

Disability

Draft WHO global disability action plan 2014–2021: Better health for all people with disability

Report by the Secretariat

1. The Executive Board at its 134th session noted an earlier version of this report.¹ The Board also provided guidance on the draft action plan, which the Secretariat has used in preparing the annexed draft disability action plan that is submitted to the Sixty-seventh World Health Assembly for adoption. The version of the report that follows has been updated (in particular paragraphs 5, 8 and 10 and the Annex).
2. There are more than 1000 million people with disability worldwide, about 15% of the global population. The prevalence of disability is rising because of ageing populations and the global increase in chronic disease conditions, and is higher in low-income countries than in high-income countries. Disability disproportionately affects women, older people and poor people.
3. People with disability face widespread barriers to accessing services, and experience poorer health outcomes, lower educational achievement, less economic participation and higher rates of poverty than people without disabilities. They are more than twice as likely to report that both the health care facilities and the skills of their health care providers are inadequate to meet their needs, nearly three times more likely to report being denied health care and four times more likely to report being treated badly.
4. Many of these barriers are avoidable and the disadvantage associated with disability can be overcome. Better health for people with disability, through improved access to health services, is a crucial enabling factor to participation and positive outcomes in areas such as education, employment, and family, community and public life. Good health will also contribute to the achievement of broader global development goals.
5. In May 2013, the Sixty-sixth World Health Assembly adopted resolution WHA66.9 on disability, in which it endorsed the recommendations of the *World report on disability*,² and requested the Director-General to prepare, in consultation with other organizations of the United Nations system and Member States, a comprehensive action plan based on the evidence in the report, and in line with the Convention on the Rights of Persons with Disabilities (adopted by the United Nations General Assembly in resolution 61/106) and the outcome document of the high-level meeting of the United

¹ See document EB134/16 and the summary records of the Executive Board at its 134th session, fourth meeting, section 2 (document EB134/2014/REC/2).

² World Health Organization, World Bank. *World report on disability*. Geneva: World Health Organization; 2011.

Nations General Assembly on disability and development (subsequently adopted by the United Nations General Assembly in resolution 68/3).

6. A “zero draft” of the disability action plan was prepared immediately after the Sixty-sixth World Health Assembly in consultation with a wide range of stakeholders, including: Member States, organizations of the United Nations system, and international and national partners such as development agencies, civil society organizations, including organizations of persons with disabilities, and professional associations. Comments on that draft, as well as the proposed process for preparing the action plan, were sought from representatives of key organizations of persons with disabilities, civil society organizations working on disability and development and United Nations entities during the Sixth session of the Conference of States Parties to the Convention on the Rights of Persons with Disabilities (New York, 17–19 July 2013), as well as experts and WHO staff.

7. The first draft of the disability action plan (31 July 2013) was reviewed through an extensive consultation process from mid-August to early November 2013, which included: a web-based consultation that was open to all (20 August to 18 October); briefing and input from members of the Committee on the Rights of Persons with Disabilities (11 September during the 10th session of the Committee, Geneva, 2–13 September); consultation with those Member States that have missions in Geneva, regional economic integration organizations and organizations of the United Nations system (Geneva, 8 October); regional consultations with Member States and other stakeholders through events led by regional offices, namely the Regional Office for Europe (electronic consultation concluded 9 October); the Regional Office for the Eastern Mediterranean (two video consultations on 9 and 23 October); the Regional Office for Africa (Brazzaville, 17–18 October); the regional offices for South-East Asia and the Western Pacific (Manila, 30–31 October); and the Regional Office for the Americas (Quito, 5–6 November), and consultations with key staff at WHO headquarters (July and October). Around 300 contributions were received from Member States, organizations of the United Nations system, organizations of persons with disabilities and other civil society entities, service providers, research institutions, WHO collaborating centres, development partners and individuals. A detailed timeline of the consultation programme and informal reports of all consultations, including details of participants, are available on the WHO website.¹

8. The Secretariat used the comments made at these informal consultations in preparing the second draft of the disability action. Comments on that text and guidance by the Executive Board at its 134th session have been reflected in the present text.

9. Pursuant to resolution WHA66.9, the draft “WHO global disability action plan 2014–2021: better health for all people with disability” aims to contribute to improving health, well-being and human rights for persons with disabilities. It provides clear objectives and actions for Member States, the Secretariat, and international and national partners. It also proposes success indicators that can be used to evaluate progress on implementation and the impact of the action plan.

ACTION BY THE HEALTH ASSEMBLY

10. The Health Assembly is invited to adopt the draft WHO global disability action plan 2014–2021: better health for all people with disability.

¹ <http://www.who.int/disabilities/actionplan/en/index.html> (last accessed 28 February 2014).

ANNEX

**DRAFT WHO GLOBAL DISABILITY ACTION PLAN 2014–2021:
BETTER HEALTH FOR ALL PEOPLE WITH DISABILITY¹**

1. In May 2013, the Sixty-sixth World Health Assembly in resolution WHA66.9 on disability endorsed the recommendations of the *World report on disability*.² The Health Assembly requested the Director-General to prepare, in consultation with Member States³ and organizations of the United Nations system, a comprehensive WHO action plan based on the evidence in the *World report on disability*, and in line with the Convention on the Rights of Persons with Disabilities (adopted by the United Nations General Assembly in resolution 61/106) and the outcome document of the high-level meeting of the United Nations General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities: the way forward, a disability-inclusive development agenda towards 2015 and beyond.

2. Disability is universal. Everybody is likely to experience disability directly or to have a family member who experiences difficulties in functioning at some point in his or her life, particularly when they grow older. Following the International Classification of Functioning, Disability and Health and its derivative version for children and youth, this action plan uses “disability” as an umbrella term for impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual (environmental and personal) factors. Disability is neither simply a biological nor a social phenomenon.

3. WHO recognizes disability as a global public health issue, a human rights issue and a development priority. Disability is a global public health issue because people with disability, throughout the life course, face widespread barriers in accessing health and related services, such as rehabilitation, and have worse health outcomes than people without disability. Some health conditions may also be a risk factor for other health problems, which are often poorly managed, such as a higher incidence of obesity in people with Down syndrome and higher prevalence of diabetes or bowel cancer in people with schizophrenia. Disability is also a human rights issue because adults, adolescents and children with disability experience stigmatization, discrimination and inequalities; they are subject to multiple violations of their rights including their dignity, for instance through acts of violence, abuse, prejudice and disrespect because of their disability, and they are denied autonomy. Disability is a development priority because of its higher prevalence in lower-income countries and because disability and poverty reinforce and perpetuate one another. Poverty increases the likelihood of impairments through malnutrition, poor health care, and dangerous living, working and travelling conditions. Disability may lead to a lower standard of living and poverty through lack of access to education and employment, and through increased expenditure related to disability.

¹ The terms “people” and “persons” with disabilities are used interchangeably throughout this action plan and include children and youth. Consistent with the Convention on the Rights of Persons with Disabilities (adopted by the United Nations General Assembly in resolution 61/106), “persons with disabilities” is used whenever the plan refers to rights and entitlements. In most other instances “people with disabilities” is used.

² World Health Organization, World Bank. *World report on disability*. Geneva: World Health Organization; 2011.

³ And, where applicable, regional economic integration organizations.

4. The action plan will be relevant to and should benefit all people with disability from birth to old age. Persons with disability include people who are traditionally understood as disabled, such as children born with cerebral palsy, wheelchair users, persons who are blind or deaf or people with intellectual impairments or mental health conditions, and also the wider group of persons who experience difficulties in functioning due to a wide range of conditions such as noncommunicable diseases, infectious diseases, neurological disorders, injuries, and conditions that result from the ageing process. Article 1 of the Convention on the Rights of Persons with Disabilities indicates that 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.

5. Much of WHO's mission is dedicated to the prevention of health conditions that may result in death, morbidity or disability. This action plan, however, is directed at improving the health, functioning and well-being of people with disability. It therefore considers prevention only in so far as persons with disabilities require the same access to preventive services and programmes as others. Prevention includes a wide range of measures aimed at reducing risks or threats to health: promotion of healthy lifestyles, such as guidance on good nutrition, the importance of regular physical exercise and avoiding tobacco use; protection of people from developing a health condition in the first place, such as immunization against infectious diseases or safe birthing practices; detection of a secondary or co-morbid health condition at an early stage, such as screening for diabetes or depression; and reduction of the impact of an established health condition, by means such as pain management, rehabilitation programmes, patient support groups or removal of barriers to access. Improving access to preventive services and programmes for persons with disabilities is important for achieving better health outcomes and is covered by Objectives 1 and 2 of this plan.

OVERVIEW OF THE GLOBAL SITUATION

6. There are more than 1000 million people with disability globally, that is about 15% of the world's population or one in seven people. Of this number, between 110 million and 190 million adults experience significant difficulties in functioning. It is estimated that some 93 million children – or one in 20 of those under 15 years of age – live with a moderate or severe disability. The number of people who experience disability will continue to increase as populations age, with the global increase in chronic health conditions. National patterns of disability are influenced by trends in health conditions and environmental and other factors, such as road traffic crashes, falls, violence, humanitarian emergencies including natural disasters and conflict, unhealthy diet and substance abuse.

7. Disability disproportionately affects women, older people, and poor people. Children from poorer households, indigenous populations and those in ethnic minority groups are also at significantly higher risk of experiencing disability. Women and girls with disability are likely to experience “double discrimination”, which includes gender-based violence, abuse and marginalization. As a result, women with disability often face additional disadvantages when compared with men with disability and women without disability. Indigenous persons, internally displaced or stateless persons, refugees, migrants and prisoners with disability also face particular challenges in accessing services. The prevalence of disability is greater in lower-income countries than higher-income countries. In its outcome document of the high-level meeting on disability and development in 2013, the United Nations General Assembly noted that an estimated 80% of people with disability live in developing countries and stressed the need to ensure that persons with disabilities are included in all aspects of development, including the post-2015 development agenda.

8. People with disability face widespread barriers in accessing services, such as those for health care (including medical care, therapy and assistive technologies), education, employment, and social services, including housing and transport. The origin of these barriers lies in, for example, inadequate legislation, policies and strategies; the lack of service provision; problems with the delivery of services; a lack of awareness and understanding about disability; negative attitudes and discrimination; lack of accessibility; inadequate funding; and lack of participation in decisions that directly affect their lives. Specific barriers also exist in relation to persons with disabilities being able to express their opinions and seek, receive and impart information and ideas on an equal basis with others and through their chosen means of communication.

9. These barriers contribute to the disadvantages experienced by people with disability. Particularly in developing countries, people with disability experience poorer health than people without disability, as well as higher rates of poverty, lower rates of educational achievement and employment, reduced independence and restricted participation. Many of the barriers they face are avoidable and the disadvantage associated with disability can be overcome. The *World report on disability* synthesizes the best available evidence on how to overcome the barriers that persons with disability face in accessing health, rehabilitation, support and assistance services, their environments (such as buildings and transport), education and employment.

VISION, GOAL, OBJECTIVES, GUIDING PRINCIPLES AND APPROACHES

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

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

12. The action plan has the following three objectives:

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

13. This action plan supports the implementation of measures that are designed to meet the rights of persons with disabilities, as enshrined in the Convention on the Rights of Persons with Disabilities, in particular Articles 9 (Accessibility), 11 (Situations of risk and humanitarian emergencies), 12 (Equal recognition before the law), 19 (Living independently and being included in the community), 20 (Personal mobility), 25 (Health), 26 (Habilitation and rehabilitation), 28 (Adequate standard of living and social protection), 31 (Statistics and data collection), 32 (International cooperation) and 33 (National implementation and monitoring). It also supports Articles 4 (General obligations), 5 (Equality and non-discrimination), 6 (Women with disabilities), 7 (Children with disabilities) and 21 (Freedom of expression and opinion, and access to information). It proposes actions to support the commitments made in the outcome document adopted by the United Nations General Assembly at its high-level meeting on disability and development (New York, 23 September 2013) to ensure access for persons with disabilities to health care services, including rehabilitation, habilitation and assistive

devices, and to improve disability data collection, analysis and monitoring and promote knowledge, social awareness and understanding of disability.

14. The action plan supports the Organization's continuing work towards mainstreaming disability in its programmes, in line with recent United Nations General Assembly resolutions.¹ It is aligned with the Twelfth General Programme of Work, 2014–2019, in particular reflecting the new political, economic, social and environmental realities and evolving health agenda. It complements and supports the implementation of other plans and strategies of the Organization, such as those on healthy ageing, reproductive, maternal and child health, emergencies and disasters, mental health, avoidable blindness and visual impairment, and noncommunicable diseases.

15. The design of the action plan is guided by the following principles, most of which are reflected in the Convention on the Rights of Persons with Disabilities:

- respect for the inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons;
- non-discrimination;
- full and effective participation and inclusion in society;
- respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- equality of opportunity;
- accessibility;
- equality between men and women;
- respect for the evolving capacities of children with disability and respect of the right of children with disability to preserve their identities;
- respect for the continued dignity and value of persons with disabilities as they grow older.

16. People with disability have unique insights about their disability and situation but have been excluded from the decision-making process about issues that directly affect their lives. In line with Article 4 of the Convention on the Rights of Persons with Disabilities, persons with disabilities through their representative organizations should be fully consulted and actively involved in all stages of formulating and implementing policies, laws, and services that relate to them.

¹ Resolutions 66/288 (The future we want), 66/229 (Convention on the Rights of Persons with Disabilities and the Optional Protocol thereto), 66/124 (High-level Meeting of the General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities), 65/186 (Realizing the Millennium Development Goals for persons with disabilities towards 2015 and beyond) and 64/131 (Realizing the Millennium Development Goals for persons with disabilities).

17. The design and implementation of the action plan are based on and guided by the following approaches:

- a human rights-based approach, including empowerment of persons with disabilities;
- a life-course approach, including the continuum of care;
- universal health coverage;
- a culturally-appropriate person-centred approach;
- multisectoral/community-based rehabilitation;¹
- universal design (see paragraph 29 below).

PROPOSED ACTIONS FOR MEMBER STATES, INTERNATIONAL AND NATIONAL PARTNERS, AND THE SECRETARIAT

18. Specific actions, detailing what can be done to achieve the plan's three objectives, are proposed for Member States, international and national partners, and the Secretariat. Options for how to implement the actions are proposed as inputs from various parties. The actions and inputs are based on the evidence of successful ways of overcoming barriers to accessing services outlined in the *World report on disability* and build on the Secretariat's technical work to enhance the quality of life of people with disability. It is essential that countries tailor their actions to their specific contexts.

19. As disability cuts across all sectors and involves diverse actors, implementation of the action plan will need the strong commitment of, provision of resources by and action from a wide range of international, regional and national partners and the development and strengthening of regional and global networks. National and local governments play the most significant roles, but other actors also have important parts to play, including organizations of the United Nations system, development organizations, organizations of persons with disabilities; service providers, including those in civil society and faith-based organizations; academic institutions; the private sector; communities; and people with disability and their families. The plan also recognizes the important contribution of formal and informal caregivers to the support of persons with disabilities and the particular support requirements they need to fulfil this role.

20. The success of the plan will depend on an effective multisectoral approach, with practical mechanisms for coordination and implementation between relevant ministries and departments responsible for the provision of health, rehabilitation and associated services for persons with disabilities. Relevant areas of government include health, disability services, social protection, welfare and community services, finance, infrastructure, transport, communications, labour and education. Effective coordination is essential, but each ministry, department and agency is primarily responsible for ensuring that its main areas of activity are accessible to and respond to the requirements of persons with disabilities.

¹ Community-based rehabilitation offers an operational methodology to realize human rights and development objectives at the community level, based on a comprehensive multisectoral approach, which can empower persons with disabilities and their families.

21. One way to facilitate multisectoral collaboration is through community-based rehabilitation. This activity has evolved to become a multisectoral strategy that offers practical guidance on how to link between, and strengthen the capacity of, mainstream services to ensure that persons with disabilities and their families have access to and benefit from education, employment, and health and social services. It is implemented through the combined efforts of persons with disabilities, their families, organizations and communities, and relevant government and nongovernmental health, education, vocational, social and other services. The approach is currently applied in more than 90 countries for rehabilitation, equalization of opportunities, poverty reduction, and social inclusion of persons with disabilities.

22. The action plan recognizes the considerable variation in contexts and starting points of countries and regions in their efforts to ensure access to health services and provide specific programmes and support for persons with disabilities. The plan is intended to provide structure and guidance but cannot be a “one-size-fits-all” solution. Actions towards achieving the plan’s objectives need to be aligned with existing regional and national obligations, policies, plans and targets.

MONITORING PROGRESS TOWARDS THE ACHIEVEMENT OF THE OBJECTIVES OF THE ACTION PLAN

23. The indicators of success set for each objective can be used to help to monitor and measure progress towards attainment of the plan’s goal. Baseline data and targets will be decided upon once the plan is approved. Given that the targets will be voluntary and global, each Member State is not expected to reach all the specific targets but can contribute to varying degrees towards their achievement. As indicated in the actions for Objective 3, the Secretariat will provide guidance, training and technical support to Member States, upon request, for improving disability data analysis and use in an efficient and cost-effective manner. Monitoring and reporting to the governing bodies on progress in implementing this action plan are recommended at the midway point (2017) and during its final year (2021).

OBJECTIVE 1: TO REMOVE BARRIERS AND IMPROVE ACCESS TO HEALTH SERVICES AND PROGRAMMES

24. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. WHO’s Constitution enshrines the enjoyment of the highest attainable standard of health as a fundamental right of every human being. The right to health includes access to timely, acceptable and affordable health care of appropriate quality. Promoting the right to health also requires Member States to generate conditions in which each person can enjoy the highest attainable standard of health and that health services are provided on the basis of free and informed consent.

25. Disability is extremely diverse. Even though some health conditions associated with disability result in extensive health care needs and others do not, all people with disability have the same general health care needs as everybody else and therefore require access to mainstream health care services. People with disability may experience greater vulnerability to preventable secondary conditions, comorbidities and age-related conditions, and may require specialist health care services. Sometimes they are subjected to treatment or other protective measures without consent. Some studies have also indicated that some groups of people with disabilities exhibit higher rates of risky behaviour such as smoking, poor diet and physical inactivity. They are also at greater risk of experiencing violence than those without disability, and have a higher risk of injury from road traffic crashes, burns or falls. For example, children with disability are three to four times more likely to experience violence. Children

with mental health conditions or intellectual impairments appear to be among the most vulnerable, with a 4.6 times higher risk of experiencing sexual violence than their non-disabled peers.

26. As well as causing disability, emergencies can also increase the vulnerability of persons with disabilities, whose basic and specific needs are frequently ignored or overlooked in emergency risk management. Those needs are often not identified and addressed before, during and after an emergency. Persons with disabilities are rarely consulted or represented in the design of emergency risk management policies and programmes.

27. Good health enables participation in a wide range of activities, including education and employment. However, evidence shows that people with disability, throughout the life course, have unequal access to health care services, have greater unmet health care needs and experience poorer levels of health compared to the general population. Health systems frequently fail to respond adequately to both the general and specific health care needs of people with disability. People with disability encounter a range of attitudinal, physical and systemic barriers when they attempt to access health care. Analysis of the World Health Survey shows that, compared with people without disability, men and women with disabilities are twice as likely to find that health care facilities and providers' skills are inadequate, three times more likely to be denied health care and four times more likely to be treated badly in the health care system. Half of persons with disabilities cannot afford required health care and they are 50% more likely than those without disability to suffer catastrophic health expenditures.¹

28. Barriers to accessing health services include: physical barriers related to the architectural design of health facilities, medical equipment or transport; health providers' lack of adequate knowledge and skills; misconceptions about the health of persons with disabilities, leading to assumptions that persons with disabilities do not require access to health promotion and disease prevention services and programmes; lack of respect or negative attitudes and behaviour towards persons with disabilities; informational barriers and communication difficulties; and inadequate information for persons with disabilities about their right to access health care services. Although both men and women face barriers to health care, men are less likely than women to consider that they or their children are sick enough to require health care services and to know where to access those services. Men also report more difficulties in accessing health care financing.

29. Article 25 of the Convention on the Rights of Persons with Disabilities reinforces the rights of persons with disabilities to enjoy the highest standard of health without discrimination on the basis of disability. Article 9 (Accessibility) outlines the measures to be taken to ensure that persons with disabilities have access, on an equal basis with others, to the physical environment, transport, information and communications (including information and communications technologies and systems), and other facilities and services open or provided to the public by both State and non-State actors and in both urban and rural areas. These measures include the identification and elimination of obstacles and barriers to accessibility in relation to buildings, roads, transportation and other indoor and outdoor facilities (including medical facilities), and information, communications and other services (including electronic and emergency services). Because of the diversity of health service users, a universal design approach is important in ensuring that products, environments, programmes

¹ When people have to pay fees or co-payments for health care, the amount can be so high in relation to income that it results in "financial catastrophe" for the individual or the household. WHO has proposed that health expenditure be viewed as catastrophic whenever it is greater than or equal to 40% of a household's non-subsistence income, i.e. income available after basic needs have been met.

and services are designed to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.

30. Health disparities will be reduced by making existing health care systems more inclusive at all levels and making public health programmes (including those for a healthy lifestyle, promoting improved diets and encouraging physical activity) accessible to persons with disabilities throughout the life course. Given that multiple factors limit access to health care for people with disability, actions are needed in all components of health care systems, including improving governance and increasing levels of awareness, knowledge and data in health and related ministries so that they may better consider disability and increase access to services. Maintaining nationally-defined social protection floors¹ containing basic social security guarantees that ensure universal access to essential health care and income security at least at a nationally defined minimum level is recommended. National health care policies need to acknowledge formally that some groups of people with disability experience health inequalities; that acknowledgement will be an essential step towards reducing health disparities, and towards making a commitment to collaboration and a coordinated approach among health care providers. Community-based rehabilitation is an important means of ensuring and improving coordination of and access to health services, particularly in rural and remote areas.

31. Successful removal of barriers and improvement in access to health services require input from persons with disabilities, who are most familiar with and affected by such barriers. Ensuring that health-related information is issued in an appropriately accessible format, and that modes of communication meet the requirements of persons with disabilities (such as sign language) is important. Some persons with disabilities may also require support to assert their right to health and equal access to health services.

OBJECTIVE 1: TO REMOVE BARRIERS AND IMPROVE ACCESS TO HEALTH SERVICES AND PROGRAMMES		
Indicators of success	Means of verification	Evidence of success
<p>1.1 X% of countries have national health policies that explicitly mention that persons with disabilities have the right to the enjoyment of the highest attainable standard of health</p> <p>1.2 X% of countries prohibit health insurers from discriminating against pre-existing disability</p> <p>1.3 Proportion of persons with disabilities who have access to the health services that they need</p> <p>1.4 X% of households with persons with disabilities incur catastrophic out-of-pocket expenditures on health services</p>	<p>Data to be collected through surveys of key informants in health ministries and civil society/organizations of persons with disabilities, administered by the Secretariat at baseline and after 5 and 10 years</p> <p>The model disability survey (see Objective 3) and other national disability and health surveys carried out as part of the monitoring framework and measurement approach to universal health coverage.</p>	<p>Existence of health policy in line with the Convention on the Rights of Persons with Disabilities</p> <p>Universal health coverage inclusive of persons with disabilities</p>

¹ International Labour Organization Social Protection Floors Recommendation, 2012 (No. 202): recommendation concerning national floors of social protection, adopted 14 June 2012.

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
<p>1.1 Develop and/or reform health and disability laws, policies, strategies and plans for consistency with the principles of the Convention on the Rights of Persons with Disabilities</p>	<ul style="list-style-type: none"> • Review and revise existing policies by eliminating discriminatory provisions to help to ensure better access for and inclusion of persons with disabilities in health and other sectors • Mobilize the health sector to contribute to the development of a multisectoral national disability strategy and action plan that ensures clear lines of responsibility and mechanisms for coordination, monitoring and reporting • Provide health sector support for monitoring and evaluating the implementation of health policies to ensure compliance with the provisions of the Convention on the Rights of Persons with Disabilities • Promote people-centered health services and the active involvement of men, women, boys and girls with disability and organizations of persons with disabilities throughout the process 	<ul style="list-style-type: none"> • Provide technical support; develop guidelines on disability-inclusive health systems strengthening to help to achieve universal coverage • Provide technical support and build capacity within health ministries and other relevant sectors for the development, implementation and monitoring of laws, policies, strategies and plans 	<ul style="list-style-type: none"> • Support opportunities for exchange on effective policies to promote the health of people with disability • Participation of relevant national bodies, including organizations of persons with disabilities and other civil society entities, in reforming health and disability laws, policies, strategies and plans

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
<p>1.2 Develop leadership and governance for disability-inclusive health</p>	<ul style="list-style-type: none"> • Identify focal points for disability within health ministries and formulate internal action plans that support inclusion and access to mainstream health care services • Ensure participation of the health sector in national coordinating bodies on disability • Ensure participation of organizations of persons with disabilities in health policy-making and quality assurance processes 	<ul style="list-style-type: none"> • Provide support to Member States to build their leadership capacity; develop and implement a training package on disability inclusion in the health sector • Host regional workshops, integrated with ongoing/related initiatives, for health ministry staff, policy-makers and representatives of organizations of persons with disabilities on universal health coverage and equity, drawing on country experience 	<ul style="list-style-type: none"> • Provide support to health ministries to build their leadership capacity for ensuring disability-inclusive health services (Article 32 of the Convention on the Rights of Persons with Disabilities) • Capacity-building for organizations of persons with disabilities to participate effectively in health service governance
<p>1.3 Remove barriers to financing and affordability through options and measures to ensure that people with disability can afford and receive the health care they need without extreme out-of-pocket and catastrophic expenditures</p>	<ul style="list-style-type: none"> • Allocate adequate resources to ensure implementation of the health components of the national disability strategy and plan of action • Ensure that financing schemes for national health care include minimum packages and poverty- and social-protection measures that target and meet the health care needs of people with disability and that information about the schemes reach persons with disabilities • Reduce or remove out-of-pocket payments for people with disability who have no means of financing health care • Promote multisectoral approaches to meeting 	<ul style="list-style-type: none"> • Provide technical assistance to countries for development of health financing measures that increase access and affordability 	<ul style="list-style-type: none"> • Provide technical and financial support to Member States in order to ensure that persons with disabilities can access mainstream health care services • Provide guidance to Member States in establishing and maintaining nationally-defined social protection floors • Support people with disability in accessing information on health care financing options

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
	<p>the indirect costs related to accessing health care (e.g. transport)</p> <ul style="list-style-type: none"> • Where private health insurance exists, ensure that it is affordable and accessible for persons with disabilities 		
<p>1.4 Remove barriers to service delivery (including impediments to physical access, information and communication, and coordination) across all health care programmes, including those on sexual and reproductive health, health promotion and other population-based public health initiatives</p>	<ul style="list-style-type: none"> • Adopt national accessibility standards (in line with universal design principles) and ensure compliance with them within mainstream health settings • Provide a broad range of reasonable accommodation measures to overcome barriers to accessing mainstream health services, including structural modifications to facilities, equipment with universal design features, adjustments to appointment systems, alternative models of service delivery, and communication of information in appropriate formats such as sign language, Braille, large print, Easy Read and pictorial information • Support mechanisms to improve the continuum of care experienced by people with disability across the life course, including: discharge planning, multidisciplinary team work, development of referral pathways and service directories 	<ul style="list-style-type: none"> • Support identification of barriers to particular services through technical assistance for collecting disability-disaggregated data on use of services • Develop resource on accessibility issues for health care facilities • Provide technical guidance to support the inclusion of people with disability in public health policies, strategies and programmes • Promote capacity-building of community-based rehabilitation programmes, especially in the areas related to health 	<ul style="list-style-type: none"> • Support user groups to audit accessibility in order to identify barriers that may prevent persons with disabilities from accessing health services • Finance pilot programmes that aim to demonstrate the benefits of including people with disability • Empower people with disability to optimize their health by providing information, training and peer support • Support development of community-based rehabilitation programmes

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
	<ul style="list-style-type: none"> • Promote and facilitate access to mainstream national and local public health initiatives that promote and protect health • Support inclusion by community-based rehabilitation programmes of health care referral within their activities 		
<p>1.5 Overcome specific challenges to the quality of health care experienced by persons with disabilities, including health workers' knowledge, attitudes and practices as well as participation of persons with disabilities in decisions that directly affect them</p>	<ul style="list-style-type: none"> • Promote increased understanding, knowledge and positive perceptions of people with disability through targeted communication and social media campaigns, developed in conjunction with organizations of persons with disabilities • Support education and training by promoting and encouraging the integration of disability into relevant undergraduate curricula and continuing education for service providers 	<ul style="list-style-type: none"> • Build understanding and promote importance of the inclusion of disability issues (including rights) in the curricula of schools of medicine and nursing, and other health-related institutions • Design model curricula on disability for personnel working in health care, rehabilitation and habilitation • Provide technical support to Member States seeking to implement model curricula on disability and health 	<ul style="list-style-type: none"> • Integrate education on the health and human rights of persons with disabilities into undergraduate and continuing education for all health care workers • Ensure people with disability are involved as providers of education and training where relevant • Provide training and support for community workers and informal caregivers who assist persons with disabilities to access health services • Provide opportunities for persons with disabilities to develop self-advocacy skills to effectively address specific challenges in accessing health services

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
<p>1.6 Meet the specific needs of persons with disabilities in all aspects of health emergency risk management, including emergency prevention, preparedness, response and recovery</p>	<ul style="list-style-type: none"> • Integrate disability in health emergency risk management policies, assessments, plans and programmes • Include actions on emergency risk management in disability policies, services and programmes 	<ul style="list-style-type: none"> • Provide technical guidance and assistance to strengthen capacities for dealing with disability in emergency risk management for health 	<ul style="list-style-type: none"> • Integrate disability across emergency risk management in global, regional and national multisectoral and health policy frameworks and forums • Include disability in risk assessments and make provision for disability in health services in emergency response and recovery

OBJECTIVE 2: TO STRENGTHEN AND EXTEND REHABILITATION, HABILITATION, ASSISTIVE TECHNOLOGY, ASSISTANCE AND SUPPORT SERVICES, AND COMMUNITY-BASED REHABILITATION

32. Not all persons with disabilities require habilitation, rehabilitation, assistive technology, assistance and support services and community-based rehabilitation, but many do. Access to various services and technologies is often a prerequisite for people with disability to be able to go to work, participate in community life, and access health care, and for children and adolescents with disability to attend school. Enabling the individual to participate and be included in the community is the focus of such services.

33. Article 26 (Habilitation and rehabilitation) of the Convention on the Rights of Persons with Disabilities outlines the need for States Parties to undertake appropriate measures to organize, strengthen and extend habilitation and rehabilitation services and programmes in the areas of health, employment, education and social services. Article 26 also stipulates that States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation. In addition, Article 4 (General obligations), Article 20 (Personal mobility), and Article 32 (International cooperation) require Member States and the international community to invest in facilitating access to quality assistive technology, for instance by making them available at affordable cost.

34. Habilitation and rehabilitation can reduce the impact of a broad range of health conditions (such as diseases and injuries). These two actions are defined in the *World report on disability* as sets of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments. Encompassing medical care, therapy and assistive technologies, such measures should begin as early as possible and be made available as close as possible to where people with disability live.

35. Assistive technologies are evolving quickly and include any item, piece of equipment or product, whether it is acquired commercially, modified or customized, that is used to increase, maintain or improve the functional capabilities of individuals with disability. Assistive technologies

include eye glasses, hearing aids, augmentative and alternative communication, walking frames, wheelchairs, and prostheses such as artificial legs. The field also covers information and communications technologies such as computers, screen-reading software and customized telephones. Assistive technologies play a significant role in enabling people with disability to function and participate.

36. Assistance and support services enable individuals with disability to undertake activities of daily life and participate in their community. These services, commonly provided through family members and social networks as well as through formal provision, include personal assistance, independent living services, respite services, sign language interpretation, employment and education support, and information and advice.

37. Community-based rehabilitation programmes can provide rehabilitation, assistive technologies and support services in countries with limited resources and empower persons with disabilities and their families. WHO's guidelines on the subject offer practical suggestions on how to build links with and strengthen the capacity of mainstream services and facilitate access to specific services.¹

38. Investments in habilitation and rehabilitation and provision of assistive technologies are beneficial because they build human capacity and can be instrumental in enabling people with limitations in functioning to remain in or return to their home or community, live independently, and participate in education, the labour market and civic life. In addition, they can reduce the need for formal support services as well as reducing the time and physical burden for caregivers.

39. Global data on the need for habilitation, rehabilitation, assistive technologies and support and assistance services, the type and quality of measures provided, and estimates of unmet need do not exist. However, national-level data reveal large gaps in the provision of and access to services in many low- and middle-income countries. Data from four southern African countries, for example, found that between only 26% and 55% of people received the medical rehabilitation they needed. Hearing aid production currently meets less than 10% of global need, and less than 3% of hearing aid needs in developing countries are met annually. The need for services may be increased by environmental factors such as disasters and conflict.

40. Significant barriers to the provision of habilitation, rehabilitation, assistive technology and assistance and support services exist, including the lack of prioritization; the lack of policies and plans; high costs and nonexistent or inadequate funding mechanisms; insufficient numbers of appropriately trained professionals, absence of facilities and equipment; and ineffective service models and lack of integration and decentralization of services (for example, rehabilitation and habilitation service provision within primary and secondary health care settings). Major rehabilitation and habilitation centres are usually located in urban areas; in rural areas, even basic therapeutic services are often not available. Travelling to secondary or tertiary rehabilitation and habilitation services can be costly and time-consuming, and public transport is often not adapted for people with mobility difficulties. Women may experience additional difficulties in travelling to health care services. Lack of research and data on needs, unmet needs, type and quality of services provided, costs, and benefits also constrains the development of effective rehabilitation and habilitation services. Furthermore, there is insufficient consultation with and involvement of persons with disabilities in the provision of rehabilitation and habilitation services.

¹ Community-based rehabilitation: CBR guidelines. Geneva: World Health Organization; 2010.

41. Habilitation and rehabilitation are cross-sectoral activities and may be provided by health professionals in conjunction with specialists in education, employment, social welfare and other fields. In resource-constrained settings these services may be provided by non-specialist workers, such as community-based rehabilitation workers, in addition to family, friends and community groups. Although health ministries will play a central role in ensuring access to appropriate, timely, affordable and high-quality services, it is important to recognize and articulate the linkages with other ministries, for example social welfare (which may provide assistive devices or subsidies for services and equipment), labour (for the provision of vocational rehabilitation), and education (for training of personnel). Nongovernmental entities, including faith-based organizations and private companies, often contribute significantly to the provision of rehabilitation and habilitation services. Governments play an important role in determining the mechanism through which these services can be coordinated and regulated across sectors and partners.

42. Habilitation and rehabilitation are voluntary activities yet some individuals may require support in making decisions about treatment choices. In all cases habilitation, rehabilitation, assistance and support services and community-based rehabilitation should empower persons with disabilities and their family members. The active participation and decision-making of persons with disabilities and the families of children with disabilities are integral to the success of habilitation, rehabilitation and assistance and support services.

OBJECTIVE 2: TO STRENGTHEN AND EXTEND REHABILITATION, HABILITATION, ASSISTIVE TECHNOLOGY, ASSISTANCE AND SUPPORT SERVICES, AND COMMUNITY-BASED REHABILITATION

Indicators of success	Means of verification	Evidence of success
<p>2.1 X% of countries have national policies on habilitation, rehabilitation and community services or programmes related to persons with disabilities</p>	<p>Use of the International Standard Classification of Occupations, and surveys by professional organizations</p>	<p>Existence of rehabilitation, habilitation and community services legislation, policy and regulation compatible with the principles of the Convention on the Rights of Persons with Disabilities</p>
<p>2.2 Number of graduates from educational institutions per 10 000 population – by level and field of education (for example, physical rehabilitation medicine, physical therapy, occupational therapy, and prosthetics and orthotics)</p>	<p>Data to be collected through surveys of key informants in health ministries and civil society/ organizations of persons with disabilities, administered by the Secretariat at baseline and after 5 and 10 years (indicator 2.3)</p>	
<p>2.3 Proportion of the population covered by community-based rehabilitation or other community services</p>	<p>Use of disability surveys such as WHO's model disability survey (indicator 2.4)</p>	
<p>2.4 Proportion of persons with disabilities that receive the assistive technologies that they need (for example hearing aids, glasses, prosthetics and/or orthotics)</p>		

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
<p>2.1 Provide leadership and governance for developing and strengthening policies, strategies and plans on habilitation, rehabilitation, assistive technology, support and assistance services, community-based rehabilitation and related strategies</p>	<ul style="list-style-type: none"> • Develop or revise legislation, policies, standards and regulatory mechanisms for habilitation, rehabilitation, assistive technology, community support and assistance services, community-based rehabilitation, and related strategies • Undertake situation analysis to inform policies and planning • Raise awareness about rehabilitation and habilitation and devise mechanisms for national sector planning, coordination and financing 	<ul style="list-style-type: none"> • Provide technical guidance; finalize and disseminate evidence-based guidelines on health-related rehabilitation • Provide technical guidance and support to build capacity within health ministries and other relevant sectors for the development, implementation and monitoring of legislation, policies, strategies and plans • Host regional events on developing and/or strengthening regional action plans on rehabilitation • Provide support for national and regional situation analyses whose results can be used in the design of plans to strengthen service delivery 	<ul style="list-style-type: none"> • Participate directly in the development of policies, strategies and plans • Provide technical inputs and support to countries that are introducing and expanding rehabilitation and habilitation services
<p>2.2 Provide adequate financial resources to ensure the provision of appropriate habilitation and rehabilitation services and assistive technologies</p>	<p>Develop or promote funding mechanisms to increase coverage and access to affordable habilitation, rehabilitation and assistive technology services.</p> <p>Depending on each country's specific circumstances, these could include a mix of:</p> <ul style="list-style-type: none"> • public funding targeted at people with disability, with priority given to essential elements of rehabilitation and habilitation including assistive technology, and at those who 	<ul style="list-style-type: none"> • Provide in collaboration with other relevant agencies evidence-based guidance for health ministries, other relevant sectors and stakeholders on appropriate funding mechanisms for rehabilitation 	<ul style="list-style-type: none"> • Advocate national leadership for increased resource allocation for rehabilitation • Provide financial support through international cooperation including in humanitarian crises

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
	<p>cannot afford to pay</p> <ul style="list-style-type: none"> • promoting equitable access to rehabilitation through health and social insurance coverage • reallocation and redistribution of existing resources • provision of support through international cooperation, for instance in humanitarian crises 		
<p>2.3 Develop and maintain a sustainable workforce for rehabilitation and habilitation as part of a broader health strategy</p>	<ul style="list-style-type: none"> • Formulate and implement national health, rehabilitation and habilitation plans to increase the numbers and capacity of human resources – both men and women – for rehabilitation • Improve working conditions, remuneration and career opportunities in order to attract and retain rehabilitation and habilitation personnel • Produce national standards in training for different types and levels of rehabilitation and habilitation personnel that can enable career development and continuing education across levels • Train health personnel for early identification, assessment and referral of people that can benefit from rehabilitation, habilitation, support and assistance services 	<ul style="list-style-type: none"> • Provide evidence-based guidance for health ministries, other relevant sectors and stakeholders on the recruitment, training and retention of rehabilitation personnel • Provide technical assistance for supporting health ministries, other relevant sectors and stakeholders to build the capacity of training providers, and develop standards for training • Design an online training package on community-based rehabilitation in order to strengthen the workforce, particularly at the community level 	<ul style="list-style-type: none"> • Produce training standards for different types and levels of specialist rehabilitation personnel • Build training capacity in accordance with national health, rehabilitation and habilitation plans • Implement measures to improve recruitment and retention of specialist rehabilitation and habilitation personnel, particularly in rural and remote areas • Train non-specialist health personnel on disability and rehabilitation and habilitation relevant to their roles and responsibilities

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
<p>2.4 Expand and strengthen rehabilitation and habilitation services ensuring integration, across the continuum of care, into primary (including community), secondary and tertiary levels of the health care system, and equitable access, including timely early intervention services for children with disabilities</p>	<ul style="list-style-type: none"> • Review existing rehabilitation and habilitation programmes and services and make necessary changes to improve coverage, effectiveness and efficiency • Integrate rehabilitation and habilitation services within existing health, social and educational infrastructure • Use community-based rehabilitation as a strategy to complement and strengthen existing rehabilitation and habilitation service provision, particularly in countries where few services are available • Establish mechanisms for effective coordination between different rehabilitation and habilitation service providers and levels of the health care system • Work with a range of stakeholders to ensure services for children with disability are available and coordinated between the responsible agencies 	<ul style="list-style-type: none"> • Support countries in integrating rehabilitation and habilitation services into the health system with a focus on decentralization of services at the primary/community level • Develop relevant tools and training packages to develop and strengthen habilitation and rehabilitation services including for children • Provide technical guidance for countries that want to develop or strengthen community-based rehabilitation programmes • Support the creation of a global database on community-based rehabilitation to indicate where programmes are being implemented and establish a related global network to provide information, training and support to programmes included in the database 	<ul style="list-style-type: none"> • Work with health ministries to expand and strengthen the provision of rehabilitation and habilitation services in line with national plans • Promote community-based rehabilitation as an effective strategy to support persons with disabilities and facilitate their access to rehabilitation services • Provide technical and financial support to ensure the delivery of high-quality community-based rehabilitation programmes, and to maintain existing networks at the global, regional and country levels • Work with relevant stakeholders to establish and streamline referral systems in order to ensure that persons with disabilities, throughout the life course, have access to the modes of service delivery they require at each level of the health system

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
<p>2.5 Make available appropriate assistive technologies that are safe, of good quality and affordable</p>	<ul style="list-style-type: none"> • Include the provision of assistive technologies in health, rehabilitation, habilitation and other relevant sectoral policies, strategies and plans, with accompanying necessary budgetary support • Design a range of financing mechanisms and programmes, such as rental systems • Define standards for assistive technology provision 	<ul style="list-style-type: none"> • Prepare and disseminate evidence-based guidance on the provision and use of assistive technologies • Provide technical assistance to Member States to build capacity to develop and strengthen provision and use of assistive technologies 	<ul style="list-style-type: none"> • Provide technical and financial support to Member States to build capacity to develop and strengthen provision of assistive technologies
<p>2.6 Promote access to a range of assistance and support services and support independent living and full inclusion in the community</p>	<ul style="list-style-type: none"> • Contribute to the development of plans that strengthen community-based assistance and support services, including sufficient human resources and funding when institutions are being closed • Strengthen referral mechanisms between rehabilitation and habilitation services and assistance and support services 	<ul style="list-style-type: none"> • Advocate and provide technical guidance on designing and implementing appropriate policy frameworks 	<ul style="list-style-type: none"> • Advocate the development of policy frameworks to ensure the effective provision of assistance and support services • Support national leadership in identifying and securing the technical and financial resources required for assistance and support services • Provide technical inputs/support to ensure that persons with disabilities and their family members and/or informal caregivers have access to community support

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
<p>2.7 Engage, support and build the capacity of persons with disabilities and their family members and/or informal caregivers in order to support independent living and full inclusion in the community</p>	<ul style="list-style-type: none"> • Include persons with disabilities and their family members and/or informal caregivers in all aspects of developing and strengthening rehabilitation, habilitation, support and assistance services • Collaborate with other sectors besides the health sector in order to ensure appropriate support is provided for informal caregivers, the majority of whom are women 	<ul style="list-style-type: none"> • Promote awareness and understanding of the rights of persons with disabilities and the role of families and/or informal caregivers • Maintain and strengthen partnerships with organizations and associations representing persons with disabilities and their family members and/or caregivers 	<ul style="list-style-type: none"> • Advocate the inclusion of persons with disabilities and their family members and/or caregivers in all aspects of developing and strengthening rehabilitation and habilitation services • Advocate the importance of informal caregivers in the lives of people with disability, and the importance of promoting their health and well-being

OBJECTIVE 3: TO STRENGTHEN COLLECTION OF RELEVANT AND INTERNATIONALLY COMPARABLE DATA ON DISABILITY AND SUPPORT RESEARCH ON DISABILITY AND RELATED SERVICES

43. Good-quality data and research on disability are essential for providing the basis for policy and programmes and for efficient allocation of resources. They are also important for deepening understanding of disability issues and successful ways to remove barriers and for ensuring that persons with disabilities can participate in and contribute to society on an equal basis.

44. There are, however, insufficient rigorous and comparable data and research related to disability and health care systems nationally and globally. Data are collected on mortality, but policy-relevant data on functioning and disability are lacking. National data collection systems, which may include censuses, population surveys and administrative data registries, do not often collect data on disability. People with disability are often excluded from trials that seek scientific evidence for the outcomes of a health intervention. The lack of evidence is a significant barrier for decision-making and in turn impacts on access to mainstream health care and specialized services for people with disability.

45. Data needed to strengthen health care systems include: number of people and health status of people with disability; social and environmental barriers, including discrimination; responsiveness of health care systems to persons with disabilities; use of health care services by people with disability; and the extent of the need, both met and unmet, for care.

46. Internationally, methodologies for collecting data on disability need to be developed, tested cross-culturally, and applied consistently. Tools are required for disaggregating data relating to people with disability. Data need to be standardized and internationally comparable in order to be able to benchmark and monitor national and international progress on disability policies and on the implementation of the principles of the Convention on the Rights of Persons with Disabilities.

Nationally, disability should be included in data collection and the data analysed and used for policy and planning. Definitions of disability, based on the International Classification of Functioning, Disability and Health, including the Children and Youth Version, can allow for the generation of internationally comparable data. The inclusion of a disability module in existing sample surveys can be a cost-effective and efficient approach to generate data on people with disability. Dedicated surveys, such as the model disability survey being prepared by the Secretariat, should provide comprehensive information on disability characteristics that is relevant for policy formulation, such as prevalence, health conditions associated with disability, use of and need for services, quality of life, opportunities, and rehabilitation and habilitation needs. Disaggregating these data further by sex, age, income or occupation is important for uncovering patterns, trends and other information about “subgroups” of people with disability. Collecting administrative data can provide specific information on users, types, quantity and cost of services.

47. Priority areas for health-related research should be selected on the basis of country contexts and may include measurement of disability and its determinants; identification of barriers to health care, rehabilitation, habilitation and assistive technology provision and strategies for overcoming them; success factors for health promotion interventions for people with disability; prevention of secondary conditions; early detection and referral of health problems through primary health care; the link between rehabilitation and habilitation needs, receipt of services, health outcomes (functioning and quality of life), and costs; models of service provision, approaches to human resource development and financing modalities; and cost-effectiveness of rehabilitation measures, including community-based rehabilitation programmes. Research on disability should be inclusive of persons with disabilities, and research agendas should be drafted with the active participation of persons with disabilities or their representative organizations.

OBJECTIVE 3: TO STRENGTHEN COLLECTION OF RELEVANT AND INTERNATIONALLY COMPARABLE DATA ON DISABILITY AND SUPPORT RESEARCH ON DISABILITY AND RELATED SERVICES

Indicators of success	Means of verification	Evidence of success
<p>3.1 X% of countries that have collected comprehensive¹ information on disability</p>	<p>Governmental responses</p>	<p>Number of countries with a valid, reliable monitoring tool providing international comparable data on the health and social situation of persons with disabilities</p>

¹ Defined as all domains of functioning (impairments in body function and structure, activities and participation), related health conditions and environmental factors. Note that most efforts to collect data on disability since 2000 do not consider environmental factors; 55 countries have collected data on all other domains. Another option would be to develop an index (for example, one point for every domain of functioning, health conditions and environmental factors to a maximum of five points).

OBJECTIVE 3: TO STRENGTHEN COLLECTION OF RELEVANT AND INTERNATIONALLY COMPARABLE DATA ON DISABILITY AND SUPPORT RESEARCH ON DISABILITY AND RELATED SERVICES		
Indicators of success	Means of verification	Evidence of success
3.2 X% of countries that provide research grants for disability research	National reporting from health and education ministries, national centres of excellence or academic bodies	Frequency of data collection broken down as having been done within the past five years or not within the past five years Research funding programmes, where they exist, that provide resources for research on disability

ACTIONS FOR OBJECTIVE 3	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
3.1 Improve disability data collection through the development and application of a standardized model disability survey	<ul style="list-style-type: none"> • Implement valid and reliable tools, consistent with the International Classification of Functioning, Disability and Health, in order to enable and improve the collection of data on disability 	<ul style="list-style-type: none"> • Develop evidence-based tools to assist and strengthen collection of data on disability, including a model disability survey • Develop guidance on involving persons with disabilities in collection, analysis and use of data on disability • Provide technical support to Member States to build capacity for disability-related data collection, analysis and use through development and implementation of training 	<ul style="list-style-type: none"> • Provide technical and financial support to the Secretariat to assist with the development of tools for the collection of data on disability • Provide technical and financial support to Member States to improve their capacity to collect data of disability
3.2 Reform national data collection systems, including health information systems, to routinely include gender- and age-disaggregated disability data based on the International Classification of	<ul style="list-style-type: none"> • Include disability in national data collection systems and provide sex- and age-disaggregated data • Strengthen administrative and service data on disability, including 	<ul style="list-style-type: none"> • Provide technical guidance to support Member States in developing and/or reforming national data collection systems, including health information systems, in order to strengthen the 	<ul style="list-style-type: none"> • Provide technical and financial support to Member States developing and/or reforming national data collection systems in order to strengthen the disability component

ACTIONS FOR OBJECTIVE 3	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
Functioning, Disability and Health	recordkeeping within health systems that is age- and sex-disaggregated	disability component	
3.3 Strengthen research on priority issues in disability, with a particular focus on the key objectives of this action plan	<ul style="list-style-type: none"> • Work with research funding agencies to promote disability as a priority issue • Support research on priority disability issues (e.g. needs and unmet needs for services, barriers to service delivery, and health and rehabilitation outcomes), with dissemination of findings and application in policy-making and planning 	<ul style="list-style-type: none"> • Prepare, publish and disseminate evidence-based guidelines for Member States and partners on priority disability issues (such as monitoring and evaluating community-based rehabilitation) • Collaborate with research partners as steward for research on priority disability issues (such as noncommunicable disease-related disability) 	<ul style="list-style-type: none"> • Support Member States and the Secretariat to conduct research on priority disability issues
3.4 Strengthen and build human resource capacity in the area of disability research in a range of disciplines	<ul style="list-style-type: none"> • Develop and implement a strategy for strengthening and building human resource capacity (including persons with disabilities) in the area of disability research • Collaborate with key education and training institutions (both national and international) to strengthen and build human resource capacity in the area of disability research • Ensure that persons with disabilities have access to the training they need to influence research agendas and become researchers 	<ul style="list-style-type: none"> • Collaborate with Member States and key national and international partners to develop strategies to strengthen and build human resource capacity in the area of disability research 	<ul style="list-style-type: none"> • Provide technical and financial support to Member States and civil society for developing and implementing strategies to strengthen and build human resource capacity in the area of disability research • Provide learning and research opportunities by linking universities in low-income countries with those in high- and middle-income countries

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