



Including Persons with Disabilities in Health Projects and Programmes



1. HEALTH SITUATION OF PERSONS WITH DISABILITIES

PERSONS WITH DISABILITIES HAVE LESS ACCESS TO HEALTH SERVICES SUCH AS HEALTH EDUCATION, PROMOTION, PREVENTION, TREATMENT AND REHABILITATION, AND THEREFORE, ARE MORE LIKELY TO EXPERIENCE UNMET HEALTH CARE NEEDS.



UNDERSTANDING DISABILITY

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

(UN Convention on the Rights of Persons with Disabilities, 2006, p.4)

An estimated 15% of the world's population, or over one billion people, have a disability. About 80% of them live in low- and middle-income countries.¹ Persons with disabilities have the same healthcare needs as everyone else, including all aspects of regular healthcare. In addition, they may require disability-specific health services and solutions. However, social, economic, and health system barriers significantly limit their access to health care and information². These include inaccessible health facilities and medical equipment, lack of appropriate health services, inadequate skills and knowledge or negative attitudes of health workers, communication barriers and prohibitive costs (for example for transportation). Persons with disabilities are more likely to live in poverty, which makes them more vulnerable to poor health and often leaves them unable to afford necessary health care. The interaction of gender and disability reinforces inequalities in health and health care access: Women with disabilities are more likely to experience sexual and domestic violence. Prejudices among service providers about sexuality and disability exclude particularly women with disabilities from maternal and reproductive health services.

"Inclusive health-care models will be key tools for governments creating poverty-reduction programmes due to the link between disability and poverty".

Stein, M.A. et al. (2009). Health Care and the UN Disability Rights Convention. *The Lancet*, 374, 1797.

In the past nine years, the GIZ Sector Project 'Inclusion of Persons with Disabilities' has been supporting health projects in more than 10 partner countries to include persons with disabilities. This publication consolidates our experience and offers guidance around how to effectively address disability issues in health planning and programming. It should serve as a resource for development practitioners and a Community of Practice, in order to translate the commitment and obligation of the Federal Ministry for Economic Co-operation and Development (BMZ) to disability inclusion in the health sector into practice.

2. FRAMEWORK FOR DISABILITY-INCLUSIVE HEALTH PROGRAMMING

A NUMBER OF INTERNATIONAL AND NATIONAL INSTRUMENTS STIPULATE THE INCLUSION OF PERSONS WITH DISABILITIES IN HEALTH PLANNING AND PROGRAMMING.

INTERNATIONAL INSTRUMENTS

The **UN Convention on the Rights of Persons with Disabilities (UN CRPD)**, 2006 has been instrumental in advancing disability as a human rights issue. Germany and most of its partner countries ratified the UN CRPD. The Convention highlights the importance of international cooperation in its implementation: Article 32 obliges States Parties to ensure that their development assistance is accessible to and inclusive of persons with disabilities. Article 25 establishes the right of persons with disabilities to the highest standard of health. It requires all measures to ensure their access to gender-sensitive health services and health-related rehabilitation. The Convention also recognises the right to habilitation and rehabilitation services, including in the area of health and access to assistive technology at an affordable cost (Articles 4, 20, 26).

The commitment of the **2030 Agenda** to 'leave no one behind' underpins the importance of the inclusion of persons with disabilities in the development journey: The Agenda and five out of 17 SDGs reference disability and persons with disabilities. Target 8 of **SDG 3 'Good Health and Well-Being'** focuses on improving access to healthcare services for all through Universal Health Coverage (UHC). A focus on disability and persons with disabilities as '*the world's largest minority group*' is essential to achieving UHC. The global SDG indicator framework suggests the disaggregation of indicators, including those for SDG 3 by disability.

GLOBAL, REGIONAL AND NATIONAL PLANS AND STRATEGIES

Global and regional disability instruments support the implementation of the UN CRPD: *The WHO global disability action plan 2015-2021* calls for improving access to health services and programmes, rehabilitation and the collection of disability data. *The Incheon Strategy to "Make the Right Real" for Persons with Disabilities in Asia and the Pacific and the Protocol to the African Charter on Human and People's Rights on the Rights of Persons with Disabilities in Africa* stipulate access to health services, and health-related rehabilitation.



Many partner countries such as Cambodia and Tanzania have national commitments to health and rehabilitation for persons with disabilities to align our work with: These include disability policies and plans that address health and rehabilitation, as well as national health plans or policies that respond to the needs of persons with disabilities.

The inclusion of persons with disabilities is an important principle of German development cooperation. The first BMZ Action Plan of 2013 will be followed by a new cross-sectoral strategy for the inclusion of persons with disabilities in German development cooperation. In line with Article 32, it specifies the commitment to disability inclusion and related targets across all sectors, including health as well as improved disability data.

3. DISABILITY INCLUSION: HOW TO TRANSLATE POLICY INTO ACTION IN THE HEALTH SECTOR

GERMAN DEVELOPMENT PRACTICE PROVIDES A RANGE OF VALUABLE EXPERIENCES AND INSIGHTS INTO HOW TO SUCCESSFULLY INCLUDE DISABILITY AND PERSONS WITH DISABILITIES IN HEALTH PLANNING AND PROGRAMMING:

Key principles of disability-inclusive health programming

PARTICIPATION OF PERSONS WITH DISABILITIES AND THEIR REPRESENTATIVE ORGANISATIONS (DPOS)

The UN CRPD highlights the obligation to involve persons with disabilities and their organisations (Disabled People's Organisations - DPOs) in its implementation. Their participation in the design, implementation and evaluation of health interventions provides us with a deeper understanding of the health situations of persons with disabilities, the barriers they experience in accessing healthcare and how we can address their health needs. Support to strengthen their organisational capacities as well as their competencies in health-specific aspects of the UN CRPD and the 2030 Agenda helps DPOs and their representatives to become important partners and peer educators. Involving a DPO umbrella organisation in health interventions also provides access to a network of local member DPOs. This offers the opportunity to address the capacity gaps of these member DPOs, but also to get their support for the disability-inclusive implementation of activities. In order to ensure the effectiveness of our interventions for persons with disabilities, their participation needs to be institutionalised in all phases of the project cycle, for example through formal partnerships or memberships in steering committees.

ENGAGEMENT OF MULTIPLE STAKEHOLDERS AND SECTORS

A broad range of stakeholders play a role in the provision of health care for persons with disabilities, including health policy makers (note: often responsibilities are split between ministries of health and social affairs), public and private service providers, local governments, NGOs, DPOs, and traditional medicine or informal health care providers. In order to strengthen capacities and (political) ownership for the inclusion of persons with disabilities in health services and programming it is crucial to build alliances with different stakeholders and engage these from local to national levels. At the same time, it is important to leverage existing relationships with government partners and to develop strong linkages between the health and disability sector. Broader partnerships beyond the health sector are vital to address those social and economic factors outside the health sector, which prevent persons with disabilities from using health services: The cooperation with actors in areas such as education, local governance and employment can unlock new opportunities in this regard.

MEASURES AND MECHANISMS TO ENSURE THE INCLUSION OF PERSONS WITH DISABILITIES

The WHO Health System Framework offers valuable guidance for the inclusion of disability in health planning and programming, as it identifies key areas of action.

INCLUSION OF PERSONS WITH DISABILITIES IN HEALTH PROGRAMMING, USING THE WHO HEALTH SYSTEMS FRAMEWORK



DISABLED PEOPLE'S ORGANISATIONS (DPOS)

Organisations that are governed, led by and comprise a majority of persons with disabilities, and thus are representative of persons with disabilities. They operate as individual organisations, coalitions, cross-disability or national, regional or international umbrella organisations.



THE WHO FRAMEWORK HIGHLIGHTS THE NEED FOR A COMPREHENSIVE APPROACH TO DISABILITY INCLUSION. SEVERAL FACTORS INTERACT TO HINDER THE ACCESS TO HEALTHCARE FOR PERSONS WITH DISABILITIES. IT IS, THEREFORE, IMPORTANT TO ADDRESS DISABILITY AND RELATED BARRIERS ACROSS ALL INTERACTING COMPONENTS IN ORDER TO EFFECT CHANGE:

SERVICE DELIVERY

Persons with disabilities often face a lack of appropriate and accessible health services and information. It is important to support adjustments, modifications and alternative service delivery models to accommodate the needs of patients with disabilities:

- Remove infrastructural barriers and apply universal design standards in healthcare construction;
- Provide reasonable accommodation in the areas of communication, information and coordination and and/ or introduce targeted services;
- Bring specialists to primary health facilities where most persons with disabilities go and promote the scaling up of community-based rehabilitation (CBR) and health services in less-resourced areas;
- Include rehabilitation within essential healthcare services and define referral pathways for persons with disabilities.

FINANCING

Costs (e.g. for transport, assistance, treatment) are a key barrier for persons with disabilities in accessing health services. In order to make health care affordable, it is important to:

- Gather evidence on the health expenditures of persons with disabilities (disaggregated by type of impairment, gender, location etc.);
- Ensure that persons with disabilities are targeted in social health protection systems, including insurance schemes, covering general health care and rehabilitation (for example through the inclusion of physiotherapy in basic healthcare packages);
- Introduce or improve exemptions and waivers and support indirect costs associated with accessing health care through multi-sector approaches or voucher schemes.

51-53% of persons with disabilities cannot afford healthcare, compared to 32-33% of people without disabilities (WHO and World Bank, 2011).

INFORMATION

The paucity of data on health challenges of persons with disabilities, their access to health care and financing hampers the planning for relevant policies and services. It is, therefore, important to:

- Include disability and persons with disabilities in health care surveillance and advocate for disability data disaggregation;
- Ensure that all data collected during health projects and programmes can be disaggregated by disability and other characteristics, such as gender, age and geographical location;
- Share and disseminate disability-related data to inform health planners and decision makers;
- Conduct or support research and collect baseline data to better understand the needs, barriers and health outcomes for persons with disabilities.

A study in four Southern African countries found that only 17-37% of persons with disabilities received the assistive devices (e.g. wheelchairs, prostheses, hearing aids) they needed (WHO and World Bank, 2011).

TECHNOLOGIES

Many persons with disabilities may require assistive devices (e.g. mobility and hearing aids, computer software) to maintain or improve functioning. To improve access to quality, affordable assistive devices, it is important to:

- Promote the inclusion of assistive devices and related procurement systems within essential healthcare services;
- Encourage health ministries to increase resources to incorporate assistive devices into their health plans and UHC strategies³;
- Support local assistive technology producers and providers, public-private partnerships and private-sector innovation and investment in producing and supplying affordable assistive technologies;
- Ensure that costs for assistive devices are covered under insurance schemes, and support the development of tools for identification and referral.

GOVERNANCE

Well-designed policies are vital for improving persons with disabilities' access to health care. In order to promote adequate legal and policy frameworks, it is important to:

- Assess national health and disability laws, policies, strategies or plans, and identify priorities to ensure compliance with the UN CRPD and improve healthcare access for persons with disabilities;
- Advocate for the inclusion of disability in national health policies and monitoring mechanisms, and strengthen the capacities of policy makers to do so;
- Support the development of health-care standards (e.g. clinical practice guidelines) and enforcement mechanisms for persons with disabilities;
- Promote the involvement of DPOs in healthcare decision-making and the formulation of health policies at all levels;
- Support the harmonisation and clarification of guidelines for exemptions and waivers for persons with disabilities and other vulnerable or poor groups.

HUMAN RESOURCES

Many challenges of persons with disabilities in accessing health care are due to prejudices or a lack of knowledge and capacities among healthcare workers about disability and inclusive practices. Therefore, it is important to:

- Integrate disability into the education and training for healthcare personnel and service providers to develop their capacity with regard to disability rights, the assessment of health issues for persons with disabilities and strategies how to accommodate patients with disabilities;
- Provide guidelines for the assessment, treatment and referral of persons with disabilities;
- Train community health workers to provide screening and preventive health care as well as referral of persons with disabilities.

PEOPLE

Persons with disabilities often lack information about health services and financing schemes (e.g. insurance schemes, exemptions or waivers for people in vulnerable situations). Therefore, it is important to:

- Provide information about available services, schemes and eligibility criteria in accessible formats (e.g. sign language, easy read information, pictures) for people with different impairments;
- Empower persons with disabilities and DPOs to provide health access awareness and peer support; Promote the dissemination of relevant information, for example through peer education in cooperation with DPOs.

INCLUSION CHECKLIST - WHERE TO START

DISABILITY INCLUSION MATTERS

GIZ is committed to further develop approaches for the full participation of persons with disabilities. It is important for us to combine theory and practical experiences and share our lessons learnt.



There is a wide range of measures to make health planning and programming inclusive of persons with disabilities. This checklist is a guide to start your disability inclusion journey: It sensitises to the needs of persons with disabilities and draws attention to programmatic opportunities and relevant aspects for the planning process.

ASSESSING DISABILITY INCLUSION IN HEALTH SYSTEMS

-  **GOVERNANCE**
How do laws, policies and/or plans support access to (general and disability-specific) healthcare and assistive technologies for persons with disabilities in the country? How effective are they?
-  **INFORMATION**
What systems are in place in the health sector to record data on disability including impairment type, age, gender and other demographic factors?
-  **HUMAN RESOURCES**
Who are key actors in the delivery of health services for women and men, girls and boys with disabilities? How aware are health personnel about disability issues and persons with disabilities' right to healthcare, and strategies to address related barriers? Which competences need to be strengthened to enhance disability inclusion skills among health care professionals?
-  **SERVICE DELIVERY**
How accessible and responsive is the delivery of health care services (general and disability-specific) for women and men, girls and boys with disabilities and their needs? What are key barriers? Which interventions or services exist to improve the accessibility of healthcare services?
-  **FINANCING**
How are persons with disabilities targeted in financing schemes and national plans for universal health coverage? Which measures exist to reduce or remove out-of-pocket payments for persons with disabilities?
-  **TECHNOLOGIES**
What is the level of availability and quality of affordable assistive technologies (e.g. mobility aids, hearing aids) Which procurement mechanisms for assistive technologies are in place and how effective are they? How effective are existing models of service provision and referral? How accessible are available eHealth solutions for person with disabilities?

INCLUSION OF DISABILITY AND PERSONS WITH DISABILITIES

IN YOUR HEALTH INTERVENTION(S)

-  Have we involved persons with disabilities and DPOs in the planning of our health project or programme?
-  Have we included activities to address or remove barriers for women and men, girls and boys with disabilities to accessing and receiving health care?
-  Have we included a disability budget line for measures to improve the accessibility of our activities for persons with different types of disabilities?
-  Have we identified a DPO as a partner to support the inclusion of disability throughout the project or programme, the implementation of specific activities such as disability-related awareness raising and training, and the evaluation?
-  Have we ensured that all data collected during our project or programme can be disaggregated by disability, and the age, gender and/or location of persons with disabilities?
-  Are measures and systems in place to follow up on the implementation of our commitment to disability inclusion in our health intervention(s) (e.g. indicators)?
-  Do we have adequate capacities and experience on disability and on disability-inclusive practices in our team in order to apply it in our work and communication?
-  Are our project delivery sites accessible for women and men with different types of disabilities?

INCLUDING DISABILITY INTO THE
PUBLIC HEALTH SYSTEM:
SOCIAL HEALTH PROTECTION
PROGRAMME (SHPP)
(2006 – 2021) IN CAMBODIA

The two GIZ health projects *Improving Maternal and New-born Care and Social Health Protection (SHP)* constitute the technical cooperation component of the Social Health Protection Programme (SHPP) in Cambodia. The SHPP aims at ensuring equitable access to quality health care services for poor and vulnerable groups and families with small children. It focused on health financing, governance, service delivery and maternal and newborn care. A 2010 study on barriers to accessing health care for persons with disabilities laid the foundation for the progressive inclusion of disability into the programme.

The SHPP introduced a range of interventions to address these challenges: A scheme to cover transportation costs for persons with disabilities was set up in cooperation with local authorities and faith-based organisation. Modifications in health facilities (e.g. ramps, communication sign boards) improved the accessibility of the buildings, and health information and communication. A costing study on the health expenditures of persons with disabilities offered critical evidence to lobby for their inclusion in the *National Social Protection Policy Framework 2016-2025*. Clinical practice guidelines, regular quality assessments and training of health professionals on the rights and needs of persons with disabilities improved the quality of health services for persons with disabilities. Clinical checklists were introduced to promote early detection of impairments in newborns and children. The development of clinical pathways and a service directory facilitated referrals to health and rehabilitation services. Inclusion awareness workshops, dance performances and the development of health promotion capacities in the national Disabled People's Organisation (DPO) promoted community understanding for inclusion and supported sexual and reproductive health education for persons with disabilities.

The Cambodian experience highlights the importance of effective cross-sectoral and interministerial coordination to streamline health-related processes, and pro-poor and disability schemes. It also drew attention to the limitations of a sector approach to disability inclusion: The programme practice showed the need for partnerships beyond the health sector in order to tackle the structural challenges in areas of education, poverty reduction etc. that influence persons with disabilities' access to health care. And it underpinned the role of DPOs in the planning and implementation of disability-inclusive health interventions. Particularly in contexts with limited space for rights-based advocacy, health education offers a vital avenue for DPOs to impact the situation of persons with disabilities.

IMPROVING ACCESS TO ASSISTIVE
TECHNOLOGY IN THE HEALTH
SECTOR: TRAINING OF ORTHOPAEDIC
SPECIALISTS IN LATIN AMERICA
(2011 – 2014)

In the context of the commitment to health in German development cooperation, the Federal Ministry for Economic Cooperation and Development (BMZ) commissioned a project to strengthen the regional orthopaedic training structures in Latin America and to increase access to relevant services for persons with physical disabilities: The GIZ, *Ottobock* - a manufacturer of assistive products for persons with reduced mobility, and the *International Society for Prosthetics and Orthotics* (ISPO) launched a development partnership that supported three training institutions in El Salvador, Colombia and Brazil under the *develoPPP.de* programme.

The three-year project supported the further development and the establishment of new study programmes according to international standards. Instructors were familiarized with modern care concepts and the required quality-management measures and the new care approaches have been integrated into the school curricula of orthopaedics. The project provided the universities with instructional materials, offered intensive specialisation training for experts in orthotics and prosthetics of the lower and upper extremities and expanded the workshop environment at the institutions. In Brazil, the first task was to create awareness among training institutions and policy makers with regard to the requirements of holistic orthopaedic training according to international standards.


The project showcases the important role of the private sector in promoting the supply of affordable assistive technologies. It contributed to the improvement of orthopaedic specialist training. Furthermore, it increased the availability and quality of orthopaedic care and related specialist referral centres (workshops and rehabilitation centres) within the health systems of the three countries.

IMPROVING ACCESS TO SEXUAL
AND REPRODUCTIVE HEALTH CARE:
REPRODUCTIVE AND FAMILY
HEALTH PROGRAMME (PSRF II)
(2015 – 2022) IN GUINEA

The *PSRF II* had three components: Strengthening the supervisory and steering functions, improving the quality of reproductive health services, and increasing the demand for and use of such services. GIZ committed to mainstreaming disability into the programme with a focus on the health service delivery component.

To ensure that this commitment translates into action, GIZ allocated funding and designated two focal points for disability inclusion. They sensitised staff and partners to disability rights and opportunities for the inclusion of persons with disabilities into the programme activities: Workshops for GIZ staff in the programme areas provided space to reflect on the health situations of persons with disabilities and discuss how the programme can contribute towards making health services more accessible. Meetings with DPOs, such as the *Réseau Guinéen des Organisations de Personnes Handicapées pour la Promotion de la Convention Internationale sur les Droits des Personnes Handicapées (ROPA-CI-DPH)*, offered the opportunity to discuss the possibilities of future cooperation. A baseline study identified barriers that prevent persons with disabilities from accessing health care and provided relevant recommendations. The findings have informed the planning of relevant stakeholders (e.g. the Ministry of Social Affairs, the Promotion of Women's Interests and Childhood; Prefectoral and Regional Health Offices). They were also incorporated into the design of the next PSRF phase, highlighting three priorities for disability inclusion: 1) Increasing awareness among health actors and persons with disabilities, 2) developing the capacities of health professionals, and 3) improving the accessibility of healthcare services. A proposal to improve the accessibility of health facilities in the commune of Mamou followed as well as the provision of sexual health education for persons with disabilities.

The experiences highlighted the importance to address disability across the different components of the health system to bring about change, and the need for indicators on disability inclusion to monitor progress. The strong support base for disability inclusion within the GIZ Steering Committee proved vital to sustain the inclusive approach and develop it further. The fact that the consulting firm which supported the programme was able to provide disability inclusion expertise through their expert was a valuable contribution in this regard.



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