ASSISTIVE TECHNOLOGY IN TAJIKISTAN:
SITUATIONAL ANALYSIS
ASSISTIVE TECHNOLOGY IN TAJIKISTAN:
SITUATIONAL ANALYSIS
Abstract

This publication summarizes the current gaps, needs and opportunities for intervention in the field of assistive technology in Tajikistan. The situational analysis was conducted under the leadership of the Ministry of Health and Social Protection, Republic of Tajikistan and with technical support from the WHO Country Office, Tajikistan. It was undertaken in collaboration with different Government ministries and State agencies, development partners, United Nations agencies, nongovernmental organizations, disabled people's organizations and users of assistive products. It adopted a realist synthesis approach, responsive to the unique social, cultural, economic and political circumstances in the country. The evaluation focuses on assistive technology policy and governance, service provision and the impact of assistive technology on the health and well-being of individual users and their families, with the aim of improving access to high-quality, affordable assistive products in Tajikistan.

Keywords

ASSISTIVE TECHNOLOGY
ASSISTIVE PRODUCTS
PRIORITY ASSISTIVE PRODUCTS
ASSISTIVE PRODUCTS – policy
ASSISTIVE PRODUCTS – products

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ISBN: 9789289054102

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Acknowledgements

This situational assessment has been made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents do not necessarily reflect the views of USAID or the United States Government.

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Also the many assistive product users who shared their experiences with us for the situational assessment on assistive technology in Tajikistan.

Peer reviewers
Michael Allen, Chapal Khasnabis, Manfred Huber, Cara L. Thanassi
# Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>APL</td>
<td>assistive products list</td>
</tr>
<tr>
<td>ATA</td>
<td>assistive technology assessment tool</td>
</tr>
<tr>
<td>ATA-N</td>
<td>assistive technology needs survey</td>
</tr>
<tr>
<td>ATA-S</td>
<td>assistive technology systems survey</td>
</tr>
<tr>
<td>CBR</td>
<td>community-based rehabilitation</td>
</tr>
<tr>
<td>ICRC</td>
<td>International Committee of the Red Cross</td>
</tr>
<tr>
<td>ISPO</td>
<td>International Society for Prosthetics and Orthotics</td>
</tr>
<tr>
<td>NOC</td>
<td>National Orthopaedic Centre</td>
</tr>
<tr>
<td>PPA</td>
<td>Agency on Public Procurement of Goods, Works and Services</td>
</tr>
<tr>
<td>SEOP</td>
<td>State Enterprise Orthopaedic Plant</td>
</tr>
<tr>
<td>TJS</td>
<td>Tajik somoni (currency)</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
</tbody>
</table>
Executive summary

Purpose

The main purpose of the situational analysis was to inform the process of developing a national assistive products list (APL) for Tajikistan, in compliance with action 2.2.11 of the National Programme on Rehabilitation of Persons with Disabilities 2017–2020. The objective was to identify the total need for different assistive products in the country, and to evaluate ways in which the assistive technology system could be strengthened.

Methods

200 persons with disabilities participated in a survey designed to collect information on self-reported need for assistive products, user experiences and barriers to access. An additional 11 focus groups made up of persons with disabilities and older adults held in-depth discussions on assistive technology. The major providers of assistive technology (Government facilities, nongovernmental organizations, local producers) were also interviewed as part of the research.

Results

Over the last three years, Tajikistan has made significant progress in improving access to assistive technology: the budget assigned to assistive technology has steadily increased, the range of assistive products provided by the Government has broadened, and assistive technology facilities have been upgraded. In 2018, Tajikistan renewed its commitment to ensuring access to assistive technology by signing the Convention on the Rights of Persons with Disabilities. The Government of Tajikistan played an important role in the adoption of World Health Assembly resolution WHA71.8 on improving access to assistive technology, and the related side event. Despite these commendable efforts, resources remain inadequate to meet the national demand for assistive products. In particular, Tajikistan lacks qualified assistive technology professionals, and funding is still insufficient. The field research revealed that assistive products are often distributed without the appropriate steps of service provision being observed. As a result, beneficiaries have received assistive products that are inappropriate or ill-fitting, or which they are unable to use. In such cases, the utility of the device is limited and it is commonly abandoned or used only on rare occasions. Many users also reported that the products they received are of low quality and durability. This issue is of particular concern, since almost half of the survey respondents claimed that they had nowhere to go for repairs. Moreover, many survey and focus group participants were unaware that they were entitled to assistive products, or did not know where or how to obtain them.

Conclusion

The results of the survey and focus group discussions were presented at a meeting with Government and other stakeholders on 20 April 2018, at which a consensus was reached on 30 assistive products for the national APL (see Annex 4). Adoption of the APL is an important milestone but, in order to reap the full benefits of assistive technology, more should be done to ensure that assistive products are of sufficiently high quality and that they are provided using appropriate service procedures. To this end, Government and development agencies are already collaborating on projects that include the expansion of the assistive technology centres in Kulob and Khorog, drafting of standards and specifications for the products on the APL and training of local staff in assistive technology (including sponsorships for study abroad). Also, the national orthopaedics centre should be strengthened to become a National Assistive Technology Centre where all products and related services from the National APL are available.
The National Programme on Rehabilitation of Persons with Disabilities 2017–2020 outlines a clear strategy for strengthening of assistive technology in Tajikistan. The multisectoral steering committee responsible for implementation, monitoring and evaluation of the National Programme on Rehabilitation of Persons with Disabilities needs to take a stronger leadership role on assistive technology. The steering committee had an active role in developing the national APL and has started to assume an oversight role for assistive technology, which needs to be reinforced through diligent review of assistive-technology-related activities.

User groups should also be involved or consulted in all decisions and activities related to assistive technology.

The Government of Tajikistan has shown considerable progress to realize the rights of persons with disabilities and to improve the provision of assistive products. To continue its efforts and commitment, Tajikistan will need to further strengthen its assistive products provision system including service delivery facilities, trained personnel and procurement of quality products at an affordable price.
1. Introduction

1.1 Background

Assistive technology enables people to live independent, productive and healthy lives. Many individuals need assistive products to participate in social activities, to work or to go to school. Without assistive products, these people are at risk of falling into poverty and social exclusion and may become a burden on their family and on society. Therefore, the positive impact of assistive technology goes beyond individual benefits: by enabling a more productive workforce and decreasing the need for hospitalization, the health and welfare costs to the State are also reduced. Consequently, access to assistive products is not only a human right protected under the Convention on the Rights of Persons with Disabilities, it is also a worthwhile long-term investment (1).

The assistive technology sector consists of five interlinked areas that are known as the “5 Ps”: policy, provision, products, personnel and people. These are the building blocks of an effective assistive technology system; to a great extent, the assistive technology sector of any country is only as strong as its weakest element. Having qualified personnel and a good provision system in place will not be enough to meet the country’s assistive technology needs if appropriate assistive products are not available. Conversely, high-quality assistive products are not sufficient in themselves – qualified personnel to assess and fit the products and equipped facilities are also necessary. Fig. 1 illustrates the 5 Ps and how the areas are interrelated (2). People are at the centre of the system, since a user-centred approach is crucial to the successful application of assistive technology.

The efficacy of assistive products depends on the context in which they are supplied. The physical environment, societal attitudes and health-care services can all act as facilitators or as barriers to their use. Inaccessible infrastructure, for example, will reduce the mobility of a wheelchair user. Likewise, societal attitudes can deter people from using assistive products, such as hearing aids, because they do not want to be stigmatized as being disabled. Moreover, in some cases, assistive products are only effective when used as part of a broader rehabilitation programme (as is often the case for orthoses); and where rehabilitation services are not available, the devices have limited utility. Taking all these factors into consideration, development of the assistive technology sector needs to go hand in hand with interventions that are aimed at reducing barriers to the use of the products, so as to maximize the benefits to both users and society.

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**Assistive technology**

is the application of organized knowledge and skills related to assistive products, including systems and services. Assistive technology is a subset of health technology.

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**Assistive products**

are any external product (including devices, equipment, instruments or software), especially designed or generally available, the primary purpose of which is to maintain or improve an individual’s functioning and independence and thereby promote his/her well-being. Assistive products are also used to prevent impairments and secondary health conditions.

Source: (1).
1.2 Main findings

The present situational analysis shows an assistive technology sector in Tajikistan that is underdeveloped and in need of greater investment, although the Government’s reforms are leading the country in the right direction.

The research suggests that only a small fraction of people in need in Tajikistan have access to appropriate assistive technology. There is a need to expand provision, but there are challenges in the lack of funding and resources. The quantity, quality and range of assistive products available through public provision are inadequate to meet the demand. Most health workers have a limited understanding of assistive technology, and there are few workers with a specialized knowledge of this technology. Crucial aspects of service provision for assistive technology are often overlooked: for instance, repair services are not accessible to everyone, or user training and follow-up are not included in the service procedures.

Public provision of assistive products in Tajikistan is centralized under the State Enterprise Orthopaedic Plant (SEOP), also known as the National Orthopaedic Centre (NOC), which is responsible for the procurement, production and distribution of all publicly funded assistive products. The focus is primarily on mobility devices, such as prostheses, orthoses, wheelchairs, walkers, crutches and orthopaedic shoes. Until recently, only mobility products were available, but in 2015 NOC started providing hearing aids, white canes and some other assistive products in different categories.

Nongovernmental and international organizations make important contributions to assistive technology in Tajikistan, including provision of high-quality assistive products, donations of machinery and material to NOC and training and sponsoring of students to study abroad. Collaboration between Government facilities and the international community is well established and very successful.

Despite all its problems, the country has taken decisive action to reform the assistive technology sector. The multisectoral National Programme on Rehabilitation of Persons with Disabilities 2017–2020 (resolution No. 455 of 28 October 2016) identifies the major gaps and guides the country in the right direction. In the last

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**Fig. 1. The 5 Ps**

---

**Tajikistan country facts**

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (3)</td>
<td>9 million</td>
</tr>
<tr>
<td>GDP per capita (4)</td>
<td>US$ 819</td>
</tr>
<tr>
<td>Rural population (5)</td>
<td>73.6%</td>
</tr>
<tr>
<td>Age distribution (3)</td>
<td></td>
</tr>
<tr>
<td>0–19 years:</td>
<td>44.3%</td>
</tr>
<tr>
<td>20–64 years:</td>
<td>52.4%</td>
</tr>
<tr>
<td>65+ years:</td>
<td>3.3%</td>
</tr>
<tr>
<td>Administrative:</td>
<td>four provinces/regions (divided into 58 districts)</td>
</tr>
</tbody>
</table>

GDP: gross domestic product.

two years, remarkable progress has been made from a policy perspective, with the signing of the Convention on the Rights of Persons with Disabilities in March 2018 (6); development of a national priority assistive products list (APL) (7); ongoing work on standards and specifications for assistive products; and an economic assessment of wheelchair production and procurement options for Tajikistan, which is currently in progress. Also, the Government of Tajikistan played an important role in the adoption in May 2018 of World Health Assembly resolution WHA71.8 on improving access to assistive technology and the related side event.

1.3 Research methodology

The aim of the present situational analysis was to assess the current state of the assistive technology sector in Tajikistan – from the perspective of both end users and providers. The research findings can be used to inform the planning and development of services for the provision of assistive products, by mapping and identifying gaps in the current provision.

The research methodology was based on the assistive technology assessment (ATA) tool developed by WHO in 2016. The ATA consists of two parts: a needs survey (ATA-N) and a systems survey (ATA-S).

For the Tajik situational analysis, a modified version of the ATA was used; one that was better suited to the country context and to meeting the goals of the research. A rapid needs survey (see Annex 1 and section 1.3.1) and focus group guidelines (see Annex 2 and section 1.3.2) were created by adapting ATA-N, and a systems survey (see Annex 3 and section 1.3.3) was drafted on the basis of ATA-S. These three research activities were conducted simultaneously between February and May 2018.

Based on the above analysis, a consensus meeting was held in Dushanbe on 20 April 2018 to draw up the priority assistive products list. The meeting involved representatives from the Ministry of Health and Social Protection and other stakeholders, including the Government, donor agencies, nongovernmental organizations, disabled people’s organizations and users of assistive products, to identify the products most needed in the country. Following extensive deliberations and on the basis of the assistive technology situation in Tajikistan, a consensus was reached on a priority APL comprising 30 products. The list is the basis for strengthening the assistive technology sector in Tajikistan.

1.3.1 Rapid needs survey

The rapid survey was developed to collect information on individual needs for assistive products among persons with disabilities. The survey was in three parts.

Part A (10 questions) dealt with the met and unmet needs for different assistive products. Participants were asked to identify assistive products that could help them and to specify whether they were currently using those products.

Part B (19 questions) dealt with assistive products in use. Only interviewees currently using assistive products were asked to complete this part, in which they had to provide additional information on the products concerned and related services.

Part C (6 questions) dealt with barriers to access. Participants who did not have the assistive products they needed, or no longer used them, were asked about the barriers that stopped them acquiring or using the devices concerned.

The survey was translated into Tajik and Russian. It was implemented with the support of seven nongovernmental organizations that work on community-based rehabilitation (CBR) in different regions of the country with the financial support of the Ministry of Health and Social Protection, through a public-private partnership. Participants were selected at random from the CBR programmes of the nongovernmental organizations. After training on the survey, two staff members from each nongovernmental organization interviewed 25–35 people with disabilities within their CBR programme. Twelve districts were covered by the survey – the locations of the interviews are shown on the map in Fig. 2 below.
Demographic characteristics of participants:

- total participants = 200
- average age = 18.1 years
- sex = 45.5% female, 54.5% male
- disability type distribution is in Table 1 below.

1.3.2 Focus groups

In parallel with the survey, 11 focus group discussions were organized at different locations in the country: five in Dushanbe, three in Sughd Region, two in Rogun and one in Tursunzade. The aim of the focus groups was to come to a better understanding of the needs of and challenges facing persons with disabilities. During the discussions, participants were encouraged to describe their experiences of obtaining and using assistive products and share their hopes and expectations for the future.

Disabled persons’ organizations – including the Association of Blind People, the National Union of Deaf People and the National Union of Disabled People of Tajikistan – helped to organize the focus groups by identifying participants and making venues available. One of the discussions was held at the elderly people’s club in Dushanbe, providing the perspective of older people on assistive technology needs. Between six and 12 people were invited to the focus groups, and the discussions lasted for one hour.
Table 1. Distribution of disabilities among rapid survey participants

<table>
<thead>
<tr>
<th>Do you have difficulty:</th>
<th>Yes, a lot of difficulty (%)</th>
<th>Yes, some difficulty (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1* Sitting or standing?</td>
<td>48.0</td>
<td>28.0</td>
<td>24.0</td>
</tr>
<tr>
<td>A2 Walking or climbing steps?</td>
<td>46.5</td>
<td>34.0</td>
<td>19.5</td>
</tr>
<tr>
<td>A3 Seeing?</td>
<td>6.5</td>
<td>18.0</td>
<td>75.5</td>
</tr>
<tr>
<td>A4 Hearing?</td>
<td>6.0</td>
<td>6.0</td>
<td>88.0</td>
</tr>
<tr>
<td>A5 Speaking/communicating?</td>
<td>22.0</td>
<td>15.0</td>
<td>63.0</td>
</tr>
<tr>
<td>A6 With pain or deformities?</td>
<td>32.0</td>
<td>44.0</td>
<td>24.0</td>
</tr>
<tr>
<td>A7 Remembering?</td>
<td>8.5</td>
<td>17.5</td>
<td>74.0</td>
</tr>
<tr>
<td>A8 With decrease/loss of sensation?</td>
<td>21.0</td>
<td>30.0</td>
<td>49.0</td>
</tr>
<tr>
<td>A9 Controlling the bladder or bowel?</td>
<td>13.5</td>
<td>21.0</td>
<td>65.5</td>
</tr>
<tr>
<td>A10 With your self-care?</td>
<td>39.0</td>
<td>37.5</td>
<td>23.5</td>
</tr>
</tbody>
</table>

* A1, A2, etc.: questions in the rapid survey – see Annex 1.

1.3.3 Systems survey

The analysis of the assistive technology system involved:
- collection and analysis of available statistical data on assistive products and disability;
- a review of policy documents and legislation;
- interviews with stakeholders and service providers; and
- visits to assistive technology centres.

1.4 Data-gathering and limitations

The analysis relies heavily on the rapid survey results, which were relatively limited in scope. Only 200 people participated in the survey, chosen at random from CBR programmes. A larger sample of people randomly selected from the entire population would have produced more accurate results to assess the overall need for assistive technology; however, this was not possible because of time and budget constraints.

Participants were in a privileged position, and were more likely than others to have obtained assistive products and related services from nongovernmental organizations. Unfortunately, other persons with disabilities in Tajikistan who are not beneficiaries of CBR programmes are likely to enjoy less favourable conditions with respect to assistive technology.

Persons with mobility impairments were overrepresented in the survey. Over 80% of participants said that they had at least some difficulty walking. People with hearing difficulties, on the other hand, accounted for only 12% of the sample, and fewer than 25% had difficulties with vision. Although it is possible that Tajikistan has a very high proportion of people with mobility impairments, the sample is more likely biased towards mobility because the CBR programmes are more likely to work with persons with these types of disability.

Focus group discussions were organized to compensate for some of the above-mentioned limitations of the survey. To ensure wider representation from all potential users of assistive technology, focus groups were organized with members of the Association of Blind People and the National Union of Deaf People, older persons and other groups around the country.
1.5 Report outline

The remainder of this report is divided into five chapters, one for each major area of the assistive technology and an additional chapter on the APL and quantifications:

- Chapter 2 – policy;
- Chapter 3 – provision;
- Chapter 4 – products and related services;
- Chapter 5 – personnel; and
- Chapter 6 – national APL and quantification of needs.

As discussed earlier in the report, people are at the heart of the system – hence, a user-centred approach is the lens used for the analysis in each chapter. The findings of the rapid survey and of the focus groups are discussed in Chapter 4. The findings of the systems survey are discussed in Chapters 2, 3 and 5. Every chapter consists of a description of the current situation, followed by a discussion and recommendations.
2. Policy

2.1 Policies and legislation

Although Tajikistan does not have a national strategy or specific policies on assistive technology, the recently signed Convention on the Rights of Persons with Disabilities and the National Programme on Rehabilitation of Persons with Disabilities 2017–2020 provide a framework and guidance for developing the sector.

Assistive technology is an integral part of the National Programme on Rehabilitation of Persons with Disabilities 2017–2020. The programme calls for a new assistive technology system that will improve access to assistive devices and relevant services. To achieve this, the programme outlines an action plan with specific objectives for the country, including the following:

- increasing access to high-quality assistive products by increasing Government funding;
- increasing awareness and enhancing knowledge among stakeholders on assistive products and their benefits;
- establishing maintenance and repair facilities;
- training staff in delivery of assistive technology services;
- reorganizing assistive technology from a distribution model to a service provision model;
- improving procurement by expanding the range and increasing the quality of assistive technology.

This comprehensive action plan addresses the greatest challenges facing the assistive technology sector, which became clear during the field research.

By endorsing the Convention on the Rights of Persons with Disabilities, Tajikistan is committed to ensuring the availability of high-quality assistive devices. Four articles of the Convention address access to assistive technology:

- Article 4 – general obligations
- Article 20 – personal mobility
- Article 26 – habilitation and rehabilitation
- Article 32 – international cooperation.

Tajikistan has no legislation on assistive technology per se, but two Government decrees (resolutions) lay down rules for provision and entitlements: resolution No. 604 of 2011 on "Rules on provision of assistive devices to people with disabilities" and resolution No. 295 of 2013 on "List of specialized assistive devices and individual use products for people with disabilities, with supply and import exempted from value added tax and customs duties".

At present, there is no body with oversight over assistive technology, but the steering committee for the National Rehabilitation Programme assumes this task. The Government has a national health information system, but it does not include data on assistive technology. NOC maintains its own database, but data are limited to the number of products provided, patients and supplies. NOC does not follow up with patients and does not keep track of assistive technology outcomes. This general lack of information precludes the possibility of monitoring and evaluation of the assistive technology sector.

2.2 Rules on provision of assistive products

Eligibility. Only people who have obtained a disability certificate from the Agency for Medical and Social Examination are eligible for a Government-funded product.

Costs. Assistive products are free of charge (financed from the State budget). Travel costs for the person with disability and his/her carer to the facilities where products are produced or delivered are reimbursed by the State. Accommodation and meals required during the production process are also financed from the State budget.

Procedure. For the person registered as disabled, the process of obtaining an assistive product usually begins at the local health-care facility (polyclinic or
psychological, medical and pedagogical commission) (Fig. 3). After assessment, the health-care facility will issue a prescription for a device to the person in need. If the request is for a Government-funded wheelchair, the applicant will also need a prescription from the Agency for Medical and Social Examination. It is important to note that these “prescriptions” do not constitute a customized plan based on individual need, with technical characteristics and measurements, special features or device requirements (8); in WHO terminology, the prescriptions are merely a referral to another facility. After obtaining a prescription, the candidate must apply to his/her local social protection department with supporting documents (copy of passport, individual rehabilitation plan and a written application) to obtain a wheelchair. After checking the documentation, the local social protection department issues an order and sends it to the Ministry of Health and Social Protection. This puts the applicant on a waiting list for a wheelchair or other device. The Ministry compiles all the orders from the local protection entities and applies for centralized procurement by NOC. For other assistive products, such as prostheses and orthoses, the patient will usually bypass the local social protection department and be referred directly to NOC.

**Fig. 3. Process for obtaining a Government-funded assistive product**

MOHSP: Ministry of Health and Social Protection; PMPC: psychological, medical and pedagogical commission.
Assistive products provided. The following products are currently provided under Government resolution No. 604:

- elbow/axillary crutches, walking sticks, walkers/rollators;
- wheelchairs, manual or assistant-controlled, for children and adults;
- prostheses for upper and lower limbs;
- orthoses and braces for upper limbs, lower limbs and spine (leather corset); and
- orthopaedic footwear (including winter footwear and footwear for prostheses).

As stated above, since 2015 the Government has started to provide additional assistive products (hearing aids, white canes and some others) from various categories of product.

In April 2018, during a meeting with the Government and stakeholders, a consensus was reached on a new national APL. The list comprises 30 priority assistive products (see Chapter 7) that are essential for the well-being of people with disabilities, older people and people with noncommunicable diseases, among others. It has been approved by the Ministry of Health and Social Protection and is currently awaiting Government approval.

Replacement and repairs. As per the current rules previously supplied assistive devices are replaced at the request of the person with disability in three situations: when the product is beyond repair, when its useful life is over, and when there is a need to change it for a different type of device. The useful life varies according to the product – from 6 months for orthopaedic shoes to 4 years for a wheelchair. Repair services for broken assistive products are guaranteed at the expense of the State.

2.3 Procurement process

The Ministry of Health and Social Protection conducts a process of procurement for assistive products every year. Procurement is conducted by open tender.

The Ministry of Health and Social Protection collects requests for assistive products (mainly wheelchairs) from the local social protection departments and compiles them into a single datasheet. The compiled requests are sent to NOC so that the latter can initiate the procurement of assistive products in accordance with the demand. The treasury department of the Ministry of Finance also specifies the total availability of financial resources for the order. On the basis of the demand and the available budget, NOC prepares a procurement list and submits a request to the Agency on Public Procurement of Goods, Works and Services (PPA) to announce a tender and invite providers of assistive products to bid.

The call for tender is publicized on the PPA web portal in Russian and in local newspapers in Tajik and Russian. The information in the tender states the quantities and very basic technical characteristics of the required assistive products. Bidders have 4 weeks to prepare and submit a proposal, including a technical report, budget and legal documents.

The commission in charge of evaluating the proposals is made up of representatives of the Ministry of Health and Social Protection, NOC and PPA. During the evaluation process, the commission reviews and compares the different proposals and selects a winner. Although there are no fixed measures for evaluating the bids, price is usually the main criterion. The commission will also take into consideration other factors, such as the time frame for delivery and the warranty provided, but the provider quoting the lowest price will usually win. After the evaluation process, the contract is signed between NOC and the successful bidder. The conditions of delivery and payment are specified in the contract.

The winner of the 2017 tender for wheelchairs was a local supplier, Zuhro 2012 LLC, with a proposed budget of TJS 860 400 (US$ 91 500), out of a total budget of TJS 893 500 (US$ 95 000) available for wheelchairs. This order consisted of 700 wheelchairs imported from China (Table 2). The price of a basic manual wheelchair was TJS 1020 (US$ 110) per unit, including transportation. The retail price of the wheelchairs was not specified, but transportation costs from China are very high – over US$ 30 per unit. Twenty electrically powered wheelchairs were included in the original budget, but authorization for this order was later denied and they were dropped from the order.
Table 2. Wheelchair procurement 2017

<table>
<thead>
<tr>
<th>Supplier</th>
<th>Model</th>
<th>Number of units</th>
<th>Cost per unit (TJS)</th>
<th>Total cost (TJS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zuhro 2012 LLC</td>
<td>Wheelchairs (manual)</td>
<td>500</td>
<td>1020</td>
<td>510 000</td>
</tr>
<tr>
<td></td>
<td>Wheelchairs with commode</td>
<td>50</td>
<td>1100</td>
<td>55 000</td>
</tr>
<tr>
<td></td>
<td>Wheelchairs with hand gear</td>
<td>50</td>
<td>2050</td>
<td>102 500</td>
</tr>
<tr>
<td></td>
<td>Wheelchairs for children</td>
<td>100</td>
<td>909</td>
<td>90 900</td>
</tr>
<tr>
<td></td>
<td>Electrically powered wheelchairs</td>
<td>20</td>
<td>5100</td>
<td>102 000</td>
</tr>
</tbody>
</table>

Other assistive products were also procured and supplied by NOC in 2017. The following ready-made products were supplied in 2017 by NOC and its regional branches: canes (2163), axillary crutches (875), white canes (242), hearing aids (216), walkers (138).

A separate annual budget is also allocated to NOC for the manufacture of assistive products. In 2017, the total budget was TJS 423 562 (US$ 45 000). This funding was used to manufacture the products shown in Table 3 below.

Table 3. Assistive products produced by NOC, 2017

<table>
<thead>
<tr>
<th>Assistive product</th>
<th>Annual production (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic footwear (pairs)</td>
<td>4200</td>
</tr>
<tr>
<td>Footwear for prostheses</td>
<td>1600</td>
</tr>
<tr>
<td>Limb prostheses</td>
<td>240</td>
</tr>
<tr>
<td>Arm prostheses</td>
<td>20</td>
</tr>
<tr>
<td>Orthoses – lower limb</td>
<td>86</td>
</tr>
<tr>
<td>Orthoses – upper limb</td>
<td>80</td>
</tr>
<tr>
<td>Orthoses – lower limb (poliomyelitis)</td>
<td>300</td>
</tr>
<tr>
<td>Orthoses – upper limb (poliomyelitis)</td>
<td>270</td>
</tr>
<tr>
<td>Crutches – axillary/elbow</td>
<td>360</td>
</tr>
<tr>
<td>Cervical collar</td>
<td>5</td>
</tr>
<tr>
<td>Corset</td>
<td>36</td>
</tr>
<tr>
<td>Mobility device</td>
<td>72</td>
</tr>
<tr>
<td>Repair of wheelchair</td>
<td>12</td>
</tr>
<tr>
<td>Repair of prostheses and orthoses</td>
<td>600</td>
</tr>
<tr>
<td>Wrist splint</td>
<td>10</td>
</tr>
</tbody>
</table>

The budget for 2018 is estimated at TJS 1.3 million (US$ 140 000) and, on the basis of the 2017 waiting lists, the following products are expected to be procured (Table 4).

Table 4. Assistive product procurement list for 2018

<table>
<thead>
<tr>
<th>Model</th>
<th>No. of units</th>
<th>Cost per unit (TJS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair (for home use)</td>
<td>500</td>
<td>1050</td>
</tr>
<tr>
<td>Wheelchair (with hand gear)</td>
<td>100</td>
<td>2200</td>
</tr>
<tr>
<td>Wheelchair (with commode)</td>
<td>50</td>
<td>1150</td>
</tr>
<tr>
<td>Wheelchair (children)</td>
<td>100</td>
<td>900</td>
</tr>
<tr>
<td>Mobility devices</td>
<td>100</td>
<td>405</td>
</tr>
<tr>
<td>Mobility devices for children</td>
<td>100</td>
<td>300</td>
</tr>
<tr>
<td>Hearing aids</td>
<td>250</td>
<td>280</td>
</tr>
<tr>
<td>Axillary crutches</td>
<td>800</td>
<td>130</td>
</tr>
<tr>
<td>Canes/walkers</td>
<td>2000</td>
<td>60</td>
</tr>
<tr>
<td>White canes</td>
<td>400</td>
<td>40</td>
</tr>
<tr>
<td>Elbow crutches for children</td>
<td>300</td>
<td>90</td>
</tr>
</tbody>
</table>

2.4 Discussion and recommendations

Most assistive products are expensive, and many persons with disabilities in Tajikistan cannot afford to pay for them. Residents of rural areas will also
need to travel to Dushanbe or Khujand to obtain devices, and this brings additional costs. Resolution No. 604 acknowledges the costs and entitles person with disability to free (Government-funded) assistive products, and the associated costs of travel and overnight stay are reimbursed by the State. The rules on provision also recognize the importance of guaranteeing repair services and replacement of the device at the end of its estimated lifespan. These are important provisions which safeguard the rights of persons with disability to access assistive technology. However, the current legal provisions also exclude many people in need from obtaining devices, for the various reasons described below.

The protocol requires the individual to have a disability certificate in order to obtain a Government-funded assistive product, and this denies access to a large part of the population in need. Not only are many people with disabilities not registered with the Government, but other groups of people who do not identify as disabled also need assistive products, most notably older persons and people with noncommunicable diseases. The current criteria should be reconsidered in favour of a model based on a functional perspective. A framework such as the International Classification of Functioning, Disability and Health offers a starting point for a new eligibility model. The newly developed national APL demonstrates the Government’s willingness to go beyond disability in the strict sense, since it includes several assistive products that are primarily used by older persons and people with noncommunicable diseases.

Many potential beneficiaries lack knowledge about their entitlements or do not know how to apply for an assistive product. Some persons may require assistance or support in the application process, since persons with disabilities are more likely to be illiterate (9). The procedure for obtaining devices is complex, and often involves extra costs – for example, getting to and from the local social protection departments might be difficult for a person with disabilities because of the physical inaccessibility of the premises and the transportation costs involved.

The absence of a Government body or committee with oversight over assistive technology hampers the development of the sector. This narrative is mirrored in many other countries in which responsibility for provision of different types of assistive technology is shared among different ministries and departments (e.g. health, social protection, education), with no clear demarcation of the roles and responsibilities of each. In these cases, and in the absence of a national assistive technology strategy, assistive technology has a tendency to “fall through the cracks”, and reform of the sector becomes challenging. The National Programme on Rehabilitation of Persons with Disabilities 2017–2020 outlines the objectives for assistive technology, but the steering committee needs to take a stronger leadership role on assistive technology. The steering committee had an active role in developing the national APL and has started to assume an oversight role for assistive technology, which needs to be reinforced through diligent review of assistive-technology-related activities. User groups should also be involved or consulted in all decisions and activities related to assistive technology.

Another barrier to the development of the assistive technology sector is lack of a comprehensive information system on assistive technology. The Government should maintain records that include feedback from users on assistive technology, which would contribute to an understanding of user needs and allow for monitoring and evaluation of progress. An essential part of an information system is to inform end users and health professionals about the existence and availability of assistive products provided by the State. Some countries have websites that provide relevant information on assistive products (10). Although this is a viable option for Tajikistan, information should also be disseminated through community-based channels, verbally or in print, to reach people in rural areas who do not have access to the Internet.

The Government tender for procurement of assistive products is available only in Tajik and Russian and is not widely publicized. As a result, the information does not reach potential suppliers that could offer more favourable terms. Translating the tender information into English and advertising it more extensively on the Internet would enable more international bidders to apply.

Finally, if Tajikistan is to fulfil its commitments under the Convention on the Rights of Persons with Disabilities, a much higher budget needs to be set aside for assistive technology. The budget should cover the
cost of procurement of a greater number of assistive products, as well as the costs of service provision. Estimates of the total need for each product on the APL in Tajikistan would make it possible to draw up an approximate budget that could be submitted to the Ministry of Finance for consideration.

**Recommendations**

1. Ensure regular discussions on assistive technology in the national steering committee.
2. Set up a comprehensive information system for assistive technology.
3. Advertise tenders for procurement more extensively.
4. Draw up estimates of total need for assistive products in the country for budgeting purposes.
3. Provision

In Tajikistan, most assistive products can be obtained only in Dushanbe or Khujand. A total of 73.6% of people in Tajikistan live in rural areas and have to travel long distances to these cities (11). For the location of providers, see Fig. 4 below.

There is no large-scale production of assistive products in Tajikistan. There are only two manufacturers, in Sughd and Vakhsh; between them they produce fewer than 50 wheelchairs a year, alongside other mobility aids. SEOP (or NOC) and nongovernmental organization workshops also manufacture small numbers of mobility devices such as walkers, standing frames and postural-support chairs.

Fig. 4. Location of assistive technology providers

Source: United Nations Office for the Coordination of Humanitarian Affairs. AT: assistive technology; NGO: nongovernmental organization; SEOP: State Enterprise Orthopaedic Plant.
3.1 Providers

3.1.1 Public providers

SEOP/NOC. The main centre in Dushanbe was founded in 1942 as an orthopaedic shoe manufacturing plant. Today NOC is the only prosthetics and orthotics provider in the country. The centre also provides mobility devices such as walkers and crutches – some of which are manufactured at the workshop using locally sourced materials, while others are imported or received as donations. Since 2015, NOC has also provided hearing aids and white canes in limited numbers, although no staff have been trained to fit these devices.

The largest facility is in Dushanbe, but NOC also has branches in Khujand, Kulob and Khorog – one in each region of the country. A total of 109 employees work in these facilities, including 10 prosthetics and orthotics technicians (two of whom obtained a category II diploma from the International Society for Prosthetics and Orthotics (ISPO) after study in Armenia), five shoemakers and one physiotherapist trained on the job. Most of the professionals working at NOC have not been trained to international standards, with the exception of the two prosthetists/orthotists trained to ISPO category II standard.

Prosthetic and orthotic materials and components used by NOC are imported from China. They are inexpensive but generally low-quality (see Chapter 4). NOC cannot afford high-end products, as it operates on a very low budget. For 2017, the budget was approximately TJS 500 000 (US$ 56 000), of which TJS 120 000 (US$ 13 500) is designated for salaries only.

In previous years, the facility suffered from shortages of materials and components that brought production to a standstill for several months. To manage its resources, NOC has introduced a quota limiting the total number of prostheses produced to 10–15 per month. Total production falls well short of the approximate 400 requests per year, and the number of people on the waiting list for these products is continuing to grow. Approximately 220 people are currently waiting for a lower limb prosthesis from NOC in Dushanbe. Even at the Khujand branch, where prostheses have been produced only since January 2017, 75 people are already on the waiting list.

NOC staff also reuse parts and components from old devices to make new ones. For example, elbow crutches are produced by recycling handles from old devices, and the pylons from old prostheses are also occasionally reused.

Although NOC centres offer repair services for all devices – they repaired 974 devices in 2017 alone – follow-up of patients is not part of the procedure.

3.1.2 Non-profit providers

United Nations agencies and international nongovernmental organizations make important contributions to the assistive technology sector through direct provision of products and by supporting public providers with training and equipment. Some of the main organizations involved are discussed below.

Operation Mercy – between 2015 and 2018, Operation Mercy donated 569 wheelchairs of different models to Tajikistan (Table 5). These wheelchairs were procured by Operation Mercy through funding from its donors. A total of 233 wheelchairs were donated for service provision through NOC. Most of the other wheelchairs (277) were delivered through the Operation Mercy wheelchair workshop in Sughd Region. WHO and the Ministry of Health and Social Protection are currently working to facilitate the integration of Operation Mercy workshops with NOC branches in Dushanbe and Khujand. Operation Mercy also produces a small number of other assistive products, such as standing frames, sitting supports and walkers, in its workshop in Sughd Region.

Table 5. Operation Mercy wheelchairs supplied to Tajikistan since 2015

<table>
<thead>
<tr>
<th>Wheelchair model</th>
<th>Number of units</th>
<th>Cost per unit (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>WM3-01S/M/L/XL</td>
<td>195</td>
<td>245</td>
</tr>
<tr>
<td>WM4X-01S/M/L/XL</td>
<td>196</td>
<td>250</td>
</tr>
<tr>
<td>K3-02</td>
<td>95</td>
<td>170</td>
</tr>
<tr>
<td>Moti-Go</td>
<td>65</td>
<td>302</td>
</tr>
<tr>
<td>Moti Start</td>
<td>8</td>
<td>120</td>
</tr>
<tr>
<td>Multi Sport $</td>
<td>10</td>
<td>420</td>
</tr>
</tbody>
</table>

Note: the sum of US$ 34 400 was spent on transportation for all the above.
Caritas – provides assistive devices mainly through social agency home-based units (SAHU) and implementing partners (local nongovernmental organizations). Caritas has a system of lending wheelchairs to its beneficiaries for set periods of time. Training manuals for the manufacture of assistive products have also been developed. Local carpenters are among those trained by Caritas in the production of devices such as toilet chairs, corner chairs and standing frames. Caritas then commissions the production of assistive products from its trainees.

ICRC MoveAbility – supports NOC with ad hoc equipment, technical support and training. The International Committee of the Red Cross (ICRC) conducted training for NOC staff and supported students in obtaining training in Viet Nam in shoemaking, prosthetics and orthotics.

UNICEF – provided NOC with equipment and machinery for the production of postural-support aids, such as standing frames and postural-support chairs.

WHO – conducted basic training for wheelchair services in December 2015. A total of 42 participants from Tajikistan and Kazakhstan learned how to correctly fit, modify and adapt wheelchairs for various users (12); how to service wheelchairs; and how to train users in using their new chairs. Since 2015, WHO has been instrumental in extending the range of assistive products provided by NOC and adding hearing and vision devices. WHO has also provided technical support for developing the national APL and is now developing standards and specifications for the devices on the list. In addition, WHO is conducting an economic assessment of the viability of local production of wheelchairs in Tajikistan.

3.1.3 Private providers

Pharmacies in Dushanbe and Khujand sell assistive products, most of which are imported from China. Walking frames, rollators, walking sticks, wheelchairs and motorized wheelchairs are available. Hearing aids (sound amplifiers) can also be purchased in various models, with costs ranging from US$ 15 to US$ 90. Additionally, reading glasses and spectacles are available at opticians in Dushanbe and Khujand, with a starting price of US$ 15 for reading glasses.

Many people obtain assistive products and services from outside the country, mainly from the Russian Federation, either in person or through relatives living abroad (see section 4.1).

3.2 Local production

3.2.1 Dilshod

Dilshod is located in the small district of Vakhsh, 120 kilometres south of Dushanbe. Wheelchairs and other mobility aids are manufactured at this workshop, using locally sourced materials. From 2012 to 2013, AAR Japan supported Dilshod in wheelchair production with equipment and training for its technicians. In 2012, the Ministry of Health and Social Protection concluded an agreement with Dilshod for the supply of 220 wheelchairs over two years, but the tender was not renewed in the following years, and the centre now struggles to find clients.

Owing to a lack of demand, production has decreased every year since 2012, and the workshop is now almost out of business. The centre currently has no full-time staff, and its doors remain closed most of the time. The trained technicians work at the centre only in their spare time, when an order is placed. Table 6 shows the output over the period 2015–2017.

Table 6. Production of wheelchairs and other assistive products by Dilshod, 2015–2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Total wheelchairs produced</th>
<th>Other assistive products</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>45</td>
<td>60</td>
</tr>
<tr>
<td>2016</td>
<td>40</td>
<td>50</td>
</tr>
<tr>
<td>2017</td>
<td>28</td>
<td>45</td>
</tr>
</tbody>
</table>
Two wheelchair models are manufactured – a three-wheel and a four-wheel model. All wheelchairs are customized to the recipient’s needs. The prices range from TJS 1500 (US$ 160) to TJS 2250 (US$ 240), depending on model and size. Repair services are also provided at the centre. Other assistive products that the workshop produces include standing frames, walkers and sitting support. The centre works with schools in the districts to meet the needs of children with disability.

The wheelchairs are outdated in design (see Fig. 5) and are not suitable for active users. Feedback from the staff of international nongovernmental organizations also highlighted concerns regarding their strength and durability. Many people who have obtained wheelchairs from Dilshod do not use them on a regular basis because they are impractical to use. The director of Dilshod acknowledges that there are problems with the wheelchairs and has asked for more training and support to produce better-quality products.

3.2.2 BODOM

This Soviet legacy industrial complex in Sughd Region, occupying 12 hectares of land, was established well before Tajikistan gained its independence. Much of the infrastructure is severely damaged, and the machinery, dating from the 1980s, has now mostly fallen into disuse. During the Soviet era, it housed a thriving industry manufacturing car parts; now, only 10% of the factory is operational, producing components for an aluminium factory. Between 1990 and 2010, BODOM moved into manufacturing bicycles, wheelchairs and other aluminium-based products and devices, including crutches and walkers. Until 2010, the centre produced 200–300 wheelchairs per year, commissioned by NOC. In 2010, the production of wheelchairs ceased because the centre lost the tender to supply NOC. BODOM wheelchairs retailed for approximately TJS 1600 (US$ 170) per unit, and could not compete with the Chinese wheelchairs that, at the time, were selling for US$ 110 per unit.

Although BODOM is no longer producing wheelchairs, it retains the capacity to do so. In 2015, a few dozen wheelchairs were produced to fulfil an order from a nongovernmental organization. According to the director, even in its present state (with only a small fraction of the factory operational), the centre has the capacity to produce up to 600 units per year. The wheelchairs it produced came in two models. The designs were very outdated, and the director himself stated that their quality was not very good, as they were too heavy – he also stated that they were for use only inside the home.

3.3 Discussion and recommendations

In their current capacity, assistive technology providers in Tajikistan cannot meet the assistive technology needs of the country. NOC will need more resources of all kinds (financial, personnel and equipment) to scale up production, procurement and provision of all devices if it is to meet the needs of the population.
Nongovernmental organizations and public providers focus mostly on mobility impairments, while sensorial, cognitive and self-care devices are overlooked. However, in recent years, NOC has started to provide hearing aids and white canes, suggesting the beginning of a transition from an orthopaedic facility to an assistive technology centre. Extending assistive technology services for people with visual and hearing impairments is a positive development. For a low resource country like Tajikistan, an assistive technology centre that caters for different types of impairments is also more efficient for both the user and the State. The advantage consists in being assessed for and fitted with different types of assistive products during a single visit at the same location, thus reducing the burden of travel to different facilities. Providing all devices at the same facility is also an efficient use of Government resources, since there can be a shared space for assessment, training and administration. This shift will require NOC to recruit competent personnel for the provision of sensorial devices.

NOC does not follow up with patients after provision of assistive products – this should become part of its standard procedures to ensure that products and services continue to meet the needs of the user. NOC staff should schedule appointments with patients for follow-up. The appointments are also an opportunity to conduct minor repairs or maintenance on the devices, or answer any questions users may have about their use.

The majority of the population of Tajikistan (73.6%) still lives in rural areas; for many people, the long distances to Dushanbe or Khujand are a significant obstacle to obtaining the products they need. The results of the survey confirmed that 37% of the people who do not have the assistive products they need attributed the cause to the device not being available in their community (see Fig. 11, p. 26). To overcome the burden of travel, some devices (e.g. crutches or walkers) should be supplied at primary health care centres by nurses or CBR workers who have received basic training. Wheelchairs are currently distributed at the district level; however, these are delivered at the local social protection departments by people who are not appropriately trained and at locations that are not equipped for wheelchair provision (i.e. they lack the tools for fitting or making adjustments or minor repairs). It would be preferable if wheelchairs were provided at health-care centres by health workers who have an understanding of the secondary complications that may arise from use of the device. In any case, whether the wheelchairs are supplied at health facilities or by local social protection departments, the staff appointed for the task should be trained in the eight steps of service provision recommended by WHO. One possibility for local social protection departments is to contract a trained technician for the supply of wheelchairs in a number of adjacent districts. Local social protection departments can also work in close collaboration with psychological, medical and pedagogical commissions and primary health care centres that may be better equipped, in terms of staff and facilities, to provide wheelchair services.

Local producers Dilshod and BODOM are unable to produce high-quality wheelchairs at a competitive cost, and are now almost out of business. Multiple factors have contributed to their failure, some of which could be mitigated through better planning, while others are beyond their control. Both centres are located far from the capital, where most economic activity takes place and where there is the highest need for wheelchairs. The wheelchair designs are outdated and not suitable for active users. The production capacity is too low to meet Government tenders, and the centres do not have good working relationships with the Government, the main purchaser of wheelchairs in the country. Although the experiences of Dilshod and BODOM suggest that local production of wheelchairs might not be sustainable, the National Rehabilitation Programme explicitly calls for an assessment of the possibility of producing assistive devices locally. In compliance with this request, an economic assessment will be conducted to examine the viability of setting up a wheelchair manufacturing centre in Dushanbe, producing better-quality wheelchairs in larger numbers, to compete in the Government yearly tender. Tajikistan enjoys favourable conditions in this respect, since labour costs are very low and transportation costs from other countries are very high; however, it should be noted that small-scale local production of wheelchairs is rarely sustainable.

Even though Dilshod and BODOM may not be efficient in producing wheelchairs for the Tajik market, they are important resources for the country. Both centres are equipped with machinery and skilled labour that is scarce in Tajikistan. Additionally, they offer
much-needed repair services and have the capacity to produce customized wheelchairs for complex cases. These centres could be reorganized to focus on repairs and adaptations for complex cases, and could be supported in these activities.

The non-profit sector has a very positive impact on assistive technology in Tajikistan. Cooperation between public providers and international organizations should be strengthened and further integrated. Public facilities should continue to benefit from the training and resources that the international community can provide. Only through this cooperation can there be an accelerated transformation of the sector with lasting effects on the country.

**Recommendations**

1. Support NOC in the transition from orthopaedic plant to assistive technology centre, in close cooperation with health facilities (primary, secondary and tertiary).
2. Introduce regular follow-up appointments with all patients who receive a Government-funded product.
3. Increase resources for NOC – financial, personnel, equipment.
4. Involve primary health care centres in the provision of basic assistive products.
5. Conduct an economic assessment of the sustainability of local wheelchair production.
6. Support local producers in providing repair services.
7. Ensure that all wheelchairs are provided only by staff trained in service provision and in facilities that are equipped for providing services that include training and minor repairs.
4. Products

4.1 Rapid survey results

During the rapid survey, the 200 participants were shown a number of assistive products and asked to select the ones that could help them (Part A of the rapid survey). The respondents were also asked whether or not they had the products they needed. Fig. 6 illustrates the results. The blue bar represents the met need (the person has the device) while the yellow represents the unmet need (the person needs, but does not have, the device). The sum of met and unmet need constitutes the total need. The products are ranked from the most-needed to the least-needed.

Fig. 6. Total need for assistive products

Part A Total need for assistive products

<table>
<thead>
<tr>
<th>Product in use (met need)</th>
<th>Product needed (unmet need)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair</td>
<td>2</td>
</tr>
<tr>
<td>Toilet chair</td>
<td>2</td>
</tr>
<tr>
<td>Wheelchair postural support</td>
<td>2</td>
</tr>
<tr>
<td>Reading glasses</td>
<td>14</td>
</tr>
<tr>
<td>Incontinence products</td>
<td>12</td>
</tr>
<tr>
<td>Rollator</td>
<td>6</td>
</tr>
<tr>
<td>Shower chair</td>
<td>0</td>
</tr>
<tr>
<td>Lumbar corset</td>
<td>2</td>
</tr>
<tr>
<td>Walker</td>
<td>0</td>
</tr>
<tr>
<td>Axillary crutches</td>
<td>13</td>
</tr>
<tr>
<td>Standing frame</td>
<td>2</td>
</tr>
<tr>
<td>Hearing aid</td>
<td>7</td>
</tr>
<tr>
<td>Protective footwear</td>
<td>15</td>
</tr>
<tr>
<td>Orthosis</td>
<td>10</td>
</tr>
<tr>
<td>Spinal orthosis</td>
<td>14</td>
</tr>
<tr>
<td>Sitting support</td>
<td>3</td>
</tr>
<tr>
<td>Orthopaedic shoes</td>
<td>10</td>
</tr>
<tr>
<td>Communication board</td>
<td>3</td>
</tr>
<tr>
<td>Communication software</td>
<td>0</td>
</tr>
<tr>
<td>Knee brace</td>
<td>1</td>
</tr>
<tr>
<td>Pressure relief cushion</td>
<td>1</td>
</tr>
<tr>
<td>Talking book</td>
<td>4</td>
</tr>
<tr>
<td>Portable ramp</td>
<td>1</td>
</tr>
<tr>
<td>White cane</td>
<td>4</td>
</tr>
<tr>
<td>Braille slate</td>
<td>5</td>
</tr>
<tr>
<td>Elbow crutches</td>
<td>3</td>
</tr>
<tr>
<td>Walking stick</td>
<td>4</td>
</tr>
<tr>
<td>Grab bar</td>
<td>5</td>
</tr>
<tr>
<td>Recorder</td>
<td>4</td>
</tr>
<tr>
<td>Optical magnifier</td>
<td>3</td>
</tr>
<tr>
<td>Alarm signaller</td>
<td>4</td>
</tr>
<tr>
<td>Club foot brace</td>
<td>0</td>
</tr>
<tr>
<td>Cervical collar</td>
<td>0</td>
</tr>
<tr>
<td>Talking watch</td>
<td>0</td>
</tr>
<tr>
<td>Simplified mobile phone</td>
<td>1</td>
</tr>
<tr>
<td>Magnetic white board</td>
<td>2</td>
</tr>
<tr>
<td>Pill organizer</td>
<td>0</td>
</tr>
<tr>
<td>Wrist brace</td>
<td>0</td>
</tr>
<tr>
<td>Prosthesis</td>
<td>1</td>
</tr>
<tr>
<td>Tripod/Quadripod</td>
<td>2</td>
</tr>
</tbody>
</table>

0 10 20 30 40 50 60 70 80
For the majority of assistive products, the need was mostly unmet. A total of 33 people of the 200 people interviewed said that they had no products at all.

Survey participants were asked to provide additional information on the assistive products they used (Part B, question B1 of the rapid survey). They answered questions relating to use of the following 126 devices:

- wheelchairs: 58
- orthoses: 14
- crutches: 13
- walkers: 13
- reading glasses: 11
- hearing aids: 5
- others: 12.

Fig. 7 shows the provenance of these assistive products.

**Fig. 7. Source of assistive products**

<table>
<thead>
<tr>
<th>Source of Product</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nongovernmental organization</td>
<td>26</td>
</tr>
<tr>
<td>Local Department of Social Protection</td>
<td>20</td>
</tr>
<tr>
<td>Shop, market or commercial centre</td>
<td>16</td>
</tr>
<tr>
<td>From facility in another country</td>
<td>14</td>
</tr>
<tr>
<td>SEOP</td>
<td>12</td>
</tr>
<tr>
<td>Hospital, health care facility</td>
<td>11</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>9</td>
</tr>
<tr>
<td>From an individual living abroad</td>
<td>5</td>
</tr>
<tr>
<td>Made by self, family or artisan</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
</tr>
</tbody>
</table>

*Six participants did not answer the question.

People obtain assistive products from a variety of sources. Nongovernmental organizations were the main providers, although they accounted for less than one quarter of the total provision. Many people obtained devices from family members living abroad or from facilities in other countries, especially the Russian Federation. As a measure of product performance, the participants were asked whether products obtained from various providers met their needs (Part B, question B6 of the rapid survey). See Fig. 8.
Although almost two thirds of respondents answered that the assistive products fully met their needs, there were significant differences between providers. A total of 96% of those who received the assistive product from a nongovernmental organization said that their needs were fully met, but only 63% and 53%, respectively, of persons who obtained the product from the public and from the private sector were equally satisfied.

Participants were also asked about the condition of the product and any problems they had with it (Part B, questions B7 and B8 of the rapid survey). A total of 60% said the product was “as good as new” but, again, there were significant differences between providers. A total of 49% of respondents who had obtained devices from the public sector said that the device had parts that broke easily, compared with only 4% of respondents with devices provided by the non-profit sector. See Fig. 9.
Fig. 9. Condition of the product and any problems experienced

Although users reported that many of the public and private sector devices break easily, almost half the participants (46%) said they rarely or never have a place where they can go for repairs (Part B, question B15 of the rapid survey). See Fig. 10.

Fig. 10. Availability of repair and maintenance services
When asked about service provision (Part B, questions B12–B14 of the rapid survey), most participants said that the assistive product was prescribed following an assessment (81%), that it was fitted/customized to their needs (77%), and that training was provided on how to use and care for the product (68%). It is encouraging that most survey participants reported that these service steps were observed. See Table 7.

### Table 7. Assessment, customization and training for assistive products

<table>
<thead>
<tr>
<th>B12 Was the product prescribed for you following an assessment? (% of respondents)</th>
<th>B13 Was the product fitted to you or customized to your needs? (% of respondents)</th>
<th>B14 Have you received any training on how to use and take care of the product? (% of respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>81</td>
<td>77</td>
</tr>
<tr>
<td>No</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>Missing (no answer)</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

In Part C of the survey, participants who reported not using a product that could help them were asked to explain why they were not using the product (Part C, question C6 of the rapid survey). Fig. 11 shows the barriers to access.

Being unable to afford the product was the main reason that stopped people from getting the device they needed – 81% mentioned this issue. Lack of availability and lack of awareness were also important barriers. A total of 48% of people said that they did not know where to obtain the devices. During the focus group discussions, it also became apparent that many persons do not even know of the existence of many products that could help them, and do not know that they are entitled to them.

### Fig. 11. Reasons for not using assistive products

C6 You told me that you do not use assistive products that could help you. What stops you from using them?

- I cannot afford them: 81%
- I do not know where to get them: 48%
- They are not available in the community: 37%
- I am not able to use them: 16%
- They do not work: 10%
- They do not suit my environment: 2%
- Other: 3%
4.2 Assistive products

4.2.1 Wheelchairs

The self-reported need for wheelchairs was higher than that for any other product. A total of 78 persons (39%) expressed a need for a wheelchair: 58 of them had a wheelchair they could use, while the remaining 20 did not. Thus the need was mostly met, since most survey participants were beneficiaries of CBR programmes and many of them had received a wheelchair from a nongovernmental organization CBR programme supported by the Ministry of Health and Social Protection. Unfortunately, only some persons with disabilities in the country are recipients of CBR programmes, so the unmet need is likely to be much higher among the general population. Persons in need of a Government-funded wheelchair are placed on a waiting list. At the current rate of wheelchair provision, as at July 2018, more than 1000 people are on the waiting list and the last person on the list is due to receive a wheelchair in December 2019.

Postural-support wheelchairs were more difficult to find – 36 persons needed such a wheelchair, but only two had access to one. Some focus group participants had modified their basic wheelchairs by installing belts and cushions to improve postural support.

Satisfaction rates were very high for wheelchairs provided by nongovernmental organizations, whereas users who received wheelchairs from public or private sources were less satisfied with their quality (Part B, questions B6.WC and B8.WC of the rapid survey). See Fig. 12. Recipients of wheelchairs provided by nongovernmental organizations received assessment, fitting and training in most cases (Part B, questions B12.WC, B13.WC and B14.WC of the rapid survey). See Table 8.

No participants who attended the focus group discussions were using Government-provided wheelchairs, but some reported negative experiences with them in the past. The local social protection departments had provided wheelchairs of the wrong size, and no adjustments had been made for the user. A mother said that her daughter had been given a wheelchair that was too big for her; they had been told that it was the only size available at the time, so they had to use pillows to fill the gaps on either side of the daughter’s pelvis. Pressure-relief cushions were never provided with the wheelchairs. Two wheelchair users had developed pressure sores in the past because of incorrectly fitted wheelchairs and a lack of pressure-relief cushions. No one had received any training on the use or maintenance of the wheelchairs. Other complaints people made about the wheelchairs included: weight (too heavy), difficulty of manoeuvring (self-propelling) or castor wheels breaking easily.

Most people made little use of their wheelchairs: some only used them for a few hours a day to go outside in the summer, and were always accompanied by other people. The Government-provided wheelchairs are not suitable for outdoor use, and this reduces the autonomy of users. During a focus group discussion in Sughd Region, one parent enthusiastically described how receiving wheelchairs from Operation Mercy had changed the lives of his two daughters, who have cerebral palsy. Previously they had used Government-funded wheelchairs, but they had felt unsafe going out in them because the wheelchair would shake when used outdoors. Now they feel much more confident going outside with the wheelchairs that have been customized for them, and they now leave the house more frequently.
Case study 1:

Seven years ago, Safo suffered a spinal cord injury that left his lower limbs paralysed. He does not work, and spends most of his days at home, sitting on a mattress. After his accident, he received a donated wheelchair from a nongovernmental organization, but he described it as never working well for him. In particular, the tyres always burst and he did not have a pressure-relief cushion. Now he has a new wheelchair. His family had to fit a belt on the frame of the wheelchair to stop his torso from tilting forward. He only uses the wheelchair to go outside the house for a few hours a day in the summer, as there is insufficient space in his flat. When he uses it outside, he always has a family member with him. In previous years, he used to go out alone, but one day he fell and injured his face, and he has been scared to be outside by himself since then. He exercises his arm muscles and they have been getting stronger. He says that, if he had a better wheelchair and some training, he would have the confidence to go out by himself again.

Fig. 12. Satisfaction with wheelchairs and problems experienced, by provider

Table 8. Assessment, fitting and training for wheelchair use, by provider

<table>
<thead>
<tr>
<th>Wheelchairs only</th>
<th>Wheelchair was prescribed following an assessment (B12.WC) (% of respondents)</th>
<th>Wheelchair was fitted according to the needs (B13.WC) (% of respondents)</th>
<th>Wheelchair training on use and maintenance (B14.WC) (% of respondents)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>63</td>
<td>37</td>
<td>58</td>
</tr>
<tr>
<td>Non-profit</td>
<td>100</td>
<td>100</td>
<td>83</td>
</tr>
<tr>
<td>Private</td>
<td>88</td>
<td>88</td>
<td>50</td>
</tr>
</tbody>
</table>
4.2.2 Self-care products

The combined need for self-care products was very high, but very few people used them. These devices, often overlooked by providers, can make a big difference to persons with disabilities and their families.

Toilet chairs were the second most frequently selected assistive product in the survey, but only two of the 61 people needing a toilet chair actually had one. Many toilets in Tajikistan require users to squat, which is difficult or impossible for persons with mobility impairments. Many wheelchair users also live in apartments with small, inaccessible bathrooms, and this also contributes to the high need for self-care assistive products.

Toilet chairs are available in the pharmacies in Dushanbe and Khujand, and NOC also procures a small number. During the focus group discussions, a participant said that incontinence products, such as adult diapers, are also available at the market, but that they are expensive.

Toilet chairs are available in the pharmacies in Dushanbe and Khujand, and NOC also procures a small number. During the focus group discussions, a participant said that incontinence products, such as adult diapers, are also available at the market, but that they are expensive.

4.2.3 Mobility aids

The survey found a high need for mobility aids other than wheelchairs, such as walkers, crutches and walking sticks. The 200 survey participants reported a combined need for 86 mobility aids of these kinds. The total need was almost twice as high for walkers and rollators (55 selected) than for axillary/elbow crutches (26 selected). In the case of walkers and axillary crutches, the need was mostly met, while in the case of rollators and elbow crutches it was mostly unmet.

In some cases, focus group participants were using crutches that were too high or too low, and complained of joint pains from using them. Incorrectly fitted crutches and walkers are harder to use and increase the chance of falls and injury. One man with lower limb paralysis due to poliomyelitis (polio) described the challenges of being a lifelong crutch user, but being unable to find crutches in Tajikistan that would hold his weight and having to replace the crutches frequently. He now uses a stronger crutch that a friend purchased for him in Dubai.

Participants also complained that the rubber tips at the bottom of the crutches wear out very fast (within 1 month); it is not easy to replace them, as they are both hard to find and expensive.

Case study 2:

Aziza is a woman in Dushanbe who uses elbow crutches to support her while walking. She obtained the crutches from NOC, but they are too short for her and not height-adjustable. She never received training on how to use the crutches. She feels pain in her shoulder muscles and her hands from using the crutches. She wishes to have crutches that are adjustable in height so that she can wear different shoes, and she would like to have padding on the handgrips to relieve the pressure on her hands. She also uses a wheelchair and needs a postural-support cushion, but cannot find one in Tajikistan.

4.2.4 Orthoses

Although 161 survey participants (80.5%) had at least some difficulty with walking, only 17 people (8.5%) reported a need for an orthosis. Lower limb orthoses may benefit people with a variety of conditions that are prevalent in Tajikistan, such as cerebral palsy, post-polio paralysis and stroke. Two factors help to explain why the self-reported need was so low.

First, a common problem among focus group participants, especially for children with cerebral palsy, was the onset of contractures. A hip, knee or ankle contracture needs to be straightened before a functional orthosis for standing or walking can be fitted. However, during the focus group discussions, it transpired that the persons affected did not know what could be done, or could not afford treatment; hence, the contractures were left untreated, in some cases for several years. People in this situation resorted to using wheelchairs or crutches, and reported a need for these assistive products during the survey.

Second, knowledge of the applications and benefits of orthoses is limited. Some potential beneficiaries did not know about the existence of orthoses that could help them. Others had negative experiences with badly fitted orthoses in the past, and did not want to go back to
using them. The lack of knowledge about orthoses also indicates that staff of nongovernmental organizations working in CBR programmes also need more training on assistive technology and its uses.

In Tajikistan, there are widespread misconceptions that exacerbate the above-mentioned problems. Some physicians in the country have been taught that contractures should never be stretched and that using an orthosis inevitably leads to muscle atrophy. More education is needed to dispel these myths and inform health-care staff about cases when orthotic treatment is indicated and what it can achieve.

Spinal orthoses are also produced at NOC, mainly cervico-thoraco-lumbo-sacral orthoses (Milwaukee models). The prosthetists and orthotists in Dushanbe said that they needed more training for spinal orthoses, especially thoraco-lumbo-sacral and lumbo-sacral orthoses, which require advanced orthotic skills.

4.2.5 Prostheses

Only the NOC centres of Dushanbe and Khujand provide prostheses. The material and components used for prosthesis manufacture are inexpensive Chinese imports, seemingly of low quality and durability. The solid ankle cushion heel (SACH) feet are fragile and wear out fast. NOC staff reported that, in some cases, when the users are active and reside in mountainous areas, the SACH feet will break within 3 months of delivery. One of the prosthetists interviewed said that the polypropylene was more difficult to use and less resistant than the type she used during her training in Viet Nam. The ethylene vinyl acetate foam used for producing liners and for padding also wears out very quickly.

The prosthetists at NOC complained that, because of incorrectly performed amputations, the residual limbs of some of their patients are not suitable for fitting prostheses. In some cases the stump is too short, or bone spurs develop because cut bones have not been rounded off and sealed. It is not uncommon for amputees to be subjected to reamputation because the first amputation has not been performed correctly.

4.2.6 Orthopaedic shoes

Orthopaedic shoes produced at NOC are custom-made for each patient, following casting and production of a mould that is stored at the centres so that it can be reutilized when shoes need to be replaced. The shoes are provided for a variety of pathologies: foot deformities, leg length discrepancy, flat feet, etc. The types of shoe produced include special footwear for prostheses and winter footwear, but not protective footwear for diabetics. Unlike orthopaedic shoes, which are generally manufactured to accommodate and compensate for foot deformities, protective footwear is designed to protect the insensate foot from pressure injuries by redistributing ground reaction forces. The number of orthopaedic shoes manufactured at NOC far exceeds that of any other product.

NOC has a long history of manufacturing orthopaedic shoes, and they are the only product that the Khorog and Kulob branches manufacture; this may begin to explain why so many are produced. The law is also generous with regards to provision of this assistive product – resolution No. 604 entitles patients to a new pair of orthopaedic shoes every 6 months. As a consequence, orthopaedic shoes are allegedly in very high demand from patients.

In 2017, over 4200 shoes were delivered, which is more than 10 times as many as the number of orthoses in the same year. It would seem that orthopaedic shoes are overprescribed. Occasionally, they will be supplied

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**Case study 3:**

Dilya, a 7-year-old girl with cerebral palsy who lives with her family in Rogun, uses bilateral ankle-foot orthoses made in the Islamic Republic of Iran. She did not go to the country; her father took her measurements and sent them to the production workshop, and they received the devices by post. She has already had two pairs made as she outgrew the old ones. She wears the orthoses at home, and her father says that they help to keep her legs straight and that she can walk, with someone holding her hands, when she uses them. When she was younger, she had ankle-foot orthoses made in Tajikistan that did not have padding and were uncomfortable to wear. They also did not have rubber soles, so they were slippery and difficult to walk with. Dilya also uses a walker that her father made for her.
to manage conditions for which a foot or ankle-foot orthosis would be more appropriate. In other situations, they are supplied for small deformities that might not justify use of the device, e.g. hallux valgus (bunion).

NOC originated as a shoe manufacturing plant and, to some extent, it is perceived as focusing primarily on this device, which leads to high demand from clients for orthopaedic shoes and a high capacity to produce them at NOC branches. NOC has evolved into an assistive technology centre that has much more to offer than orthopaedic shoes, and it needs to work on changing its image accordingly and offering more alternative products to its clients.

There was dissatisfaction among the focus group participants regarding the quality of the orthopaedic shoes. The shoes are uncomfortable and lose their shape quickly. For many users, the appearance of the shoes was an issue, with some saying they were embarrassed to wear them.

NOC needs to strengthen the knowledge and skills of its staff in orthopaedic shoe production. The newly trained shoemakers who recently joined the organization can make important contributions if given the chance to practise what they have learned. To capitalize on their knowledge and skills, NOC needs to enable them to work with different materials and designs and be flexible enough to modernize its production procedures.

4.2.7 Reading glasses

Reading glasses are the most-needed sensory product, ranked fourth of all the products in the survey. Although the product is available from opticians and pharmacies in Dushanbe and Khujand, and relatively inexpensive compared with other products, the survey revealed that only 14 of the 34 persons who needed them had access to glasses.

Reading glasses are mostly needed by older persons, and this was also apparent during the focus group discussion with older persons in Dushanbe, in which the majority of participants used or needed reading glasses. Some of the participants told us they could not afford the US$ 10–20 required to buy them.

4.2.8 Products for people with blindness

The schools for the blind in Tajikistan are equipped with Braille slates, and children are taught to read and write in Braille. However, there are no providers of Braille slates for personal use, and Braille paper is expensive. To support the education of children and adults with blindness, the Italian society for blind people made a donation of 4.5 tonnes of Braille paper to Tajikistan in September 2017, with WHO and Ministry of Health and Social Protection facilitation.

Folding white canes are available from NOC in limited numbers (see Fig. 13). During the focus group discussion with the Association of Blind People, one participant said these are too heavy and not good for sensing the environment as the rubber tips are not designed for the purpose and do not convey sensation well. Also, at NOC there are no mobility orientation instructors; the white canes provided are not always the right length for the user, often being too long.

Two members of the Association of Blind People were trained by the charity CBM in Jordan to become mobility orientation instructors. NOC should work in collaboration with these trainers for the provision of white canes and other vision-related devices.
4.2.9 Hearing aids

Hearing aids are available only in the private sector, and most Tajik people cannot afford them. The SOMEAD private clinic in Dushanbe sells them for US$ 500–600.

NOC provides some personal sound amplifiers, and pharmacies also sell sound amplifiers for as little as US$ 20. Unlike hearing aids, which differentiate between different frequencies of sound, sound amplifiers make all sounds louder. Although they are not the most suitable assistive solutions for persons with hearing impairments, they are still useful for many older persons who experience gradual hearing loss, with the advantage that they are relatively inexpensive. Unfortunately, the sound amplifiers sold in pharmacies in Dushanbe and Khujand are of poor quality.

The focus group participants had experienced a variety of problems with the hearing aids and sounds amplifiers. For some people, they did not work at all. In other cases, people struggled to use them because they were the wrong size, or the device whistled in their ear, or they did not know how to use them. Out of exasperation, these people quickly abandoned the device. The lack of diagnostic equipment for hearing loss also poses a challenge for provision.

Sound amplifiers can be useful for some people with disabling hearing loss, but in Tajikistan their quality is very low. Introducing standards and specifications for these devices would ensure that they meet minimum criteria and are safe to use.

4.3 Discussion and recommendations

There is a need to increase the supply of all assistive products and to broaden the range of devices provided, taking into account the real needs of the population. The survey found a high need for many assistive products that are currently not provided by the Government, such as reading glasses and various self-care products. Fortunately, these devices are part of the recently developed national APL.

The survey and focus group discussions revealed dissatisfaction with Government-provided products. Most of the participants reported that the devices do not work as they should, and that they are difficult to use and break easily. The overall quality of Government-procured products is very low. Devices that do not perform well are often abandoned or used only on rare occasions. Some products and components are of such low quality that they are not worth investing in at all. Introducing minimum standards and specifications for each assistive product would be an effective way of avoiding the procurement of substandard products.

In an effort to provide more assistive products, the Government is procuring less expensive products. However, it may end up spending more over time by procuring low-quality products that break down more easily and consequently need to be replaced more often. In other words, it is more cost-effective for the State to provide a device for US$ 80 that is likely to last for five years than to provide a device that costs US$ 50 but is likely to be broken beyond repair within the first year. Procuring high-end, expensive products is not necessary, but high-quality, low-cost products can be found, and spending slightly more on such products would be more cost-effective than procuring the cheapest products available. “Number-boasting” about assistive product provision is a common problem in many countries: nongovernmental organizations and governments alike are guilty of this. Providers misleadingly point to the number of assistive products donated or supplied as a measure of accomplishment when, in fact, the indicator of success should be the utility of those products to the users and the duration of their useful life.

The provision of all assistive products should follow appropriate service provision steps, including assessment, fitting and training in the use and maintenance of the product. The results of the survey and the discussions in the focus groups clearly showed that these service steps are often neglected. The multisectoral National Programme on Rehabilitation of Persons with Disabilities 2017–2020 also acknowledges this to be a problem and aims to change assistive technology from a distribution model to a service provision model. When assessment, fitting and training are ignored, the user may be in a situation...
where he/she is unable to use the product or may feel pain or discomfort when using it, or the wrong product may have been prescribed. In such cases, the assistive products are likely to be abandoned.

All devices will eventually break or wear out, but almost half the survey participants said they rarely or never had a place to go for repairs. Increasing the number and accessibility of maintenance and repair services would enable the products to serve the users for longer.

**Recommendations**

1. Adopt the national APL.
2. Introduce technical specifications and minimum standards for all assistive products on the APL.
3. Increase availability and accessibility of repair centres for APL products.
4. Enforce a procedure for the provision of all assistive products that includes follow-up of patients.
5. Train CBR workers and health-care staff in the uses and benefits of assistive products.
5. Personnel

5.1 Types of personnel

The lack of trained specialists and rehabilitation professionals is one of the main challenges holding back the assistive technology sector. There are no hearing-aid technicians, physiotherapists, occupational therapists, wheelchair technicians or speech therapists trained to international standards, and only two ISPO-certified prosthetists/orthotists (category II). People currently working in any of these capacities have learned on the job and through short training courses.

Rehabilitation practices in the country are not favourable for the professional development of assistive technology specialists. As the country’s rehabilitation system has always operated in the absence of these professionals, there is limited perceived need for them and the skills they bring. Indeed, some rehabilitation and assistive technology professionals do not even have official recognition – for instance, prosthetists/orthotists and speech therapists are not included in the All-Republic Classifier of Occupations in Tajikistan. Although the latter lists physical and occupational therapists, there is no education, training or licensing for these professions.

The country struggles to retain qualified health professionals, who have much better career prospects abroad (5). Salaries are low in Tajikistan, and working conditions are better in other countries, such as the Russian Federation. Therefore, the most talented workers will often leave the country when the opportunity arises.

The health workforce comprises mainly physicians of different specializations and a relatively high number of nurses (Table 9). Only one in six physicians works in rural areas, but a higher proportion of nurses is deployed to these areas. These health workers could potentially constitute an important resource for assistive technology, but unfortunately most are not knowledgeable about assistive products and their use, and they currently play no role in provision.

5.2 Educational facilities

There is currently no professional human resource development in the fields of physiotherapy, occupational therapy, prosthetics and orthotics, speech therapy, physical medicine or rehabilitation. Universities in Tajikistan do not have courses on these disciplines, and there are no professionals qualified to international standards to teach such courses.

The Ministry of Health and Social Protection, WHO and ICRC MoveAbility have sponsored students to study abroad in India and Viet Nam. WHO has sponsored one physiotherapist, one occupational therapist, four rehabilitation therapy assistants and two physical medical rehabilitation students, with binding agreements that they will work in Tajikistan for a number of years on completion of their respective programmes. It is envisaged that, when these trained professionals return, education programmes can

<table>
<thead>
<tr>
<th>Health workforce</th>
<th>Total number of personnel</th>
<th>Number of female personnel</th>
<th>Number of personnel working in rural areas</th>
<th>Number of personnel in public services</th>
<th>Average salary in public services (TJS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians (all specializations)</td>
<td>18 716</td>
<td>7 205</td>
<td>3 142</td>
<td>17 392</td>
<td>945</td>
</tr>
<tr>
<td>Nurses</td>
<td>51 788</td>
<td>43 623</td>
<td>17 977</td>
<td>50 379</td>
<td>586</td>
</tr>
</tbody>
</table>

*Data source: Ministry of Health and Social Protection, statistical reporting form No. 17 “Report on health workforce”.*
be introduced in the country with the support of international professional associations.

5.3 Task-shifting

In the absence of qualified assistive technology professionals, training of non-specialists, such as nurses and CBR workers, in the provision of assistive products becomes very important. Many assistive products can be delivered by "generalists" with minimum training but, regrettably, health workers do not receive any relevant training in assistive technology. Medical doctors also do not receive training in assistive products, and even the commissions of the Agency for Medical and Social Examination have little information on the assistive products available and their uses. The action plan of the multisectoral National Programme on Rehabilitation of Persons with Disabilities 2017–2020 includes the introduction of rehabilitation and assistive technology courses for medical doctors and nurses, which will address the need for new graduates who will join the labour market equipped with these skills.

A number of short training courses on rehabilitation and assistive technology have been provided by international and nongovernmental organizations, including UNICEF and WHO. Participants spoke very highly of these courses, but sustainability remains an issue in the absence of formal supervision and continuing education. Participants also complained of the lack of formal Government-recognized certification for these courses and the lack of opportunities to refresh and upgrade their knowledge.

5.4 Discussion and recommendations

A multidisciplinary health workforce is necessary to meet the assistive technology needs of any country. Low-income countries should strive for the right balance of rehabilitation and assistive technology "specialists" (prosthetists and orthotists, occupational therapists, speech therapists, audiologists, etc.), skilled in the provision of specific types of product, and "generalists" (nurses, CBR workers, etc.) with basic training in providing assistive technology (13). The situation of Tajikistan is that assistive technology specialists are lacking and generalists have no training in assistive technology. Developing the right skill-mix is the long-term objective, and a strategy is needed to achieve this. The multisectoral National Programme on Rehabilitation of Persons with Disabilities 2017–2020 envisages actions to enhance capacity and diversify the health workforce, including calls to review university curricula, retain trained health workers in the country and recognize more rehabilitation professions.

Ideally, all health-care workers should have baseline competencies for all the assistive devices on the APL. Generalists need to be trained in the provision of simple assistive devices, and should be equipped to provide the population with these products at a district level. “Simple” devices are those products that do not need advanced skills for manufacture or fitting, such as crutches, walkers, canes and reading glasses. For people in need of more complex devices or for cases of higher complexity, the generalists should be able to refer patients to specialized centres at the regional level, such as NOC and its branches. Eventually, a network of centres providing assistive products at district level and supported by NOC should be involved in the provision of assistive technology. Implementing this strategy requires a phased approach, starting with the consolidation of all four branches of NOC as fully functional independent assistive technology centres with qualified staff. At a later stage, NOC should strengthen ties with selected district hospitals and provide resources and training. Finally, staff members of the district hospitals (or primary health units) should be in a position to deliver simple devices and rely on NOC for referrals and additional support. This model (Fig. 14) ensures that the greatest need for basic devices in the communities is met, while allowing individuals with higher levels of need to be seen by personnel with additional specialized training.

Higher-education institutes in Tajikistan do not offer degrees for rehabilitation and assistive technology professionals; therefore, it is important to support students in studying these disciplines abroad. In the long term, training of such professionals within Tajikistan is a necessary step to ensure a stable supply of personnel, as the sector expands and other specialists retire or leave the country. A module or component on assistive technology should be included...
in all training courses for the health-care professions. For example, the nurse training curriculum should include training related to all products of the APL and how to fit selected products.

Training of the current health workforce (outside the education system) requires a different approach. A professional education programme based on the “train the trainer” principle, in which assistive technology advisors are trained to train health-care staff working in different districts across the country in assistive technology provision, would need to be implemented.

**Recommendations**

1. Allow primary-level health workers to provide basic assistive products.
2. Include assistive technology in the university curriculum of nurses and other health professionals.
3. Enable NOC to support the staff of primary health care centres in providing assistive technology.
4. Increase opportunities for the training of assistive technology specialists in-country and abroad.
6. National Assistive Products List and quantification of needs

Following the completion of the rapid survey, focus group discussions and systems survey, the results were used to develop a national APL of the most highly needed assistive products for Tajikistan. The results from Part A of the survey (met and unmet need) were also used to derive estimates of the total need for each of the assistive products included in the APL.

6.1 National Assistive Products List

The consensus meeting on 20 April 2018 in Dushanbe brought together representatives from the Ministry of Health and Social Protection and other stakeholders, including the Government, donor agencies, nongovernmental organizations, disabled people’s organizations and users of assistive products, to identify the products most needed in the country. The findings of the rapid survey and focus group discussions were presented during the meeting. The 57 participants were divided into five groups according to their interests and expertise – three groups were assigned to discuss “mobility and self-care” products, and the remaining two “sensorial and cognitive” products. Building on the current list of assistive products provided by the Tajik Government (12 items), the groups were asked to select an additional 7–9 products to be included in the APL. Following the group work, discordances between the groups were settled in the plenary discussion, during which every participant had a chance to speak in favour or against inclusion of any device. Where disagreements persisted, the issue was put to a vote.

A consensus was reached on 30 assistive products that were included on the first national APL for Tajikistan (see Table 10 and Annex 4).

6.2 Quantification of needs

6.2.1 Methodology

Quantifying the national annual need for assistive products on the APL is very important for planning services and procurement. No data on assistive product needs are available in Tajikistan, and finding accurate estimates would require an extensive census of the population. Nevertheless, by making some assumptions, it is possible to arrive at some broad estimates, while acknowledging that these may contain a certain degree of error. At best, these estimates should be used as a landmark, and will need to be refined as more evidence emerges.

Three methods were used for calculating estimates of need for the assistive products on the APL (Fig. 15). The nature of the product and available information determined the method used to obtain data on the device concerned.

1. Survey results. The results from the rapid survey were used to derive needs estimates for most mobility and self-care products on the APL, including estimates for wheelchairs, incontinence products, crutches, shower chairs, etc. Survey results were not used for estimating the need for products that help people with vision, hearing and cognition impairments, as these people were underrepresented in the survey. The survey was relatively limited as the participants were selected from CBR programmes and the sample was relatively small. Nevertheless, the results can be used to calculate broad needs estimates for products on the APL and approximate ratios for the number of each product needed annually.
Table 10. Priority Assistive Products List

<table>
<thead>
<tr>
<th>Mobility products</th>
<th>Mobility products – local production</th>
<th>Mobility products – procurement</th>
<th>Communication and cognitive products</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Walking sticks</td>
<td>14. Sitting supports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Standing frames</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision products</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Braille slates</td>
<td>27. Hearing aids</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Magnifiers, optical</td>
<td>28. Closed captioning displays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Reading glasses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. White canes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing products</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Toilet chairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Shower chairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Incontinence products</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobility products – procurement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Club foot braces</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Protective footwear – diabetic and neuropathic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Lumbar corsets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Pressure-relief cushions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-care products</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Toilet chairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Shower chairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Incontinence products</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Fig. 15. Three methods of estimating need

1. Rapid survey (Part A)  
   Used for most mobility devices

2. National data on pathologies/conditions  
   Where pertinent national data are available and sufficient to derive estimates

3. International estimates  
   Global estimates or estimates from other countries for use of specific devices
2. **Indirect method.** For most of the remaining products on the APL, estimates of the total need were obtained from the prevalence or incidence of related pathologies or conditions. Some conditions or pathologies are strongly associated with specific assistive products, and some APL products are needed predominantly by people who live with particular conditions. To derive estimates from these correlations, three sets of data are used:

- prevalence or incidence rates for the pathologies/conditions most strongly correlated with use of the devices
- evidence or studies on the degree of correlation between each pathology/condition and assistive products
- demography of the country and age distribution.

3. **International data.** For some APL products, there were no country or regional data, so international data were used to derive estimates. Also, some assistive products are useful to people with diverse conditions or pathologies, so it is impractical to base the estimates on correlations with pathologies or medical conditions. In these cases, international data were also used.

### Formulae and examples

1. **Survey results.** Almost 150 000 people are registered as person with disability (D) and entitled to Government-funded assistive products. Data on the survey need (Sn) for different assistive products was collected during the survey and are presented in Fig. 6. By multiplying the number of people who reported a need for a product by the total number of registered people with disabilities in the country, we obtain an estimate of the number of people who need the device. To calculate the annual need, the approximate lifespan of the device (L) also needs to be part of the equation, as this will determine the replacement rate. By dividing the total number of persons in need by the average lifespan the device annual estimates are found. Approximate lifespan was based on international norms and maximum lifespan for any products was set at 7 years with appropriate repairs and maintenance facilities. See Annex 2.

   **Box 1. Calculation method from survey results**
   
   **Formula:** Sn (%) x D / L = annual estimated need
   
   **Example:** Manual wheelchairs → 39% x 150 000 / 5 = 11 700*
   
   *Estimated need for the registered population with disabilities – excludes need for wheelchairs among non-registered persons.

2. **Indirect method.** Estimates are based on national or regional data on the prevalence of certain conditions/pathologies that are associated with need for an assistive product. For example, there is a very strong correlation between number of lower limb amputations and the need for prostheses, or between presbyopia and the need for reading glasses. Studies providing evidence on the degree of correlation between the condition/pathology and product need were consulted to determine a numerical value for the correlation. A maximum correlation of 0.9 was set (taking into account personal preferences and counter-indications to product use). The estimated cases (Ec) of people with the condition/pathology multiplied by the correlation (C) factor divided by product lifespan (L) produces the annual needs estimates. See Annex 2.

   **Box 2. Calculation method from indirect sources**
   
   **Formula:** Ec x C / L = annual estimated need
   
   **Example:** reading glasses → 702 167 x 0.9 / 7 = 90 279
   
   **Example:** protective footwear → 687 551 x 0.15 / 3 = 34 378

3. **International data.** In the absence of regional/national data, statistics from other countries or global estimates on the need for assistive products are applied.
to Tajikistan. This method produces inaccurate results depending on the differences in demographics, history, health-care systems and many other factors that affect health risks. Nevertheless, a comparison with the need in other countries is an indication of the possible need in Tajikistan, especially for those assistive products where there is no intrinsic factor that significantly alters need within a country (e.g. communication boards, lower limb orthoses). Using global estimates or estimates from countries that have similar contexts is likely to produce more accurate results.

**Example.** Communication boards can help people with a variety of conditions (speech impairments, autism, locked-in syndrome (pseudocoma), etc.). A study in the United Kingdom of Great Britain and Northern Ireland found that approximately 0.5% of the population of the country could benefit from communication boards. Although the United Kingdom and Tajikistan are very different countries, no data were found from more similar populations, so the United Kingdom estimates were used.

**Box 3. Calculation method from international sources**

Example: communication boards → 
\[(9 \times 10^6 \times 0.5) \times 0.9 / 7 = 5816\]

### 6.2.2 Annual estimates

See Table 11 for annual estimates and Annex 5 for more information.

#### Table 11. Annual estimates of need for products on the Assistive Products List

<table>
<thead>
<tr>
<th>No.</th>
<th>Assistive product</th>
<th>Item</th>
<th>Annual need</th>
<th>No.</th>
<th>Assistive product</th>
<th>Item</th>
<th>Annual need</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reading glasses</td>
<td>Unit</td>
<td>90 279</td>
<td>16</td>
<td>Simplified mobile phones</td>
<td>Unit</td>
<td>3 235</td>
</tr>
<tr>
<td>2</td>
<td>Hearing aids</td>
<td>Unit</td>
<td>56 329</td>
<td>17</td>
<td>Standing frame</td>
<td>Unit</td>
<td>3 150</td>
</tr>
<tr>
<td>3</td>
<td>Protective footwear</td>
<td>Pair</td>
<td>34 378</td>
<td>18</td>
<td>Axillary crutches</td>
<td>Pair</td>
<td>3 150</td>
</tr>
<tr>
<td>4</td>
<td>Wheelchair</td>
<td>Unit</td>
<td>11 700</td>
<td>19</td>
<td>Sitting support</td>
<td>Unit</td>
<td>2 250</td>
</tr>
<tr>
<td>5</td>
<td>Toilet chair</td>
<td>Unit</td>
<td>9 150</td>
<td>20</td>
<td>Magnifiers, optical</td>
<td>Unit</td>
<td>1 186</td>
</tr>
<tr>
<td>6</td>
<td>Incontinence products</td>
<td>Set</td>
<td>8 250</td>
<td>21</td>
<td>Prosthesis, lower limb</td>
<td>Unit</td>
<td>900</td>
</tr>
<tr>
<td>7</td>
<td>Communication board</td>
<td>Unit</td>
<td>5 816</td>
<td>22</td>
<td>Walking stick</td>
<td>Unit</td>
<td>750</td>
</tr>
<tr>
<td>8</td>
<td>Lumbar corset</td>
<td>Unit</td>
<td>5 500</td>
<td>23</td>
<td>Elbow crutches</td>
<td>Pair</td>
<td>750</td>
</tr>
<tr>
<td>9</td>
<td>Wheelchair with postural support</td>
<td>Unit</td>
<td>5 400</td>
<td>24</td>
<td>White cane</td>
<td>Unit</td>
<td>593</td>
</tr>
<tr>
<td>10</td>
<td>Rollator</td>
<td>Unit</td>
<td>4 650</td>
<td>25</td>
<td>Braille slate</td>
<td>Unit</td>
<td>593</td>
</tr>
<tr>
<td>11</td>
<td>Shower chair</td>
<td>Unit</td>
<td>4 350</td>
<td>26</td>
<td>Club foot brace</td>
<td>Unit</td>
<td>245</td>
</tr>
<tr>
<td>12</td>
<td>Orthosis – spinal (rigid)</td>
<td>Unit</td>
<td>4 203</td>
<td>27</td>
<td>Orthosis, upper limb</td>
<td>Unit</td>
<td>223</td>
</tr>
<tr>
<td>13</td>
<td>Orthosis – lower limb</td>
<td>Unit</td>
<td>3 659</td>
<td>28</td>
<td>Prosthesis, upper limb</td>
<td>Unit</td>
<td>162</td>
</tr>
<tr>
<td>14</td>
<td>Orthopaedic shoe</td>
<td>Pair</td>
<td>3 500</td>
<td>29</td>
<td>Pressure-relief cushion*</td>
<td>Unit</td>
<td>NA</td>
</tr>
<tr>
<td>15</td>
<td>Walker</td>
<td>Unit</td>
<td>3 300</td>
<td>30</td>
<td>Closed captioning</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

*Pressure-relief cushions should be provided with every wheelchair.
7. Conclusion and way forward

7.1 Positive developments and encouraging signs

There have been many positive developments in the sector over the last few years. The Convention on the Rights of Persons with Disabilities was signed in March 2018, committing the Government to the provision of assistive technology. In 2016, the multisectoral National Programme on Rehabilitation of Persons with Disabilities 2017–2020 was adopted. This lays out a comprehensive plan for developing the assistive technology sector. The financial budget for assistive technology has increased over the years and is forecast to grow exponentially in the coming years – the budget for 2019 will be in excess of TJS 2 million. The Government of Tajikistan played an important role in the adoption in May 2018 of World Health Assembly resolution WHA71.8 on improving access to assistive technology and the related side event. It is evident that there is a real political will to develop the assistive technology sector in the country and the way forward is already mapped out.

The national APL has been drawn up, thereby increasing the range of assistive products provided by the Government. This list was based on the needs of the population, as reported through the rapid needs survey. The survey was also used to derive estimates of the need for the various products on the APL to help the Government plan the procurement of these products. The APL improves access to a greater number of devices and upholds the right to equal participation in society of a greater number of persons with disabilities. Technical specifications for the products on the APL are already being drafted, and these will strengthen procurement practices and ensure the quality of devices entering the country.

The capacity of NOC to provide assistive technology services has also increased significantly over the last few years. The Khujand branch has extended its services to include provision of a greater variety of assistive products, including prosthetics and orthotics services. The Government is already working to expand the capacity of the Kulob branch to provide a variety of assistive products, and it plans to increase the capacity of the Khorog branch by 2019. Since 2015, NOC has also started to look beyond mobility products and provide hearing aids and white canes, making it more of an assistive technology centre.

7.2 Gaps to be addressed and way forward

Policy. Policies should be more inclusive of all potential beneficiaries of assistive technology. At present, only people who are registered as disabled are eligible for assistive technology. Not only are many people with disability not registered with the Government, but many people who are not disabled also need assistive products. Several products on the APL, such as reading glasses and protective footwear, are used primarily by elderly people or people with noncommunicable diseases. These groups of people should qualify for assistive products through the Government mechanism, and the eligibility criteria should be changed to include them.

Government policies should facilitate access to appropriate assistive technology services for all those in need – this includes raising awareness about assistive products and ensuring that procedures to obtain them are not difficult or costly. The Ministry of Health and Social Protection acknowledges this policy gap and is expanding the eligibility criteria to include all groups in need.

Products. The survey and the focus groups revealed dissatisfaction with Government-provided products. Low-quality products do not meet the needs of the user, break more often and have a shorter lifespan. As a result, although they are generally less expensive, they are not good long-term investments.
Introducing standards and specifications for all the products on the APL would ensure that the products meet minimum requirements. Price must not be the only criteria for evaluating bids on Government tenders – the functionality, safety and durability of the devices are equally important.

**Provision.** Successful assistive technology applications require assistive products to be accompanied by appropriate services (including assessment, fitting and user training) and repair and maintenance, so that the products continue to benefit the user over time. Unfortunately, the research found that assistive products are often still distributed without appropriate services. NOC does not follow up with patients, and most users do not have access to repair services when their assistive products break.

The National Programme on Rehabilitation of Persons with Disabilities 2017–2020 calls for assistive technology to be changed from a distribution model to a service provision model. For this shift to occur, a mandatory procedure for the provision of all assistive products needs to be observed. Follow-up of users and repair and maintenance services should be available. Investing in repair and maintenance facilities is cost-effective in the long term, as the devices will need to be replaced less frequently if they are adequately maintained and repaired. Therefore, in planning assistive technology services, part of the budget must be allocated to the additional services that go with the product.

**Personnel.** There is a shortage of skilled assistive technology professionals in the country. Moreover, the general health workforce is not knowledgeable about assistive technology and its applications. There are no higher-education facilities in Tajikistan that offer degrees or professional development for assistive technology professionals.

Educational programmes must be strengthened in Tajikistan to address the shortage of skilled assistive technology professionals. While education programmes are being developed, students need to be supported to study professions related to assistive technology abroad. Non-specialized health workers (e.g. nurses) should also receive training in assistive technology so that they are in a position to assess and provide some assistive products at primary health care centres.
References


## Annex 1. Rapid survey

### Part A. Needs for assistive products

<table>
<thead>
<tr>
<th>Interviewer’s name:</th>
<th>ID:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondent’s name:</td>
<td>Age (years):</td>
<td></td>
</tr>
<tr>
<td>Place:</td>
<td>Sex:</td>
<td>Male</td>
</tr>
<tr>
<td>District:</td>
<td>Province:</td>
<td>Telephone:</td>
</tr>
</tbody>
</table>

#### Which of the following products do you think are useful to you? Tick the black box if you already have and use the product and the red box if you need but do not have the product. You may choose more than one.

**A1.** Do you have difficulty sitting or standing?  
*Examples: Child/adult/older adult cannot sit or stand independently.*

- □ No  
- Yes →
- Some difficulty □
- A lot of difficulty □

- **Standing frame**

- **Sitting support**

- **Grab bar**

**A2.** Do you have difficulty walking or climbing steps?  
*Examples: Due to discomfort, pain, tiredness, risk of falling, limb loss, difficult to climb steps or walk independently inside or outside the house.*

- □ No  
- Yes →
- Some difficulty □
- A lot of difficulty □

- **Walking stick**

- **Tripod/quadripod**

- **Axillary crutch**

- **Walker**

- **Rollator**

- **Elbow crutches**

- **Orthosis**

- **Knee brace**

- **Prosthesis**

- **Wheelchair**

- **Wheelchair with postural support**

- **Portable ramp**
### A3. Do you have difficulty seeing?
*Examples: Reading books, newspapers, smart phones or signboards, identifying people across the road.*

- [ ] No
- [ ] Yes
- [ ] Some difficulty
- [ ] A lot of difficulty

- White cane
- Braille slate
- Reading glasses

### A4. Do you have difficulty hearing?
*Examples: Problems hearing when others talk or when answering the phone.*

- [ ] No
- [ ] Yes
- [ ] Some difficulty
- [ ] A lot of difficulty

- Alarm signaller
- Hearing aid

### A5. Do you have difficulty speaking or communicating?
*Examples: Understanding others or being understood.*

- [ ] No
- [ ] Yes
- [ ] Some difficulty
- [ ] A lot of difficulty

- Communication board
- Communication software

### A6. Do you have pain or deformities in your hands, arms, feet, neck or back?
*Examples: Arthritis, spinal deformity, wrist-drop.*

- [ ] No
- [ ] Yes
- [ ] Some difficulty
- [ ] A lot of difficulty

- Cervical collar
- Lumbar corset
- Spinal orthosis
- Wrist brace
- Club foot brace
- Orthopaedic shoes

### A7. Do you have difficulty remembering?
*Examples: Forgetting appointments, medication, phone numbers, difficulty preparing meals or finding places.*

- [ ] No
- [ ] Yes
- [ ] Some difficulty
- [ ] A lot of difficulty

- Pill organizer
- Magnetic white board
- Simplified mobile phone
- Recorder
### Which of the following products do you think are useful to you?
Tick the black box if you already have and use the product and the red box if you need but do not have the product. You may choose more than one.

<table>
<thead>
<tr>
<th>Product</th>
<th>[ ]</th>
<th>[ ]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protective footwear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure-relief cushion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incontinence products (diaper, pull-up underwear)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Shower chair</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Toilet chair</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### A8. Do you have difficulty with decrease/loss of sensation in feet, legs, hands, buttocks or back? *Examples: Numbness, ulcers in feet, buttocks or back.*
- [ ] No
- [ ] Yes
  - Some difficulty
  - A lot of difficulty

### A9. Do you have difficulty controlling the bladder or bowel? *Examples: Leaking of urine or stool or wetting pants.*
- [ ] No
- [ ] Yes
  - Some difficulty
  - A lot of difficulty

### A10. Do you have difficulty with your self-care? *Examples: Eating, dressing, bathing or toileting.*
- [ ] No
- [ ] Yes
  - Some difficulty
  - A lot of difficulty

### A11. If you answered yes to any of the questions, can you think of any other assistive product that could help you with your condition? Please specify:

### A12. Do you have a disability certificate?
- [ ] Yes
- [ ] No
  - If yes, which disability category: category I [ ] category II [ ] category III [ ]
### Part B. Assistive products in use

| B0 | ATA needs ID number:  
(Same as in Part A.) |

[Fill out one Part B for each product in use – one for each black box ticked in Part A, and only for the products listed below]

**Select type of product used as indicated in Part A**

- Orthosis
- Orthopaedic shoes
- Prosthesis
- Wheelchair
- Wheelchair with postural support
- Walking stick
- Tripod/quadripod
- Auxillary crutches
- Elbow crutches
- Walker
- Rollator
- White cane
- Braille slate
- Hearing aid
- Communication board
- Communication software
- Reading glasses

| B1 | From where did you get the assistive product?  
- Shop, market or commercial centre
- Pharmacy
- Hospital, health-care facility or rehabilitation centre
- From a facility in another country
- State Enterprise Orthopaedic Plant (SEOP) / National Orthopaedic centre
- Local department of social protection
- NGO1 (specify):
- Webshop on the Internet
- Made by self, family or artisan
- From an individual living abroad
- Other (specify):
- Missing (specify): |

| B2 | Approximately how much did you pay for the product? |

| B3 | How long did you have to wait for the product, from the time it was prescribed to you until it was delivered?  
- Less than 1 week
- Between 1 week and 1 month
- Between 1 and 3 months
- Between 3 months and 1 year
- Over 1 year
- Missing (specify): |

| B4 | How far did you have to travel to get the product?  
- Less than 30 min
- Between 30 min and 2 hours
- Between 2 and 4 hours
- Between 6 and 8 hours
- More than 8 hours
- Missing (specify): |

---

1 Editor’s note: NGO: nongovernmental organization.
B5  How long have you been using the product?

- Less than 1 year
- Between 1 and 3 years
- Between 3 and 5 years
- More than 5 years
- Missing (specify):

B6  Does the product meet your needs? (Does it do everything that you want it to do?)

- Yes
- Mostly
- Partly
- No
- Missing (specify):

B7  In what condition is the product?

- As good as new
- In need of maintenance but still working well
- In need of maintenance and not working well
- Does not work at all
- Missing (specify):

B8  What kinds of problem have you had with the product?

Parts that fail or break easily (list):

- No problems with product
- Missing (specify):

B9  What, if anything, would you like to change about the product to make it better? (More than one option can be selected.)

- Size
- Weight
- Easier to move
- Appearance
- Easier to use
- Reliability
- Other (specify):
- I do not want to change anything
- Missing (specify):

B10  How easy is it for you to use the assistive product within your home?

- Very easy
- Somewhat easy
- Somewhat difficult
- Very difficult
- I do not use it at home
- Missing (specify):

B11  How easy is it for you to use the assistive product outside home?

- Very easy
- Somewhat easy
- Somewhat difficult
- Very difficult
- I do not use it outside home
- Missing (specify):

B12  Was the product prescribed for you following an assessment (i.e. looking at you, asking you questions or taking measurements)?

- Yes
- No
- Missing (specify):

B13  Was the product fitted to you or customized to your needs?

- Yes
- No
- Missing (specify):
### B14 Have you received any training on how to use and take care of the product? If yes, from whom? (More than one option can be selected.)

- **No**
- Yes, by:
  - Physician
  - Nurse
  - Occupational therapist
  - Pharmacist
  - Prosthetist or orthotist
  - **Physiotherapist**
  - **Missing (specify):**

### B15 If there is something wrong with the product, is there somewhere you can go for repairs or maintenance?

- **Always**
- **Often**
- **Sometimes**
- **Rarely or never**
  - **Missing (specify):**

### B16 How important is the product for you to do your work or go to school?

- **Very important**
- **Important**
- **Of some importance**
- **Not important**
  - **Not applicable**
  - **Missing (specify):**

### B17 How important is the product for you to participate in social events and be an active member of your community?

- **Very important**
- **Important**
- **Of some importance**
- **Not important**
  - **Not applicable**
  - **Missing (specify):**

### B18 How important is the product to your health?

- **Very important**
- **Important**
- **Of some importance**
- **Not important**
  - **Not applicable**
  - **Missing (specify):**

### B19 How important is the product to your enjoyment of life?

- **Very important**
- **Important**
- **Of some importance**
- **Not important**
  - **Not applicable**
  - **Missing (specify):**

---

Additional comments:
### Part C. Abandonment of and barriers to use of assistive products

**C0**  
ATA needs ID number:  
(Same as in Part A.)

[Fill out one Part C for each product in need – one for each red box ticked in Part A]

<table>
<thead>
<tr>
<th>Select type of product in need as indicated in Part A</th>
<th>Skip instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Standing frame</td>
<td>□ Talking watch</td>
</tr>
<tr>
<td>□ Sitting support</td>
<td>□ Talking book</td>
</tr>
<tr>
<td>□ Grab bar</td>
<td>□ Alarm signaler</td>
</tr>
<tr>
<td>□ Walking stick</td>
<td>□ Hearing aid</td>
</tr>
<tr>
<td>□ Tripod/quadripod</td>
<td>□ Communication board</td>
</tr>
<tr>
<td>□ Axillary crutches</td>
<td>□ Communication software</td>
</tr>
<tr>
<td>□ Elbow crutches</td>
<td>□ Cervical collar</td>
</tr>
<tr>
<td>□ Walker</td>
<td>□ Lumbar corset</td>
</tr>
<tr>
<td>□ Rollator</td>
<td>□ Spinal orthosis</td>
</tr>
<tr>
<td>□ Orthosis</td>
<td>□ Wrist brace</td>
</tr>
<tr>
<td>□ Orthopaedic shoes</td>
<td>□ Club foot brace</td>
</tr>
<tr>
<td>□ Prosthesis</td>
<td>□ Pill organizer</td>
</tr>
<tr>
<td>□ Knee brace</td>
<td>□ Magnetic foot brace</td>
</tr>
<tr>
<td>□ Wheelchair</td>
<td>□ Simplified mobile phone</td>
</tr>
<tr>
<td>□ Wheelchair with postural support</td>
<td>□ Recorder</td>
</tr>
<tr>
<td>□ Portable ramp</td>
<td>□ Protective footwear</td>
</tr>
<tr>
<td>□ White cane</td>
<td>□ Pressure relief cushion</td>
</tr>
<tr>
<td>□ Braille slate</td>
<td>□ Incontinence products</td>
</tr>
<tr>
<td>□ Reading glasses</td>
<td>□ Shower chair</td>
</tr>
<tr>
<td>□ Optical magnifier</td>
<td>□ Toilet chair</td>
</tr>
<tr>
<td>□ Other (specify)</td>
<td>□ Other (specify)</td>
</tr>
</tbody>
</table>

**C1** Have you used any assistive product of this kind in the past?  
□ Yes  □ No  
If "No", go to C6.

**C2** Do you have an assistive product of this kind that you no longer use?  
□ Yes  □ No  
If "No", go to C6.

**C3** How long have you had the assistive product?  
□ Less than 1 year  □ Missing (specify):  
□ Between 1 and 3 years  
□ Between 3 and 5 years  
□ More than 5 years

**C4** Is the product in working condition?  
□ Yes  □ No  
If "No", go to C6.
Why are you no longer using the product? (More than one option can be selected)

- No longer needed
- Ineffective
- Too difficult to use
- Unsuitable to my environment
- Pain
- Poor fit
- Too heavy
- Dislike appearance
- Other (specify):
- Missing (specify):

You told me that you do not use assistive products that could help you. What stops you from using them? (More than one option can be selected)

- They are not available in the community
- I do not know where to get them
- I cannot afford them
- They do not work
- I am not able to use them
- They do not suit my environment
- Other (specify):
- Missing (specify):

Additional comments:
Annex 2. Focus group guidelines

Assistive technology assessment – Focus group guidelines

1. Products in use – (participants look at the form and tick devices they have)

1.1 Can you tell me how and where you got the products that you use?

☐ What difficulties did you face in getting the products? (cost, travel, waiting times, don’t know where to go, etc.)

☐ Who supported you in getting the product? (Who told you about where to go?)

☐ Did someone fit/adjust the product to your personal needs? Did someone teach you how to use the product and how to take care of it? (Any other problem with the service?)

1.2 How would you rate the quality of the device?

☐ Does the product work well? Have you had any problems with the device? Does it do everything you want it to do?

☐ If it breaks, where do you go for repairs?

☐ What would you like to change about the device? How would you want to improve it? (Less heavy, easier to use, better looking, etc.)

1.3 How important is the device to you?

☐ Where do you use the device? (Do you use it outside the house? Why not?)

☐ What does the device enable you to do? (Go to work/school, stay healthy, participate in activities)

☐ What does the device mean to you?

2. Needed products – (participants look at the list and tick the devices they need)

2.1 Why have you been unable to get or use these assistive products?

☐ Have you used any such products in the past? Why have you stopped using them?

☐ What other products might you need?
3. How to improve the assistive technology sector

3.1 We have discussed many problems and situations regarding the assistive technology sector such as ..........

☐ In your opinion, how does the assistive technology sector need to change in the future to better meet your needs?

☐ What changes are your priority?

☐ What products should be included?

☐ How would you like service provision to be organized in the future?
Annex 3. Systems survey

OVERSIGHT

1. What are the regulatory bodies for assistive technology and what are their roles?

2. Is there a national committee to address the issue of assistive technology? If “Yes”, who leads the committee?

3. Is there an assistive technology national strategy, plan or programme?

4. What legislation or policies regulate the provision of assistive technology?

PROCUREMENT, SUPPLY AND DISTRIBUTION

5. What is the Government budget for procurement of assistive products?

6. By what mechanism does the Government procure assistive products?
   - ☐ Bulk purchase
   - ☐ Yearly tendering
   - ☐ Individual need
   - ☐ Other (specify):

7. Which products are procured by the Government and from whom? (Use table)

8. After procurement, how are the assistive products distributed among the various structures?

9. Wheelchair procurement
   Technical specifications for procurement of wheelchairs:
   Type of wheelchairs procured:
   - ☐ Wheelchair for active user
   - ☐ Manual assistant-controlled wheelchair
   - ☐ Wheelchair with postural support

<table>
<thead>
<tr>
<th>Supplier</th>
<th>Model</th>
<th>Number of units</th>
<th>Cost per unit</th>
<th>Transportation cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

REGULATIONS

10. What regulations and standards do assistive products need to comply with before being placed in the market?

11. Do assistive products need to be registered with a Government authority before being placed in the market?

12. Who is authorized to prescribe different assistive products?

13. Who is authorized to fit different assistive products?
### FACILITIES AND PERSONNEL

14. Health workforce in the country:

<table>
<thead>
<tr>
<th>Health workforce</th>
<th>Total number of personnel</th>
<th>Number of female personnel</th>
<th>Number of personnel working in rural areas</th>
<th>Number of personnel in public services</th>
<th>Average salary in public services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social workers</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

15. Certified specialists in the country:

<table>
<thead>
<tr>
<th>Certified specialists</th>
<th>Total number of personnel</th>
<th>Number of female personnel</th>
<th>Number of personnel working in rural areas</th>
<th>Number of personnel in public services</th>
<th>Average salary in public services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation doctors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopaedic doctors</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetists/Orthotists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wheelchair technicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiotherapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational therapists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmologists</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Opticians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Braille teachers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobility orientation trainers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiologists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing aid technicians</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech and language therapists</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Neurologists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biomedical engineers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBR workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

16. Which public facilities provide assistive technology services?
17. What Government financing schemes for assistive products exist? (More than one option can be selected.)
- Assistive products are included in national health insurance.
- Assistive products are provided free of charge (or at subsidized cost) at facilities with a medical prescription.
- Vouchers or cash are provided for assistive products after a needs assessment.
- Other (specify):

18. Who is entitled to assistive products under these schemes?

19. Which assistive products are provided under these schemes?

20. Is there any out-of-pocket payment from the beneficiary?

21. Does the Government have a national health information system?
    If “Yes”, are assistive-technology-related data included?

22. Does the Government have a general information system on assistive technology?
    If “Yes”, what kind of data are collected?
    Yes
    - Registry of assistive products
    - Number of products provided
    - Number of users
    - Other (specify):
    No

23. Is there a monitoring and evaluation strategy for assistive technology provision in the country?
    If “Yes”, which agencies are responsible for monitoring and evaluation?

24. Are there any agencies or institutes conducting research in the field of assistive technology?
    If “Yes”, which one(s)?
### Annex 4. Assistive Products List

**Mobility products**

1. Wheelchairs (manual)
2. Wheelchairs (manual) with postural support/postural-support kit
3. Axillary crutches
4. Elbow crutches
5. Rollators
6. Walking frames
7. Walking sticks

**Mobility products – local production**

8. Orthopaedic shoes
9. Orthoses – lower limb
10. Orthoses – upper limb
11. Orthoses – spinal
12. Prostheses – lower limb
13. Prostheses – upper limb
14. Sitting supports
15. Standing frames

**Mobility products – procurement**

16. Club foot braces
17. Protective footwear – diabetic and neuropathic
18. Lumbar corsets
19. Pressure relief cushions
**Self-care products**

20. Toilet chair

21. Shower chairs

22. Incontinence products

**Vision products**

23. Braille slates

24. Magnifiers, optical

25. Reading glasses

26. White canes

**Hearing products**

27. Hearing aids

28. Closed captioning displays

**Communication and cognitive products**

29. Communication boards

30. Simplified mobile phones
### Annex 5. Quantification calculations

#### Table A5.1. Indirect calculations

<table>
<thead>
<tr>
<th>Assistive product (AP)</th>
<th>Condition/pathology</th>
<th>Sample size</th>
<th>Incidence (%)</th>
<th>Prevalence (%)</th>
<th>Total cases (Tc)</th>
<th>Correlation (C)*</th>
<th>Lifespan (L)**</th>
<th>Total annual need</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthoses, spinal (rigid)</td>
<td>Scoliosis aged 10 to 15</td>
<td>420317</td>
<td>10.0</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td><a href="http://countrymeters.info/en/Tajikistan#population_2017">http://countrymeters.info/en/Tajikistan#population_2017</a></td>
</tr>
<tr>
<td>Club foot braces</td>
<td>Club foot (2017)</td>
<td>272197</td>
<td>0.1</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Communica- tion boards</td>
<td>Need for AAC based on UK data</td>
<td>9046722</td>
<td>0.5</td>
<td>4534</td>
<td>0.9</td>
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<td>Orthoses – lower limb</td>
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<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Orthoses – upper limb</td>
<td>Orthoses – upper limb</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
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<tr>
<td>Prostheses – upper limb</td>
<td>Prostheses – upper limb</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>162</td>
</tr>
<tr>
<td>Braille slates</td>
<td>Blindness</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Magnifiers, low vision</td>
<td>Blindness</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>1186</td>
</tr>
<tr>
<td>White canes</td>
<td>Blindness</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>993</td>
</tr>
</tbody>
</table>

*Correlation (C)* and **Lifespan (L)** are not explicitly provided in the table.
<table>
<thead>
<tr>
<th>Assistive product (AP)</th>
<th>Condition/pathology (C/P)</th>
<th>Sample analysed</th>
<th>Sample size</th>
<th>Incidence (%)</th>
<th>Prevalence (%)</th>
<th>Total cases (Tc)</th>
<th>Correlation (C)*</th>
<th>Lifespan (L)**</th>
<th>Subtotal</th>
<th>Total annual need</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aids</td>
<td>Disabling hearing loss</td>
<td>Population age &gt; 65 years</td>
<td>292 681</td>
<td>NA</td>
<td>36.6</td>
<td>107 121</td>
<td>0.8</td>
<td>5</td>
<td>17 139</td>
<td>56 329</td>
<td><a href="http://www.who.int/deafness/estimates/en/">http://www.who.int/deafness/estimates/en/</a></td>
</tr>
<tr>
<td>NA</td>
<td>Disabling hearing loss</td>
<td>Population 35–64 years</td>
<td>2 294 258</td>
<td>NA</td>
<td>6.6</td>
<td>151 421</td>
<td>0.8</td>
<td>5</td>
<td>24 227</td>
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<tr>
<td>NA</td>
<td>Disabling hearing loss</td>
<td>Population 15–34 years</td>
<td>3 278 939</td>
<td>NA</td>
<td>1.3</td>
<td>42 626</td>
<td>0.8</td>
<td>5</td>
<td>6 820</td>
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<tr>
<td>NA</td>
<td>Disabling hearing loss</td>
<td>Population 0–14 years</td>
<td>3 180 545</td>
<td>NA</td>
<td>1.6</td>
<td>50 889</td>
<td>0.8</td>
<td>5</td>
<td>8 142</td>
<td></td>
<td></td>
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</table>

* max. correlation set at 0.9
** max. lifespan set at 7 years

AAC: augmentative and alternative communication.
### Table A5.2. Survey calculations

<table>
<thead>
<tr>
<th>Assistive product (AP)</th>
<th>Total need (survey) No. (%)</th>
<th>Sample size*</th>
<th>Total people in need</th>
<th>Lifespan (L)</th>
<th>Total annual need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair</td>
<td>78 (39.0)</td>
<td>150 000</td>
<td>58 500</td>
<td>5</td>
<td>11 700</td>
</tr>
<tr>
<td>Toilet chair</td>
<td>61 (30.5)</td>
<td>150 000</td>
<td>45 750</td>
<td>5</td>
<td>9150</td>
</tr>
<tr>
<td>Incontinence products</td>
<td>33 (16.5)</td>
<td>150 000</td>
<td>24 750</td>
<td>3</td>
<td>8250</td>
</tr>
<tr>
<td>Lumbar corset</td>
<td>22 (11.0)</td>
<td>150 000</td>
<td>16 500</td>
<td>3</td>
<td>5500</td>
</tr>
<tr>
<td>Wheelchair with postural support</td>
<td>36 (18.0)</td>
<td>150 000</td>
<td>27 000</td>
<td>5</td>
<td>5400</td>
</tr>
<tr>
<td>Rollator</td>
<td>31 (15.5)</td>
<td>150 000</td>
<td>23 250</td>
<td>5</td>
<td>4650</td>
</tr>
<tr>
<td>Shower chair</td>
<td>29 (14.5)</td>
<td>150 000</td>
<td>21 750</td>
<td>5</td>
<td>4350</td>
</tr>
<tr>
<td>Orthopaedic shoes</td>
<td>14 (7.0)</td>
<td>150 000</td>
<td>10 500</td>
<td>3</td>
<td>3500</td>
</tr>
<tr>
<td>Walker</td>
<td>22 (11.0)</td>
<td>150 000</td>
<td>16 500</td>
<td>5</td>
<td>3300</td>
</tr>
<tr>
<td>Standing frame</td>
<td>21 (10.5)</td>
<td>150 000</td>
<td>15 750</td>
<td>5</td>
<td>3150</td>
</tr>
<tr>
<td>Axillary crutches</td>
<td>21 (10.5)</td>
<td>150 000</td>
<td>15 750</td>
<td>5</td>
<td>3150</td>
</tr>
<tr>
<td>Sitting support</td>
<td>15 (7.5)</td>
<td>150 000</td>
<td>11 250</td>
<td>5</td>
<td>2250</td>
</tr>
<tr>
<td>Walking stick</td>
<td>5 (2.5)</td>
<td>150 000</td>
<td>3 750</td>
<td>5</td>
<td>750</td>
</tr>
<tr>
<td>Elbow crutches</td>
<td>5 (2.5)</td>
<td>150 000</td>
<td>3 750</td>
<td>5</td>
<td>750</td>
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*Registered as person with disability with Government (rounded to nearest 500 people).

### Fig. A5.1. Population structure, Tajikistan, 2018

- Male
- Female

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<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
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<tr>
<td>0–4</td>
<td>5.7%</td>
<td>6.7%</td>
</tr>
<tr>
<td>5–9</td>
<td>4.6%</td>
<td>4.6%</td>
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<tr>
<td>10–14</td>
<td>4.6%</td>
<td>4.6%</td>
</tr>
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<td>15–19</td>
<td>4.5%</td>
<td>4.6%</td>
</tr>
<tr>
<td>20–24</td>
<td>4.6%</td>
<td>4.6%</td>
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<td>25–29</td>
<td>4.6%</td>
<td>4.6%</td>
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<tr>
<td>30–34</td>
<td>4.2%</td>
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<tr>
<td>35–39</td>
<td>2.9%</td>
<td>2.5%</td>
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<tr>
<td>40–44</td>
<td>2.3%</td>
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<td>45–49</td>
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<td>50–54</td>
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<tr>
<td>55–59</td>
<td>1.8%</td>
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</tr>
<tr>
<td>60–64</td>
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<td>0.7%</td>
</tr>
<tr>
<td>65–69</td>
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<tr>
<td>70–74</td>
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<td>75–79</td>
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<td>80–84</td>
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<td>85–89</td>
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<td>90–94</td>
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<tr>
<td>95–99</td>
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<tr>
<td>+100</td>
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Assistive Technology in Tajikistan: situational analysis

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

### MEMBER STATES

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