on Mental Retardation	EMR	Egypt
Belarusian Association of Assistance to Handicapped Children	EUR ²²	Belarus
Union of the Deaf in Bulgaria	EUR	Bulgaria
The association of Disabled Persons	EUR	Czech Republic
The Board of Representatives from the Organizations of Disabled People	EUR	Czech Republic
Dansk Blindesamfund	EUR	Denmark
Danske Döves Landsforbund	EUR	Denmark
Estonian Mentally Disabled People Support Organization	EUR	Estonia
Finnish Association for Mental Health	EUR	Finland
National Association of the Disabled in Finland	EUR	Finland
The Finish Federation of the Visually Impaired	EUR	Finland
ATHAREP	EUR	France
Groupement Francais des Personnes Handikapées	EUR	France
UNAPEI	EUR	France
Interessenvertretung Selbstbestimmt Leben	EUR	Germany
CLIMAX	EUR	Greece
NAMHI	EUR	Ireland
The Centre for the Blind in Israel	EUR	Israel
NGO (No name reported)	EUR	Malta
Central Board of Moldavian Blind Union	EUR	Moldova
HUMANITAS	EUR	Moldova
CUN	EUR	Netherlands
The Norwegian Association of the Deaf	EUR	Norway
Polish Association of the Blind	EUR	Poland
Romanian National Association of the Deaf	EUR	Romania
Societatea Romana Speranta	EUR	Romania
The National Organizations of Disabled People in Romania	EUR	Romania
All – Russian Society of the Deaf	EUR	Russian Federation
All Russian Society of Disabled People	EUR	Russian Federation

²¹ EMR: Eastern Mediterranean Region.

²² EUR: Europe.

All-Russian Association of the Blind	EUR	Russian Federation
Interregional Union of Life Help for Mentally Handicapped persons	EUR	Russian Federation
We to children	EUR	Russian Federation
Slovak Union of the Deaf and Hard of Hearing	EUR	Slovak Republic
Alliance of Organizations of Disabled People in Slovakia	EUR	Slovakia
Association of the Blind and Partially Sighted of Slovenia	EUR	Slovenia
Handikappförbundens Samarbetsorgan	EUR	Sweden
The Swedish Association of the Visually Impaired	EUR	Sweden
The Swedish National Society for Persons with Mental Handicap	EUR	Sweden
Association of the Deaf and Hard of Hearing Persons of Macedonia	EUR	The former Yugoslav Republic of Macedonia
Republic Centre for Helping Persons with Mental Handicap	EUR	The former Yugoslav Republic of Macedonia
UK Advocacy Network, Mental Health Service Users	EUR	United Kingdom
Royal National Institute for the Blind	EUR	United Kingdom
Azerbaijan Association of the Blind	EUR	Azerbaijan
Indonesian Society for the Care of Children	SEAR ²³	Indonesia
National Federation of the Disabled	SEAR	Nepal
Nepal Association of the Blind	SEAR	Nepal
Sri Lanka Confederation of Organizations of the Handicapped People	SEAR	Sri Lanka
Goodwill Industries of Thailand, National council on Social Welfare of Thailand	SEAR	Thailand
National Federation of the Blind	SEAR	Bangladesh
Hong Chi Association	WPR ²⁴	China
Joint Council for the Physically and mentally Disabled Hong Kong	WPR	China
The Hong Kong Society of the Blind	WPR	China
Fiji National Council for Disabled Persons	WPR	Fiji
National Rehabilitation Medicine Hospital	WPR	Fiji
United Blind Persons of Fiji	WPR	Fiji
Japanese Society for Rehabilitation of Persons with Disabilities	WPR	Japan
NGO (No name reported)	WPR	Japan
World Federation of the Deaf Regional Secretariat in Asia/Pacific	WPR	Japan
Malaysian Leprosy Relief Association	WPR	Malaysia
ICH	WPR	New Zealand
Korea Blind Union	WPR	Republic of Korea
Korean Society for Rehabilitation of Persons with Disabilities	WPR	Republic of Korea
Disabled Persons Federation	WPR	China
Total 115		

²³ SEAR: South East Asian Region.

²⁴ WPR: Western Pacific Region.

Annex V. Eleven Member States not respecting the deadline for sending the questionnaire

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AUSTRALIA

Medical care

The medical care system in Australia provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organizations of persons with disabilities are *often* involved in the planning and evaluation of the above-mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Professionals paid by state expenditures are *at all times* involved as medical care providers. Family members are *often* involved as medical care providers. Voluntary workers in the municipality, professionals paid by NGOs and voluntary workers of NGOs are *sometimes* involved as medical care providers.

Medical care is provided free of charge by Government Ministries, it is paid by social insurance schemes, it is fully paid by the patient and it is partially paid by the patient.

Children, all adults and the elderly are covered by social insurance schemes. Between 81-100 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved.

Medical care reach villages and poor urban areas in the form of primary health care.

Information in Braille, information on tape, sign language interpretation and easy reading information is services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Australia. Community based rehabilitation exist at the local, district, provincial and national level.

Between 5-20 percent of persons with disabilities receive rehabilitation. (Based on information provided by the commonwealth rehabilitation service. Although most people in Australia with a profound or severe disability have access to rehabilitation services, we are unable to specify the exact number or proportion.)

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level* nurse, primary health care worker are involved; at the *district level* are the following groups involved: doctor (general practitioner), paediatrician, prosthetic/orthotic professional, nurse, psychologist, primary health care worker, physiotherapist, occupational therapist and speech therapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* physiotherapist, speech therapist, occupational therapist, social workers and rehabilitation consultants are involved.

Rehabilitation services are available at community level through community-based rehabilitation and through non-governmental organizations.

Persons with disabilities participate in the provision of rehabilitation services through the formulation and evaluation of rehabilitation programs and through CBR. The families of persons with disabilities participate in the provision of rehabilitation services through the formulation and evaluation of rehabilitation programs and through CBR. The organizations of persons with disabilities participate in the provision of rehabilitation services through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors and counsellors and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by Government Ministries and by persons with disabilities; *partially* financed by Government Ministries, social insurance schemes and persons with disabilities pay by themselves.

The Government of Australia is involved in the provision of assistive devices through development and production of assistive devices, distribution, maintenance and repair and through information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices and visual devices.

Personal assistance is provided at home, school, work, during leisure, at health and social service.

The following actors finance personal assistance: *fully* Government Ministries and persons with disabilities pay by themselves, *partially* by persons with disabilities pay by themselves.

Support is provided to families with children with disabilities. This support is financed *fully* by Government Ministries, *partially* by social insurance schemes, persons with disabilities pay by themselves and by NGOs.

Interpreter service (sign language and speech interpretation) is provided at school, at work.

Interpreter service is financed *partially* by Government Ministries and persons with disabilities pay by themselves.

Persons with disabilities and/or their organizations are involved in the planning of support services.

Personnel training

Government Ministries ensure that all authorities/agencies providing services in the disability field give training to their personnel. This is expressed through policy adopted by Government Ministries and through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic and orthotic professionals, occupational therapists, physiotherapists, social workers and community workers.

Staff's training programs are developed in consultation with organizations of persons with disabilities.

Persons with disabilities are involved in staff training programs as advisers.

BARBADOS

Medical care

The medical care system in Barbados provides services for persons with disabilities.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organizations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above-mentioned programs.

Detection methods for children with disabilities are performed: at mother and child health care (6 months – 3 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members, professionals paid by municipality and professionals paid by state expenditures are *at all times* involved as medical care providers. Voluntary workers in the municipality, professionals paid by NGOs and voluntary workers of NGOs are *sometimes* involved as medical care providers.

Medical care is provided free of charge by Government Ministries.

Only working adults are covered by social insurance schemes. Between 0-20 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, nurse, primary health care worker, physiotherapist and occupational. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Barbados. Institutional rehabilitation programs exist at the national level.

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes) and persons with disabilities due to mental illness (e.g. schizophrenia).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *national level* paediatrician, prosthetic/orthotic professional, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist.

Rehabilitation services are available at community level through primary health care.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by persons with disabilities.

The Government of Barbados is involved in the provision of assistive devices through distribution and maintenance and repair.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, hearing devices and visual devices.

The following actors finance personal assistance: *partially* by Government Ministries, social insurance schemes and persons with disabilities.

Interpreter service (sign language and speech interpretation) is provided at school and at other services in society.

Interpreter service is financed *partially* by government ministries and NGOs.

Persons with disabilities and/or their organizations are involved in the planning of support services.

Personnel training

Government Ministries in Barbados ensure that all authorities/agencies providing services in the disability field give training to their personnel through policy adopted by Government Ministries through supervision of training curriculum of medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, nurses, occupational therapists, physiotherapists, social workers.

Persons with disabilities are involved in staff training programs as advisers.

CONGO DEMOCRATIC REPUBLIC OF

Medical care

The medical care system in Congo provides services for persons with disabilities.

The medical care system includes programs for prevention and diagnosis as well as for treatment of impairment. It includes also programs for counselling for parents.

The organizations of persons with disabilities are *never* involved in the planning and evaluation of the above-mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months).

Family members and professionals paid by NGOs are *often* involved as medical care providers.

Medical care is paid fully by the patient.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, nurse, and primary health care worker. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, primary health care worker, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, primary health care worker, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Information in Braille, sign language interpretation and easy reading information is services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Congo. Institutional rehabilitation programs exist at the local, district, provincial and national level.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level* are the following groups involved: doctor (general practitioner) and other specialised doctors. At the *district level* are the following groups involved: doctor (general practitioner) and other specialised doctors. At the *provincial level* are the following groups involved: doctor (general practitioner) and other specialised doctors are involved. At the *national level* are the following groups involved: doctor (general practitioner) and other specialised doctors are involved.

Rehabilitation services are available at community level through non-governmental organizations.

The organizations of persons with disabilities participate in the provision of rehabilitation services through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors and counsellors and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by persons with disabilities themselves; *partially* financed by NGOs.

Personal assistance is provided at home, at school at health and social service.

Interpreter service (sign language and speech interpretation) is provided at school, at work and at health service.

Interpreter service is financed *fully* by NGOs.

Persons with disabilities and/or their organizations are involved in the planning of support services.

GABON

Medical care

The medical care system in Gabon provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention.

The organizations of persons with disabilities are *never* involved in the planning and evaluation of the above-mentioned programs.

Detection methods for children with disabilities are performed: at mother and child health care (6 months – 3 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Professionals paid by state expenditures are *at all times* involved as medical care providers. Professionals paid by NGOs are *sometimes* involved as medical care providers.

Medical care is paid by social insurance schemes, it is fully paid by the patient and it is partially paid by the patient.

Children, only working adults and the elderly are covered by social insurance schemes. The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner) and nurse. At the *provincial level* doctor (general practitioner), other specialised doctors and nurse are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist and speech therapist are involved.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Gabon. Institutional rehabilitation programs exist at the national level. Community based rehabilitation exist at the national level.

Less than five percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes) and persons with disabilities due to mental illness (e.g. schizophrenia).

The following groups of medical and paramedical staff that are available in rehabilitation at the *district level* are the following groups involved: doctor (general practitioner) and primary health care worker. At the *provincial level* doctor (general practitioner), other specialised doctors and primary health care worker are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, primary health care worker, CBR staff and speech therapist are involved.

The organizations of persons with disabilities participate in the provision of rehabilitation services as trained teachers, instructors and counsellors and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by Government Ministries and social insurance schemes, *partially* financed by NGOs. Only working adults are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Gabon is involved in the provision of assistive devices through distribution and through information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches and visual devices.

Support is provided to families with children with disabilities. This support is financed partially by Government Ministries and municipalities.

Personnel training

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, primary health care workers, nurses prosthetic and orthotic professionals, occupational therapists, physiotherapists, social workers and community workers.

GREECE

Medical care

The medical care system in Greece provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organizations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above-mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants with disabilities are provided medical care within the same system as other infants. Children with disabilities are not provided medical care within the same system as other children due to lack of specific programs and due to lack of training.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Professionals paid by state expenditures are *at all times* involved as medical care providers. Family members are *often* involved as medical care providers. Voluntary workers in the municipality, professionals paid by NGOs and voluntary workers of NGOs are *sometimes* involved as medical care providers.

Medical care is provided free of charge by Government Ministries, it is paid by social insurance schemes.

Children, all adults and the elderly are covered by social insurance schemes. Between 81-100 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, nurse, and primary health care worker. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, primary health care worker and physiotherapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Easy reading information is services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Greece. Institutional rehabilitation programs exist at the district, provincial and national level. Community based rehabilitation exist at the provincial and national level.

Between 41-60 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes) and persons with disabilities due to mental illness (e.g. schizophrenia).

The following groups of medical and paramedical staff that are available in rehabilitation at the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, nurse, primary health care worker, CBR staff, physiotherapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, primary health care worker, CBR staff, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved.

Rehabilitation services are available at community level through primary health care, through community-based rehabilitation and through non-governmental organizations.

Persons with disabilities participate in the provision of rehabilitation services through the formulation and evaluation of rehabilitation programs and as trained teachers, instructors and counsellors. The families of persons with disabilities participate in the provision of rehabilitation services through the design and organization of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors and counsellors and through CBR. The organizations of persons with disabilities participate in the provision of rehabilitation services through the design and organization of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors and counsellors and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *partially* financed by Government Ministries, social insurance schemes, persons with disabilities pay by themselves and by NGOs. Children, all adults and the elderly are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Greece is involved in the provision of assistive devices through development and production of assistive devices, distribution, maintenance and repair and through information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices and visual devices.

Personal assistance is provided at social service.

The following actors finance personal assistance: *fully* persons with disabilities pay by themselves, *partially* by Government Ministries.

Support is provided to families with children with disabilities. This support is financed partially by Government Ministries.

Interpreter service (sign language and speech interpretation) is provided at school.

Interpreter service is financed *fully* by Government Ministries.

Personnel training

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, primary health care workers and nurses.

GUINEA-BISSAU

Medical care

The medical care system in Guinea-Bissau provides services for persons with disabilities.

The medical care system includes programs for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organizations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above-mentioned programs.

Family members and professionals paid by state expenditures are *at all times* involved as medical care providers. Professionals paid by NGOs and voluntary workers of NGOs are *often* involved as medical care providers.

Medical care is provided free of charge by Government Ministries, it is paid by social insurance schemes and it is fully paid by the patient.

Children, all adults and the elderly are covered by social insurance schemes. Between 0-20 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner) and nurse. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist, physiotherapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Rehabilitation

Institutional rehabilitation programs exist at the national level.

Less than five percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments and persons with disabilities due to mental illness (e.g. schizophrenia).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *national level* doctor (general practitioner), other specialised doctors, prosthetic/orthotic professional, nurse, psychologist and physiotherapist are involved.

Rehabilitation services are available at community level.

The organizations of persons with disabilities participate in the provision of rehabilitation services through the design and organization of rehabilitation services and through the formulation and evaluation of rehabilitation programs and as trained teachers, instructors and counsellors.

Support services

Assistive devices and equipment for persons with disabilities are *partially* financed by Government Ministries, social insurance schemes, persons with disabilities pay by themselves and by NGOs. Children and all adults are covered by social insurance schemes regarding the provision of assistive devices.

The Government of Guinea-Bissau is involved in the provision of assistive devices through distribution of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices and visual devices.

Personal assistance is provided at home.

The following actors finance personal assistance: *partially* by Government Ministries, social insurance schemes and NGOs.

Support is provided to families with children with disabilities. This support is financed partially by Government Ministries, social insurance schemes and NGOs.

Personnel training

Government Ministries in Guinea-Bissau ensure that all authorities/agencies providing service in the disability field give training to their personnel through policy adopted by Government Ministries. Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, nurses, prosthetic and orthotic professionals and physiotherapists.

KAZAKHSTAN

Medical care

The medical care system in Kazakhstan provides services for persons with disabilities.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organizations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above-mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months).

Medical care is provided free of charge by Government Ministries, it is paid partially by the patient.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner) and paediatrician. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors and nurse are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors and nurse are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Easy reading information is services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with severe sight impairment (blind).

All age groups are involved in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level* doctor (general practitioner), paediatrician, nurse and primary health care worker; at the *district level* are the following groups involved: doctor (general practitioner), paediatrician, nurse. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, nurse are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors and nurse are involved.

The organizations of persons with disabilities participate in the provision of rehabilitation services as trained teachers, instructors and counsellors.

MALAWI

Medical care

The medical care system in Malawi provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organizations of persons with disabilities are *never* involved in the planning and evaluation of the above-mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members, voluntary workers in the municipality, professionals paid by municipality, professionals paid by NGOs and voluntary workers of NGOs are *sometimes* involved as medical care providers.

Medical care is provided free of charge by Government Ministries.

The following groups of medical and paramedical staff are available in medical care at the *local level*: primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), CBR workers, nurse, psychologist and physiotherapist. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, nurse and physiotherapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist and physiotherapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care.

Sign language interpretation and easy reading information is services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

Institutional rehabilitation programs exist at the provincial level. Community based rehabilitation exist at the district level.

Between 21-40 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes) and persons with disabilities due to mental illness (e.g. schizophrenia).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level* are the following groups involved: primary health care worker. At the *district level* doctor (general practitioner), nurse, psychologist, primary health care worker, physiotherapist are involved. At the *provincial level* doctor (general practitioner), paediatrician, nurse, psychologist, physiotherapist are involved. At the *national level* doctor

(general practitioner), paediatrician, prosthetic/orthotic professional, nurse, psychologist, physiotherapist are involved.

Support services

Assistive devices and equipment for persons with disabilities are *partially* financed by Government Ministries, municipalities and by NGOs.

The Government of Malawi is involved in the provision of assistive devices through development and production of assistive devices, distribution, maintenance and repair and through information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: wheelchairs, crutches, visual devices and devices for daily living.

Personal assistance is provided at home, school, during leisure and at health and social service.

Support is provided to families with children with disabilities.

Interpreter service (sign language and speech interpretation) is provided at home and at school.

Interpreter service is financed *partially* by Government Ministries.

Personnel training

Government Ministries ensure that all authorities/agencies providing services in the disability field give training to their personnel. This is expressed through supervision of training curriculum for medical and paramedical staff. Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, nurses, prosthetic and orthotic professionals, occupational therapists and physiotherapists.

NIGERIA

Medical care

The medical care system in Nigeria provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for necessary referrals and counselling for parents.

The organizations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above-mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members, professional paid by municipality, professionals paid by state expenditures and voluntary workers of NGOs are *often* involved as medical care providers. Voluntary workers in the municipality and professionals paid by NGOs are *sometimes* involved as medical care providers.

Medical care is paid partially by the patient.

Between 0-20 percent of the population are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), CBR workers, nurse and primary health care worker. At the *provincial level* doctor (general practitioner), other specialised doctors, nurse, psychologist, speech therapist, occupational therapist and physiotherapist are involved. At the *national level* doctor (general practitioner), other specialised doctors, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and community based rehabilitation.

Sign language interpretation is services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in Nigeria. Institutional rehabilitation programs exist at the provincial and national level. Community based rehabilitation exist at the district level.

Between 6-20 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia) and persons with disabilities due to mental illness (e.g. schizophrenia).

All age groups are included in rehabilitation services.

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level* nurse, primary health care worker and CBR staff; at the *district level* are the following groups involved: doctor (general practitioner), other specialised doctors, nurse, primary health care worker, CBR staff. At the *provincial level* doctor (general practitioner), other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, primary health care worker and occupational therapist are involved. At the *national level* doctor (general practitioner), other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Rehabilitation services are available at community level through primary health care, through community-based rehabilitation and through non-governmental organizations.

Persons with disabilities participate in the provision of rehabilitation services through the design and organization of rehabilitation services and through the formulation and evaluation of rehabilitation programs. The families of persons with disabilities participate in the provision of rehabilitation services through the formulation and evaluation of rehabilitation programs and as trained teachers, instructors and counsellors. The organizations of persons with disabilities participate in the provision of rehabilitation services through the design and organization of rehabilitation services and through the formulation and evaluation of rehabilitation programs and as trained teachers, instructors and counsellors.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by persons with disabilities; *partially* financed by Government Ministries, municipalities, persons with disabilities pay by themselves and by NGOs.

The Government of Nigeria is involved in the provision of assistive devices through development and production of assistive devices, distribution, maintenance and repair and through information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices and computers.

Personal assistance is provided at home, school and work.

The following actors finance personal assistance: *fully* by NGOs, *partially* by Government Ministries.

Support is provided to families with children with disabilities. This support is financed *fully* by NGOs; *partially* by Government Ministries.

Interpreter service (sign language and speech interpretation) is provided at school.

Interpreter service is financed *fully* by Government Ministries and NGOs.

Persons with disabilities and/or their organizations are involved in the planning of support services.

Personnel training

Government Ministries ensure that all authorities/agencies providing services in the disability field give training to their personnel. This is expressed through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic and orthotic professionals, occupational therapists, physiotherapists, social workers and community workers.

Staff's training programs are developed in consultation with organizations of persons with disabilities.

Persons with disabilities are involved in staff training programs as advisers.

MICRONESIA FEDERATED STATES OF

Medical care

The medical care system in Micronesia provides services for persons with disabilities; there is no tendency to treat certain groups of persons with disabilities outside the general medical care services.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organizations of persons with disabilities are *always* involved in the planning and evaluation of the above-mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Family members, voluntary workers in the municipality, professionals paid by municipality are *at all times* involved as medical care providers.

Medical care is provided free of charge by Government Ministries.

Only working adults are covered by social insurance schemes.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), paediatrician, other specialised doctors, nurse, primary health care worker, physiotherapist, speech therapist and occupational therapist.

Medical care reach villages and poor urban areas in the form of primary health care.

Information in Braille, sign language interpretation and easy reading information is services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

Community based rehabilitation exist at the local level.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes), persons with disabilities due to mental illness (e.g. schizophrenia) and persons with multiple/severe disabilities.

All age groups are included in rehabilitation services.

Support services

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices, visual devices, devices for daily living and computers.

Personal assistance is provided at home, school, at health and social service.

The following actors finance personal assistance: *fully* Government Ministries.

Support is provided to families with children with disabilities. This support is financed *fully* by Government Ministries.

Interpreter service (sign language and speech interpretation) is provided at home and at school.

Interpreter service is financed *fully* by Government Ministries.

Persons with disabilities and/or their organizations are involved in the planning of support services.

Personnel training

Government Ministries ensure that all authorities/agencies providing services in the disability field give training to their personnel. This is expressed through policy adopted by Government Ministries.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, primary health care workers, nurses, occupational therapists, physiotherapists, social workers and community workers.

Persons with disabilities are involved in staff training programs as teachers and as advisers.

THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

Medical care

The medical care system in The Former Yugoslav Republic of Macedonia provides services for persons with disabilities.

The medical care system includes programs for prevention, early detection and diagnosis as well as for treatment of impairment. It includes also programs for rehabilitation techniques, necessary referrals and counselling for parents.

The organizations of persons with disabilities are *sometimes* involved in the planning and evaluation of the above-mentioned programs.

Detection methods for children with disabilities are performed: when the child is born (0-6 months), at mother and child health care (6 months – 3 years) and at health care in pre-school/school age (4-7 years).

Infants and children with disabilities are provided medical care within the same system as other infants and children.

Persons with disabilities are provided regular medical treatment in order to preserve or improve their level of functioning.

Professionals paid by state expenditures are *at all times* involved as medical care providers. Professionals paid by NGOs and voluntary workers of NGOs are *sometimes* involved as medical care providers. According to the law for health care, family members can provide care assistance but not medical care.

Medical care is provided free of charge by Government Ministries, it is paid by social insurance schemes and partially paid by the patient for certain diseases.

Children, all adults and the elderly are covered by social insurance schemes. Between 61-80 percent of the population are covered by social insurance schemes. According to the law for health care, all citizens have opportunity to be health insured. This percentage is the result of the economic situation in the country.

The following groups of medical and paramedical staff are available in medical care at the *local level*: doctor (general practitioner), nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, other specialised doctors, nurse, psychologist and primary health care worker. At the *provincial level* doctor (general practitioner), paediatrician, other specialised doctors, CBR workers, nurse, psychologist, primary health care worker, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* doctor (general practitioner), paediatrician, other specialised doctors, CBR worker, nurse, psychologist, physiotherapist, speech therapist and occupational therapist are involved.

Medical care services reach villages and poor urban areas in the form of primary health care and community based rehabilitation.

Information in Braille, information on tape, sign language interpretation and easy reading information is services provided in order to facilitate information and communication between persons with disabilities and staff in health care.

Rehabilitation

There is a national rehabilitation program for persons with disabilities in The Former Yugoslav Republic of Macedonia. Institutional rehabilitation programs exist at the provincial and national level. Community based rehabilitation exist at the provincial and national level.

Between 81-100 percent of persons with disabilities receive rehabilitation.

The groups of persons with disabilities receiving rehabilitation services are persons with mobility impairments, persons with hearing impairments, deaf people, persons with severe sight impairment (blind), persons with intellectual disabilities (mental handicap), persons with learning difficulties (e.g. dyslexia), persons with disabilities due to chronic diseases (e.g. epilepsy, diabetes) and persons with disabilities due to mental illness (e.g. schizophrenia).

The following groups of medical and paramedical staff that are available in rehabilitation at the *local level* are the following groups involved: doctor (general practitioner), nurse and primary health care worker. At the *district level* are the following groups involved: doctor (general practitioner), paediatrician, prosthetic/orthotic professional, nurse and primary health care worker. At the *provincial level* paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, CBR staff, physiotherapist, speech therapist and occupational therapist are involved. At the *national level* paediatrician, other specialised doctors, prosthetic/orthotic professional, nurse, psychologist, CBR staff, physiotherapist, speech therapist and occupational therapist are involved.

Rehabilitation services are available at community level through primary health care and through non-governmental organizations.

The organizations of persons with disabilities participate in the provision of rehabilitation services through the design and organization of rehabilitation services and through the formulation and evaluation of rehabilitation programs, as trained teachers, instructors and counsellors and through CBR.

Support services

Assistive devices and equipment for persons with disabilities are *fully* financed by social insurance schemes, *partially* financed by social insurance schemes, persons with disabilities pay by themselves and by NGOs. Children, all adults and the elderly are covered by social insurance schemes regarding the provision of assistive devices.

The Government of The Former Yugoslav Republic of Macedonia is involved in the provision of assistive devices through development and production of assistive devices, distribution, maintenance and repair and through information about availability of assistive devices.

The Government provides the following kinds of assistive devices/equipment: prostheses/orthoses, wheelchairs, crutches, hearing devices and visual devices and devises for daily living.

Personal assistance is provided at home, at school, at work, during leisure and at health and social service and at other services in society.

The following actors finance personal assistance: *fully* by social insurance schemes, *partially* by social insurance schemes, persons with disabilities pay by themselves and by NGOs.

Support is provided to families with children with disabilities. This support is financed fully by social insurance schemes, *partially* by social insurance schemes, persons with disabilities pay by themselves and by NGOs.

Interpreter service (sign language and speech interpretation) is provided at school, work, during leisure, at health service, at social service and at other services in society.

Interpreter service is financed *fully* by social insurance schemes, *partially* by social insurance schemes, persons with disabilities pay by themselves and by NGOs.

Persons with disabilities and/or their organizations are involved in the planning of support services.

Personnel training

Government Ministries ensure that all authorities/agencies providing services in the disability field give training to their personnel. This is expressed through policy adopted by Government Ministries and through supervision of training curriculum for medical and paramedical staff.

Disability issues are a component in the training curriculum of the following professional groups providing services to persons with disabilities: paediatrician, other specialised doctors, general practitioners, primary health care workers, nurses, prosthetic and orthotic professionals, occupational therapists and physiotherapists.

Staff's training programs are developed in consultation with organizations of persons with disabilities.

Persons with disabilities are involved in staff training programs as advisers.