Assistive Technology Country Capacity Assessment

ANALYSIS OF CAPACITY & RECOMMENDED ACTIONS

January 2020

Liberia

LEGEND

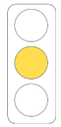
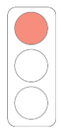
Criteria for success: *What does it mean to have system capacity to provide AT? What is the outcome we want to see?*

Status: *What is Liberia's current status on this outcome?*

Rationale (for status): *What is the evidence for this status?*

Recommended actions: *What can we do to achieve the outcome we want to see?*

Responsible stakeholders*: Who should be involved in achieving the outcome?*

			ANALYSIS OF CAPACITY	*POTENTIAL ACTIONS TO SUPPORT ACCELERATING ACCESS TO AT*	
ATA-C Item	**Criteria for success**	**Status**	**Rationale**	**Recommended actions**	**Responsible stakeholders**
Policy, Program, and Financing for AT					
ATA-C item 2.1 - 2.3	1) Assistive technology has a legal framework		▪ CRPD ratified by Liberia (however, did not ratified the optional protocol) ▪ Revised National Commission on Disability Establishment Act (2011) that bestows expanded mandate and role to NCD has not bene fully passed by national legislature; currently tabled at the Senate ▪ No other legal framework or national policy exists to formalize rights of PWDs or AT access	**Strengthen national legislations related to PWDs and access to AT** ▪ Form advocacy group inclusive of civil society organizations and champions from the disabled community, and advocate for the full ratification of the CRPD (i.e. inclusive of the optional protocol): (i) Develop briefing document for government stakeholders on the CRPD, the optional protocol, and landscape of AT in Liberia (based on findings from ATA-C assessment) (ii) Identify key government partners for advocacy, including Office of the Vice President and the Group of 77 (iii) Conduct dialogue between CSOs and government entities to increase awareness and solidify political commitment ▪ Form advocacy group inclusive of CSOs and champions from the disabled community, and advocate for the revised NCD Act (2011) to be fully passed by the national legislature: (i) Identify key government partners for advocacy, including Office of the Vice President and the Group of 77 (ii) Conduct dialogue between CSOs and government entities to increase awareness and solidify political commitment ▪ Disseminate the National Action Plan for Inclusion of PWDs (2018-2022) widely to all relevant stakeholders	MOH, MGCSP, MOE, NCD, NUOD and DPOs (including FATDA and other end-user groups), Group of the 77, Office of the Vice President
ATA-C item 1.1. - 1.4	2) Unified national strategy or policy for increased access to AT exists, with clear roles, responsibilities, and strong coordination among government entities for its successful implementation		▪ No unified national strategy or policy for AT ▪ National Action Plan for Inclusion of PWDs developed but not implemented o Only 2 performance indicators touch upon AT, but activities to achieve them are not specific ▪ Mandates of several government entities are related to AT but lacks delineation of roles/responsibilities ▪ There is awareness on importance of AT among individual champions within key government entities, but no central platform exists for holistic policymaking nor advocacy to promote AT to stakeholders not currently involved o No coordinating mechanism or knowledge-sharing platform for AT among gov't entities o Gov't plays very limited role in ensuring AT availability and access, and AT-related interventions are often donor-driven and fragmented	**Establish a coordinated national effort for increased access to AT and rehabilitation services** ▪ Establish cross-sectoral technical working group (TWG) for AT and rehabilitation services as coordination, knowledge-sharing, and implementation oversight mechanism, inclusive of representatives from relevant line ministries, other government agencies, disabled people's organizations (DPOs), non-government organizations, donors, and private sector partners ▪ Leverage monthly meetings of the Alliance for Disabilities to discuss issues related to AT, present findings and recommendations from ATA-C assessment; include additional stakeholders in meetings to ensure coordination between non-government and government partners ▪ Develop national AT policy and strategy, with detailed M&E plan, to formalize government commitment to improve AT access, delineate roles & responsibilities among relevant government entities, and guide stakeholders in achieving objective including those under the domains of 'Health Care' and 'Independent Living and Self-Determination' in the NAP (2018-2022) ▪ Integrate considerations for AT availability and access into existing national policy or strategic documents, such as the EPHS ▪ *Also see recommendations for Criteria #3, #5*	MOH, MGCSP, MOE, NCD, NUOD and DPOs (including FATDA and other end-user groups), WHO, UNICEF, CHAI, AIFO, Lions Clubs International, LVPEI

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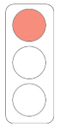
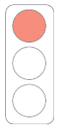
ATA-C Item	**Criteria for success**	**Status**	**Rationale**	**Recommended actions**	**Responsible stakeholders**
ATA-C item 1.5 - 1.7	3) Government entities implement programs for AT (e.g., provision, training, standards/regulation, procurement, etc.) with defined monitoring and evaluation plan		▪ Gov't entities do not lead implementation of AT programs for provision, training, standard/regulation, procurement, etc.; programs largely donor-driven and fragmented ▪ National M&E plans and indicators do not exist for AT programs	**Build and improve the government's capacity to implement programs for AT, across areas of standards/regulations, procurement and supply chain, workforce, provision, data systems, etc.** ▪ Establish national programs for AT within or across relevant government agencies, including but not limited to Ministries of Health; Gender, Children and Social Protection; Education; and National Commission on Disabilities, Liberia Medicines and Health Products Regulatory Authority (LMHRA), Liberia Medical & Dental Council (LMDC) ○ AT programs should be integrated into existing ministry departments, units, or programs whenever possible ○ Develop detailed M&E plans for national programs ▪ Build the capacity of existing government departments and units to more effectively lead or coordinate implementation of AT activities: ○ Build capacity of LMHRA to regulate AT manufacturing, procurement and product standards, distribution, and importing ○ Build the capacity of procurement and supply chain units within MOH, MGCSP, MOE to improve procurement and supply chain processes related to AT ▪ *Also see recommendations for Criteria #2, #17, #18*	MOH, MGCSP, MOE, NCD, NUOD and DPOs (including FATDA and other end-user groups), LMHRA, LMDC, WHO, UNICEF
ATA-C item 1.8	4) Sufficient government financing exists to support programs for AT (e.g. provision, training, standards/regulation, procurement, etc.)		▪ Gov't financing does not exist to support AT programs due to limited national budget ○ Limited allocation in national budget for AT in any gov't entities (e.g. MOH, MGCSP, MOE, NCD) ▪ Donors and non-gov't partners gap-fill financing roles	**Advocate for and sustain availability of financial resources to support AT (across areas of standards/regulations, procurement and supply chain, workforce, provision, data systems, etc.)** ▪ Conduct detailed resource mapping among partners to understand technical and financial resource coverage across different facilities, counties, disabilities and AT types, and to reduce duplication of efforts and maximize population coverage ○ Where possible, link complementary resources for AT, e.g. connect equipment and material availability at Jackson F. Doe Hospital with workforce availability and skills at Monrovia Rehabilitation Center for the local production of assistive products ▪ Based on national AT policy and strategic plan, develop detailed and realistic budget for activity implementation and an associated resource mobilization strategy that considers a wide range of assistive products as well as provision of AT across all sectors (health, education, labor, etc.): ○ Develop Investment Case for AT to more effective use limited resources to maximize impact, and to advocate for donor funding (short/medium term), including identification of capital investments to kick-off initial implementation ○ Explore corporate social responsibility (CSR) programs with local private sector partners (e.g. Orange, Lonestar, etc.) (short/medium/long term) ○ Advocate for inclusion of ear-marked AT funding in national budget (medium/long term) ▪ Utilize government fiscal space analyses to identify opportunities to widen fiscal space for AT and rehabilitation services	MOH, MGCSP, MOE, NCD, MFDP, NUOD and DPOs (including FATDA and other end-user groups), Group of the 77, Office of the Vice President; Implementing Partners

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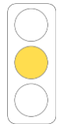
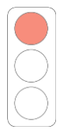
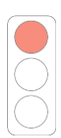
ATA-C item 2.4 - 2.5	5) National health financing scheme provides appropriate coverage for AT		▪ There is no national health insurance
			  ○ MOH NSWPP provides for the Essential Package of Health Services (EPHS), however:
			  • Health services are often not free
			  • Essential package of services does not include AT provision
			▪ There is no national social/welfare insurance
			  ○ NASSCORP is largest administrator of social insurance, with NPS and EIS peripherally related to old-age/disability and AT; but excludes individuals who are unemployed, informally employed, or work with non-registered organizations
				Advocate for the inclusion of AT into existing or planned national health insurance or social welfare schemes or programs
				▪ Work to include AT and rehabilitation services into social/welfare insurance, through any or all of the following:
				  ○ Include AT and rehabilitation services into the NASSCORP social welfare scheme (which is yet to be implemented)
				  ○ Expansion of social insurance coverage to cover unemployed individuals and individuals in the informal employment sector
				  ○ Establishment of a new national social insurance scheme that includes AT coverage
				▪ Work with national and international suppliers for assistive products and with in-country AT providers to advocate for reduce or subsidized pricing of AT services for beneficiaries covered under NASSCORP (or any other schemes)
				▪ Leverage the planned/upcoming review and update of the EPHS to ensure that AT and rehabilitation services are included, and that these services are integrated into each level of the health system as appropriate
				▪ Leverage discussions on Universal Healthcare Coverage and planning for a national health insurance mechanism (e.g. Health Equity Fund, Revolving Drug Fund) to ensure that AT and rehabilitation services are covered for all who require them
					MOH, MGCSP, MOE, NCD, MFDP, NASSCORP, NUOD and DPOs (including FATDA and other end-user groups), MFDP

Products & Procurement Systems					
ATA-C item 3.3 and 3.7	6) Country has a national assistive products list (APL) or similar, with sufficient technical specifications		▪ National APL does not exist ▪ National Standard Therapeutic Guidelines/Essential Medicines List does not include AT ▪ No other national technical specifications for assistive devices are available	**Develop national assistive products list (APL) and other technical specifications** ▪ Develop a national APL, modelled after the WHO APL and adapted based on Liberia's context, environment, demand and need, ensuring there is inclusion of a wide range of product types to cover various disabilities/functional impairments ▪ Develop technical specifications for manufacturing, importing, and procurement of assistive products on the national APL *(see recommendations from Criteria #6)* ▪ Leverage on the planned review of the National Standard Therapeutic Guidelines & Essential Medicines List (STG/EML) to ensure expansion into/incorporation of AT	MOH, MGCSP, MOE, NCD, LMHRA, NUOD and DPOs (including FATDA and other end-user groups), WHO, UNICEF

ATA-C item 3.2 - 3.3.	7) Assistive products are regulated		▪ Regulatory structures and mechanisms for assistive products are non-existent across both public and private sectors
			▪ Within public sector, mechanisms such as those within MOH and LMHRA do not currently consider AT
			  ○ e.g. Essential Medicines List, National Guidelines for Donation of Drugs and Medical Supplies, product registration processes
				Establish guidelines/standards and regulatory mechanism for assistive products
				▪ Review, revise or update guidelines/standards within the LMHRA regarding product manufacturing and importing, product registration, and product quality & safety, to ensure that assistive products are included and considered
				  ○ International guidelines such as WHO's Assistive Product Specifications (APS) for Procurements should be adapted to align with the Liberian context
				  ○ Establish registry of national and international AT manufacturers and suppliers pre-qualified by LMHRA
				▪ Incorporate AT into any post-market surveillance systems (e.g. through expansion of scope of health products under purview of LMHRA Pharmacovigilance Unit) to monitor quality, safety, and efficacy of assistive products and adherence to regulatory standards
				▪ Incorporate AT into revision/update of the National Guidelines for Donation of Drugs and Medical Supplies, to ensure donors and non-government partners adhere to product quality and safety standards
				▪ *Also see recommendations from Criteria #3, #6*
					MOH, MGCSP, MOE, NCD, NUOD and DPOs (including FATDA and other end-user groups), LMHRA

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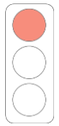
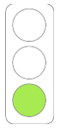
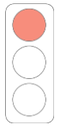
ATA-C item 3.1, 3.4 - 3.11	8) There is an established government procurement system for AT, and sufficient categories of assistive products are available through government procurement		▪ Gov't is not undertaking procurement of assistive products
			  ○ Gov't procurement systems exist but does not consider nor include AT
			  ○ AT procurement is reliant on donors/non-gov't actors, or through donations
				Establish and integrate a government procurement system for assistive technology into the existing supply chain and procurement system
				▪ Ensure that non-government organizations' procurement of AT is coordinated throughout the government (through the relevant TWG), as a stepping stone to government-led procurement of AT in the long-run
				▪ Build capacity of and leverage existing government units and platforms (e.g. for procurement, supply chain management, quantification, Central Medical Store [CMS]) to lead and coordinate AT procurement, as part of broader supply chain strengthening
				  ○ Across functions of tendering, awarding, managing contracts; forecasting and quantification; storage and distribution
				▪ Establish or incorporate AT into existing government procurement/supply chain policies, processes and forms, using technical specifications for priority assistive products
				
				Ensure that assistive products on the national APL are available in Liberia through government procurement
				▪ Based on national APL, begin to scale up government procurement through aggregation of demand for select assistive products across ministries and sectors to enable centralized procurement
				▪ Work with non-government partners and donors to negotiate for reduced or subsidized prices of assistive products based on demand
				▪ *Also see recommendations from Criteria #3, #6*
					MOH, MGCSP, MOE, NCD, Public Procurement & Concession Commission (PPCC)

ATA-C item 3.16	9) Assistive products are exempt from tax and duties		▪ A wide range of assistive products are currently exempt from tax and duties	**Maintain and increase the range of assistive product categories that are exempt from tax and duties** ▪ Ensure that assistive product categories on the national APL (to-be-developed) are tax-exempt	MOH, MGCSP, MOE, NCD, LMHRA, Liberia Revenue Agency (LRA)
Not applicable	10) In-country capacity exists for production or assembly of a wide range of assistive products		▪ While there was previously capacity for small-scale production of assistive products in the country (e.g. through rehabilitation center and programs in Ganta), support and resources have dwindled in recent years, resulting in cease in local production of AT	**Improve high-quality local production or assembly of a wide range of assistive products** ▪ Develop capacity for local AT production (either parts or complete products) through approaches such as small business incentives, training programs for local manufacturer and engagement of local communities ▪ Link complementary resources for AT production currently in country (e.g. connect facilities with raw materials and equipment available with those that have workforce skills for production) ▪ Explore public-private partnerships and corporate social responsibility programs to catalyze investment in the local AT market and expand local production capacities ▪ Initiate training programs in health training institutions or other vocational training schools on AT production; conduct skills upgrade of workforce involved in existing AT production in the country	MOH, MGCSP, MOE, NCD, LMHRA, NUOD and DPOs (including FATDA and other end-user groups), health training institutions and other vocational training schools, health facilities and rehabilitation centers

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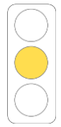
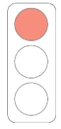
HUMAN RESOURCES					

ATA-C item 4.2 - 4.5	11) Workforce related to AT is sufficiently available		▪ There are cadres within health or other workforce that could be leveraged for AT provision
			  ○ e.g. certificate training program initiated for ophthalmic nursing; school teachers trained on basic vision screening and spectacles provision
			  ○ However, there is still shortage of general health workforce: nationally, HCW (professional and non-professional) to population ratio is 11.8 per 10,000 population, significantly below WHO target of 23 SBAs per 10,000 population to achieve sufficient coverage of essential health services (HRH Census, 2016)
			▪ Specialized AT workforce is lacking
			  ○ Very limited number of specialist doctors or AT professionals (ophthalmologists, orthopedic surgeons, mobility orientation trainers, physiotherapists, prosthetic & orthotic (P&O) technicians, etc.); cannot meet demand for service
			▪ Community-based rehabilitation (CBR) workers generally not available
				Increase the quantity, quality, and skill diversity of the public sector workforce (both health and non-health) as related to AT service delivery
				▪ Assess gaps in the AT workforce through surveys or rapid assessments to identify personnel needs at different levels of the AT provision system, and to inform workforce development priorities and plans
				▪ Incorporate considerations and priorities for AT workforce development into existing national human resource plans and policies across various sectors (health, social welfare, education, etc.) to ensure integration
				▪ Develop and implement policies and standards regarding eligible cadres (health and non-health) for AT service delivery (across all functions e.g. prescription, provision, assessment & fitting, repair & replacement, referrals), with clear delineation and coordination across relevant line ministries linked to AT provision
				▪ Train specialized AT workforce across health, social welfare, and education, prioritizing cadres as needed based on population demand and category of products on national APL
				▪ Train CBR workers to develop community-based delivery of AT and rehabilitation services, leveraging existing community health cadres where possible
				▪ Build the AT workforce through task-shifting of basic AT delivery to existing cadres of workers (both health and non-health, e.g. nurse, physician assistant, teacher, social worker, etc.)
				▪ Develop and implement policies to outline recognition/classification, scope of work, salary & benefits, retention strategy and career pathway/continuing professional development for the AT workforce (whether newly trained or through task-shifting)
				▪ *Also see recommendations for Criteria #12*
					MOH, MGCSP, MOE, NCD, NUOD and DPOs (including FATDA and other end-user groups), WHO, UNICEF, health training institutions and other vocational training schools, professional regulatory boards

ATA-C item 4.6 - 4.7	12) Structures/resources to build or strengthen the capacity of workforce in AT is available		▪ Training institutions available for narrow range of health workforce ○ AT or rehabilitation sciences courses or curricula not included in HCW training programs ▪ Low capacity and lack of resources in country to offer specialized AT training	**Establish and strengthen structures and capacity of the country to develop AT workforce** ▪ Develop pre-service and in-service curricula and training materials for AT and rehabilitation services based on international best standards ▪ Introduce and integrate courses, certificate, diploma, and/or degree programs related to AT and rehabilitation services within existing education institutions, for the eligible workforce across health, social welfare, education ▪ Build capacity of education institutions to train AT specialists; establish center of excellence to provide training in collaboration with existing institutions such as Monrovia Rehabilitation Center and Liberia Eye Center ▪ Conduct training-of-trainers within existing health, social welfare, or education workforce, to cascade training of basic AT delivery as part of task-shifting ▪ Establish or expand scholarships (both government and non-government) for students to pursue pre-service or in-service training in AT abroad ▪ Establish professional associations (for examination and licensing, accreditations, etc.) for AT workforce, working alongside existing regulatory bodies such as the LMDC ▪ *Also see recommendations for Criteria #11*	MOH, MGCSP, MOE, NCD, WHO, UNICEF, health training institutions and other vocational training schools, professional regulatory boards

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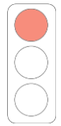
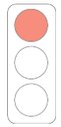
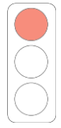
PROVISION OF ASSISTIVE TECHNOLOGY					
ATA-C item 5.1 - 5.6	13) The provision of assistive products is guided by clear guidelines or standard		▪ No national guidelines or service standards for AT provision ▪ Quality of AT provision varies widely from one provider to another	**Develop national guidelines and service standards to guide high-quality and safe provision of AT** ▪ Develop and enforce use of national guidelines and service standards for AT based on international best practice and adapted for Liberian cultural and socioeconomic context ▪ Orient existing AT specialists to the most updated international standards for service delivery ▪ Develop and implement mechanisms within existing bodies or newly-established regulatory bodies to monitor adherence to service standards; mechanisms should include clear performance indicators at the provider level, facility level, and from perspectives of the end-user *(also see recommendations for Criteria #15)*	MOH, MGCSP, MOE, NCD, NUOD and DPOs (including FATDA and other end-user groups), health facilities, WHO, UNICEF, health training institutions and other vocational training schools, professional regulatory boards

ATA-C item 5.7	14) Assistive product service provision largely occurs in facilities within the governmental sector		▪ AT service provision mainly occurs in only 2 public health facilities
			  ○ JFK Liberia Eye Center, JFK Monrovia Rehabilitation Center
			▪ Significant challenges in AT service delivery in public sector
			  ○ Lack of human, material, and financial resources
			▪ Private and faith-based organizations also make up significant portion of AT service provision
			  ○ Ganta Methodist Hospital Orthopedic and Optical Centers, Ganta Leprosy Rehabilitation Center, Phebe Optical Center, etc.
				Increase the provision of assistive products in public sector facilities
				▪ Integrate AT provision (or referrals) into routine health service delivery
				  ○ Identify public health facilities where AT provision could be added into existing package of services offered, across primary, secondary, and tertiary levels of care, as well as at the community-level
				▪ Work to decentralize AT services to ensure greater coverage of the population (e.g. through expanding the facility-based and community-based AT workforce, increasing local AT production, etc.)
				  ○ Allocate human and financial resources to increase the number of service delivery points over time, across all sectors (health, social welfare, education)
				▪ *Also see recommendations for Criteria #11, #16*
					MOH, MGCSP, MOE, NCD, NUOD and DPOs (including FATDA and other end-user groups), health facilities, WHO, UNICEF, health training institutions and other vocational training schools, professional regulatory boards

ATA-C item 5.5 and 5.9	15) Assistive product service provision is person-centered		▪ No current system to collect information on user satisfaction or impact of received AT on health and other outcomes ○ None in public facilities, private facilities, or NGOs; previously, Monrovia Rehabilitation Center and Handicap International worked together on a user satisfaction survey, as well as capture user satisfaction as part of follow-up ▪ Therefore no current/up-to-date routine data to be utilized to improve service provision	**Strengthen person-centeredness within assistive product service provision** ▪ Rebuild and strengthen systems to routinely collect user satisfaction and impact information, including development of necessary tools for data collection ▪ Conduct operational research on satisfaction and well-being outcomes of AT end-users ▪ Disseminate data and findings from data systems and operational research back to service providers to improve service delivery ▪ Establish programs for peer-to-peer training and support (e.g. for AT user training, repairs) between AT users to address barriers in AT workforce and access to facilities, as well as to improve interactions among users and promote community-building	MOH, MGCSP, MOE, NCD, NUOD and DPOs (including FATDA and other end-user groups), health facilities, WHO, UNICEF

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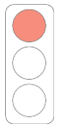
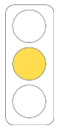
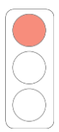
ATA-C Item	**Criteria for success**	**Status**	**Rationale**	**Recommended actions**	**Responsible stakeholders**

ATA-C item 5.8	16) Assistive product service provision is well-connected and coordinated		▪ No formal referral mechanisms to connect users to providers
			  ○ Patients/clients may be referred informally to JFK MRC for prescription or provision of AT
			  ○ However, there is absence of standardized documentation, clear care-seeking and follow-up pathway, directory of specialists/providers, etc.
			▪ Service provision is fragmented and no coordinated among different stakeholders involved
				Develop a well-connected and coordinated AT provision system, inclusive of a formal referral mechanism to link patients/clients to facilities, and to connect facilities
				▪ Develop directory of AT providers and rehabilitation services across all sectors, and disseminate to patients/clients and providers for their use; also develop complementary patient care-seeking pathway maps
				▪ Integrate AT into existing referral systems within health, social welfare, and education sector
				▪ Develop and enforce use of appropriate referral and follow-up documentation for AT provider use; Train AT workforce on AT referral processes
					MOH, MGCSP, MOE, NCD, NUOD and DPOs (including FATDA and other end-user groups), health facilities, WHO, UNICEF

DATA AND INFORMATION SYSTEMS					

ATA-C item 6.2	17) Reliable information is collected to accurately estimate the need and demand for AT		▪ Gov't does not collect routine data on disabilities and functional limitations, therefore cannot estimate population need for AT
			▪ Most disability data are from national surveys and are outdated (Population & Housing Census, 2008; Labour Force Survey, 2010)
			▪ Some health facilities that provide AT and rehab services have patient records to capture disability diagnoses, but these are not aggregated nationally on HMIS
			  ○ e.g. Liberia Eye Center using eyeSmart Electronic Medical Record database, Ganta United Methodist Hospital patient records
			▪ Gov't collects some routine data on limited number of health conditions relevant to AT, but data are incomplete
			  ○ e.g. Health Management Information System (HMIS) has data elements on eye health conditions
				Strengthen existing information systems to expand data coverage on health conditions and functional limitations that require AT
				▪ Conduct nation-wide survey on disabilities and functional limitations
				  ○ If possible, leverage upcoming DHS to include disabilities/functional limitations data
				▪ Engage and encourage research institutions to participate and fill gaps on data availability through research activities
				▪ Develop national M&E and data collection plan for disabilities and AT need/demand data, as part of the national AT policy and strategic plan, and incorporate new data elements into existing HMIS
				  ○ Leveraging on revision and roll-out of new HMIS facility ledgers and reporting forms to ensure data elements on disabilities and non-communicable diseases & injuries (NCDIs) are included
				  ○ Conduct training for facility-based providers and central ministry HMIS staff on the recording, aggregation, analysis and use of key disability and NCDI indicators
				▪ Develop and implement strategy to collect and disseminate disability/AT data outside across all relevant government agencies, beyond MOH (which currently hosts the HMIS), and promote utilization of data for evidence-based decisions in AT programming
					MOH, MGCSP, MOE, NCD, LISGIS, NUOD and DPOs (including FATDA and other end-user groups), health facilities, WHO, UNICEF

ATA-C item 6.1	18) Information is collected on the provision and utilization of AT		▪ Gov't does not collect routine AT provision and utilization data ▪ Some health facilities that provide AT and rehab services have patient records to capture AT provision and utilization, but these are not aggregated nationally on HMIS ▪ Donors, DPOs, and other non-government organizations that provide or donate assistive devices have internal records on AT volumes provided	**Establish information systems for data coverage on the provision and utilization of AT** ▪ Conduct nation-wide survey on disabilities and functional limitations (including AT use) ○ If possible, leverage upcoming DHS to include AT use data ▪ Incorporate new data elements on AT provision (service volume) into existing HMIS ▪ *Also see recommendations for Criteria #17*	MOH, MGCSP, MOE, NCD, LISGIS, NUOD and DPOs (including FATDA and other end-user groups), health facilities, WHO, UNICEF