Health equity for persons with disabilities

Guide for action

World Health Organization

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ISBN 978-92-4-010151-7 (electronic version)
ISBN 978-92-4-010152-4 (print version)

Suggested citation. Health equity for persons with disabilities: guide for action. Geneva: World Health Organization; 2024. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at https://iris.who.int/.

Design and layout by Inis Communication

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Foreword

An estimated 1.3 billion people globally experience significant disability. This figure has grown over the last decade and will continue to rise due to demographic and epidemiological changes. In 2022, the World Health Organization launched the *Global report on health equity for persons with disabilities.* This report demonstrated that many persons with disabilities are still being left behind. Experiencing persistent health inequities, persons with disabilities die earlier, they have poorer health and functioning, and they are more affected by health emergencies than the general population. These differences are largely associated with unjust factors both inside and beyond the health sector and are avoidable. The Global Report called upon Member States to take actions to make health sector more inclusive for persons with disabilities through the primary health care approach. This will be essential for countries to make health coverage truly universal and to progress towards other health-related targets in the Sustainable Development Goals.

As requested in the World Health Assembly Resolution 74.8 on the Highest Attainable Standard of Health for Persons with Disabilities, WHO is now providing the technical knowledge and capacity-building support needed to incorporate a disability-sensitive and inclusive approach across the health sector in countries. The *Health equity for persons with disabilities: guide for action* (Guide for Action) is a foundational tool to support Member States to implement the recommendations of the Global Report, in line with the Convention on the Rights of Persons with Disabilities. The Guide for Action also supports WHO's General Programme of Work 14 by reducing health inequities through addressing determinants of health; strengthening the primary health care approaches; and making health services more accessible and equitable for all.

Achieving health equity for persons with disabilities will be a process, not a one-time event. The Guide for Action seeks to strengthen the meaningful participation of persons with disabilities and their representative organizations in health sector governance and decision-making processes. In this way, all health initiatives, programmes and services will increasingly consider the diverse health requirements, but also the skills and capacities that persons with disabilities bring to the health sector and their communities.

We hope that governments, health partners and civil society, including organizations of persons with disabilities, will work together to implement the *Health equity for persons with disabilities: guide for action*, so that persons with disabilities can realize the highest attainable standard of health. We look forward to providing continued technical support to countries, and sharing the lessons learned with stakeholders globally.

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Acknowledgements

The World Health Organization (WHO) would like to thank the many individuals who contributed to the development of this document. The document was written by Emma Pearce, with technical support from Darryl Barrett, Kaloyan Kamenov, Nick Corby, Mélanie Gréaux, Charlotte Axelsson, Maria Francesca Moro, Julius Rosenhan and Juliet Milgate, under the overall guidance of Alarcos Cieza, Unit Head, Sensory Functions, Disability and Rehabilitation and Bente Mikkelsen, Director, Department for Noncommunicable Diseases, Disability and Rehabilitation.

The document has benefited from contributions from the following WHO staff across the three levels of the organization:

Hala Sakr Ali, Mohammad Ameel, Ambroise Ane, Eyob Zere Asbu, Shannon Barkley, Melanie Bertram, Nathalie Drew Bold, Mina Brajovic, Marzia Calvi, Bochen Cao, Matteo Cesari, Shelly Chadha, Giorgio Cometto, Antony Duttine, Abdelrahman Elwishahy, Susana Lidia Gomez Reyes, Rachel Mary Hammonds, Lucinda Hiam, Ernesto Jaramillo, Stuart Keel, Mary Kessi, Pauline Kleinitz, Theadora Swift Koller, Etienne Krug, Aku Kwamie, Bethany-Kate Lewis, Daniel Low-Beer, Alia Cynthia Luz, Carey McCarthy, Jody-Anne Mills, Andrew Mirelman, Ryoko Miyazaki-Krause, Cathal Morgan, Derrick Muneene, Taina Tea Imreli Nakari, Devaki Nambiar, Marjolaine Nicod, Ismail Ali Oumalkhair, Christina Catherine Pallitto, Sunil Pokhrel, Nuria Toro Polanco, Martine Annette Prüss, Pauliina Nykanen-Rettaroli, Chaira Retis, Juan Pablo Peña Rosas, Anna Laura Ross, Dikaios Sakellariou, Binta Sako, Kylie Shae, Sudhvir Singh, Karin Eva Elisabet Stenberg, Yuka Sumi, Juan Tello, Jotheeswaran Amuthavalli Thiyagarajan, Tashi Tobgay, Tamitza Toroyan, Kavitha Viswanathan, and Natalia Wroblewska.

The World Health Organization would like to thank the numerous contributors for their support and guidance. Without their dedication, time, and expertise this toolkit would not have been possible.

Technical contributors

Shitaye Astawes (African Disability Forum, Ethiopia), Habtamu Buli (FHI-360, United States of America), Kim Bulkeley (WHO Collaborating Centre for Strengthening Rehabilitation Capacity in Health Systems, University of Sydney, Australia), Jarrod Clyne (International Disability Alliance, Belgium), Sarah Collinson (Sightsavers, United Kingdom of Great Britain and Northern Ireland), Saleck Ould Dah (Sightsavers, Côte d'Ivoire), Alexandra Devine (Centre for Health Equity, University of Melbourne, Australia), Markaya Henderson (European Disability Forum, Belgium), Phyllis Heydt (The Missing Billion, Kenya), Hannah Kuper (The London School of

Hygiene and Tropical Medicine, United Kingdom of Great Britain and Northern Ireland) Muriel Mac-Seing (Université de Montréal, Canada), Andrea Pregel (Sightsavers, Italy), Nathan Rowe (Down Syndrome International, United Kingdom of Great Britain and Northern Ireland), Astou Sarr (Sightsavers, Côte d'Ivoire), Michael Schwinger (CBM International, Germany), Camilla Williamson (HelpAge International, Spain), and Brooke Winterburn (Humanity & Inclusion, Kenya).

Pilot countries

The Ministry of Health and partner organizations, including organizations of persons with disabilities, in the United Republic of Tanzania, Malaysia, Montenegro, and Côte d'Ivoire.

Other contributors

WHO also wishes to acknowledge the following entities for their generous financial support in the development, piloting, publication and dissemination of the document: CBM International, Qatar Foundation, Sightsavers.

Acronyms and abbreviations

CRPD	Convention on the Rights of Persons with Disabilities
GBV	gender-based violence
IASC	Inter-Agency Standing Committee
NCDs	noncommunicable diseases
NGOs	nongovernmental organizations
NHPSPs	national health policies, strategies and plans
OPDs	organizations of persons with disabilities
PHC	primary health care
RHIS	routine health information systems
SDGs	Sustainable Development Goals
SOGIESC	sexual orientation, gender identity and expression, and sex characteristics
UHC	universal health coverage
WHA	World Health Assembly
WHO	World Health Organization

Background

The World Health Organization (WHO) estimates that 16% of the global population has a significant disability, with increasing prevalence due to a rise in noncommunicable diseases (NCDs), people living longer and ageing with limitations in functioning. The *Global report on health equity for persons with disabilities* (referred to hereafter as the "*Global report*") *(1)*, launched in December 2022, demonstrates that persons with disabilities continue to experience health inequities: they are more likely to die earlier, experience poorer health, and have greater limitations in functioning. The health inequities faced by persons with disabilities are the result of avoidable, unjust, and unfair conditions, including structural factors, such as stigma and discrimination; social determinants, such as poverty and lack of education; disease risk factors, such as tobacco consumption, alcohol and substance use, and unhealthy diets; and the attitudinal, institutional, and physical barriers faced at all levels of health systems.

(Note: The icons used throughout this Guide for Action are interpreted in **Box 1**).

WHO *Global report on health equity for persons with disabilities*

Health equity for persons with disabilities: guide for action (referred to hereafter as the *Disability inclusion guide for action*) provides practical guidance on the process that ministries of health should lead on to integrate disability inclusion into health systems governance, planning, and monitoring processes. It serves as the foundational resource to enable ministries of health and partners to implement the recommendations in the *Global report*. It supports Member States to meet commitments to "leave no one behind" and achieve the highest attainable standard of health for all people, as outlined in the Sustainable Development Goals (SDGs) *(2)*, the Convention on the Rights of Persons with Disabilities (CRPD) *(3)*, and World Health Assembly resolution 74.8 *(4)*. These commitments to addressing health inequities faced by persons with disabilities are also reiterated in the 2023 Political Declaration of the High-level Meeting on Universal Health Coverage *(5)*.

Box 1. What do the different icons used indicate?

Disability inclusion guide for action tools

Additional tools and resources

Country examples

The *Disability inclusion guide for action* is aligned with, and supports, implementation of strategic objectives outlined in WHO's draft fourteenth general programme of work *(6)*. Most notably, these objectives promote ensuring that persons with disabilities are included in programmes that address determinants of health; strengthening the primary health care approach and essential health system capacities to overcome barriers to services faced by persons with disabilities; and that access to essential health services during emergencies is sustained and equitable for all.

Strategic entry points for disability inclusion in health systems strengthening

Strengthening health systems using a primary health care (PHC) approach is the key strategy for achieving universal health coverage (UHC). Health equity for persons with disabilities will be achieved only if disability-inclusive strategies are firmly adopted in health systems strengthening and within mainstream health actions *(1)*. The *Disability inclusion guide for action* provides detailed guidance on how to integrate disability inclusion across efforts in strengthening health systems, using a PHC approach (see **Box 2**).

Further information about PHC can be found at: *Operational framework for primary health care: transforming vision into action (7).*

Box 2. Primary health care approach

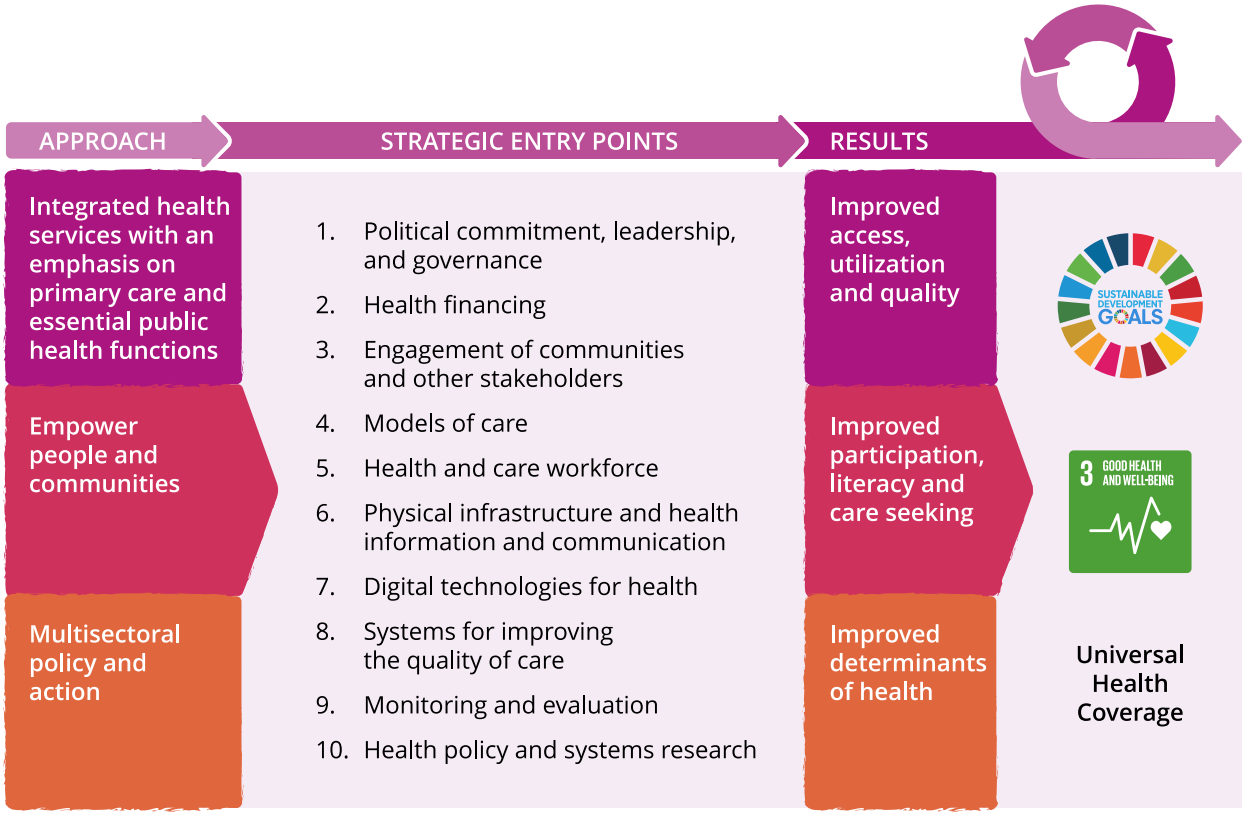
Primary health care is a whole-of-society approach to health that aims to maximize the level and distribution of health and well-being through three components: i) primary care and essential public health functions as the core of integrated health services; ii) multisectoral policy and action; and iii) empowered people and communities. Primary health care supports integrated delivery of health services so that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services through the different functions, activities and sites of care within the health system and throughout the life course. The modern concept of primary health care is comprehensive and promotes health, equity, and efficiency. The primary health care approach aligns with and contributes to universal health coverage and the SDGs *(7)*.

The *Global report (1)* recommends 40 targeted actions for disability inclusion across the 10 strategic entry points to advance global health priorities without leaving behind persons with disabilities. The 10 strategic entry points for disability inclusion in the health system, as outlined in **Figure 1**, are adapted from the original primary health care framework and are aligned with the health systems building blocks.

Taking actions on disability inclusion across all health system strengthening building blocks will contribute to increased access, utilization, and quality of health care for persons with disabilities; greater care seeking and participation in health activities; and improved social, biological, behavioural, commercial and environmental determinants of health. All these factors contribute to improved health outcomes for persons with disabilities, and in turn the achievement of global health goals relating to UHC and healthier populations (see **Figure 1**).

The implementation of actions across the 10 strategic entry points needs to take into consideration the context, strengths and weaknesses of the health system, and the priorities of stakeholders and communities. Countries must also decide, depending on their circumstances and in partnership with persons with disabilities, which entry points to prioritize in addressing the health inequities experienced by persons with disabilities. All strategies and actions must take a gender transformative and intersectional lens, so that every person benefits and is included *(1)*. The *Disability inclusion guide for action* supports ministries of health and their partners through a series of steps to prioritize and contextualize the recommended actions as set out in the *Global report (1)*.

Figure 1. Framework for health systems strengthening through primary health care approach – 10 strategic entry points for disability inclusion[a]



[a] *Sources: The Operational framework for primary health care: transforming vision into action (7); and the Global report on health equity for persons with disabilities (1).*

Scope and target audience

While a range of social, environmental, and commercial determinants affect health equity for persons with disabilities, the *Disability inclusion guide for action* focuses on the contributing factors which relate to the health system – namely, the attitudinal, institutional, and physical barriers faced by persons with disabilities at all levels of the health system. It supports ministries of health and their partners both in advancing health equity for persons with disabilities by identifying entry points, and in planning appropriate actions that strengthen disability inclusion across the health system. In many countries, this will include cross-sectoral public health interventions and other intersectoral actions which are priorities for the health sector.

Ministries of health are the primary users of the *Disability inclusion guide for action*, taking the overall lead in coordinating and implementing the process. However, the participation of persons with disabilities and their representative organizations is essential and central to the process. The *Disability inclusion guide for action* includes components which engage other ministries and stakeholders involved in implementation of disability-inclusive actions. These could include ministries of finance, social welfare and education, and organizations engaged in cross-sectoral public health interventions or providing disability programmes and services.

The *Disability inclusion guide for action* is designed for use at national levels, however the process and tools could also be adapted for use in local, district or regional level planning, depending on the dimension and range of decentralization and degree of autonomy of subnational planning authorities *(8)*.

Core concepts that inform the *Disability inclusion guide for action*

> **The level of health care for persons with disabilities is a litmus test – a measure of our true commitment to achieving universal health care and creating a healthier and safer society for everyone.**
>
> —Dr Mina Brajović, Head of WHO Country Office in Montenegro *(9)*.

The *Disability inclusion guide for action* contributes to health equity. Health inequities are differences in health outcomes that are avoidable and unjust. In general, health equity is the absence of unfair, avoidable, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically, or by other dimensions of inequality (e.g. age, sex, gender, ethnicity, disability, or sexual orientation). With health equity, every individual has a fair opportunity to realize their full health potential without being disadvantaged in achieving it *(1)*.

Box 3. A note about ableism

The Office of the United Nations High Commissioner of Human Rights describes ableism as: "'the belief system that underlies the negative attitudes, stereotypes and stigma that devalue persons with disabilities on the basis of their actual or perceived impairments. Ableism considers persons with disabilities as being less worthy of respect and consideration, less able to contribute and participate, and of less inherent value than others" *(10)*.

These beliefs may be adopted consciously or unconsciously. As with racism, sexism and ageism, ableism is embedded in our institutions, systems and broader society. Ultimately, ableism limits the opportunities of persons with disabilities, and contributes to their exclusion in all spheres of life, including those relating to health and well-being *(10, 11)*.

A primary health care approach to health systems strengthening can address the contributing factors to health inequities. Taking this approach, the *Disability inclusion guide for action* seeks to address the contributing factors to health inequities faced by persons with disabilities in the health system. These factors include a lack of inclusion of persons with disabilities in governance and decision-making processes in the health sector; gaps in knowledge, negative attitudes, and

discriminatory practices among health-care workers (see **Box 3**); inaccessible health facilities and information; and lack of information or data collection and analysis on disability.

Health equity for persons with disabilities will only be achieved if disability-inclusive strategies are implemented in mainstream health actions. Persons with disabilities are entitled to the same health services as every other person in the population. For example, women with disabilities need access to the full range of women's health services, such as cervical and breast cancer screening; the barriers faced by children with disabilities need to be addressed in childhood vaccination programmes; and HIV information, education and communication needs to reach persons with intellectual disabilities in a way that they can understand. This means that all health programmes must address barriers and provide reasonable accommodation to persons with disabilities. For certain people with disabilities, some health services, for example rehabilitation services, may be necessary intermittently over their life course (see **Box 4** for more information).

Box 4. Rehabilitation and assistive technology

Rehabilitation and assistive technology are health services which seek to address the impact of health conditions on a person's life by focusing primarily on improving their functioning and reducing the experience of disability *(12)*. Persons with and without disabilities may require these services at different points in their lives. The *Disability inclusion guide for action* is focused on ensuring that persons with disabilities have the same access as others to all health services, including those services which seek to improve their function. National rehabilitation plans, as promoted through the Rehabilitation 2030 initiative,[a] should be integral to an inclusive health system and, where these services are limited, dedicated rehabilitation and assistive technology planning should take place. However, they cannot replace an inclusive approach across the health sector for persons with disabilities.

[a] See: https://www.who.int/initiatives/rehabilitation-2030.

The *Disability inclusion guide for action* is focused on disability inclusion in the health sector. Disability inclusion refers to the meaningful participation of persons with disabilities and the promotion and mainstreaming of their rights into the health sector, as outlined in the CRPD. Disability inclusion in the health sector cannot be meaningfully achieved without collaboration and partnership with other ministries and government departments, disability and health nongovernmental organizations (NGOs) and service providers, development partners and organizations of persons with disabilities.

Achieving health equity requires planning for persons with disabilities in all their diversity. Persons with disabilities are not a homogeneous group. Individuals with different types of disabilities experience different barriers in accessing the health services; some are more marginalized than others. For example, persons with intellectual disabilities, persons with deafblindness, and persons with mental health conditions and psychosocial disabilities may face more complex stigma and discrimination, and different barriers in the health sector.

All strategies and actions must take an intersectional approach. An intersectional approach recognizes that "people's lives are shaped by their identities, relationships, and social factors. These combine to create intersecting forms of privilege and oppression depending on a person's context and existing power structures such as patriarchy, ableism, colonialism, imperialism, homophobia and racism" *(13, p. 8)*. The intersectional forms of stigma and discrimination experienced by persons with disabilities are influenced by societal power structures and their respective identities, which may vary between context, over time throughout the life course.

Further information is available at: ***Intersectionality resource guide and toolkit: an intersectional approach to leave no one behind (13).***

Achieving health equity for persons with disabilities will be a process, not a one-time event. The *Disability inclusion guide for action* seeks to strengthen the inclusion of persons with disabilities in health sector structures and processes to contribute to the development, implementation and monitoring of national health policies, strategies, and plans. Lessons learned during implementation of disability-inclusive actions, as well as monitoring of health equity indicators, should inform and be reflected in future health sector priorities on an ongoing basis.

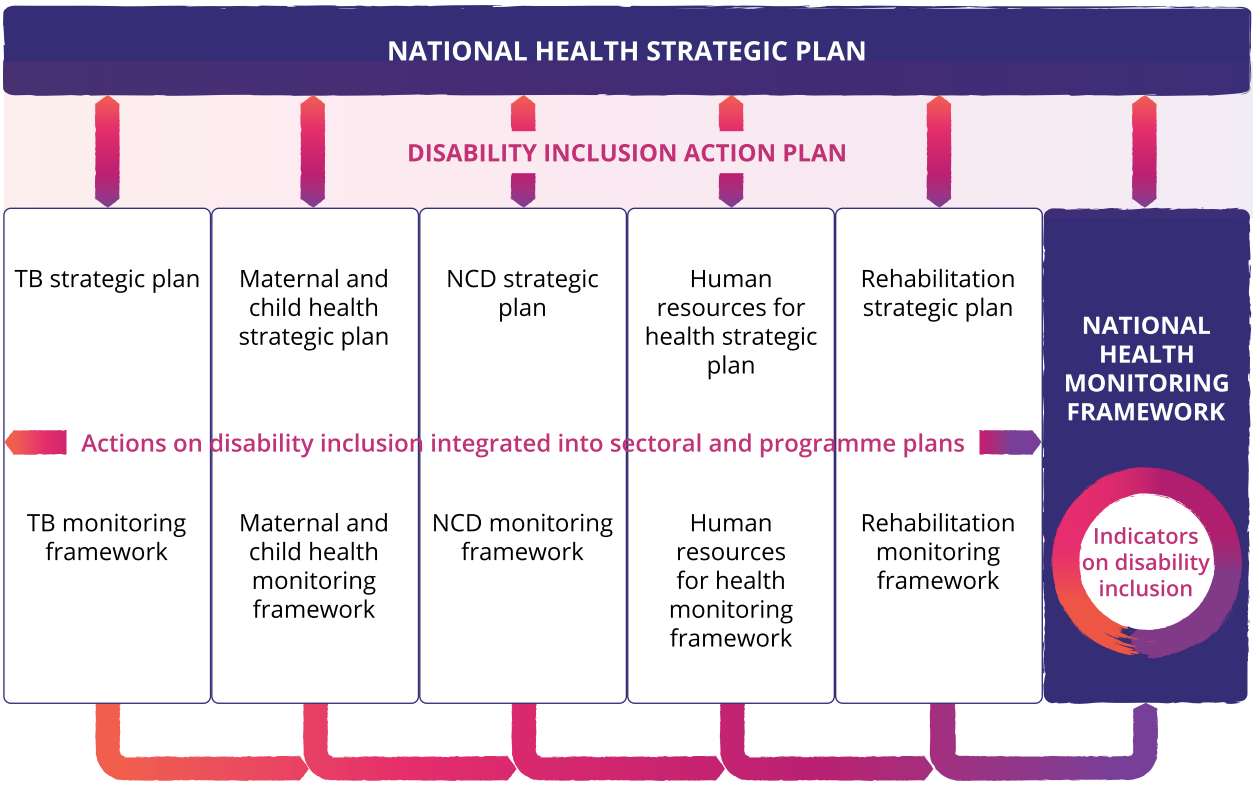
Integration into health sector processes

National health policies, strategies and plans (NHPSPs) play an essential role in defining a country's vision, policy directions and strategies for ensuring the health of its population. NHPSPs provide the framework for dealing with the complex range of issues needed to address priority health issues and improve the critical health outcomes of the population *(8)*. National health strategic plans typically set forth the strategic objectives, priority programmes or health issues, and health system investments that will be made over a specific fiscal time frame, in line with commitments of national health policies.

Figure 2 illustrates how actions developed through the *Disability inclusion guide for action* can be integrated into national health strategic plans. This includes plans for the wider health sector and plans relating to priority areas of health – for example, those focused on specific conditions (e.g. HIV, NCDs and mental health conditions), types of programmes (e.g. rehabilitation, sexual and reproductive health, health promotion and health emergency), or aspects of health system strengthening (e.g. human resources and primary health care).

The *Disability inclusion guide for action* can be undertaken separately or as part of wider health sector strategic planning processes, with components being integrated into sector assessment and planning tools. **Annex 2** provides an overview of the global health sector assessment and planning tools which intersect with *Disability inclusion guide for action* process.

Figure 2. Illustrative integration of disability action plans into national health policies, strategies and plans[a]



[a] Adapted from: *Rehabilitation in health systems: guide for action (5)*.

Note: Sectoral and programmatic strategic plans are depicted as examples only.

NCD: noncommunicable disease; TB: tuberculosis.

Participation of persons with disabilities

> **We like to be involved in the process from the very beginning – to share our inputs. We must seize this opportunity to achieve our common goals.**
>
> —Mr Wong Yoon Loong, National Council for the Blind, Malaysia.[1]

Persons with disabilities and their representative organizations at national and local levels must be meaningfully engaged in all phases of the *Disability inclusion guide for action* process, in line with human rights-based approaches. The lived experiences of persons with disabilities are critical to ensure the accurate identification of the gaps in the health system. Furthermore, including persons with disabilities in decision-making processes is essential to prioritization and the development of actions which are responsive to their diverse health requirements, skills, and capacities.

Organizations of persons with disabilities (OPDs) are led, directed, and governed by persons with disabilities and in many countries serve as representative organizations and intermediary bodies between policymakers and the wider community of persons with disabilities. They can operate as individual organizations, coalitions, or umbrella organizations made up of member organizations representing different disability constituencies (e.g. persons with physical impairments; persons with deafblindness; women with disabilities; Indigenous peoples with disabilities; persons with psychosocial disabilities) *(14)*. Some OPDs, such as those representing persons with intellectual disabilities, dementia and/or children with disabilities, include family members or relatives. The role of parents, relatives and caregivers in such organizations is to assist and empower persons with disabilities to have a voice, and as such they promote and use supported decision-making processes to ensure and respect the rights of persons with disabilities to be consulted, to express their own views and contribute to decision-making *(15)*.

In some contexts, OPDs may not exist (for example, in a selected region or a newly established refugee camp), or existing OPDs may not represent the diversity of persons with disabilities in the community (for example, they may represent people with only one type of impairment). As such, it is important to also engage individuals and groups of persons with disabilities which represent the diversity of the disability community, considering gender, age, and type of impairment,

[1] Briefing on Disability Inclusion in the Health System, Pulse Grand Hotel, Putrajaya, 30 April 2024.

among other factors. Particular attention should be given to the participation of underrepresented groups, such as women with disabilities, persons with intellectual disabilities, persons with psychosocial disabilities, persons with deafblindness, persons with multiple disabilities, and those living in rural or remote areas, among others, who are more often excluded from decision-making processes. The identification of such individuals and groups can be conducted in collaboration with national, regional, and international OPDs, which may have individual members or contacts at the local level. Other civil society organizations, health service providers for persons with disabilities, and local governments may also be able to support the identification and engagement of persons with disabilities from specific groups *(14)*.

Organizations working on disability inclusion and disability service providers can be important allies in advocacy on the rights of persons with disabilities and may support their access to health services. Health services and other programmes which target persons with disabilities (e.g. community-based rehabilitation) may also have established mechanisms to ensure participation of service users in decision-making processes. As such, these groups should also be consulted in the *Disability inclusion guide for action* process and may be able to support or facilitate individuals and groups of persons with disabilities to participate directly in the process.

Overview of the *Disability inclusion guide for action*

The *Disability inclusion guide for action* is a toolkit for guiding the planning process from its initial stages through to implementation. The process is organized in a cycle of four overlapping and continuous phases:

1. **Prepare** for the *Disability inclusion guide for action* process by identifying and engaging relevant stakeholders.
2. **Assess** the situation of disability inclusion in each of the 10 strategic entry points across the health system.
3. **Design** disability inclusive actions for the health sector, prioritizing action areas and identifying available resources.
4. **Implement and monitor** disability inclusive actions in health sector policies, plans, and programmes.

Phases 1, 2 and 3 may be undertaken periodically, and can be integrated into the strategic planning processes of the wider health sector. Phase 4 is ongoing, with monitoring and evaluation informing adaptations to disability inclusive actions in annual operational planning cycles, as well as future health sector strategic planning.

Each phase comprises three steps which provide detailed guidance and associated tools. Links to the respective tools are given throughout the text, as well as at the end of this guide and on the WHO website).

The development process of the *Disability inclusion guide for action* is described in **Annex 1**. An overview of the four phases, timelines, and the three-steps for each phase, is provided in **Figure 3** (see also **Annex 3)**.

Figure 3. Summary of the *Disability inclusion guide for action*

1. Prepare (3–6 months)

1.1 Confirm roles, responsibilities, and resources.

1.2 Identify, engage and dialogue with stakeholders.

1.3 Establish a Disability inclusion guide for action Working Group.

2. Assess (3–6 months)

2.1 Collect data and information.

2.2 Assess the status of disability inclusion in the health sector.

2.3 Document and validate findings.

4. Implement and monitor (ongoing, in line with health sector strategic planning cycle)

4.1 Disseminate and integrate the action plan.

4.2 Facilitate intersectoral coordination and shared learning.

4.3 Evaluate and report on the results to contribute to future strategic planning.

3. Design (3–6 months)

3.1 Prioritize entry points and actions with costing.

3.2 Develop a monitoring and evaluation framework.

3.3 Validate, finalize and endorse the plan.

Country example: Using the *Disability inclusion guide for action* to develop a new Plan of Action on Inclusive Health Care for Persons with Disabilities in Malaysia

The process of the *Disability inclusion guide for action* involves building on the successes of previous strategies and plans relating to disability inclusion, and identifying opportunities to integrate these into wider sector priorities.

The Ministry of Health of Malaysia has been implementing targeted health programmes for persons with disabilities since the 1990s. The first national health programme and plan of action for the health of persons with disabilities was launched in 1996 and led to the development of national programmes to address impairments through early identification and multidisciplinary interventions for children with disabilities, as well as to the strengthening of rehabilitation services. The second, *Health care for persons with disabilities: plan of action (2011–2020)*[a] sought to improve and maintain the health of persons with disabilities through seven strategies: i) advocacy on issues and policies; ii) increased accessibility to facilities and services; iii) the empowerment of individuals, families, and communities; iv) strengthening intersectoral collaboration; v) ensuring an adequate and competent workforce; vi) intensified research and development; and vii) the development of health programmes for specific disabilities.

WHO's *Disability inclusion guide for action* process was used to develop the third National Plan of Action for Inclusive Health Care for Persons with Disabilities 2024–2030. This included documenting the progress made through the previous plan of action, and mapping opportunities to integrate disability inclusion into wider health sector reforms outlined in the *Health White Paper for Malaysia* of 2023 *(16)*, particularly those relating to health promotion and disease prevention, equitable health financing, and strengthening health system governance all open opportunities for greater disability inclusion.

[a] See: https://hq.moh.gov.my/bpkk/images/Kesihatan_Orang_Kurang_Upaya/PDF/Akta_dan_Dasar/4_Health_Care_for_Persons_with_Disabilities_Plan_of_Action_2011-2020.pdf.

Phase 1: Prepare

Phase 1 supports the organization of the *Disability inclusion guide for action*. It includes identifying and engaging appropriate stakeholders, confirming their roles and responsibilities, and establishing a Working Group to ensure participatory decision-making.

1.1 Confirm roles, responsibilities and resources

Before undertaking the *Disability inclusion guide for action* process, each country's Ministry of Health should identify a focal point (if not already existing) to oversee the process. The tasks of the focal point include coordinating the Working Group and any consultants engaged in the process; convening workshops and meetings with stakeholders; and ensuring appropriate approval processes for reports and action plans developed. Selection of the focal points should be conducted by the Ministry of Health leadership and senior management, ensuring that there is higher-level commitment to, and ownership of, the process. Ideally, the Ministry of Health focal point will be positioned within a team overseeing the planning of health systems; in this way disability can be mainstreamed effectively within the ministry internally, and relevant departments and divisions engaged throughout the process. The Ministry of Health can source additional technical support to undertake the *Disability inclusion guide for action* process through WHO and/or through the recruitment of consultants to conduct selected activities (e.g. the situation assessment).[2]

[2] Technical support is available by contacting the WHO country office or by emailing: disability@who.int.

In terms of resources, a budget should be prepared to cover the costs of in-person Working Group meetings and consultative meetings with other stakeholders. The *Disability inclusion guide for action* process must be accessible to persons with different types of impairments and those who use different languages. As such, the budget should include costs for accessible transportation; accessible venues; and the production of documents and materials in different languages and in a variety of formats (e.g. screen-reader accessible files, Easy-to-Read, and large print versions). The availability of sign language interpreters and personal assistants or support people should also be factored in. The budget may include international and national consultants recruited to support different phases of the process, including undertaking the situation assessment and facilitating action planning. Again, funding for reasonable accommodation for consultants, facilitators or experts with disabilities engaged in the process should be incorporated into the budget. Finally, depending on the availability, capacity and priorities of OPDs, a budget line should be included for OPDs to consult with their wider membership – for example to gather wider feedback and validate the action plan being developed.

Tool 1: Budget template for the *Disability inclusion guide for action* process

1.2 Identify, engage and dialogue with stakeholders

A stakeholder mapping should be undertaken to identify the full range of stakeholders (i.e. from both the health and disability communities) to engage in different stages of the *Disability inclusion guide for action* process (see **Box 5**). Stakeholder mapping should address questions such as:

- Who are the key players – both formal and informal – in the health and disability fields?
- What are the relationships between the actors?
- Who has the power or influence in this situation?
- How do the actors influence the policy process?
- What kind of governance mechanisms already exist or need to be established to oversee the process (e.g. working groups, steering committees)?

Box 5. Examples of stakeholders to engage in the *Disability inclusion guide for action* process

Government	**Ministry of Health departments** responsible for policy, planning and budgeting, quality assurance, workforce development, and monitoring and evaluation.
	Ministries and government departments *responsible for disability service provision.*
	Other ministries responsible for finance, social welfare, community development, women and children.
	National level **disability councils and committees** representing persons with disabilities to national parliaments.
	National statistics offices which usually coordinate and oversee the collection of population demographic and health data.
Civil society	**Organizations/groups of persons with disabilities**, including the **national umbrella body**; **underrepresented groups**, including women with disabilities; persons with psychosocial disabilities; persons with intellectual disabilities; persons with deafblindness; Indigenous peoples with disabilities; and migrants and refugees with disabilities.
	Disability-inclusive community groups, such as women's rights organizations; youth organizations; refugee and migrant associations; and those working with persons of diverse sexual orientation, gender identity and expression and sex characteristics.
	Families and caregivers of persons with disabilities, including formal and informal groups and associations.
Service providers	**National/subnational partners** in the public and private health sectors delivering **major health programmes**, such as community health/primary health care, health promotion, maternal and child health and telehealth services.
	Organizations working on disability inclusion or delivering health services often used by persons with disabilities (e.g. rehabilitation and assistive technology, community-based rehabilitation. These may be public or private sector providers or NGOs).
Institutions	**Health-care workforce training institutions**, including universities or schools of medicine, nursing or public health – particularly those responsible for the development and accreditation of curriculums.
	National human rights institutions responsible for protecting, promoting, and monitoring the implementation of the CRPD or its national equivalent policy.
	Health research institutions responsible for the development and implementation of national health research agendas.
Regulatory and professional bodies	**Councils** for licensing health professionals.
	Professional organizations (e.g. medical associations).
	Registration and accreditation bodies for private and public health facilities.

Development partners	**United Nations bodies** comprising many funds, programmes and specialized agencies supporting the health sector – for example, WHO, UNICEF, UNFPA, UNAIDS, UN Women, and – in countries with forced displacement – UNHCR and IOM. World Bank and relevant regional **multilateral development banks,** such as the Inter-American Development Bank, Asian Development Bank, and the African Development Bank. **Government partners and other donors** supporting the development of the health system and/or wider disability inclusive development.

A map can be developed which visually displays the actors in the disability and health fields and their relationships to each other using labels and arrows indicating the flow of resources versus action *(8)*.

Initial policy dialogue on the next steps in the process is essential among stakeholders "to raise issues, share perspectives, find common ground, and reach agreement or consensus, if possible" *(17)*, including establishing their roles in the process. Meetings should be convened with key stakeholders to share information about the WHO *Global report on health equity for persons with disabilities (1)*, brief them on the *Disability inclusion guide for action* process and receive their feedback on initial priorities and potential adaptations. Meetings can take a range of different formats, including practice- and evidence-informed discussions, workshops, and consultations. They can also provide an opportunity for capacity-building among stakeholders, particularly on key principles relating to primary health care, health systems strengthening, disability inclusion and the CRPD, all of which underpin the *Disability inclusion guide for action* process. These meetings serve to clarify the scope of the assessment and planning process, for example by recognizing that assessment and planning do not address rehabilitation services comprehensively. If rehabilitation services need strengthening, a separate targeted assessment and planning process is recommended using WHO's *Rehabilitation in health systems: guide for action (12)*. Creating spaces for persons with disabilities to share their perspectives in these meetings will help to ensure that the *Disability inclusion guide for action* process remains grounded and relevant to the lived experiences of persons with disabilities.

Tool 2: Key messages on health equity for persons with disabilities

Country example: Policy dialogue in Côte Ivoire

The policy dialogue on health equity for persons with disabilities, which took place in Abidjan, Côte d'Ivoire on 12 December 2023, was an important step in mobilizing stakeholders and building momentum towards the implementation of the *Disability inclusion guide for action* in the country. Organized by the Ministry of Health of Côte d'Ivoire, WHO and Sightsavers, the policy dialogue brought together almost 50 stakeholders to discuss health equity for persons with disabilities. Among them, governmental representatives from various Ministry of Health directorates and programmes attended (e.g., Directorate-General for Health and Public Hygiene; Directorate-General for Universal Health Coverage; Directorate-General for Communication and Public Relations; Eye Health National Programme; NTD National Programme; Maternal and Child Health National Programme; AIDS National Programme) as well as other ministries (e.g. Ministry of Employment and Social Protection; Ministry of Women, Family, and Children; Ministry of National Education). Those invited included several UN agencies including WHO, UNCIEF and UNFPA; multilateral organizations such as USAID, the World Bank, and the African Development Bank; international NGOs including Sightsavers, Speak Up Africa, FHI 360; and national OPDs – COPHCI[a],FAHCI[b] and CAPHCI[c].

Engaging OPDs from the onset of this policy dialogue contributed to its success. It allowed for the voices, experiences and aspirations of Ivorians with disabilities to be meaningfully recentred in the discussions. The three main national OPDs, COPHCI, FAHCI and CAPHCI, were selected because of their strong engagement in other projects in the country that support inclusive development for persons with disabilities. Prior to the policy dialogue, OPD representatives met with organizers to clarify the purpose of the policy dialogue. They were also invited to join one of the virtual preparatory meetings to shape the agenda and advise on reasonable accommodations to ensure the meaningful participation from persons with disabilities. In the months that followed, the Ministry of Health designated its focal point to formally initiate implementation of the *Disability inclusion guide for action* in Côte d'Ivoire – the first French-speaking country in the world to start this process.

[a] Confederation of Disabled People's Organizations in Côte d'Ivoire.

[b] Federal of Associations for the social promotion of the Handicapped of Côte d'Ivoire.

[c] Coordination of Disabled Persons' Associations in Côte d'Ivoire.

> **"It was a real opportunity for disabled people's organizations to take part in such an important and prestigious event dealing with their inclusion, particularly in the field of health, which is the foundation of all social and human progress [ ] We would like to share with you our enthusiasm but also our commitment to making this report our own. We are also prepared to play our full part in the process of domesticating this report and, above all, its effective implementation in Côte d'Ivoire."**
>
> —Letter from Mr Souleymane Coulibaly, President of COPHCI].

1.3 Establish a *Disability inclusion guide for action* Working Group

As with other forms of health sector planning, participatory decision-making processes strengthen not only accountability and transparency across the health sector, but also ownership over the actions developed which, in turn, will support implementation. It is essential to bring together a multidisciplinary group – with lived experiences and expertise in disability inclusion – to fully understand the health sector challenges and potential solutions to address the health inequities faced by persons with disabilities.

A Working Group needs to be established that comprises selected representatives from the Ministry of Health and other governmental departments, health service providers, research institutes, human rights bodies, and civil society, including OPDs and other groups of persons with disabilities; it should also include representatives with expertise in health equity, gender equality, human rights and the social determinants of health *(18)*. The Working Group will inform the situation assessment, contribute to the action planning processes, and support the government in later implementation, monitoring, and evaluation.

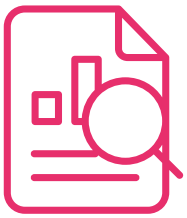
Tool 3: Terms of Reference for Working Group

The Working Group should be sufficiently large (upwards of 10 representatives) to reflect the different types of expertise, but need not be static. New members can be invited to join at different stages of the process where additional or new expertise is required. Some countries may have committees or groups already established which can serve in the role of the *Disability inclusion guide for action* Working Group.

Country example: Establishing a Working Group in Montenegro

At the start of the *Disability inclusion guide for action* process in Montenegro, a Working Group was formed to contribute throughout (e.g. by strengthening data collection and widening the engagement of key stakeholders) and to shape the final Action Plan (e.g. to review data collected to identify gaps/ opportunities and to agree evidence-based activities and milestones). The Working Group included representatives of the Montenegrin Ministry of Health, other Montenegrin government ministries, UN agencies and civil society organizations (including OPDs). Striking a balance between the diversity and number of Working Group members to ensure that meetings remained both practical and reflective of key stakeholders was of critical importance. The Working Group in Montenegro totalled 15 members; each was responsible for obtaining feedback on Working Group outputs from colleagues and peers in their own organizations and/or from partners. OPD representation was also crucial. Of the 15 Working Group members, two represented OPDs. The Montenegrin Ministry of Health widely advertised the role(s) for OPD representatives and two were selected based on discussion between OPDs. The OPD representatives were invited to a pre-meeting to strengthen their understanding of the process and the importance of their role in the Working Group, as well as to identify any accommodations required to facilitate their full participation. They proved central to the *Disability inclusion guide for action* process, providing insights and lived experiences that strengthened both the analysis of information and data and the focus of the subsequent Action Plan.

Phase 2. Assess



A situation assessment of disability inclusion in the health sector, based on the 10 strategic entry points in the *Global report (1)*, should be conducted to understand the national context, current health sector priorities, and the health sector planning cycle/ process to which the *Disability inclusion guide for action* can align and contribute. The situation assessment is conducted by collecting data and information, and then by completing **Tool 8: Disability Inclusive Health System Assessment** with the Working Group. Together these steps provide the evidence of the gaps and opportunities to strengthen disability inclusion across the health sector, which will inform decision-making relating to prioritization and action planning in Phase 3.

(A note about ethical approvals: In some countries, it may be necessary to seek clearance from an ethics review board or committee before commencing the assessment. The Working Group should identify what approvals are necessary, and any additional partners which might be needed to support the approval process and obtain the necessary clearances – for example academic partners as needed).

2.1 Collect data and information

At a minimum, the situation assessment should collect and analyse appropriate information and data from existing data sources, key documents or literature; conduct stakeholder

interviews and consultations with persons with disabilities; and undertake visits to selected health services. (A more detailed description of the process which can be adapted to country contexts and priorities is provided in **Annex 4**.)

Document review

The situation assessment should include a comprehensive document review, drawing on publicly available literature, as well as documents identified by Ministry of Health focal points and the Working Group. Introductory information about the priorities of the Ministry of Health in health system strengthening can be collected through the Introductory Information Form in **Tool 4**, along with disability inclusive actions already undertaken at different levels of the health system, and evidence of implementation. This form should be completed by the Ministry of Health focal point and shared with any consultants undertaking the situation assessment, along with any documents that may not be available online. The document review will also help to identify and develop a list of stakeholders to be interviewed in later activities of the situation assessment.

The document review should include global health and databases; national legislation, policies, strategies and plans which are related to the health of persons with disabilities; health sector funding mechanisms and budgets; administrative and health information system data sources; census and population survey data and reports; human rights reports and publications from OPDs; and organizational and academic assessments, research, and evaluations.

The document review provides contextual information about the country or setting in question – for example population size; distribution by geographical areas (urban versus rural); gender, age, and a range of socioeconomic factors; ethnic or cultural groups in the community; and education and literacy levels. All these factors need to be considered when designing disability-inclusive actions. Where available, information on specific health services should also be included as well as social protection instruments available to persons with disabilities. The document review step can also help to establish the main indicators being used to monitor health outcomes in the population, including available data sources, and whether these have the potential to track health equity for persons with disabilities.

Tool 4: Introductory Information Form

Stakeholder interviews

Following selection of the list of stakeholders from the desk review, interviews can be conducted either online or in person, with representatives from government

departments, OPDs, development partners, health workers, service providers, professional associations, training and research institutions, and other civil society organizations. When conducting interviews with persons with disabilities and/or representatives from OPD, it is important to enquire what communication method and language is preferred, and any other reasonable accommodation that may be required, such as information in accessible formats, sign language interpretation and/or captioning. Some persons with disabilities may wish to have the questions available in advance of the interview. When conducting interviews in person, select a location to meet which is safe and accessible to the individual with disabilities, first seeking advice and agreement from the participant about suitability.

Tool 5: Stakeholder Interview Guide

Consultations with persons with disabilities

In addition to interviewing representatives from OPDs, consultations should also be conducted with persons with disabilities and their families, to gather wider perspectives from health service users on the gaps and opportunities to strengthen disability inclusion in the health sector. Consultations can be conducted in partnership with OPDs and other disability organizations.

When possible, separate consultations should be conducted with women with disabilities, men with disabilities, and parents of children with disabilities from rural and urban areas, so that their unique experiences and perspectives can be explored. To ensure different perspectives, and also for every person to contribute, each consultation group should ideally number 8–12 participants. Groups should include people with a diverse range of disabilities, including older people and people with intellectual or psychosocial impairments.

In certain circumstances, it may be appropriate to conduct separate discussions with representatives from a single disability group (such as persons with intellectual disabilities) to create a safer and more inclusive space for all participants to engage. Other groups to consider in some contexts may include children, adolescents, and young people with disabilities; refugees and displaced persons with disabilities; Indigenous people; ethnic, religious, or other minorities; people with disabilities of diverse sexual, orientation, gender identity and expression and sex characteristics (SOGIESC); and people living in residential or institutional settings.

Tool 6: Consultation Discussion Guide for Persons with Disabilities

Reasonable accommodation, transport, interpreters, and support people should be provided for participants of group discussions (see **Box 6**). Facilitators of group discussions can adopt a range of participatory approaches and activities, tailoring the discussion to the communication preferences of the participants. For example, activities involving illustrations, storytelling, art, or role-plays can be helpful for people to share their perspectives and ideas.

Further information is available in: *Guidelines on consulting with persons with disabilities (14).*

Safely consulting persons with disabilities

The principle of "Do No Harm" must be prioritized when consulting with persons with disabilities; participants should not face unanticipated risks or be adversely impacted by participating in consultations. This requires strategies to be established to ensure confidentiality, creating space for frank feedback about health services without backlash from service providers and other stakeholders. All focal points, consultants and facilitators should use respectful language, be aware of gender and power dynamics. Participants in consultations should be informed not to disclose personal health information and only share information that they feel comfortable with *(14)*.

During consultations issues may arise which require follow-up; such issues may include access to psychosocial support for those who may experience emotional distress during consultations or concerns regarding personal safety. Many countries report violence and abuse being perpetrated against persons with disabilities in health-care settings *(1)*. As such, it is important to identify appropriate rights-based support for survivors of different types of violence, share information about these services during consultations, and offer to refer those interested in seeking this support, in line with national standard operating procedures relating to safeguarding, child protection and gender-based violence (GBV).

The publication *How to support survivors of gender-based violence when a GBV actor is not available in your area (19)* provides guidance on how to respond to reports of violence using a survivor-centred approach.

Box 6. Tips for conducting consultations with persons with disabilities

- **Seek advice from OPDs to identify an appropriate location and venue.** Ideally the venue selected needs to be familiar to persons with disabilities and feel safe to them. The entrance, meeting room, toilets and break area will need to be accessible, especially to wheelchair-users. There also needs to be sufficient space for interpreters, support people and assistants, as well as adequate signage and lighting.
- **Provide clear information in advance about the event**. Information needs to be brief and to the point, and include advice on how details gathered during the consultation will be used. Present the questions to be discussed in advance so that participants can consider these and prepare themselves properly.
- **Ask participants** if they have any specific **reasonable accommodation** needs.
- **Ensure the availability of a quiet room** for those who may wish to take a break from the discussion and/or no longer wish to participate.
- **Provide microphones** so that everyone can hear the discussion as needed. Live captioning and hearing loops may also be required in some locations or contexts.
- **Brief facilitators, presenters, and interpreters** in advance on the topic to be discussed during the consultation and clarify appropriate terminology. Check materials and presentations for accessibility.
- **Provide transport support and/or per diems** to participants, interpreters, support people and assistants.
- **Make available food and refreshments** during the meeting for participants, interpreters, support people and assistants.
- **Pay attention to the role of support persons** and make sure that they do not speak for persons with disabilities. Participants may ask their support person to clarify a point made by the facilitator, or to explain something. The participant may also ask the facilitator to clarify something or to slow down their speech or to pause.

Adapted from: Guidelines on consulting with persons with disabilities. United Nations Disability Inclusion Strategy: 2022 (14).

Country example: Consulting with persons with disabilities in Malaysia

In Malaysia, consultations with persons with disabilities were organized by the Malaysian Confederation of the Disabled and the National Council for the Blind. Four consultation groups were organized: women with disabilities; men with disabilities; adolescents with disabilities; and parents or caregivers of persons with disabilities. Participants had a range of different impairments, representing persons with physical and intellectual impairments; persons who were Deaf or hard of hearing; persons who were blind or vision impaired; and persons with psychosocial disabilities and neurodiversity.

A separate consultation group with adolescents aged 14–18 years was organized with support from the Ministry of Education. This offered an opportunity to gather the perspectives of young people with disabilities on disability inclusion in school health programmes, and their ideas on how to make health services more welcoming. Recommendations included having more interactive and engaging health activities – "animations, practical exercises and games".

> **I want to be strong and healthy so that I can study and learn. It means getting medicine when you have a fever. It is about both physical and mental health. For me, being healthy is also about dancing and celebrating.**
>
> (Adolescent with disabilities.)

Service visits

Service visits to primary, secondary, and tertiary level facilities complement stakeholder interviews and consultations by collecting observational information about accessibility to facilities, and reflections from health workers on the challenges and barriers encountered by persons with disabilities and how these may have been adapted to be more inclusive. Where appropriate, the Working Group and/or OPDs can be invited to join the visiting team so that their views can be shared on the barriers and/or promising practices demonstrated by the health service.

The selection of sites to visit can be based on a range of criteria and decided in consultation with the Working Group. Ideally, health facilities in both rural and urban locations should be visited; visits should include one at the primary care level of the health system, and another at either secondary or tertiary level. These will provide an overview of the different models of care and referral mechanisms that

persons with disabilities encounter when they have a health condition. In some contexts, information may be gathered through consultations and stakeholder interviews which can guide site selection. For example, facilities may be included because of reports of potential promising practices and approaches to disability inclusion which could be documented and expanded across the health sector. Likewise, accessibility audits of existing facilities may have already been conducted as part of recent or ongoing projects led by civil society organizations or other stakeholders, which can be considered when selecting services to visit.

Tool 7: Service Visit Guide

Facility staff may feel uneasy about service visits, fearing that their work is being monitored and judged. Prior to service visits, the Ministry of Health should explain to facility staff the purpose of the visit and how the information collected will be used in the wider situation assessment. A sense of partnership and cooperation with the staff should be fostered around a common goal of improving the quality and accessibility of services for persons with disabilities *(20)*. This should also be explained to any health workers approached during the site visit. Information gathered during the service visit will inform the situation assessment; it should also be fed back to facility management, providing entry points for basic improvements and recommending a more in depth accessibility audit, as appropriate.

The Disability-inclusive health services toolkit: a resources for health facilities in the WHO Western Pacific Region *(21)* includes a physical accessibility audit checklist and examples of low-cost strategies to address barriers identified.

2.2 Assess status of disability inclusion in health sector

Drawing on the information gathered in the previous step, the Working Group should assess the status of disability inclusion in the health sector using **Tool 8** (Disability Inclusive Health System Assessment). This can be conducted through a workshop facilitated by the Ministry of Health, with support from WHO and/or consultants, as needed. During the workshop, preliminary findings from the situation assessment thus far should be presented. Following this, through a series of facilitated activities or group discussions, the Working Group should be asked to score each entry point in terms of progress on disability inclusion.

The Disability Inclusive Health System Assessment tool (Tool 8) outlines the criteria for each strategic entry point which demonstrates different levels of disability

inclusion; each of these levels is described in **Figure 4**. Working Group members must read the descriptions for each criterion, agree on a score, and provide evidence – through additional documents and information – relating to the criteria in question. As the Disability Inclusive Health Systems Assessment will provide the basis of prioritizing entry points and actions in Phase 3, it is essential to have a level of consensus among Working Group members on these scores.

Tool 8: Disability Inclusive Health Systems Assessment

Figure 4. Disability inclusive health system assessment – scoring scale

1. Needs establishing	• Disability inclusion is at a very low level or missing. • Criteria are not yet established or just emerging.
2. Needs major strengthening	• Disability inclusion is at a low level. • Criteria are established but there are many areas that need improvement.
3. Needs minor strengthening	• Disability inclusion is at a moderate level. • Criteria are well established but have some areas for improvement.
4. Needs no immediate action	• Disability inclusion is at a high level. • Only isolated concerns that need monitoring and addressing over time.

2.3 Document and validate findings

The findings of the situation assessment, including the Disability Inclusive Health Systems Assessment, should be documented in a preliminary report, which is shared with the Working Group for review and feedback. Health facilities and other organizations who participated in the situation assessment should also have an opportunity to review the draft report, so that they are aware of how the information provided has been used and, if necessary, clarify any points.

As described in global guidelines on national health strategic planning *(8)*, if the well-founded critical views of stakeholders are considered in the situation assessment, a willingness to align, harmonize and contribute resources increases. Conversely, if the situation assessment is perceived to be biased, obscuring obvious

weaknesses, the Ministry of Health may have difficulties obtaining a consensus with stakeholders, and have less support for the implementation of disability-inclusive actions.

A consultative process should therefore be established to raise awareness of findings among a wider network of stakeholders and promote greater social participation in advancing health equity for persons with disabilities. Where possible, the main gaps and opportunities to strengthen disability inclusion in the health sector should be summarized in Easy-to-Read format, to be shared more widely through networks of persons with disabilities. Working Group members who are working with, and mobilizing, groups of persons with disabilities at community levels (e.g. OPD representatives and disability service providers) can convene additional meetings to share this information, gather feedback and bring back additional recommendations to the Working Group.

The finalized draft of the situation assessment report should be endorsed or approved through appropriate Ministry of Health structures, ensuring their ownership and leadership in the wider *Disability inclusion guide for action* process.

Tool 9: Template for Situation Assessment Report of the *Disability inclusion guide for action*

Phase 3. Design

Phase 3 of the *Disability inclusion guide for action* takes the gaps and opportunities identified in the situation assessment (Phase 2), and develops prioritized actions on disability inclusion for integration into the wider health sector and programmatic strategic and operational plans. Phase 3 also includes the development of a monitoring and evaluation framework – to track both the progress in the implementation of the action plan, and the outputs and outcomes as they relate to health equity for persons with disabilities.

3.1 Prioritize entry points and actions with timelines and costing

This step includes identifying the entry points, gaps and opportunities for disability inclusion which best address the most important needs identified in the situation assessment. The Working Group will design actions to be implemented in line with health sector strategic planning cycles, while taking into consideration the current and emerging health sector priorities, available resources, and existing or emerging partnerships which can be leveraged.

As, historically, disability inclusion in the health sector has received less attention, it is likely that the situation assessment will highlight many gaps to be addressed; it is therefore important to establish a transparent priority-setting process with the Working Group. The Ministry of Health, with support from WHO as needed, should facilitate a workshop with the Working Group to undertake this prioritization process and develop appropriate actions. The process of priority-setting should explore the options available and reach consensus among Working Group members.

The 40 targeted actions for disability inclusion across the 10 strategic entry points, as outlined in the *Global report (1)* (see **Tool 2**), can be presented as a starting point for the Working Group to consider in the prioritization process. Based on the selected priorities, these actions should then be contextualized, while considering the wider health sector priorities over the proposed time frame. The responsibilities of different stakeholders should be established, including contributions which can be made through existing programming, and timelines for implementation of the action plan.

Tool 10: Template for Action Planning of the *Disability inclusion guide for action*

The action plan needs to consider health budget processes, including identifying barriers to funding disability inclusion, and opportunities to leverage existing or future investments. The action plan may have actions which do not require additional funding and/or can be effectively implemented through existing programmatic resources. Other actions may require the mobilization of resources from within and outside the Ministry of Health. While specific proposals to access donor funds can be developed, it may also be possible to resource the action plan through wider funding for the national strategic health plan, and/or within the budgets of specific sectoral/programme plans.

Country example: Turning the situation assessment into an action plan in Montenegro

Data collected for the situation assessment were scored by the *Disability inclusion guide for action* Working Group against all 22 criteria across the 10 strategic entry points. This was to help identify both the strengths to build upon, and the opportunities available to improve disability inclusion across the health system. Working Group members then developed an action plan that responded to gaps evidenced by the situation assessment and utilized existing strategic priorities. For example, the situation assessment revealed that there were no quality-of-care standards in Montenegro; this led to a focus in the action plan to integrate existing protocols or create protocols for the care of persons with disabilities by medical and non-medical staff, including the identification/diagnostics and intervention services for adults.

The scoring and action planning were conducted by Working Group members in separate two-day workshops. The workshops obtained multiple scores to increase confidence in the conclusions reached; the data collected were validated and substantial time was set aside for discussion between Working Group members. All the ideas and activities generated were reviewed and revised by Working Groups members, both to prioritize and ensure their connection to other ongoing initiatives, and to agree key practical elements (e.g. the phasing of any activities, stakeholders responsible, budget implications and measures of success).

Prioritizing disability-inclusive actions

In line with global guidelines on UHC *(22)*, it is important that priority actions on disability inclusion respond to and respect principles of fairness – and the overlapping concern for equity – among persons with disabilities. This involves considering which groups of persons with disabilities have the greatest need for health services and are the furthest behind in accessing them; and which entry points in the health system present the greatest gap and/or opportunity to advance equity for persons with disabilities.

A wide range of methods are used for priority-setting in the health sector. One commonly-used method is prioritizing based on need and feasibility using a 2x2 grid (see **Box 7**). It will usually be possible to identify "quick wins" and "low-hanging fruit" to include in the action plan *(8)*. These may be changes to existing health sector activities which are relatively easy to achieve and, because they are politically feasible, affordable and technically possible, be addressed first *(8)* (e.g. by adapting or adding questions in existing population surveys). Other actions, such as making mandatory the training on disability inclusion for all health workers, may require

longer-term changes to the health system, but are still important to include given the wide-ranging impact on health equity for persons with disabilities.

Box 7. Prioritizing actions[a]

High need/high feasibility	High need/low feasibility
These actions are important to addressing health inequity for persons with disabilities AND will result in sustained impactful changes in the health system.	These actions are important to addressing health inequity for persons with disabilities BUT are unlikely to make sustained impactful changes in the health system.
They are the highest priority actions and should be given sufficient resources to maintain and continuously improve.	They are long-term actions which have significant potential, but focusing on too many of these actions may be impractical.
Low need/high feasibility	**Low need/low feasibility**
These actions may have less of an impact on health inequities for persons with disabilities BUT they have the potential to make sustained changes in the health system.	These actions have less impact on health inequities for persons with disabilities AND are unlikely to make sustained impactful changes in the health system.
The actions are often politically important to undertake and can establish a foundation upon which future actions can be built.	They are the lowest priority actions which can be deprioritized, allowing for resources to be allocated to higher priority items.

[a] Adapted from: *Strategizing national health in the 21st century: a handbook (8).*

Further information on consensus and prioritization methods for health planning is available in: Strategizing national health in the 21st century: a handbook *(8, p. 203–204)*.

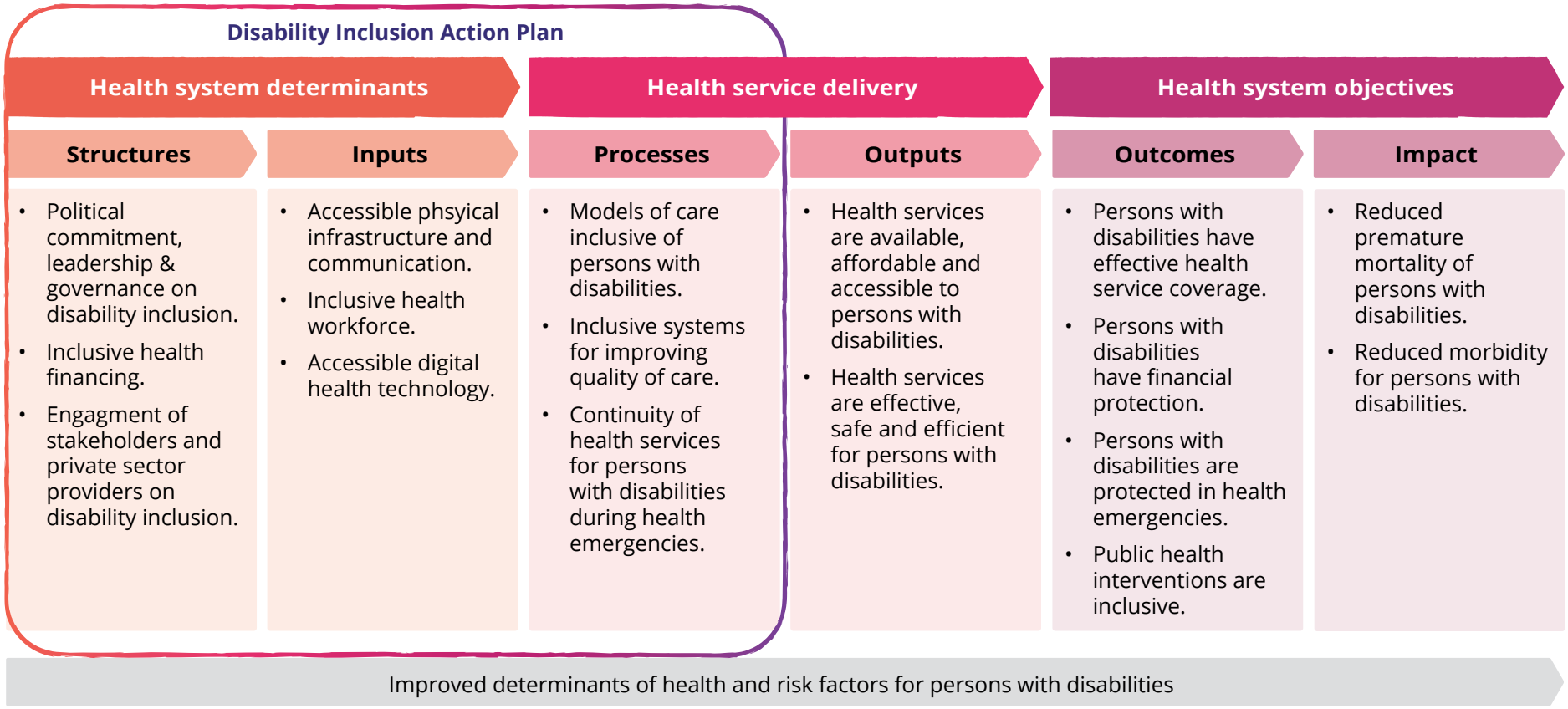
3.2 Develop a monitoring and evaluation framework

The monitoring and evaluation of disability inclusion in the health system and the health outcomes for persons with disabilities helps to identify gaps, determine priorities, set baselines and targets, and track progress towards health equity. The monitoring and evaluation framework developed for the action plan should not be a parallel framework and must be aligned with and feed into the monitoring and evaluation framework of the wider health sector. It should be developed in close partnership with the Ministry of Health departments and divisions responsible for monitoring the strategic plans of the health sector, and the statistical offices and research institutions which oversee national level population health surveys.

Results chain

The monitoring and evaluation framework should be aligned with the wider monitoring and evaluation results chain of the health sector. An example of the results chain for disability inclusion in health systems, based on the primary health care measurement framework, is provided in **Figure 5** *(23)*. The disability-inclusive actions developed should seek to strengthen **health system inputs, structures, and processes**, leading to **improved access and quality of health services** for persons with disabilities, which contributes to persons with disabilities having **universal health coverage, protection in health emergencies and inclusion in public health interventions**. This in turn **improves the health status** of persons with disabilities, which is largely measured through indicators relating to morbidity and mortality.

Figure 5: Example results chain for disability inclusion in health system



Indicators

Disability inclusion indicators for each level of the results chain can be expanded from the wider health sector monitoring framework, often outlined in the health sector strategic plan. These will usually be adapted from the PHC measurement framework *(23)*, SDG indicators and the Global Reference List of 100 Core Health Indicators *(24)*. **Tool 11** provides options which countries can select and adapt.

Tool 11: Menu of Disability Inclusive Health Indicators

When selecting or designing disability-inclusive indicators, it is important to first consider:

- which indicators are currently being used to measure the different levels of the results framework for the wider health sector;
- how these indicators are measured (e.g. through routine health facility data, population-based surveys, etc.) and when these data were last collected; and
- the tools used to collect the data: were there any questions included on disability which could allow for more detailed disability-disaggregated data analysis?

This will help to identify which indicators are practical to measure and/or which data collection tools are a priority for adaptation in the future to effectively track disability inclusion in the health system and health outcomes for persons with disabilities.

Data sources

There are essentially two broad categories of data sources: i) population-based; and ii) institution-based. Surveillance systems, which combine population-based and institution-based data, are sometimes classified as a third category of data sources. Other systems which link different data sources to monitor health equities are continuing to emerge globally and in different countries.

Population-based data sources include sources that have information on every individual in a population (for example, census data) and sources that have information on a representative sample of the population (for example, household surveys). National census and household surveys may provide information about the prevalence of disability, and/or some of the social determinants which may affect health equity for this group. These data sets may also collect information on population health which can be disaggregated by disability for analysis. In some countries, a range of disability-focused population-based surveys or studies have been conducted which can provide valuable information about disability inclusion in health systems, and about the health and well-being of persons with disabilities.

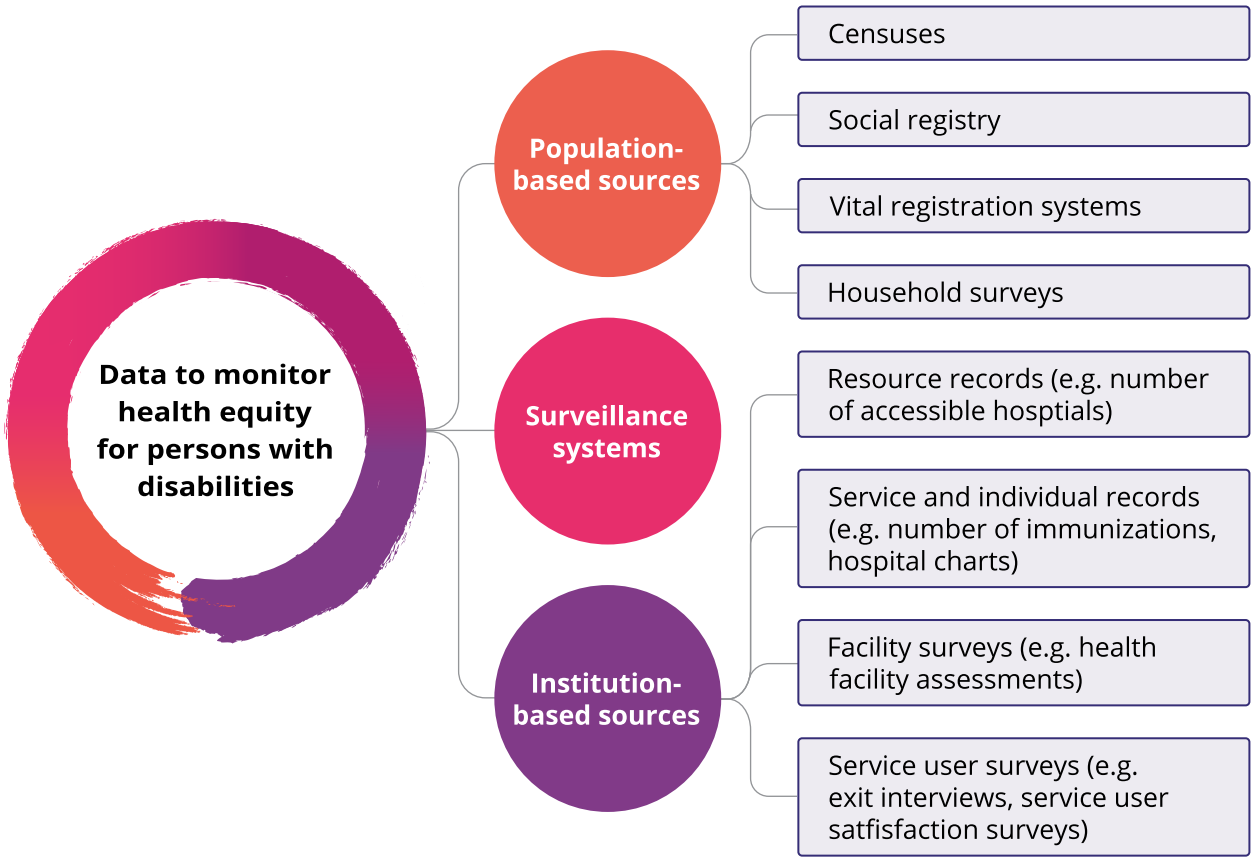
Note: Where quantitative data on disability are available, it is important to also reflect on the limitations of instruments or the questions used to define disability, and whether there is a need to establish a standardized method that can generate more comparable data.

Further information can be found in the WHO publication: *Data collection and disaggregation on disability: overview of instruments and methodologies (25).*

Institution-based data sources gather data in the course of administrative and operational activities *(26)*. Routine health information systems (RHIS) provide a substantial source of continuous (usually monthly) information relevant to PHC performance at district and facility levels, including on service utilization, service delivery, safety and efficiency, service coverage, and morbidity and mortality. Where available, electronic health records feed into RHIS providing information on quality care and improved outcomes for individual service users *(23)*. It is important to note that institution level data include only people who have interacted with a given facility or service, and in many countries, there are gaps in standardization and/or fragmentation which may limit their use when monitoring health equity *(26)* (see **Figure 6** and **Annex 5**).

Common sources of qualitative data for monitoring purposes include exit interviews with service users with disabilities which can explore change in satisfaction levels and quality of care, and facility level assessments which can include questions on how facilities meet accessibility standards. Stakeholder interviews and consultations can also be used to gather information about the ongoing barriers faced by persons with disabilities in accessing the health system, as well as their changing health priorities and recommendations since the situation assessment – one of several methods used to evaluate the implementation of the action plan. Finally, **Tool 8** provides valuable qualitative information relating to a range of indicators at the inputs, structures and processes levels of the results framework.

Figure 6. Types of data sources commonly used for health sector monitoring[a]



[a] Adapted from the *Handbook on health inequality monitoring with a special focus on low- and middle-income countries (26)*

Using information from monitoring and evaluation

The monitoring and evaluation framework should provide information on disability inclusion in the health system and priority health issues for persons with disabilities which can then inform policy discussions and revisions to the national strategic and operational plans, including resource allocation. The monitoring process should include an annual evaluation meeting of the Working Group, or an equivalent body, to reflect on the activities undertaken in the previous year; available data should be analysed to demonstrate progress towards outputs and outcomes, and fed into annual health sector operational planning for the following year. Information and data collected that relate to disability inclusion in the health system, and health outcomes of persons with disabilities, can also contribute to other types reporting, such as human rights monitoring.

It is important that evaluation processes are adapted to the country context, and feed into wider health system evaluation activities. For example, disability can be integrated into regular assessments/evaluations of health workforce competency or in specific health sector plans. Evaluations on disability inclusion in the health system could also become a standard part of annual or biennial health sector planning. Finally, the *Disability inclusion guide for action* is designed to be a continuous cycle, with repeated assessments – ideally aligned with the health sector strategic planning cycle – to identify successes and ongoing gaps and inform revisions to the action plan.

3.3 Validate, finalize, and endorse the action plan

The Ministry of Health and the Working Group, with support from WHO as needed, should draft the action plan and monitoring and evaluation framework documents. Once a draft has been developed and agreed upon within the Working Group, it should be presented to key stakeholders for feedback and revised accordingly. Consultations should include those groups identified in the stakeholder mapping and engaged in the situation assessment, including persons with disabilities.

Inclusive consultations and feedback will not only improve the action plan, but also generate greater support for its implementation. Representatives of OPDs in the Working Group could be funded to conduct wider consultations, workshops and events with persons with persons with disabilities, gathering their feedback and representing this in Working Group discussions and decision-making. Again, documents should be made available in local languages and accessible formats, with Easy-to-Read summaries to support sharing information with people with different literacy and understanding levels.

Once finalized, the Disability Inclusion Action Plan should be officially endorsed by governments and ministries, including sections of the Ministry of Health responsible for the implementation of health strategies and plans, as well as those responsible for health financing/budgeting, up to leadership levels.

Country example: Validation exercise in Tanzania

The Ministry of Health, with the support of WHO, has developed a three-year action plan (2024–2026) with priority actions to advance health equity for persons with disabilities in mainland Tanzania. The Action Plan was developed using the WHO *Disability inclusion guide for action* process and is aligned with the priorities of the Health Sector Strategic Plan V July 2021 – June 2026 (HSSP V).[a] SHIVYAWATA, the Tanzania Federation of Disabled People's Organizations, was a member of the Working Group contributing to all phases. In the situation assessment, SHIVYAWATA convened consultation groups with OPD members living in urban and rural areas. Following the drafting of the Action Plan, SHIVYAWATA returned to these consultation groups to share the proposed actions and gather their feedback. In this way, the Action Plan was endorsed more widely by OPDs, fostering their voice and participation in future disability inclusive actions across the health sector.

> *Access to quality health services for persons with disabilities in Tanzania has been a long-term journey that has gone with serious dissatisfaction for years; and that had never considered equity, particularly for vulnerable groups that are encountering limitations to access. The Action Plan developed is full of our opinion and counted on our participation at all stages of creating it. Through validation sessions held in Dar es Salaam and Dodoma, we cross-checked and verified its contents. We, therefore, made it; and it is ours. It will serve our purpose and retain past stories in history in the struggle to ensure no one is left behind.*
>
> — Jonas Lubago, Secretary-General, SHIVYAWATA
> The Tanzania Federation of Disabled People's Organizations.

[a] See: https://extranet.who.int/countryplanningcycles/planning-cycle-files/health-sector-strategic-plan-hssp-v-2021-2026.

Phase 4. Implement and monitor

4.1 Disseminate and integrate the action plan

The action plan of the *Disability inclusion guide for action* must be communicated and disseminated to relevant Ministry of Health personnel, making clear the institutional commitment and responsibility of different departments and programmes in implementation. Disability-inclusive actions outlined in the action plan should be embedded in the work plans of respective Ministry of Health departments, programmes, and technical working groups responsible for the development and implementation of NHPSPs. For example, disability-inclusive actions relating to health emergencies should be integrated into health emergency programme planning and implementation (see **Box 8**).

In most countries, the *Disability inclusion guide for action* Working Group will continue its role – ideally, as a permanent structure in the Ministry of Health – overseeing implementation and monitoring progress and feeding into health sector planning, as described in previous sections. This Working Group or equivalent body should serve as a formal body to provide advice and feedback on disability inclusion in all NHPSPs, contributing to wider health sector governance. Clear reporting procedures should be established, with dedicated Ministry of Health staff time and resources to coordinate the group.

Box 8. Disability-inclusive health emergency preparedness, response, and recovery plans

The strengthening of inclusive health systems is a prerequisite for inclusive health emergency preparedness and response plans that reach every person *(27)*. While implementation of the Disability Inclusion Action Plan will cross over multiple health departments and programmes, particular attention should be given to actions which can be integrated into health emergency preparedness, response, and recovery (including reconstruction) plans – one of the 40 recommended actions in the *Global report (1)*. Such actions could include:

- Participation and engagement of persons with disabilities and their representative organizations in health emergency planning processes, including in health emergencies exercises and drills and early warning mechanisms.
- Reviewing health emergency protocols to ensure non-discrimination against persons with disabilities, including mechanisms to identify and address bias in triage and health service delivery.
- Preparing health workers involved in health emergency response to be able to address the needs of persons with disabilities, including sensitization to address negative attitudes and practices.
- Integrating disability into health sector risk assessments to understand the potential risks of disruption of services to persons with disabilities (e.g. supply chains and logistics for specific medication or assistive technology, and disruption of long-term rehabilitation).
- The replacement of common medicines and assistive devices used by persons with disabilities when preparing stockpiles of supplies for health emergencies.
- Setting guidelines for public health emergency information to be produced in a range of accessible formats and disseminated through disability networks.
- Ensuring continuity of services for persons with disabilities, such as social support, interpreters, rehabilitation, and assistive technology services.
- Collecting and analysing sex-, age- and disability-disaggregated data in health emergencies, including in rapid needs assessments and after-action reviews.

Further information can be found in Chapter 5 of the Inter-Agency Standing Committee's *Guidelines: inclusion of persons with disabilities in humanitarian action (28)*.

Country example: Integrating disability inclusive actions into wider health sector priorities in Montenegro

To facilitate implementation, help realize efficiencies in both cost and effort, and to embed a focus on health equity and disability inclusion across the health sector, Montenegro's Action Plan will be integrated into national health strategies, protocols and initiatives. In 2024, Montenegro started to develop a Strategy for Health Care Quality Assurance.[a] The situation assessment in Montenegro found no quality-of-care standards (nor routine audits of health facilities to examine quality of care), no clear standardized referral protocol, and no feedback and complaint processes that are routinely accessible to, or accessed by, persons with disabilities. The Action Plan subsequently sought to prioritize quality of care in two ways:

1. By strengthening the independence of Defenders of Patients' Rights – this involves increasing the number of persons with disabilities employed in this role and raising awareness among persons with disabilities of Defenders of Patients' Rights and related complaint processes.
2. Integrating into existing protocols, or creating new protocols for the care of persons with disabilities by medical and non-medical staff, including identification/diagnostics and intervention services for adults.

Both findings from the situation assessment and actions from the Action Plan were fed into the development process of the Strategy for Health Care Quality Assurance, strengthening the disability perspective of this sector-wide strategy.

[a] See: https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/montenegro/montenegro.pdf.

4.2 Facilitate intersectoral coordination and shared learning

If implemented effectively, stakeholders from within the Ministry of Health, other government departments, appropriate implementing partners and OPDs, will have been engaged in the planning processes for the *Disability inclusion guide for action*. Ongoing intersectoral coordination and collaboration, including integrating disability into new and emerging health policy initiatives, will support effective implementation of the action plan. This can be achieved by members of the Working Group (or equivalent body) representing disability issues in key technical working groups, coordination bodies and forums. These representatives can also bring new policies, strategies, and plans being developed, back to disability stakeholders, including OPDs, for technical inputs relating to disability inclusion.

Furthermore, the capacity development of stakeholders – within the Ministry of Health and the wider health and disability sectors – may be needed to advance some actions outlined in the plan. Again, the Working Group (or equivalent body) will usually have a range of technical skills and even training packages on disability inclusion which can be delivered during implementation of the action plan. OPDs should also be supported (operationally and financially) to build a pool of resource people who can contribute to health sector capacity development initiatives.

Finally, as disability inclusion in health systems and addressing health equity for persons with disabilities remains an emerging focus in many countries, strategies for disability inclusion need to be shared between stakeholders with reflections on what works, and why it works. As such, facilitated sharing and learning opportunities between sectors, including civil society and OPDs, will support the implementation of the action plan.

4.3 Analyse and report on the results, to contribute to future strategic planning cycles

Progress on disability inclusion in the health sector should be monitored and evaluated in line with the framework developed in Phase 3. It is important that monitoring and evaluation processes feed into wider health system reporting. Information gathered through the monitoring and evaluation framework should be analysed and documented appropriately, ideally in wider health sector strategic plan reviews and reports. Action plan implementation and monitoring can also contribute to national monitoring mechanisms, such as national disability strategies and reports of Member States to the Committee on the Rights of Persons with Disabilities. Finally, progress, outcomes and ongoing challenges in the implementation of the action plan should be shared with relevant stakeholders, in the interests of transparency and accountability. Again, this can be done in partnership with OPDs represented in the Working Group, and through policy dialogues and events.

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Annex 1. Approach to development

The *Disability inclusion guide for action* was developed in consultation with selected World Health Organization (WHO) country offices, Ministries of Health and country stakeholders, including organizations of persons with disabilities, who piloted tools and informed iterations of the toolkit. This section describes the different phases of development and consultation process used to develop the *Disability inclusion guide for action*.

Stage 1: Development of the draft *Disability inclusion guide for action*

A draft *Disability inclusion guide for action*, with detailed descriptions of phases and steps, and complementary tools and resources was drafted by the WHO Disability Team. The conceptual framework of the *Disability inclusion guide for action* draws on and aligns with other key frameworks and approaches in health *(1–8)*.

Stage 2: Piloting the draft *Disability inclusion guide for action* in countries

The *Disability inclusion guide for action* tools were then piloted in selected countries, facilitating the engagement of and feedback from a wide range of local stakeholders, and validating it as resource. Pilot countries included the United Republic of Tanzania, Malaysia, Montenegro, and Côte d'Ivoire.

Criteria for pilot countries

Pilot countries were selected in consultation with WHO Regional Office focal points for disability, and met the following criteria:

- Formal request to WHO from a ministry of health for technical support to address health inequities for persons with disabilities.
- A focal point in the ministry of health who can dedicate time to the coordination of the in-country activities and stakeholders.
- Interest and willingness from local organizations of persons with disabilities in pilot countries to engage in the Guide for Action process.

Other factors to be considered when selecting pilot countries included the diversity of resource settings, regions, and contexts. Furthermore, countries at different stages in addressing health equity for persons with disabilities were considered, with some countries building on existing disability inclusion action plans and others developing their first plan.

Technical support provided to pilot countries

WHO provided technical support to pilot countries to implement the *Disability inclusion guide for action*, gathering feedback from stakeholder throughout and revising the process and tools accordingly. As required, materials were translated into local languages for use in pilot countries. Technical support included 2–3 visits from the WHO Disability Team to each pilot country to:

- Raise awareness with stakeholders about health equity for persons with disabilities and engage them in the *Disability inclusion guide for action* process.
- Conduct the situation assessment, including desk-based document review, in-consultations with stakeholders and persons with disabilities, and co-facilitating workshops with the *Disability inclusion guide for action* Working Groups established in each country.
- Co-facilitate the Action Planning workshop with the *Disability inclusion guide for action* Working Group.

The WHO Disability Team also provided feedback and advice to Ministries of Health focal points on the establishment of the Disability Inclusion Working Group in each country and drafted and revised the situation assessment report and action plan based on feedback from the Working Group. WHO is continuing to provide technical support for pilot countries in the implementation of the action plans developed in the *Disability inclusion guide for action* process.

Stage 3: Consulting and revising the draft *Disability inclusion guide for action*

The draft *Disability inclusion guide for action* was then further developed, reviewed and finalized based on feedback from internal and external consultation groups. The internal consultation group consisted of WHO staff in selected departments and units at headquarters and regional *office levels. Three internal consultations were conducted – one on outline of the Disability inclusion guide for action,* one on the full draft of the Disability inclusion guide for action, and one focused on feedback from regional office colleagues.

The external consultation group comprised of international experts, organizations of persons with disabilities and other civil society organizations in the fields of disability, development, and health, ensuring that the toolkit is based on the best available evidence and relevant legal and policy frameworks. One consultation was conducted with the external consultation group on the full draft of the *Disability inclusion guide for action*. Declaration of interest forms were signed by external stakeholders and no conflict of interests was reported by any of them.

Assessment and management of conflict of interest from external experts

Finally, country examples demonstrating different phases and steps of the *Disability inclusion guide for action* process in pilot countries were drafted by the WHO Disability Team and shared with country partners for their feedback. Partners in pilot countries were also invited to share reflections on the *Disability inclusion guide for action* process, which were then included as quotes in the final publication. Email consent for country examples were obtained from individuals who were quoted, as well as Ministries of health and WHO country office focal points for disability.

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Annex 2. Alignment with global health system assessment and planning tools

This section provides an overview of the assessment and planning tools of the global health sector which intersect with the *Disability inclusion guide for action* process.

Health sector tool	What does this tool provide?	How does the ***Disability inclusion guide for action*** relate to this tool?
Strategizing national health in the 21st century: a handbook (1)	Guidance for countries on how to design national health policies, strategies and plans (NHPSPs), including how to increase inclusiveness and the participation of service providers and the population.	The *Disability inclusion guide for action* can inform population consultation on needs and expectations; situation analysis of the health sector; priority setting for NHPSPs; strategic and operational planning; and monitoring and evaluation phases outlined in this Guide.
Health systems performance assessment framework for universal health coverage (2)	Guidance on collecting information on, and examining, the performance of both functions of the health system (i.e. health system governance, financing, resource generation, and service delivery).	The *Disability inclusion guide for action* situation assessment can be undertaken as part of the wider health systems performance assessment, and provide information on how the functions of the health systems are performing for persons with disabilities.
Harmonized Health Facility Assessment (HHFA) (3)	A comprehensive health facility survey that assesses service availability and readiness, quality of care, and management and finance. HHFA data can support evidence-based decision-making in health sector reviews, planning, management, and policy-making.	Questions on the accessibility of services and information can be added to service availability and readiness assessment tools. Persons with disabilities can be interviewed to identify potential differences in quality of care. Questions on the participation of persons with disabilities in decision-making can be added to management questionnaires.

Health sector tool	What does this tool provide?	How does the *Disability inclusion guide for action* relate to this tool?
The Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook (4)	An eight-step process that supports countries to identify concrete, meaningful and evidence- based actions to address in- country inequities through health programmes.	Whereas the *Disability inclusion guide for action* focuses on the building blocks of the wider health system, Innov8 focuses more on how health programmes can identify and address underlying mechanisms or drivers of inequity. Some of the information gathered through the implementation of Innov8 can inform the *Disability inclusion guide for action* process and vice versa.
Handbook for conducting assessments of barriers to effective coverage with health services – in support of equity-oriented reforms towards universal health coverage (5)	An assessment of health service barriers that supports national health authorities in identifying barriers to both supply and demand of health services, thereby contributing to the reduction of health inequities and the closing of coverage gaps.	The *Disability inclusion guide for action* situation assessment aligns with the methodology for health service barriers assessment. Information gathered through assessments of barriers can inform the *Disability inclusion guide for action* process and vice versa.
Voice, agency, empowerment – handbook on social participation for universal health coverage (6)	Practical guidance on strengthening meaningful engagement of diverse stakeholders, including the population, communities, and civil society, in national health policy-making.	The *Disability inclusion guide for action* can support health policy-makers to ensure the voice and participation of persons with disabilities in new or existing participatory health governance mechanisms.
WHO QualityRights Assessment (7) and *Training module (8)*	A comprehensive process for assessing and improving quality of care and application of human rights in mental health and social care facilities for persons with psychosocial disabilities.	The QualityRights toolkit can provide valuable information and strategies to strengthen health services for persons with psychosocial disabilities, feeding in participation, assessment, and action planning processes of the *Disability inclusion guide for action*.
Disability-inclusive health services toolkit (9) and *Training package (10)*	Provides practical guidance to managers and staff of health-care facilities and services, health policy-makers, and nongovernmental organizations, on identifying and addressing barriers to health information and services.	Can support the implementation of disability-inclusive actions developed in the *Disability inclusion guide for action* process, particularly in setting standards on the accessibility of health infrastructure, communication and information, and providing training to health service providers.

Health sector tool	What does this tool provide?	How does the *Disability inclusion guide for action* relate to this tool?
Primary health care (PHC) measurement framework (11)	Guidance on how to assess, track and monitor PHC performance to accelerate progress towards universal health coverage (UHC) and the health-related Sustainable Development Goals.	The monitoring and evaluation framework of the *Disability inclusion guide for action* is aligned with the conceptual framework of the PHC measurement. As such, disability-inclusive health service indicators can be measured through adapted PHC monitoring mechanisms, and also provide inputs on how efforts to advance UHC are reaching persons with disabilities.
WHO's Rehabilitation in health systems: guide for action (12)	Assists countries to develop a comprehensive, coherent and beneficial strategic plan on rehabilitation, using a health system strengthening approach.	The guide for action can be used for more targeted assessments and the planning of rehabilitation services, while taking into consideration the needs of persons with disabilities in these processes.

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Annex 3. *Disability inclusion guide for action:* timeline of steps in Tanzania

2022

December

Organizations of persons with disabilities (OPDs) and Government attended the online launching and agreed to have country level actions.

2023

April

The Ministry of Health of Tanzania hosts a consultative workshop to gather feedback from stakeholders on the ***Disability Inclusion Guide for Action*** **process.**

May

Ministry of Health requests support. A budget is prepared and funded by WHO.

June

Working Group is established with representation from the Ministry of Health, UN agencies, OPDs and nongovernmental organizations.

July

Online meeting with Working Group to plan a situation assessment.

2023

July

Desk research and planning in-country information gathering.

August

In-person interviews, consultations and service visits. Situation assessment workshop with Working Group to complete Disability Inclusive Health systems assessment.

September–October

Drafting and revising of situation assessment report based on feedback from Working Group.

2023

November

Action planning workshop with Working Group.

December

Drafting and revising of the action plan based on feedback from Working Group.

2024

January–June

Revising of monitoring and evaluation framework and validation with OPDs.

2024

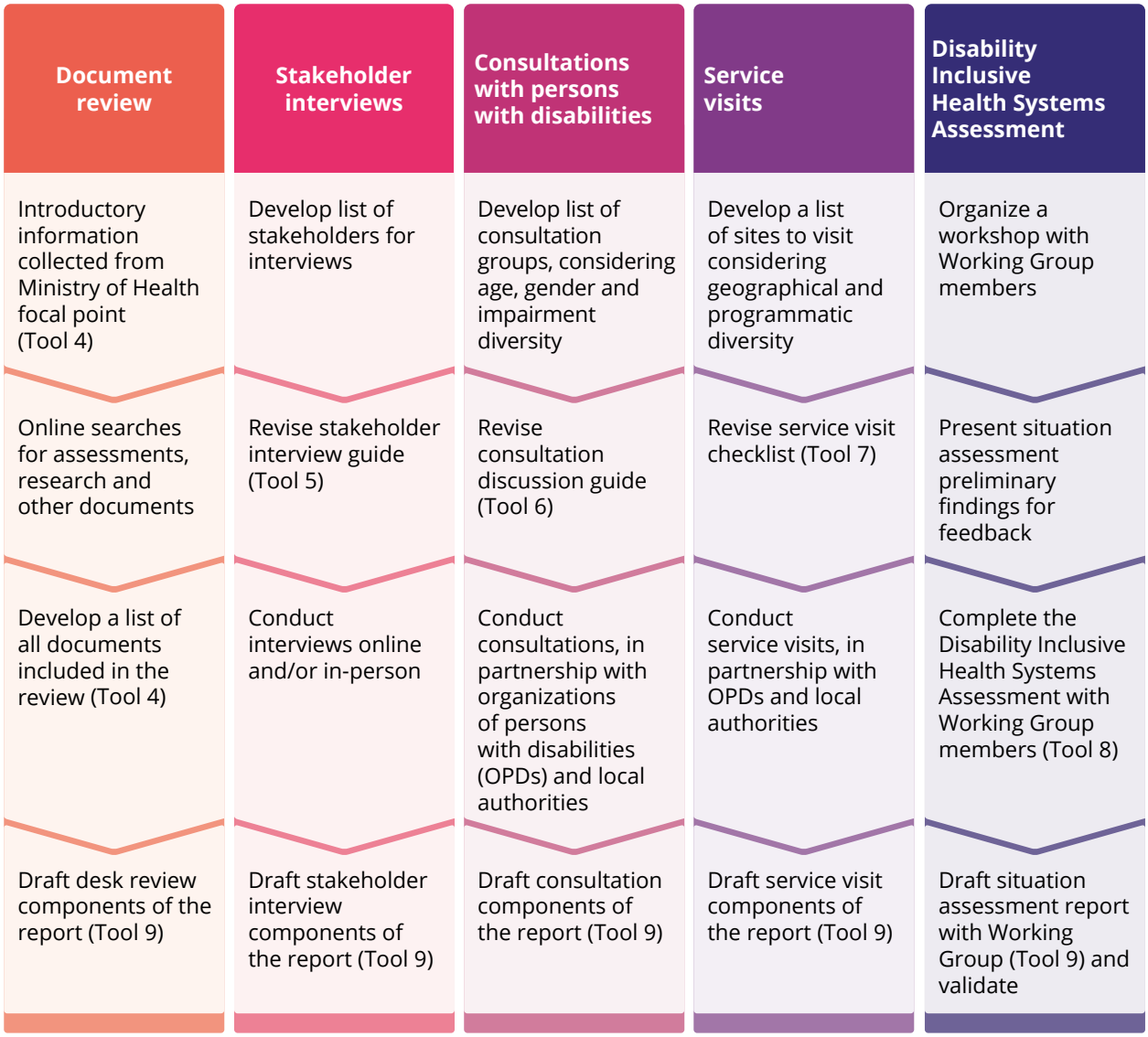
Launch of action plan to be implemented from 2024 to 2026.

2026

Feed into review of the national health sector strategic plan.

Annex 4. *Disability inclusion guide for action* situation assessment

The following diagram provides a detailed illustration of the *Disability inclusion guide for action* situation assessment process which can be adapted to suit country contexts and priorities.[a]



[a] Diagram adapted from "Assessing barriers to effective coverage with health services" (presentation by Theadora Swift Koller, 23 April 2021).

Note: The Tools referred to in the diagram can be found in the subsequent "Tools" section of this Guide.

Annex 5. Data sources to monitor health equity for persons with disabilities

Population-based data sources		
Type of data source	**Description of data source**	**How can this data source be used to monitor health equity for persons with disabilities?**
Censuses	Population and household censuses determine the size of populations and demographic characteristics of subgroups in the population.	Many country censuses now include questions on functional limitations, allowing for estimations of the numbers and percentage of persons with disabilities in the population.[a] Censuses usually include limited health data, but disability-disaggregated analysis may provide information about some determinants of health.
Vital registration systems	Vital registration systems record the occurrence of births, deaths, marriages, and divorces in a population.	In countries where these systems are functioning properly, they serve as the best and most reliable source of fertility, mortality, and cause-of-death data. Additional questions on disability, among other stratifiers, can facilitate disaggregated analysis on health equity for persons with disabilities at impact levels.
Social registries	Social registries are information systems that support outreach, intake, registration, and determination of potential eligibility social programmes, benefits and services[a].	Social registries may identify persons with disabilities who are eligible for social programmes, benefits and services providing information relating to indicators on social protection and health insurance coverage.[a]

Type of data source	Description of data source	How can this data source be used to monitor health equity for persons with disabilities?
Household surveys	Household surveys are currently the most common data source for health inequality monitoring in low- and middle-income countries[b]. Usually, household surveys cover a large number of indicators relating to health systems determinants, health service delivery, and health outcomes. Examples of household surveys which play an important role in health monitoring are the Demographic and Health Survey, Multiple Indicator Cluster Survey, and Malaria Indicator Survey. There are also a range of household surveys which focus on disability, such as the Model Disability Survey.	Some of the global health survey tools now include questions on disability; this allows for a disaggregated analysis of health indicators relating to social determinants, risk factors and health outcomes for persons with disabilities.[a] Disability surveys provide comprehensive information about the levels of disability in a population, identifying unmet needs and the barriers and inequalities faced by people who experience different levels of disabilities.
Institution-based data sources		
Resource records	Resource records provide administrative data on number of health facilities and staff, as well as data on health expenditure. Examples of specific data sources include national health accounts, national health workforce accounts, and facility censuses, which feed into databases the number, type, and distribution of health services.	With the addition of questions/components on disability, these tools can become data sources to track indicators on disability inclusion in the structures, inputs, and processes of the health system. They could include monitoring health expenditure on disability inclusion, the physical accessibility of health facilities, and the training of health workers, as well as the diversity of the health workforce at national levels.
Service and individual records (including electronic medical records)	These records provide information on the services delivered, such as number of procedures, activities, or interventions.	Where disability is identified in the records of individuals receiving health interventions, it may be possible use these data to report on the number of persons with disabilities receiving tracer health service interventions, as set out in the monitoring and evaluation framework.

Type of data source	Description of data source	How can this data source be used to monitor health equity for persons with disabilities?
Facility surveys	A range of health indicators are monitored through facility surveys and assessment tools, which are often linked to the quality assurance mechanism in the health system. Such tools include the Harmonized Health Facility Assessment[c], which assesses service availability, readiness, quality, and management.	Questions on disability inclusion can be integrated into facility surveys providing data to monitor indicators relating to the accessibility of facilities; health information and communication; the implementation of standards and guidelines on inclusive essential health service delivery; and the capacity of health staff.
Service user surveys	Service user surveys commonly include exit interviews and follow-up surveys with service users; they are often linked to the quality assurance mechanism in the health system.	Surveys of clients with disabilities can provide information on indictors relating to quality of care, identifying potential discrimination, or gaps in trust and communication with service providers. Additional information can be gathered on the perceived barriers to accessing health services, noting that additional population-based data are needed to understand the barriers faced by those unable to access services.
Surveillance systems		
Surveillance systems	Surveillance systems, which combine population- and institution-based data, are sometimes classified as a third category of data sources. Different types of surveillance systems, include: • Outbreak disease surveillance systems which aim to track cases of epidemic-prone diseases as well as their risk factors. • Sentinel surveillance systems, in which a sample of clinics is used for intensified monitoring, commonly used by disease programmes such as HIV and malaria. • Risk factor surveillance which often draws on data from surveys for use in monitoring NCDs. • Demographic surveillance which may be undertaken to monitor mortality, cause of death and other health-related data in a local population[d].	As with other data sources, including questions on disability in the demographic sections of data collection tools will allow for the disaggregated analysis of indicators relating to health outcomes and impact among persons with disabilities, compared to the general population or the population of persons without disabilities.

Note: It is important to reflect on the limitations of instruments or the questions used to define disability, and whether these may have affected the quality of data collected.

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Tool 1. Budget template for the *Disability inclusion guide for action* process

The following template is designed to support the costing of activities relating to the different phases of the *Disability inclusion guide for action* process. The number of meetings, group discussions and workshops may vary between countries and should be budgeted accordingly. Per diems, daily subsistence allowance, and transportation allowances should be aligned with appropriate protocols of the Ministry of Health and the partners involved. This template is also available in Excel format on the World Health Organization website.

PHASE 1: PREPARE					
ACTIVITY/ITEM	**UNIT DESCRIPTION**	**UNITS**	**RATE**	**DAYS**	**SUBTOTAL**
Consultant (approx. 10 days)					
Fees for consultative meeting	Number of days				
Reasonable accommodation for consultant (if needed)					
Consultative meeting to brief stakeholders: A 1–2-day meeting with approximately 40 participants					
Accessible venue hire, including refreshments and meals	Number of people				
Local language interpreters	Number of interpreters				
Sign language interpreters	Number of interpreters				
Stationary (e.g. flip charts, markers, etc.)	Lump sum				
Printing and language translation, including Braille and Easy-to-Read versions, as appropriate	Pages				
Per diem/daily subsistence allowance					

*Ministry of Health staff	Number of people				
*Other government staff	Number of people				
*United Nations agencies	Number of people				
*Local nongovernmental organizations	Number of people				
*International nongovernmental organizations	Number of people				
*Drivers	Number of people				
Reasonable accommodation for persons with disabilities					
*Accessible transport for organizations of persons with disabilities	Number of people				
*Per diem/daily subsistence allowance for support people and interpreters	Number of people				
Other costs (please list below)					
			SUBTOTAL		

PHASE 2: ASSESS					
ACTIVITY/ITEM	**UNIT DESCRIPTION**	**UNITS**	**RATE**	**GROUPS**	**SUBTOTAL**
Consultants (approx. 30 days)					
Fees for situation assessment	Number of days				
Reasonable accommodation for consultant (if needed)					
Stakeholder interviews					
Reasonable accommodation for persons with disabilities being interviewed					
*Accessible transport for organizations of persons with disabilities	Number of people				

*Per diem/daily subsistence allowance for support people and interpreters	Number of people				
Other costs (please list below)					
Service visits					
Reasonable accommodation for colleagues from organizations of persons with disabilities joining site visits					
*Accessible transport for organizations of persons with disabilities	Number of people				
*Per diem/daily subsistence allowance for support people and interpreters	Number of people				
Other costs (please list below)					
Consultations with persons with disabilities: At least four consultation groups with 8–12 people each group					
Refreshments	Number of people				
Local language interpreters	Number of interpreters				
Sign language interpreters	Number of interpreters				
Reasonable accommodation for persons with disabilities					
*Accessible transport for organizations of persons with disabilities	Number of people				
*Accessible transport for consultation participants	Number of people				
*Per diem/daily subsistence allowance for support people and interpreters	Number of people				
Other costs (please list below)					

Situation assessment workshop with Working Group: A 2–3-day meeting with approximately 20 participants					
Venue hire, including refreshments and meals	Number of people				
Local language interpreters	Number of interpreters				
Sign language interpreters	Number of interpreters				
Stationary (e.g. flip charts, markers, etc.)	Lump sum				
Printing and language translation, including Braille and Easy-to-Read versions, as appropriate	Pages				
Per diem/daily subsistence allowance					
*Ministry of Health staff	Number of people				
*Other government staff	Number of people				
*United Nations agencies	Number of people				
*Local nongovernmental organizations	Number of people				
*International nongovernmental organizations	Number of people				
*Drivers	Number of people				
Reasonable accommodation for persons with disabilities					
*Accessible transport for organizations of persons with disabilities	Number of people				
*Per diem/daily subsistence allowance for support people and interpreters					
Other costs (please list below)					
			SUBTOTAL		

PHASE 3: DESIGN					
ACTIVITY/ITEM	**UNIT DESCRIPTION**	**UNITS**	**RATE**	**DAYS**	**SUBTOTAL**
Consultant (approx. 30 days)					
Fees for consultative meeting	Number of days				
Reasonable accommodation for consultant (if needed)					
Action planning workshop with Working Group: A 2–3-day meeting with approximately 20 participants					
Venue hire, including refreshments and meals	Number of people				
Local language interpreters	Number of interpreters				
Sign language interpreters	Number of interpreters				
Stationary (e.g. flip charts, markers, etc.)	Lump sum				
Printing and language translation, including Braille and Easy-to-Read versions, as appropriate	Pages				
Per diem/daily subsistence allowance					
*Ministry of Health staff	Number of people				
*Other government staff	Number of people				
*United Nations agencies	Number of people				
*Local nongovernmental organizations	Number of people				
*International nongovernmental organizations	Number of people				
*Drivers	Number of people				
Reasonable accommodation for persons with disabilities					
*Accessible transport for organizations of persons with disabilities	Number of people				
*Per diem/daily subsistence allowance for support people and interpreters	Number of people				

Other costs (please list below)					
Validation of action plan with persons with disabilities: At least four consultation groups with 8–12 people each group					
Refreshments	Number of people				
Local language interpreters	Number of interpreters				
Sign language interpreters	Number of interpreters				
Reasonable accommodation for persons with disabilities					
*Accessible transport for colleagues from organizations of persons with disabilities	Number of people				
*Accessible transport for consultation participants	Number of people				
*Per diem/daily subsistence allowance for support people and interpreters	Number of people				
Other costs (please list below)					
Launch event: A 1-day meeting with approximately 40 participants					
Venue hire, including refreshments and meals	Number of people				
Local language interpreters	Number of interpreters				
Sign language interpreters	Number of interpreters				
Stationary (e.g. flip charts, markers, etc.)	Lump sum				
Printing and language translation, including Braille and Easy-to-Read versions, as appropriate	Pages				
Per diem/daily subsistence allowance					
*Ministry of Health staff	Number of people				
*Other government staff	Number of people				

*United Nations agencies	Number of people				
*Local nongovernmental organizations	Number of people				
*International nongovernmental organizations	Number of people				
*Drivers	Number of people				
Reasonable accommodation for persons with disabilities					
*Accessible transport for persons with disabilities	Number of people				
*Per diem/daily subsistence allowance for support people and interpreters	Number of people				
Other costs (please list below)					
			SUBTOTAL		
TOTAL FOR *DISABILITY INCLUSION GUIDE FOR ACTION* PROCESS					

Tool 2. Key messages on health equity for persons with disabilities

Health equity for persons with disabilities

1.3 BILLION people globally have significant disability

1 in 6 people

80% is the estimated number of persons with disabilities living in **low- and middle-income countries** where access to basic health services are especially limited for persons with disabilities

Persons with disabilities experience health inequities

Many of them:

- Are likely to die **20 years** earlier
- Experience poorer health – having more than **double** the risk of developing conditions such as diabetes, stroke or depression
- Have more limitations in functioning – for example inaccessible health facilities are up to **6 times** more hindering for them

Health inequities arise from unfair conditions that affect persons with disabilities disproportionally. These conditions are part of the socioeconomic and political context, social determinants of health, risk factors, and health system barriers

Investing in health equity for persons with disabilities means investing in Health for All, bringing high dividends to individuals and communities

There could be a

US$10 return per **US$1 spent**

on implementing disability inclusive prevention and care for noncommunicable diseases

Interventions such as family planning and vaccination could be highly cost-effective when provided in disability inclusive manner, despite the additional cost required

Achieving

SDG 3

and the global health priorities of

- **pursuing universal health coverage**
- **preventing and responding to health emergencies**
- **promoting healthier populations**

FOR ALL requires action to address health inequities for persons with disabilities

Countries are only 40 steps away from achieving health equity for persons with disabilities

All governments and health sector partners need to commit to **3 recommended principles** when implementing actions

- **Include health equity at the center of all actions**
- **Empower and include persons with disabilities**
- **Monitor the impact of health section actions for persons with disabilities**

WHO/UCN/NCD/SDR/2022.01

World Health Organization

actions to achieve health equity for persons with disabilities

Political commitment, leadership, and governance

1 Prioritize health equity for persons with disabilities

2 Establish a human rights-based approach to health

3 Assume a stewardship role for disability inclusion in the health sector

4 Make international cooperation more effective by increasing funding to address health inequities for persons with disabilities

5 Integrate disability inclusion in national health strategies, including preparedness and response plans for health emergencies

6 Set actions that are specific to the health sector in national disability strategies or plans

7 Establish a committee or a focal point the Ministry of Health for disability inclusion

8 Integrate disability inclusion in the accountability mechanisms of the health sector

9 Create disability networks, partnerships and alliances

10 Ensure the existing mechanisms for social protection support the diverse health needs of persons with disabilities

Health financing

11 Adopt progressive universalism as a core principle, and as a driver of health financing, putting persons with disabilities at the centre

12 Consider health services for specific impairments and health conditions in packages of care for universal health coverage

13 Include into health-care budgets the costs of making facilities and services accessible

Engagement of stakeholders and private sector providers

14 Engage persons with disabilities and their representative organizations in health sector processes

15 Include gender-sensitive actions that target persons with disabilities in the strategies to empower people in their communities

16 Engage the providers of informal support for persons with disabilities

17 Engage persons with disabilities in research and including them in the health research workforce

18 Request that providers in the private sector support the delivery of disability-inclusive health services

Models of care

19 Enable the provision of integrated people-centred care that is accessible and close to where people live

20 Ensure universal access to assistive products

21 Invest more finances in support persons, interpreters, and assistants to meet the health needs of persons with disabilities

22 Consider the full spectrum of health services along a continuum of care for persons with disabilities

23 Strengthen models of care for children with disabilities

24 Promote deinstitutionalization

Health and care workforce

25 Develop competencies for disability inclusion in the education of all health and care workers

26 Provide training in disability inclusion for all health service providers

27 Ensure the availability of a skilled health and care workforce

28 Include persons with disabilities in the health and care workforce

29 Train all non-medical staff working in the health sector on issues related to accessibility and respectful communication

30 Guarantee free and informed consent for persons with disabilities

Physical infrastructure

31 Incorporate a universal design-based approach to the development or refurbishment of health facilities and services

32 Provide appropriate reasonable accommodation for persons with disabilities

Digital technologies for health

33 Adopt a systems-approach to the digital delivery of health services with health equity as a key principle

34 Adopt international standards for accessibility of digital health technologies

Quality of care

35 Integrate the specific needs and priorities of persons with disabilities into existing health safety protocols

36 Ensure disability-inclusive feedback mechanisms for quality of health services

37 Consider the specific needs of persons with disabilities in systems to monitor care pathways

Monitoring and evaluation

38 Create a monitoring and evaluation plan for disability inclusion

39 Integrate indicators for disability inclusion into the monitoring and evaluation frameworks of country health systems

Health policy and systems research

40 Develop a national health policy and systems research agenda on disability

WHO/UCN/NCD/SDR/2022.02

World Health Organization

Tool 3. Terms of reference for working group

The *Disability inclusion guide for action* is a planning tool developed by the World Health Organization to support ministries of health to advance health equity for persons with disabilities. The Working Group, coordinated by the Ministry of Health, will inform the situation assessment, contribute to the action planning processes, and support the government in the later implementation, monitoring, and evaluation of actions developed. The Working Group comprises selected representatives from the Ministry of Health and other government departments, health service providers, research institutes, human rights bodies, and civil society, including organizations of persons with disabilities and other groups of persons with disabilities. Gender balance and diversity of types of impairments will be considered in the composition of the Working Group. New members may be invited to join at different points in the process when additional or new expertise is required.

Terms of reference:

- Identify stakeholders from the areas of disability and health to engage in the *Disability inclusion guide for action* process.
- Participate in meetings and workshops relating to the *Disability inclusion guide for action*, including capacity-building activities, as appropriate.
- Provide information that assists in the completion of the Introductory Information Collation Template.
- Contribute to, and review, the draft report for the situation assessment of health equity for persons with disabilities.
- Review and provide feedback on the draft Disability Inclusion Action Plan including monitoring and capacity-building requirements.
- Support the government to implement the action plan, and engage in its monitoring, evaluation, and review processes.

Membership composition can include:

Government	**Ministry of Health departments** responsible for policy, planning and budgeting, quality assurance, workforce development, and monitoring and evaluation. **Government ministries and government departments responsible for disability service provision**. **Other ministries** responsible for finance, social welfare, community development, and women and children. National level **disability councils and committees** representing persons with disabilities to parliament. **National statistics offices** which usually coordinate and oversee the collection of population demographic and health data.
Civil society	Organizations/groups of persons with disabilities, including the **national umbrella body of organizations of persons with disabilities** and **underrepresented groups**, such as women with disabilities, persons with psychosocial disabilities, person with intellectual disabilities, persons with deafblindness, Indigenous peoples with disabilities, and migrants and refugees with disabilities. **Disability-inclusive community groups**, such as women's rights organizations, young people's organizations, refugee and migrant associations, and people working with persons of diverse sexual orientation, gender identity and expression and sex characteristics. **Families and caregivers** of persons with disabilities, including formal and informal groups and associations.
Service providers	National/subnational partners in the public and private health sectors delivering **major health programmes**, such as community health/ primary health care, health promotion, maternal and child health and telehealth services. **Organizations working on disability inclusion or delivering health services often used by persons with disabilities** (e.g. rehabilitation and assistive technology, community-based rehabilitation) – these may be public sector, nongovernmental organizations or private sector providers.
Institutions	**Health care workforce training institutions**, including universities or schools of medicine, nursing or public health, particularly those responsible for the development and accreditation of curriculums. **National human rights institutions** responsible for protecting, promoting, and monitoring the implementation of the Convention on the Rights of Persons with Disabilities or its national equivalent policy. **Health research institutions**, responsible for the development and implementation of national health research agendas.
Regulatory and professional bodies	**Councils** for licensing health professionals. Professional organizations (e.g. medical associations). **Registration and accreditation bodies** for private and public health facilities.

Development partners	**United Nations bodies** comprising many funds, programmes and specialized agencies supporting the health sector – for example, WHO, UNICEF, UNFPA, UNAIDS, UN Women, and in countries with forced displacement, UNHCR and IOM.[a]
	The World Bank and relevant regional **multilateral development banks,** such as the Inter-American Development Bank, the Asian Development Bank, and the African Development Bank.
	Government partners and other donors supporting the development of the health system and/or wider disability inclusive development.

[a] UNFPA: United Nations Population Fund; UNHRC: United Nations High Commissioner for Refugees; IOM: International Organization for Migration.

Time commitment

Throughout the *Disability inclusion guide for action* process, Working Group members will be expected to participate in two workshops (each 2–3 days in duration). Additional online planning and feedback meetings may be organized at critical points in the process. The cost of accessible transportation, interpreters and other reasonable accommodation for organizations of persons with disabilities members will be provided, to be reimbursed by the Ministry of Health and its partners.

Tool 4. Template for introductory information form

Tool 4 provides the template of the form designed to collect introductory information about the priorities of the Ministry of Health in strengthening the health system, disability inclusive actions already undertaken, and evidence of implementation in relation to each of the 10 strategic entry points. The information gathered from this form and the documents shared will be used in the desk research component of the situation assessment.

General information

Name of country and area in which the *Disability inclusion guide for action* is being undertaken
Country:
State/region/province:
Details of person completing this form
Name:
Role/position:
Organization:
Email and phone number:

What is the main policy framework(s) guiding the health sector?

Who are the main development partners involved in the health sector (e.g. government, multilateral, United Nations, nongovernmental organizations or private sector partners)?

1. Political commitment, leadership, and governance

1.1. What are the key priorities for the Ministry of Health relating to leadership and governance over the next __ years? For example, relating to health policies, strategies or plans, or decision-making committees/processes.

1.2. How has disability inclusion been considered in these priorities (e.g. alignment with national disability strategies and implementation of the Convention on the Rights of Persons with Disabilities)?

1.3. What evidence is available on the implementation of these priorities? Please share any relevant reports, evaluations and/or data sources.

Comments and additional information:

2. Health financing

2.1. What are the key priorities for the Ministry of Health relating to health financing over the next __ years? For example, development of health care packages and health insurance schemes.

2.2. How has disability inclusion been considered in these priorities (e.g. budgeting for disability inclusion)?

2.3. What evidence is available on the implementation of these priorities? Please share any relevant reports, evaluations and/or data.

Comments and additional information:

3. Engagement of stakeholders and private sector providers

3.1. What are the key priorities for the Ministry of Health relating to engagement of stakeholders and private sector providers over the next __ years? For example, plans to develop formal mechanisms, such as Technical Working Groups, to contribute to decision-making on wider health actions.

3.2. How has disability inclusion been considered in these priorities?

3.3. What evidence is available on the implementation of these priorities? Please share any relevant reports, evaluations and/or data.

Comments and additional information:

4. Models of care

4.1. What are the key priorities for the Ministry of Health relating to models of care over the next __ years? For example, strengthening access at primary, secondary and tertiary levels, and referral mechanisms.

4.2. How has disability inclusion been considered in these priorities?

4.3. What evidence is available on the implementation of these priorities? Please share any relevant reports, evaluations and/or data.

Comments and additional information:

5. Health and care workforce

5.1. What are the key priorities for the Ministry of Health relating to workforce development over the next __ years? For example, human resources for health strategies, developing new curriculums and training accreditation processes.

5.2. How has disability inclusion been considered in these priorities (e.g. disability content in curriculums, in-service training courses, sign language training)?

5.3. What evidence is available on the implementation of these priorities? Please share any relevant reports, evaluations and/or data.

Comments and additional information:

6. Physical infrastructure and communication

6.1. What are the key priorities for the Ministry of Health relating to health infrastructure and communication over the next __ years? For example, the refurbishment or construction of new health facilities, or major health information, education, and communication campaigns.

6.2. How has disability inclusion been considered in these priorities?

6.3. What evidence is available on the implementation of these priorities? Please share any relevant reports, evaluations and/or data.

Comments and additional information:

7. Digital technologies for health

7.1. What are the key priorities for the Ministry of Health relating to digital health over the next __ years? For example, platforms for the delivery of telemedicine, e-learning and data management.

7.2. How has disability inclusion been considered in these priorities?

7.3. What evidence is available on the implementation of these priorities? Please share any relevant reports, evaluations and/or data.

Comments and additional information:

8. Systems for improving quality of care

8.1. What are the key priorities for the Ministry of Health relating to quality of care over the next __ years? For example, monitoring user satisfaction, assessment, and certification of facilities.

8.2. How has disability inclusion been considered in these priorities?

8.3. What evidence is available on the implementation of these priorities? Please share any relevant reports, evaluations and/or data.

Comments and additional information:

9. Monitoring and evaluation

9.1. What are the key priorities for the Ministry of Health relating to health monitoring and evaluation the next __ years? For example, strengthening health information systems and tracking health system indicators.

9.2. How has disability inclusion been considered in these priorities?

9.3. What evidence is available on the implementation of these priorities? Please share any relevant reports, evaluations and/or data.

Comments and additional information:

10. Health policy and systems research

10.1. What are the key priorities for the Ministry of Health relating to health policy and systems over the next __ years? For example, what health topics are a priority for research?

10.2. How has disability inclusion been considered in these priorities?

10.3. What evidence is available on the implementation of these priorities? Please share any relevant reports, evaluations and/or data.

Comments and additional information:

Tool 5. Stakeholder interview guide

Tool 5 provides a guide to the process of interviewing potential stakeholders involved in the *Disability inclusion guide for action*.

Name of stakeholder:

Role/position:

Organization:

Introduction

As the interviewer, introduce yourself to the interviewee and provide a very brief overview of the *Disability inclusion guide for action* process and lead organizations (e.g. Ministry of Health, and other partners as appropriate).

Explain that the objective of the interview is to gather perspectives on disability inclusion in the health sector – what is working and what needs to be improved – and that the information provided will contribute to a situation assessment. This assessment will inform the development of an action plan to improve disability inclusion in the health system.

Ensure that the stakeholder understands that participation is voluntary – this means that they do not have to answer any questions and can end the interview at any time.

Ask the stakeholder not to share any personal health information about individuals during the interview. Notes will be taken, but no names are to be included in the report. The duration of the interview will be up to 1 hour.

Check if the stakeholder has any questions at this point and whether they agree to continue with the interview.

Questions

1. What type of health activities does your organization undertake? How does the organization work with the Ministry of Health?
2. Does your organization currently consider the health of persons with disabilities in its work?

- If so, how? What stakeholders does it engage with in this work? How does it engage persons with disabilities in this priority?

3. What priorities will the organization be advancing or contributing to over the next 3 years?
4. Do you/your organization plan to include the health of persons with disabilities in these priorities?
   - If yes, how? What stakeholders do you/your organization plan to engage with in these priorities? How will persons with disabilities be engaged in this priority?
5. Does your organization monitor disability inclusion in health activities?
   - If yes, how? What type of data is collected and how is it disaggregated by disability?
6. What do you consider are the challenges and opportunities to strengthen disability inclusion in the wider health system?

Challenges:

Opportunities:

7. Is there anything else that you would like to share about this topic?

Tool 6. Consultation discussion guide for persons with disabilities

Tool 6 provides a guide to the process of conducting consultation discussions with persons with disabilities.

Date:

Group:

Summary of participants (gender, age, type of impairments):

Introduction

As the facilitator, introduce yourself to participants and provide a very brief overview of the *Disability inclusion guide for action* process and lead organizations (e.g. the Ministry of Health, and other partners as appropriate).

Explain that the objective of the consultation is to gather perspectives on disability inclusion in the health sector – what is working and what needs to be improved and that the information provided will contribute to a situation assessment. This assessment will inform the development of an action plan to improve disability inclusion in the health system.

Ensure that participants understand that participation in the consultation is voluntary – this means that participants do not have to answer any questions and can leave at any time. Clarify that no health services will be provided today – and that the aim of the consultation is to gather information and to learn from the participants.

Ask participants not to share any personal health information about themselves or others – that all information is private and must be kept confidential. Notes will be taken, but no names will be included in the report. The duration of the interview will be up to 1 hour.

Ensure that all participants give their informed consent and ask: Does anyone have any questions for me before we begin the discussion today? Would anyone like to leave? Participants can be invited to introduce themselves (by providing their first name only).

Example questions to be asked:

Staying healthy in daily life

In your country, there may be programmes to support the population to live healthy lives, through better diet, hygiene, exercise, among many other things. We call these health promotion campaigns.

1. How do health promotion activities in your country include persons with disabilities?

Prompts: Have you seen any strategies to make these activities accessible to everyone? What are some of the barriers faced by persons with disabilities when accessing these activities? Are these barriers different people of different genders, and people with different types of disabilities?

2. Where do persons with disabilities get information about health issues?

Prompts: Have you seen any strategies to make health information accessible to everyone? What are some of the barriers faced by persons with disabilities when accessing health information? Are these barriers different for women, men, and people with different types of disabilities?

Accessing health care services

We all need to seek health care services to stay healthy or to access when we are unwell, have an illness or injury.

3. How do health care services in your country include persons with disabilities?

Prompts: Have you seen any strategies to make health care services accessible to everyone? What are some of the barriers faced by persons with disabilities when accessing health services? Are these barriers different for women, men, and people with different types of disabilities?

4. When the health care system is not meeting the needs of, or working effectively for, the general population, how do users of services give feedback or lodge a complaint about health services?

Prompts: Have you seen any strategies to make these feedback and complaint systems accessible to everyone? What are some of the barriers faced by persons with disabilities when giving feedback or making a complaint? Are these barriers different for women, men, and people with different types of disabilities?

Health care planning and decision-making

Let's now talk about how the health system is run in your country and how decisions are made about the services to be provided to the community.

5. How does the community participate in decisions about health services?

Prompts: Have you seen any strategies to make these community decision-making processes accessible to everyone? What are some of the barriers faced by persons with disabilities in participating in these community decision-making processes?

6. What about in health emergencies, such as with the COVID-19 pandemic?

Prompts: Have you seen any strategies to ensure inclusion of persons with disabilities in these emergency responses? What are some of the barriers faced by persons with disabilities in these types of emergencies? Are these barriers different for women, men, and people with different types of disabilities?

Final recommendations

7. What recommendations do you have for us on how to improve the health system for persons with disabilities?

Prompts: What are the most important areas to improve in the health system? How can persons with disabilities and their organizations contribute to these improvements?

Optional question

To facilitate reflection and participation from everyone!

8. What does being healthy mean to you?

Thank participants for their ideas and perspectives and explain how information will be shared back to them throughout the *Disability inclusion guide for action* process. Provide contact details of focal points (e.g. the organizations of persons with disabilities, Ministry of Health focal point or other partners leading this process) for further questions.

Tool 7. Service visit guide

Tool 7 provides a guide to the service visits conducted as part of the *Disability inclusion guide for action* process.

Date:

Facility name/location:

Names of participants visiting facility:

Service/facility staff consulted during the visit:

Overview
What health services are provided at the facility? Prompts: Ask about types of health programmes, level of care and referral networks, and target population demographics and health needs.
Has the facility taken actions to make these services more inclusive to persons with disabilities? Prompts: Does the facility, for example, conduct accessibility audits and adaptations; share information about services to persons with disabilities in the community; train health staff; or provide interpreters and support people?
Does the health service or facility have data on service users with disabilities? Prompts: On registration, does the facility or health service record whether service users have a disability? If so, how do they identify if a service user has a disability? What questions do they ask? Are these data used for disability-disaggregated analysis of service usage?
How does the health service or facility monitor quality of care? Prompts: Are the mechanisms for standard feedback, safeguarding and complaints accessible to persons with disabilities?

Accessibility of service or facility

During the visit, consider general accessibility features, such as those listed below. Please note, this is not designed to be a comprehensive accessibility audit.

Area	Questions	Yes	No
Transport and parking facilities	Is there wheelchair access from the street to the front entrance?		
	Are there parking spaces close to the building entrance?		
	Are ambulance and other transport services available to service users?		
Building access	Is the main entrance to the facility wheelchair accessible (e.g. free of steps, portable ramp available, door width)?		
	Are the pathways and corridors within the facility level and with minimal obstacles?		
	Do pathways and corridors have tactile guidance for people who are blind?		
	Are there people available to provide assistance to persons with disabilities, if required?		
	Are door staff/security staff aware of any policies regarding priority of treatment for persons with disabilities?		
	Is there a functioning and accessible lift between floors (and is the lift large enough to accommodate a wheelchair user)?		
Wards, examination and treatment rooms	Are the doors wide enough for wheelchair access?		
	Is there sufficient space to accommodate wheelchairs and assistants/support people?		
	Are examination tables height adjustable?		
Toilets and hygiene facilities	Are there any wheelchair accessible toilets in the facility?		
	Are handbasins, taps, soap, etc accessible to wheelchair users?		
Communication	Is service signage readable, e.g. in Braille or large print, or using understandable symbols (e.g. for accessible entrances, toilets etc)?		
	Is health information available in accessible formats (e.g. in large print, Braille, simplified formats for people with intellectual disability; sign language interpreters)?		
	Are people with communication difficulties requiring assistance able to access support and/or interpreters?		

Area	Questions	Yes	No
Emergency evacuation	Do emergency plans for evacuating the facility consider persons with disabilities?		
	Are emergency exits clear from obstacles and accessible to persons with mobility and vision impairments?		

Comments

Conclusions

Strengths

Weaknesses

Opportunities

Tool 8. Disability inclusive health systems assessment

The following Disability Inclusive Health Systems Assessment Tool supports the Ministry of Health in identifying strengths and weaknesses relating to disability inclusion across the 10 strategic entry points; these can then be considered in later phases of action planning. The tool provides a framework for the wider situation assessment and can serve to track progress over time in the implementation of disability inclusive action plans.

The Ministry of Health and the Working Group, with support from the World Health Organization, as needed, should complete the Disability Inclusive Health Systems Assessment Tool, drawing on preliminary findings from the situation assessment, as well as the knowledge and experience of Working Group members.

Scoring scale

Using the scoring scale template provided below, the Working Group must select a score from 1 to 4 based on the criteria presented under each of the 10 strategic entry points. Ideally, this happens in the situation assessment workshop, where the Working Group will discuss which criteria are being met, along with the evidence available that demonstrates the criteria are being met. They then agree on a score.

The scoring scale of 1–4 indicates that disability inclusion:

1. Needs establishing

The score of 1 implies that disability inclusion is at a very low level or missing. The criterion is not yet established or is just emerging.

2. Needs major strengthening

The score of 2 implies that disability inclusion is at a low level. The criterion is established but there are many areas that need improvement.

3. Needs minor strengthening

The score of 3 implies that disability inclusion is at a moderate level. The criterion is well established but there are a few areas for improvement.

4. Needs no immediate action

The score of 4 implies that disability inclusion is at a high level. However, there may be isolated concerns that need monitoring and addressing over time.

Strategic entry point 1. Political commitment, leadership, and governance

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
National legislation and policy *Refers to legislation and policy (e.g. Disability Acts, National Health Policy, mental health-related policies and laws) which support disability inclusion in the health sector in line with the Convention on the Rights of Persons with Disabilities.*	NO explicit commitments relating to the health needs of persons with disabilities in national laws and policies.	National laws and policies make some commitments to the health needs of persons with disabilities. BUT These commitments are NOT aligned with the Convention on the Rights of Persons with Disabilities.	National laws and policies make some commitments to the health needs of persons with disabilities. AND These commitments ARE aligned with the Convention on the Rights of Persons with Disabilities. BUT The commitments are NOT comprehensive or systematic.	National laws and policies make detailed commitments to the health needs of persons with disabilities. AND These commitments ARE aligned with the Convention on the Rights of Persons with Disabilities. AND The commitments ARE comprehensive or systematic.

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Health strategies and plans *Refers to health strategies and plans (e.g. the national health sector strategic plan) which support the implementation of health laws and policies. Health strategies and plans detail goals and objectives to be achieved at national or subnational levels over a specified time frame.*	Health strategies and plans make NO explicit commitments to persons with disabilities NOR reference persons with disabilities in passing with other marginalized groups.	Health strategies and plans make explicit commitments to the inclusion of persons with disabilities. BUT They fail to identify priority areas or concrete actions.	Health strategies and plans make explicit commitments to the inclusion of persons with disabilities. AND They identify priority areas or concrete actions. BUT There are GAPS in implementation.	Health strategies and plans make explicit commitments to the inclusion of persons with disabilities. AND They identify priority areas or concrete actions AND These actions are implemented.
Governance and coordination *Refers to oversight, accountability, and decision-making mechanisms within the health sector on an ongoing basis (i.e. outside of the* Disability inclusion guide for action *process)*	There is NO permanent focal point/committee within the Ministry of Health which oversees and monitors disability inclusion in the health sector.	There is a permanent focal point OR committee within the Ministry of Health which oversees and monitors disability inclusion in the health sector. Organizations of persons with disabilities are NOT involved in these processes.	There is a permanent focal point within the Ministry of Health which oversees disability inclusion. AND A committee (or equivalent) which contributes to decision-making and monitoring of disability inclusion in the health sector. Organizations of persons with disabilities participate in SOME of these processes.	There is a permanent focal point within the Ministry of Health which oversees disability inclusion. AND A committee (or equivalent) which contributes to decision-making and monitoring of disability inclusion in the health sector. Organizations of persons with disabilities participate in ALL of these processes.

Strategic entry point 2. Health financing

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Health benefits and insurance schemes *Refers to whether persons with disabilities have access to health insurance coverage.*	Health benefits and insurance schemes do NOT reference disadvantaged groups in the population NOR persons with disabilities.	Health benefits and insurance schemes reference inclusion of disadvantaged groups in the population. BUT Persons with disabilities face discrimination on the basis of disability or pre-existing conditions.	Health benefits and insurance schemes explicitly reference inclusion of persons with disabilities. AND Persons with disabilities do not face discrimination on the basis of disability or pre-existing conditions. BUT Implementation and participation from persons with disabilities is LIMITED.	Health benefits and insurance schemes explicitly reference inclusion of persons with disabilities. AND Persons with disabilities do not face discrimination on the basis of disability or pre-existing conditions. AND Implementation and participation from persons with disabilities is acceptable.

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Affordability of health services *Refers to out-of-pocket costs paid by individuals when accessing health services and interventions, including fees and co-pays for services, medications, and assistive products.*	Persons with disabilities have HIGH out-of-pocket costs OR are unable to access MANY health services and interventions due to financial barriers. There is NO support available to cover to out-of-pocket costs.	Persons with disabilities have HIGH out-of-pocket costs OR are unable to access MANY health services and interventions due to financial barriers. There is support available to cover SOME health care costs. BUT The mechanism for accessing this support is NOT clearly established.	Persons with disabilities have SOME out-of-pocket costs OR are unable to access SOME health services and interventions due to financial barriers. There is support available to cover SOME health care costs. AND The mechanism for accessing this support is clearly established.	Persons with disabilities have no or minimal out-of-pocket costs NOR do they face financial barriers when accessing health services and interventions. There is support available to cover a wide range of health care costs. AND The mechanism for accessing this support is clearly established.

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Social protection *Refers to how persons with disabilities are included in mechanisms which support poor and at-risk populations – for example, social safety nets, cash transfers, and disability benefits. Such benefits can contribute to the associated costs of accessing health care (e.g. transportation, interpreters, support people).*	Social protection mechanisms do NOT exist. AND There are NO disability assessment, determination and eligibility processes established.	Social protection mechanisms include SOME schemes or benefits for persons with disabilities. BUT There are NO disability assessment, determination and eligibility processes established.	Social protection mechanisms include SOME schemes or benefits for persons with disabilities. AND There ARE disability assessment, determination and eligibility processes clearly established. BUT Persons with disabilities report they face some BARRIERS when accessing these mechanisms.	Social protection mechanisms include SOME schemes or benefits for persons with disabilities. AND There ARE disability assessment, determination and eligibility processes clearly established. AND Persons with disabilities report they can access these mechanisms.

Strategic entry point 3. Engagement of stakeholders and private sector providers

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Engaging disability stakeholders *Refers to the engagement of disability stakeholders and diverse groups of persons with disabilities in health sector decision-making.*	Disability stakeholders are NOT consulted when making decisions on some health services. AND There are NO formal mechanisms to engage disability stakeholders in health sector decision-making.	Disability stakeholders ARE consulted when making decisions on some health services. BUT There are NO formal mechanisms to engage disability stakeholders in wider health sector decision-making.	Disability stakeholders ARE consulted when making decisions on some health services. AND There ARE formal mechanisms in place for disability stakeholders to participate in decision-making on wider health actions. BUT There are NO strategies for participation from diverse groups of persons with disabilities.	Disability stakeholders ARE consulted when making decisions on some health services. AND There ARE formal mechanisms in place for disability stakeholders to participate in decision-making on wider health actions. AND There ARE strategies for participation from diverse groups of persons with disabilities.

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Coordinating health service providers *Refers to the coordination of all actors providing health services (e.g. private sector, public sector, and civil society organizations), including regulation and monitoring of disability inclusion.*	Information is NOT available to the Ministry of Health (including from other government ministries) about actors that provide health services to persons with disabilities.	Information is available to the Ministry of Health about actors that provide health services to persons with disabilities. BUT NO mechanism has been established to coordinate/strengthen disability inclusion among all health service providers.	A mechanism involving the Ministry of Health has been established to coordinate/strengthen disability inclusion among all health service providers. BUT NO standards/ regulations have been developed to guide disability inclusion among all service providers. AND Implementation of disability inclusion is NOT monitored and/or guided by standards/ regulations.	A mechanism involving the Ministry of Health has been established to coordinate/strengthen disability inclusion among health service providers. AND Standards/regulations have been developed to guide disability inclusion among all service providers. AND Implementation of these standards/ regulations ARE routinely monitored.

Strategic entry point 4. Models of care

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Health care packages *Refers to the packages of services offered at each level in the health care system.*	Health care packages or their implementation plans do NOT reference inclusion of persons with disabilities.	Health care packages or their implementation plans reference inclusion of persons with disabilities. BUT They do NOT include services commonly needed by persons with disabilities (e.g. assistive products, rehabilitation, early identification and care for children with disabilities, and community-based mental health care).	Health care packages include universal provision of assistive products, rehabilitation, early identification and care for children with disabilities, and community-based mental health care. BUT There are GAPS in the implementation of service packages.	Health care packages include universal provision of assistive products, rehabilitation, early identification and care for children with disabilities, and community-based mental health care. AND Persons with disabilities report that they have access to these service packages.

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Inclusive health service planning *Refers to how health services are planned and organized at different levels in the health system to deliver health care packages. For example, council level health planning processes, health facility committees and similar mechanisms.*	Health service planning guidelines or planning mechanisms do NOT reference the inclusion of persons with disabilities.	Health service planning guidelines or planning mechanisms reference the inclusion of persons with disabilities. BUT There are NO references to concrete strategies/ actions to ensure their inclusion.	Health service planning guidelines or planning mechanisms reference the inclusion of persons with disabilities. AND There ARE references to concrete strategies/ actions to ensure their inclusion (e.g. suggested activities and indicators in planning guidelines). BUT These guidelines and mechanisms are applied in a LIMITED way across the health system.	Health service planning guidelines or planning mechanisms reference the inclusion of persons with disabilities. AND There ARE references to concrete strategies/ actions to ensure their inclusion (e.g. suggested activities and indicators in planning guidelines). AND These guidelines and mechanisms ARE comprehensively applied across the health system.

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Health emergency preparedness and response *Refers to the inclusion of persons with disabilities in health emergency processes.*	Health emergency planning guidelines do NOT reference the inclusion of persons with disabilities.	Health emergency planning guidelines reference ensuring continuity of services and emergency-related health support for persons with disabilities.	Health emergency planning guidelines reference ensuring continuity of services and emergency-related health support for persons with disabilities, including mental health and psychosocial support. BUT These guidelines are implemented in a LIMITED way in health emergency responses.	Health emergency planning guidelines reference ensuring continuity of services and emergency-related health support for persons with disabilities, including mental health and psychosocial support. AND These guidelines are comprehensively implemented in health emergency responses.

Strategic entry point 5. Health and care workforce

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Health workforce competency *Refers to establishing competencies and providing training to all health workers.* Note: "Health workforce" refers to health professionals, health associate professionals, personal care workers in health services, health management and support personnel, as outlined in the International Classification of Health Workers.	There are NO competencies or mandatory training requirements on disability inclusion for members of the health care workforce.	Disability inclusion is referenced in some training curricula for health care workers. BUT It is NOT systematic nor integrated into accreditation training programmes, nor mandatory for employment in the health sector.	All accredited health care training programmes have content on disability inclusion. AND It is mandatory to have training on disability inclusion for employment in the health sector. BUT Organizations of persons with disabilities are NOT involved in these training programmes.	All accredited health care training programmes have content on disability inclusion. AND It is mandatory to have training on disability inclusion for employment in the health sector. AND Organizations of persons with disabilities ARE involved in the development and delivery of these training programmes.

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Health workforce diversity Refers to inclusion of persons with disabilities in the health care workforce. Note: In some countries, national legislation may be automatically considered/adopted as institutional policy, in which case these criteria will assess implementation in institutional plans and monitoring mechanisms.	Institutional policies or plans do NOT reference the inclusion of students and staff with disabilities.	Institutional policies or plans reference the inclusion of students and staff with disabilities. BUT There is NO reference to ensuring accessibility and reasonable accommodation.	Accessibility and reasonable accommodation for students and staff with disabilities is a criterion for accreditation of training and/or health service facilities. BUT There are NO mechanisms in place to monitor the inclusion of persons with disabilities in the health workforce.	Accessibility and reasonable accommodation for students and staff with disabilities is a criterion for accreditation of training and/or health service facilities. AND There ARE mechanisms in place to monitor the inclusion of persons with disabilities in the health workforce.

Strategic entry point 6. Physical infrastructure and communication

Indicators	Scoring criteria			
	1: Needs establishing	**2: Needs major strengthening**	**3: Needs minor strengthening**	**4: Needs no immediate action**
Accessibility of facilities *Refers to the physical accessibility of health facilities, including facility design and refurbishment, amenities, safety, transportation, sanitation and waste disposal, telecommunications connectivity, or power supply.*	There is NO legislation, policy, or standards in the country for health infrastructure to meet certain accessibility standards.	There is legislation, policy, or standards on accessibility of health infrastructure. BUT There are NO plans to progressively improve accessibility of health facilities.	There is legislation, policy, or standards on accessibility of health infrastructure. AND There ARE clear plans to progressively improve accessibility of health facilities.	There is legislation, policy, or standards on accessibility of health infrastructure. AND Plans to progressively improve accessibility of health facilities ARE being implemented and monitored.
Accessibility of health information and communication *Refers to persons with disabilities having access to all health information and communication provided in accessible formats (e.g. Braille, Easy-Read, captioning, sign language).*	Health information and communication is NOT produced in accessible formats (e.g. Braille, Easy-Read, captioning, sign language).	Some health information and communication are produced in accessible formats (e.g. Braille, Easy-Read, captioning, sign language). BUT There are NO standards or mechanisms to ensure accessibility of health information and communication.	Health information and communication ARE produced in accessible formats (e.g. Braille, Easy-Read, captioning, sign language). AND There ARE standards or mechanisms to ensure accessibility of health information and communication. BUT There is NO monitoring of implementation.	Health information and communication ARE produced in accessible formats (e.g. Braille, Easy-Read, captioning, sign language). AND There ARE standards or mechanisms to ensure accessibility of health information and communication. AND Implementation is being monitored in partnership with organizations of persons with disabilities.

Strategic entry point 7. Digital technologies for health

Note: N/A (not applicable) can be used where there are NO current or planned digital health services.

Indicators	Scoring criteria			
	1: Needs establishing	**2: Needs major strengthening**	**3: Needs minor strengthening**	**4: Needs no immediate action**
Accessibility of digital health technologies *Refers to the universal design of digital applications and software in line with international standards, such as the* Web Content Accessibility Guidelines (WCAG)*, or the WHO-ITU global standard on accessibility of telehealth services.*	Digital health services are NOT accessible to persons with disabilities. AND There are NO accessibility standards or features in place. AND Persons with disabilities are NOT consulted in the design and monitoring of digital health initiatives.	Standards on the accessibility of digital health technologies have been adopted. BUT There is NO plan for systematic implementation. AND Persons with disabilities are NOT consulted in the design and monitoring of digital health initiatives.	Standards on the accessibility of digital health technologies have been adopted. AND There is a plan for systematic implementation. BUT Persons with disabilities are NOT consulted in the design and monitoring of digital health initiatives.	Standards on the accessibility of digital health technologies have been adopted. AND There is a plan for implementation. AND Persons with disabilities ARE consulted in the design and monitoring of digital health initiatives.

Strategic entry point 8. Quality of care

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Care pathways and referral mechanisms *Refers to the availability of coordinated multidisciplinary care plans and the provision of an efficient and confidential referral system within and across facilities and levels of care.*	Care pathways and referral mechanisms do NOT consider the specific needs of persons with disabilities.	Care pathways and referral mechanisms do NOT consider the specific needs of persons with disabilities. BUT There are plans to strengthen referral mechanisms that recognize the needs of persons with disabilities.	Care pathways and referral mechanisms DO consider the specific needs of persons with disabilities. BUT Persons with disabilities report poor performance of these mechanisms.	Care pathways and referral mechanisms DO consider the specific needs of persons with disabilities. AND Persons with disabilities report good performance of selected mechanisms.

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Informed consent processes for persons with disabilities *Refers to processes which ensure that persons with disabilities, including persons with psychosocial and intellectual disabilities, have the same rights as any person in making their own decisions about their health care, in line with the Convention on the Rights of Persons with Disabilities.*	There are NO procedures in place to prevent the admission and treatment of persons with disabilities without their free and informed consent. AND There are NO procedures in place to ensure that persons with disabilities, including persons with psychosocial and intellectual disabilities, are enabled to provide informed consent (e.g. information provided in a way they can understand; supported decision-making approaches; and advance planning).	There ARE procedures in place to prevent the admission and treatment of persons with disabilities without their free and informed consent. BUT There are NO measures in place to enable persons with disabilities, including persons with psychosocial and intellectual disabilities, to provide informed consent (e.g. information provided in a way they can understand; supported decision-making approaches; and advance planning).	There ARE procedures in place to prevent the admission and treatment of persons with disabilities without their free and informed consent. AND There ARE measures in place to enable persons with disabilities, including persons with psychosocial and intellectual disabilities, to provide informed consent (e.g. information provided in a way they can understand; supported decision-making approaches; and advance planning). BUT These measures are implemented in a LIMITED way across the health sector (e.g. isolated training and guidance is provided, but are NOT YET integrated into workforce competencies and quality assurance mechanisms).	There ARE procedures in place to prevent the admission and treatment of persons with disabilities without their free and informed consent. AND There ARE measures in place to enable persons with disabilities, including persons with psychosocial and intellectual disabilities, to provide informed consent (e.g. information provided in a way they can understand; supported decision-making approaches; and advance planning). AND These measures are implemented in a comprehensive way across the health sector (e.g. integrated into workforce competencies and quality assurance mechanisms).

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Feedback, safeguarding and complaint processes *Refers to feedback and compliant processes, as well as safeguarding mechanisms, such as those which prevent and respond to discrimination, violence, sexual abuse, exploitation, and harassment.*	Standard feedback, safeguarding and complaint mechanisms are NOT accessible to persons with disabilities. AND Persons with disabilities are NOT aware of these mechanisms.	Standard feedback, safeguarding and complaint mechanisms include reasonable accommodation for persons with disabilities. BUT Persons with disabilities are either NOT aware of these mechanisms or report ongoing BARRIERS to accessing these mechanisms.	Standard feedback, safeguarding and complaint mechanisms include reasonable accommodation for persons with disabilities. AND Persons with disabilities ARE aware of these mechanisms. BUT They report some BARRIERS to accessing these mechanisms.	Standard feedback, safeguarding and complaint mechanisms include reasonable accommodation for persons with disabilities. AND Persons with disabilities ARE aware of these mechanisms. AND They report being able to access these mechanisms.

Strategic entry point 9. Monitoring and evaluation

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Population-based health surveys *Refers to the collection, analysis, and reporting of disability disaggregated data from population-based health surveys (e.g. Demographic and Health Surveys; WHO STEPS NCD surveillance; Multiple Indicator Cluster Survey).*	NO disability data are collected through the national health surveys.	Disability data ARE collected through national health surveys. BUT Disability-disaggregated data analysis is NOT being undertaken. AND These disability data are NOT used by the Ministry of Health for planning.	Disability data ARE collected through national health surveys. AND Disability-disaggregated data analysis is being undertaken. BUT These disability data are NOT used by the Ministry of Health for planning.	Disability data ARE collected through national health surveys. AND Disability-disaggregated data analysis is being undertaken. AND These disability data ARE used by the Ministry of Health for planning.
Routine health information systems *Refers to the routine collection, analysis, and reporting of administrative, institution and facility-based disability data in the health sector.*	NO disability data are collected through routine health information systems.	Some disability data ARE collected and recorded in the routine health information systems. BUT Data collection on disability is NOT systematic. AND Disability-disaggregated data analysis is NOT being undertaken.	Disability data ARE systematically collected through routine health information systems. BUT Disability-disaggregated data analysis is NOT being undertaken. AND These disability data are NOT used by the Ministry of Health for planning.	Disability data ARE systematically collected through routine health information systems. AND Disability-disaggregated data analysis is being undertaken. AND These disability data ARE used by the Ministry of Health for planning.

Strategic entry point 10. Health policy and systems research

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Disability inclusive health research agendas *Refers to national health research strategies and plans, including research on disability issues or relating to persons with disabilities.*	There are NO examples of research on the health of persons with disabilities. AND Health policy and systems research agenda in the country does NOT reference research on the health of persons with disabilities.	There ARE isolated examples of research on the health of persons with disabilities. BUT These research projects are NOT linked to the wider health policy and systems research agenda.	There ARE comprehensive examples of research on the health of persons with disabilities. BUT These research projects are NOT linked to the wider health policy and systems research agenda.	There ARE comprehensive examples of research on the health of persons with disabilities. AND These research projects ARE linked to the wider health policy and systems research agenda.

Indicators	Scoring criteria			
	1: Needs establishing	2: Needs major strengthening	3: Needs minor strengthening	4: Needs no immediate action
Disability inclusive health research processes Refers to disability inclusion in the health research guidelines and protocols adopted and implemented in the country and used for all health research projects.	National health research guidelines and protocols do NOT exist. AND Inclusion of persons with disabilities and/or disability are NOT considered in national health research guidelines and protocols.	The inclusion of persons with disabilities and/or disability ARE referenced in national health research guidelines and protocols. BUT Implementation is NOT enforced through institutional review boards.	The inclusion of persons with disabilities and/or disability ARE referenced in national health research guidelines and protocols. AND Implementation is enforced through institutional review boards. BUT Disability stakeholders, including organizations of persons with disabilities, are NOT participating in the design, implementation, and dissemination of mainstream health research.	The inclusion of persons with disabilities and/or disability ARE referenced in national health research guidelines and protocols. AND Implementation is enforced through institutional review boards. AND Disability stakeholders, including organizations of persons with disabilities, ARE participating in the design, implementation, and dissemination of mainstream health research.

Template for summary scores

Strategic entry point	Scores
1. Political commitment, leadership, and governance	
National health legislation and policy	
Health strategies and plans	
Governance and coordination	
2. Health financing	
Health benefits and insurance schemes	
Affordability of health services	
Social protection	
3. Engagement of stakeholders and private sector providers	
Engaging disability stakeholders	
Coordinating health service providers	
4. Models of care	
Health care packages	
Inclusive health service planning	
Health emergency preparedness and response	
5. Health and care workforce	
Health workforce competency	
Health workforce diversity	
6. Physical infrastructure and communication	
Accessibility of health facilities	
Accessibility of health information and communication	
7. Digital technologies for health	
Accessibility of digital health technologies	
8. Quality of care	
Care pathways and referral mechanisms	
Informed consent	
Feedback, safeguarding, and complaint processes	
9. Monitoring and evaluation	
Population-based health surveys	
Routine health information systems	
10. Health policy and systems research	
Disability inclusive health research agendas	
Disability inclusive health research processes	

Tool 9. Template for situation assessment report[3]

Acknowledgements

Contents

Acronyms and abbreviations

Executive summary

A summary of the report to include:

- an overview of current health sector priorities, including status of current strategic plan;
- scores for the Disability Inclusive Health System Assessment; and
- gaps and opportunities identified for strengthening disability inclusion across the 10 strategic entry points.

Introduction

An introduction of the report to include:

- an explanation of the background and rational for the situation assessment, including both the global and country perspectives;
- the links between health equity for persons with disabilities and international human rights frameworks, such as the Convention on the Rights of Persons with Disabilities; and global health goals, such as the health-related Sustainable Development Goals;
- a description of government commitments to improve health equity for persons with disabilities, and how this is aligned with national and subnational health sector policies, strategies, and plans; and
- an outline of the objectives of the *Disability inclusion guide for action*, and how the situation assessment contributes to this process.

Methodology

This should include a description of the methodology used for the situation assessment, including the range of stakeholders involved and consultation processes used. The section can be expanded from the guidance provided in Phase 2, highlighting how the methodology was adapted to the country context.

[3] *Note: Examples of Situation Assessment Reports from countries that have implemented the* Disability inclusion guide for action *can be sourced from the WHO website or by emailing:* disability@who.int.

Limitations

As with all assessments, there will be limitations which should be considered when reading the findings of the report. Limitations may include the following:

- The situation assessment was not designed to capture all activities being undertaken in the country to improve the health of persons with disabilities: rather it focuses on health system-level strategies, gaps, and opportunities to strengthen disability inclusion in the health sector.
- There are limitations in accessing data and information, and/or having documents available in appropriate formats and languages for the person undertaking the review.
- There is diversity in the population of persons with disabilities who are consulted through group discussions; and there may be underrepresented groups who may not have had equal opportunity to participate and share their perspectives in the situation assessment.

Country overview

- Present the basic information about the country, its population, socioeconomic situation, and relevant features.
- Provide an overview of key health issues faced by the wider population, including health emergencies and recognized health inequities (for example, between men and women, urban and rural populations, and perhaps among ethnic and religious groups).
- Describe the basic structure of the health system and high-level priorities outlined in the health sector strategic plan.

Disability prevalence

- Outline the existing disability prevalence data sources, which could include the national census, demographic health surveys or disability-specific surveys, such as the Model Disability Survey.
- Present the available data on the prevalence of disability, disaggregated by sex, age and functional limitation, and possibly geographical location.
- Highlight the potential gaps or limitations relating to disability prevalence data, such as the absence of prevalence data, pros and cons of the type of questions used, or where there may be substantially lower or higher prevalence rates than the global estimate.

Socioeconomic situation of persons with disabilities

- Outline the existing data sources which provide information about the socioeconomic situation of persons with disabilities – again, these could include the national census, demographic health surveys or disability-specific surveys, such as the Model Disability Survey.

- Present the available data on the socioeconomic situation of persons with disabilities, such as household income, literacy levels, and the person's education and employment status – disaggregated by sex, age, and possibly geographical location.
- Highlight the potential gaps or limitations relating to socioeconomic data, such as the absence of data on important factors, the pros and cons of the type of questions used, or the lack of disaggregation.

Situation assessment for 10 strategic entry points

This section presents the evidence upon which the Disability Inclusive Health System Assessment scores are based, including links to references and key documents, and quotes from persons with disabilities.

- Synthesize the data and information gathered in the situation assessment.
- Discuss the gaps and opportunities as related to each of the criteria for the 10 strategic entry points. Each entry point should have its own subsection allowing for easy navigation of the document for readers with interest in specific topics, and for future action planning activities.

Conclusion

- Bring together the main findings of the situation assessment, highlighting:
  - the strengths or opportunities relating to disability inclusion in the health sector;
  - the challenges and gaps which should be addressed in Phase 3; and
  - next steps in the *Disability inclusion guide for action* process.

Annexes

- List the resources included in the situation assessment.
- Provide the background information and materials about the *Disability inclusion guide for action* process and the Disability Inclusive Health Systems Assessment tool.

Tool 10. Template for action planning[4]

The Ministry of Health, with support from the World Health Organization, as needed, should facilitate a workshop with the Working Group to review the gaps and opportunities identified in the situation assessment; prioritize areas for action – taking into consideration the perspectives of persons with disabilities; and develop appropriate disability inclusion actions which can be integrated into current and emerging health sector priorities. The template provided below can be used to document the actions that will be taken by stakeholders during a defined period of time (usually aligned with the health sector strategic planning cycle), along with information about potential resources to support implementation. These resources may already be available through the Ministry of Health, existing projects, and contributions from stakeholders and partners. It may also be possible to resource the action plan through wider funding for the national strategic health plan, and/or within the budgets of specific sectoral/programme plans. Action areas proposed in the template reflect criteria in the Disability Inclusive Health System Assessment. However, Working Groups may develop actions for a selected number of action areas only, based on the prioritization process, available resources, and time frame.

[4] *Note: The Action Planning Template below shows only* **example** *actions, stakeholders, timelines and resources for each strategic entry point, under each Action area. Full action plans developed from countries that have implemented the* Disability inclusion guide for action *can be sourced from the* **WHO website** *or by emailing:* disability@who.int.

Strategic entry point 1. Political commitment, leadership and governance

Action area 1.1. Governance and coordination mechanism for disability inclusion in the health sector			
Actions	**Key stakeholders and their roles in each activity**	**Timeline**	**Resources available/needed**
EXAMPLE Establish a Disability Inclusion Technical Working Group to oversee and monitor disability inclusion in the health sector.	Ministry of Health: to coordinate the Disability Inclusion Technical Working Group, establish terms of reference, and formalize membership. Other Technical Working Group members: to identify representatives of their organizations, capacity-build, and allocate appropriate resources to ensure continuity and meaningful participation.	Year 1 and ongoing	**Resources available for**: • Ministry of Health and Technical Working Group member human resources. • Meeting venues provided by Technical Working Group member and partners. **Resources needed for**: • Transportation, sign interpretation and assistants for organizations of persons with disabilities members.

Action area 1.2. Disability inclusion in national health policies, strategies, and plans (NHPSP)			
Actions	**Key stakeholders and their roles in each activity**	**Timeline**	**Resources available/needed**
EXAMPLE Disability Inclusion Technical Working Group participates in NHPSP processes, including advocacy and inputs to further health planning that addresses their priority needs – e.g. rehabilitation and assistive technology planning.	Ministry of Health: to coordinate the Disability Inclusion Technical Working Group, and make sure it is referenced in concept notes relating to the strategic planning of the health sector. Other Technical Working Group members: to raise issues of health equity for persons with disabilities in other Technical Working Groups, policy and planning consultation processes, and in multisectoral coordination forums or bodies (e.g. national councils and committees on disability).	Years 2 & 3 after formation of the Technical Working Group	**Resources available for**: • Ministry of Health and Technical Working Group member human resources. • Meeting venues provided by Technical Working Group member and partners. **Resources needed for**: • Transportation, sign interpretation and assistants for members of organizations of persons with disabilities.

Strategic entry point 2. Health financing

Action area 2.1. Acceptable health insurance and benefits coverage for persons with disabilities			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Develop guidelines on how persons with disabilities should be considered in the development of universal health insurance scheme regulations and guidelines.	Disability Inclusion Technical Working Group: to develop the guidelines and present to the Technical Working Group on health financing and social protection.	Year 2	**Resources available for**: • Technical expertise through the Disability Inclusion Technical Working Group. **Resources needed for:** • None needed

Action area 2.2. Making health services affordable to persons with disabilities			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Review criteria for exemptions/ subsidies for different types of health services, taking into account the extent and complexity of health needs of persons with disabilities.	Ministry of Health, Ministry of Social Welfare, Ministry of Finance, and local government authorities responsible for service provision.	Year 1	**Resources available for**: • Staff time of ministries and local government authorities. • Technical expertise through the Disability Inclusion Technical Working Group. **Resources needed for**: • None needed

Action area 2.3. Social protection mechanisms consider associated costs of accessing health care			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Conduct an assessment of associated costs of accessing health care for persons with disabilities (e.g. transportation, interpreters, support people).	Ministry of Health, Ministry of Social Welfare, local government authorities: responsible for service provision.	Year 1	**Resources available for**: • Staff time of Ministry of Health, local government authorities and Ministry of Social Welfare. • Technical expertise through the Disability Inclusion Technical Working Group. **Resources needed for**: • Consultant for data collection and analysis.

Strategic entry point 3. Engagement of stakeholders and private sector providers

Action area 3.1. Strengthening engagement of disability stakeholders in health sector processes			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Develop strategies for consultation and engagement with underrepresented groups, such as women, children and young people with disabilities; persons with intellectual or psychosocial disabilities; and refugees with disabilities, on health sector actions.	National level organizations of persons with disabilities: to identify members from underrepresented groups who are interested in becoming focal points. Disability nongovernmental organizations: to provide capacity-building and training on health equity and the health system. Ministry of Health and other government departments: to invite representatives to consultations on health sector priorities.	Years 1 & 2	**Resources available for**: • Technical and training expertise through nongovernmental organizations. **Resources needed for**: • 2 trainings: 30 participants; 3 days for each training. • Transportation, sign interpretation and assistants for organizations of persons with disabilities members to attend training.

Action area 3.2. Coordinating health service providers			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Conduct a stakeholder mapping to determine who the private sector actors are in the country and establish regulatory/ reporting mechanisms on disability inclusion.	Ministry of Health: to coordinate the mapping and regulatory/reporting mechanism. Regulatory bodies: to support the implementation of the regulatory/reporting mechanism.	Year 3	**Resources available for**: • Technical expertise through disability nongovernmental organizations. **Resources needed for**: • Workshop with regulatory bodies to design mechanism. • Transportation, sign interpretation and assistants for organizations of persons with disabilities members to attend workshop.

Strategic entry point 4. Models of care

Action area 4.1. Disability inclusive health care packages			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Develop and cost the provision of rehabilitation, assistive products, and early identification and care for children with disabilities in the national essential services package.	Ministry of Health (Policy & Planning) and WHO: to prepare comprehensive assessments, e.g. labour market (including workforce) and service demand–supply studies. Disability Inclusion Technical Working Group: to review and provide feedback. Organizations of persons with disabilities and parents of children with disabilities: to share and validate service package with members.	Year 1–3	**Resources available for**: • Technical support from WHO and the Disability Inclusion Technical Working Group. • WHO's Rehabilitation in health systems: guide for action; Guide for rehabilitation workforce evaluation (GROWE), and Package of interventions for rehabilitation. **Resources needed for**: • Validation meeting: 1 day; 40 people.

Action area 4.2. Disability inclusive health service planning			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Include persons with disabilities and their families in community consultation and engagement plans for primary health care service development, especially persons with psychosocial disabilities and those living in rural and remote areas.	Ministry of Health & Local Government Authorities: to set criteria for representation of persons with disabilities in council health management and health facility governance committees. Organizations of persons with disabilities and disability nongovernmental organizations: to raise awareness about these mechanisms with persons with disabilities.	Year 2 & 3	**Resources available for**: • Technical expertise through the Disability Inclusion Technical Working Group. **Resources needed for**: • None needed

Action area 4.3. Disability inclusive health emergency preparedness and response			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Include persons with disabilities as a subpopulation in the upcoming simulation exercise which will inform revisions to the national health emergency preparedness plan.	Ministry of Health (Health emergency) and disability nongovernmental organizations: to develop simulation exercise tools and case studies. Organizations of persons with disabilities: to identify representatives with different types of impairments to participate in the exercise, and the debrief and reporting process.	Year 3	Resources available for: • Technical and training expertise through nongovernmental organizations. Resources needed for: • Transportation, sign interpretation and assistants for organizations of persons with disabilities members to attend exercise and meetings. • Funding for an Easy-to-Read summary of findings from the exercise and next steps.

Strategic entry point 5. Health and care workforce

Action area 5.1. Improving health workforce competency on disability inclusion			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Develop core competencies and training materials on disability inclusion for the health workforce (pre-service and in-service).	Ministry of Health (Human Resources Development: to establish expert group and integrate core competencies into annual training needs assessment. Disability Inclusion Technical Working Group: to link to existing training initiatives, tools, and resources on disability inclusion for the health sector. National Council for Technical and Vocational Education and Training: to ensure that competencies are included in all health care workforce curriculums. Academic institutions: to deliver health care workforce curriculum. WHO: can advise on global norms and standards relating to core competencies on disability inclusion.	Years 1 & 2	**Resources available for**: • Technical support from WHO. • Training tools and resources through the Disability Inclusion Technical Working Group. **Resources needed for**: • Expert group workshop to develop core competencies – 1 workshop; 30 participants; for 3 days. • Consultant to develop and test training materials. • Validation meeting – 30 participants; for 1 day. • Vendor to put training package online • (ensuring accessibility standards).

Action area 5.2. Including persons with disabilities in the health workforce			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Review accreditation criteria for health care training institutions and facilities to include reasonable accommodation students and staff with disabilities.	Ministry of Health (Quality Assurance) & health registration bodies: to provide information about audit and accreditation tools and resources. Disability nongovernmental organizations: to provide technical advice on the criteria to include audit and accreditation tools for health service providers and training institutions. Organizations of persons with disabilities: to consult (confidentially) with students and health professionals with disabilities about whether training institutions and service providers are meeting these criteria.	Years 1–3	**Resources available for**: • Technical support through the Disability Inclusion Technical Working Group. **Resources needed for**: • Transportation, sign interpretation and assistants for organizations of persons with disabilities members to attend meetings.

Strategic entry point 6. Physical infrastructure and communication

Action area 6.1. Improving accessibility of health facilities and infrastructure			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Review existing health infrastructure standards and guidelines to consider the needs of all persons with disabilities.	Ministry of Health (Building & Infrastructure Unit): to identify and review relevant infrastructure standards. Local government authorities: to prepare structural and architectural drawings (to be approved by the Ministry of Health). Ministry of Infrastructure Development: to interpret national policies and strategies relating to accessible infrastructure development. National building authority: to participate in the review of standards and guidelines. Disability nongovernmental organizations and organizations of persons with disabilities: to share guidelines on accessibility of infrastructure.	Year 1	**Resources available for**: • Technical expertise through the Disability Inclusion Technical Working Group. • Global standards and guidelines on accessible infrastructure. **Resources needed for**: • None needed

Action area 6.2. Improving accessibility of health information and communication			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/ needed**
EXAMPLE Develop and implement guidelines on accessible health information and communication, including provision of sign language interpreter services and information in accessible formats, such as Braille, Easy-Read and captioning.	Ministry of Health (Health Promotion & Government Communication Unit): to develop and adopt the guidelines and standards. Disability nongovernmental organizations and organizations of persons with disabilities: to share existing guidelines and standards on accessibility of information and communication. Local government authorities: to disseminate accessibility standards and guidelines to local planning bodies. Organizations of persons with disabilities: responsible for accessibility audits of health information and communication.	Year 1	**Resources available for**: • Technical expertise through the Disability Inclusion Technical Working Group. • Global standards and guidelines on accessible information and communication. **Resources needed for**: • Expert group workshop to develop guidelines. • Transportation, sign interpretation and assistants for organizations of persons with disabilities members conducting audits.

Strategic entry point 7. Digital technologies for health

Action area 7.1. Adopting standards on accessibility of digital health technologies			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Contextualize and implement the WHO–ITU global standard for accessibility of telehealth services.	Ministry of Health (Information Communication Technology): to coordinate this activity and integrating standards into the implementation of the Digital Health Strategy. National Digital Health Steering Committee/ National Digital Health Secretariat/Monitoring and Evaluation and Information Technology and Communication Technical Working Group: to integrate standards into the implementation of the Digital Health Strategy. Ministry of Information, Communication and Technology: to adopt standards and support implementation. Development Partners Group on Disability (DPG- Disability): to make implementation of the standards a donor requirement for any telemedicine and technology- based projects. Health technology partners (e.g. PATH): to implement the standards in health technology projects. Mobile telecommunication companies: to make telehealth services toll free. Digital Health Centre: to provide expertise and technological services for the implementation of the standards.	Year 1–3	**Resources available for**: • Digital health governance mechanisms already exist. • Availability of global standards. **Resources needed for**: • Workshop with stakeholders to contextualize standards: 1 workshop; 30 participants; for 1 day.

Strategic entry point 8. Quality of care

Action area 8.1. Disability inclusion in care pathways and referral mechanisms			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Identify priority care pathways to revise and strengthen multidisciplinary coordination, support and follow-up for persons with disabilities. Include organizations of persons with disabilities and parents of children with disabilities in consultation processes.	Ministry of Health (programmes): to identify care pathways and referral mechanisms being reviewed and consult with the Disability Inclusion Technical Working Group. Disability Inclusion Technical Working Group: to participate in consultation processes for any health care pathways and referral mechanisms being reviewed.	Years 2 & 3	**Resources available for**: • Technical expertise through the Disability Inclusion Technical Working Group. **Resources needed for**: • None needed.

Action area 8.2. Strengthening informed consent processes for persons with disabilities			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Review informed consent procedures and guidelines in line with Convention on the Rights of Persons with Disabilities (e.g. including measures such as accessible information and communication; and provision of supported decision-making).	Ministry of Health (quality assurance): to identify appropriate procedures and guidelines for review. Disability Inclusion Technical Working Group: to participate in consultation processes undertaken in the review process. Organizations of persons with disabilities: to facilitate engagement of underrepresented groups in consultation processes, with a focus on persons with psychosocial or intellectual disabilities. Disability support services: to provide links to supportive decision-making services (where available) and input on appropriate terminology and approaches. National human rights institutions: to provide guidance on alignment with human rights frameworks.	Years 2–3	**Resources available for**: • Technical expertise through the Disability Inclusion Technical Working Group. **Resources needed for**: • Workshop with stakeholders to review the informed consent procedures. • Production and dissemination of public awareness raising materials.

Action area 8.3. Disability inclusion in quality improvement systems			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/ needed**
EXAMPLE Review feedback systems at national and facility levels for accessibility, in line with standards developed under action area 6.2.	Ministry of Health (Health Quality Assurance): to coordinate this activity. PO-RALG and SHIVYAWATA: to share accessibility standards when undertaking the SRA pilot (activity 8.2.1).	Year 2	This activity intersects with action areas 6.2 and 8.1. No additional resources are required.

Strategic entry point 9. Monitoring and evaluation

Action area 9.1. Strengthening disability data collection, analysis and reporting through population health surveys			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Integrate questions on disability into the national Demographic and Health Survey (DHS).	Statistics offices and national health institutes: to adapt tools, integrate into training modules and run analysis. Disability Inclusion Technical Working Group: to participate in DHS meetings and advise on tool adaptations. Disability nongovernmental organizations: to provide training to DHS data collectors on disability. Ministry of Health: to include disability disaggregated analysis in population health reports.	Every 4 years with DHS	**Resources available for**: • DHS and disability data collection tools and technical resources. • WHO technical support and guidelines on disability data collection. • Other government ministries and departments – can contribute lessons learned from other forms of disability data collection and analysis in population health surveys. No additional resources are required.

Action area 9.2. Strengthening disability data collection, analysis and reporting through routine health information systems			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Adapt and pilot facility level data collection tools (for both administrative and service user data) to include questions on disability.	Ministry of Health (Health Information System Programme): to coordinate activity. Disability Inclusion Technical Working Group: to participate in workshops with Ministry of Health and advise on pilot locations. Disability nongovernmental organizations: to share lessons learned in disaggregating health information by disability. Local government and health facilities: to pilot data disaggregation and provide feedback. University partners: to make adaptations to appropriate tools and platforms.	Year 1	**Resources available for**: • DHIS2 tools and technical resources. • WHO technical support and guidelines on disability data collection. • Other government ministries and departments – can contribute lessons learned from other forms of disability data collection and analysis. **Resources needed for**: • Workshop with Ministry of Health and Disability Inclusion Technical Working Group: 1 workshop; 30 participants; for 2 days.

Strategic entry point 10. Health systems and policy research

Action area 10.1. Disability inclusive health research agendas			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Integrate research priorities relating to health equity for persons with disabilities into the National Health Research Agenda.	National Institute of Medical Research (Committee on Research Agenda): to coordinate activity. Disability Inclusion Technical Working Group: can contribute expertise on research gaps on health equity for persons with disabilities. Organizations of persons with disabilities: can share the priorities of persons with disabilities for health research based on their experiences as health service users.	Year 2	**Resources available for**: • Evaluation of current national research priorities already has indicators on inclusion of persons with disabilities. **Resources needed for**: • Transportation, sign interpretation and assistants for organizations of persons with disabilities members to participate in meetings.

Action area 10.2. Disability inclusive health research processes			
Actions	**Key stakeholders and their roles in each action**	**Timeline**	**Resources available/needed**
EXAMPLE Include a member with disabilities on the National Health Research Ethics Committee.	National Institute of Medical Research: to coordinate activity and drafting Terms of Reference (TOR). Disability Inclusion Technical Working Group: to provide feedback on TOR and selection process. Organizations of persons with disabilities: will share TOR/call for applications with members and persons with disabilities.	Year 1	**Resources available for**: • Technical expertise through the Disability Inclusion Technical Working Group. **Resources needed for**: • Reasonable accommodation for member with disabilities to attend monthly ethical review board meetings. • Orientation and training on ethics processes for new member.

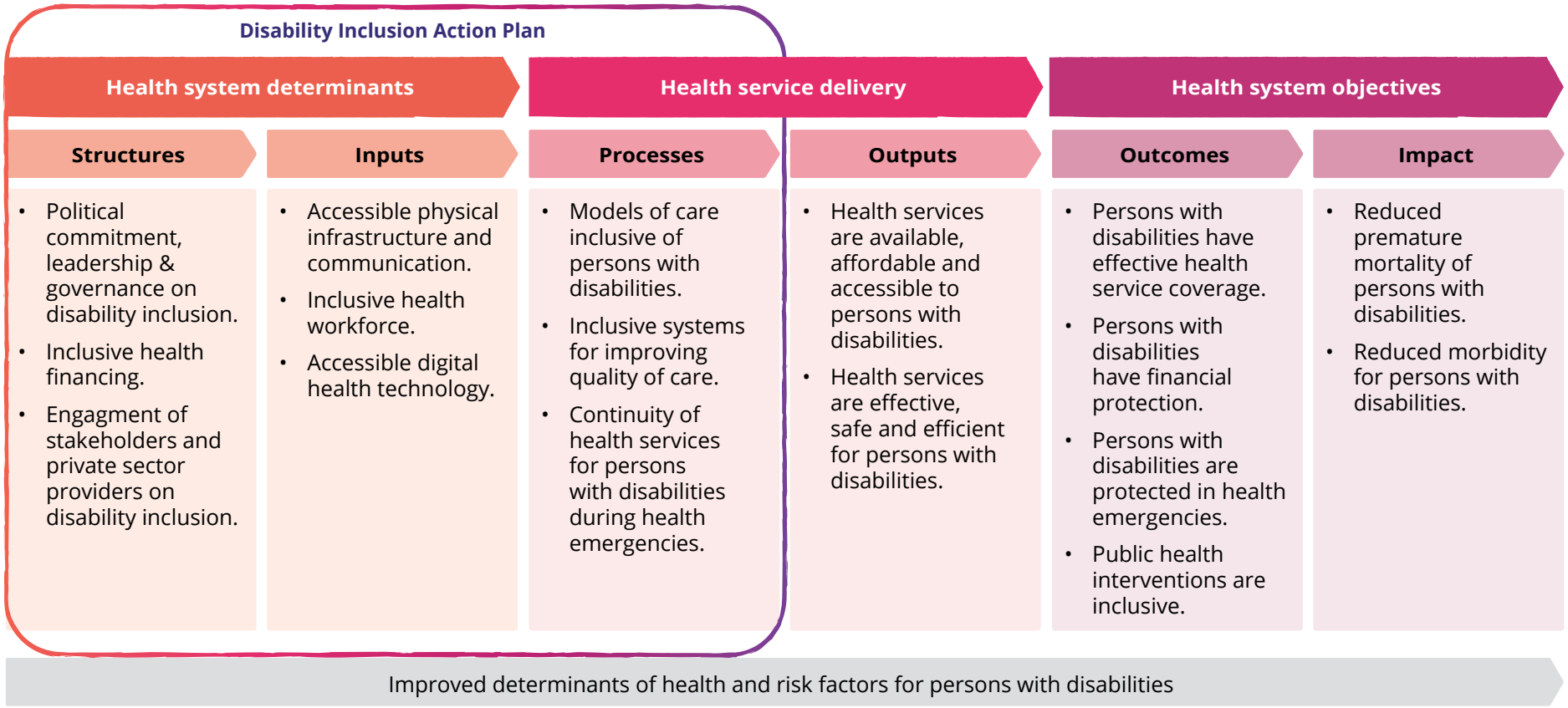
Tool 11. Menu of disability inclusive health indicators[5]

The Menu of Disability Inclusive Health Indicators is based on the following simplified results chain diagram, linking disability inclusive actions developed through the *Disability inclusion guide for action* process, with inputs, output, outcomes, and results in the Primary health care measurement framework and the global health indicators of the SDGs.

A note about terminology:

- **Structures/inputs/processes** are the actions needed to advance disability inclusion in the health sector.
- **Outputs** are the results of these actions on health service delivery – access and quality – for persons with disabilities.
- **Outcomes** are the intermediate effects of these actions and outputs on universal health coverage, health emergencies and public health interventions.
- **Impacts** are the long-term effects of these actions, outputs, and outcomes on health equity for persons with disabilities, measured through indicators relating to morbidity, mortality, and functional limitation.

[5] *Note: The Menu of Disability Inclusive Health Indicators will be reviewed periodically and updated as priorities evolve, and evidence of successful measurement methods grows. Additional guidance will also be developed to accompany the Menu of Disability Inclusive Health Indicators tool on selection of indicators, and how to identify baselines and targets.*


Disability Inclusion Action Plan
Health system determinants
Health service delivery
Health system objectives
Structures
Inputs
Processes
Outputs
Outcomes
Impact
• Political commitment, leadership & governance on disability inclusion.
• Inclusive health financing.
• Engagment of stakeholders and private sector providers on disability inclusion.
• Accessible physical infrastructure and communication.
• Inclusive health workforce.
• Accessible digital health technology.
• Models of care inclusive of persons with disabilities.
• Inclusive systems for improving quality of care.
• Continuity of health services for persons with disabilities during health emergencies.
• Health services are available, affordable and accessible to persons with disabilities.
• Health services are effective, safe and efficient for persons with disabilities.
• Persons with disabilities have effective health service coverage.
• Persons with disabilities have financial protection.
• Persons with disabilities are protected in health emergencies.
• Public health interventions are inclusive.
• Reduced premature mortality of persons with disabilities.
• Reduced morbidity for persons with disabilities.
Improved determinants of health and risk factors for persons with disabilities

Menu of indicators for country selection for monitoring disability inclusion in health

Countries are encouraged to first select a set of indicators from the menu, based on the action plan developed, and then select priority indicators, used for monitoring health outcomes and impact in the wider health sector monitoring framework. The proposed indicators are aligned with indicators for the primary health care (PHC) measurement framework, and Sustainable Development Goals (SDGs). As such, disability inclusion indicators can be integrated into wider health system monitoring frameworks (with appropriate adaptations to data collection methods).

Indicator tiers

Tier 1: Feasible to collect, monitor and track in most countries.

Tier 2: Considered desirable, but not necessarily feasible for all contexts, and in some cases requiring further development and testing.

Global: Smaller subset of indicators which are considered highly relevant for global reporting and monitoring.

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
Political commitment, leadership, and governance						
1	Disability inclusive national health policies, strategies and plans (NHPSPs)	Percentage of NHPSPs developed over defined time period with concrete actions on disability inclusion	Health system determinants – Structures	Tier 1 & Global	3[a] – Existence of national health policy oriented to PHC and universal health coverage (UHC) (Tier 1 & Global)	Qualitative assessment – *Disability inclusion guide for action:* disability inclusive health systems assessment
2	Governance mechanism on disability inclusion in the health sector	Existence of a focal point/ committee to oversee disability inclusion in the Ministry of Health	Health system determinants – Structures	Tier 1 & Global	Not applicable (N/A)	Qualitative assessment – *Disability inclusion guide for action:* disability inclusive health systems assessment
Health financing						
3	Disability inclusive health budgeting	Expenditure on disability inclusion in health (including reasonable accommodation, making health care facilities and services accessible)	Health system determinants – Structures	Tier 2	17 – Sources of expenditure on health (and PHC specific) (Tier 2)	National health accounts
4	Health insurance coverage among persons with disabilities	Percentage of women, men, and children with disabilities with any type of health insurance	Health system determinants – Structures	Tier 1	N/A	Demographic and Health Surveys (with disability disaggregation)

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
Engagement of stakeholders and private sector providers						
5	Multi-stakeholder coordination on disability inclusion	Existence of coordination mechanism to ensure disability inclusive health services	Health system determinants – Structures	Tier 1 & Global	7 – Coordination mechanisms with multistakeholder participation and community engagement (Tier 1 & Global)	Qualitative assessment – *Disability inclusion guide for action*: disability inclusive health systems assessment
6	Participation of persons with disabilities in health service decision-making	Existence of national, subnational, and local strategies for participation of persons with disabilities and their representative organizations in community decision-making on health services	Health system determinants – Structures	Tier 1 & Global	8 – Existence of national, subnational, and local strategies for community participation (Tier 2)	Qualitative assessment – *Disability inclusion guide for action*: disability inclusive health systems assessment
Accessible physical infrastructure and communication						
7	Standards and guidelines on accessible health facilities and services	Existence of accessibility standards or guidelines for health facilities and services	Health system determinants – Inputs	Tier 1 & Global	N/A	Qualitative assessment – *Disability inclusion guide for action*: disability inclusive health systems assessment

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
8	Health facilities are physically accessible	Percentage of health facilities that meet accessibility standards and guidelines	Health system determinants – Inputs	Tier 1	22 – Health facility density/distribution (including primary care) (Tier 1 & Global) 23 – Availability of basic water, sanitation, and hygiene (WASH) amenities (Tier 1 & Global)	Facility surveys
9	Health information and community are accessible	Percentage of health facilities which have health information and communication available in accessible formats, e.g. Braille, Easy Read, captioning, sign language	Health system determinants – Inputs	Tier 1	25 – Availability of communications (Tier 1)	Facility surveys
Inclusive health workforce						
10	Health worker training on disability inclusion	Percentage of accredited health training courses (pre- and in-service) with an appropriate disability inclusion module	Health system determinants – Inputs	Tier 1 & Global	28 – Accreditation mechanisms for education and training institutions (Tier 2) 29 – National systems for continuing professional development (Tier 2)	Qualitative assessment – *Disability inclusion guide for action:* disability inclusive health systems assessment

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
11	Health workforce diversity	Percentage of health workforce who identify as having a disability (disaggregated by sex, age, and type of role)	Health system determinants – Inputs	Tier 2	27 – Health worker density and distribution [SDG 3.c.1] (Tier 1 + Global)	National health workforce accounts (with disability disaggregation) Ministry of Labour databases
Accessible digital health technology						
12	Adoption of standards on digital accessibility	Existence of national level digital accessibility standards, aligned with international standards and guidelines	Health system determinants – Inputs	Tier 1 & Global	42 – National e health strategy (Tier 2)	Qualitative assessment – *Disability inclusion guide for action*: disability inclusive health systems assessment
13	Access to telemedicine services for persons with disabilities	Percentage of persons with disabilities reporting access to telehealth services (disaggregated by sex, age, and type of service)	Health system determinants – Inputs	Tier 2	43 – Telemedicine access (Tier 2)	Population-based health surveys (with disability disaggregation)
Models of care for persons with disabilities						
14	Inclusive essential health service package planning	Essential health service package includes rehabilitation and assistive products	Health service delivery – Processes	Tier 1 & Global	45 – Service package meeting criteria (Tier 1 + Global)	Qualitative assessment – *Disability inclusion guide for action*: disability inclusive health systems assessment

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
15	Proactive population outreach includes persons with disabilities	Percentage of community-based health service guidelines with concrete actions on disability inclusion	Health service delivery – Processes	Tier 1	58 – Proactive population outreach (Tier 1)	Qualitative assessment – *Disability inclusion guide for action*: disability inclusive health systems assessment
Inclusive systems for improving quality of care						
16	Disability inclusive quality improvement and safety planning at national levels	National policy, strategy, or plan for improvement of quality and safety includes concrete actions relating to the rights of persons with disabilities	Health service delivery – Processes	Tier 1 & Global	4 – Existence of policy, strategy, or plan for improvement of quality and safety (Tier 1 + Global)	Qualitative assessment – *Disability inclusion guide for action*: disability inclusive health systems assessment
17	Disability inclusive quality improvement mechanisms in health facilities	Percentage of facilities with disability integrated into systems to support quality improvement	Health service delivery – Processes	Tier 1	60 – Percentage of facilities with systems to support quality improvement (Tier 1)	Facility surveys
Continuity of health services for persons with disabilities during health emergencies						
18	Existence of strategies to maintain essential health services for persons with disabilities during health emergencies	National health emergency and disaster risk management strategy or plan includes concrete actions to ensure continuity of services and emergency-related health support for persons with disabilities	Health service delivery – Processes	Tier 2	5 – Existence of health emergency and disaster risk management strategies (Tier 2)	Qualitative assessment – *Disability inclusion guide for action*: Disability inclusive health systems assessment

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
Health services are available, affordable, and accessible to persons with disabilities						
19	Inclusive essential health service delivery	Percentage of health facilities implementing guidelines on disability inclusion in the essential health care package	Health service delivery – Outputs	Tier 2	66 – Percentage of facilities offering services according to national defined service package (Tier 1)	Facility surveys
20	Barriers to accessing health services	Perceived barriers to access (geographical, financial, sociocultural) for persons with disabilities	Health service delivery – Outputs	Tier 1 & Global	63 – Perceived barriers to access (geographical, financial, sociocultural) (Tier 1)	Demographic and Health Surveys (with disability disaggregation). Facility surveys (existing interviews)
Health services are effective, safe, and efficient for persons with disabilities						
21	Experience of care	(a) Percentage of persons with disabilities reporting satisfactory care	Health service delivery – Outputs	Tier 1	74 – Patient-reported experiences (Tier 1) 75 – People's perceptions of health system and services (Tier 2)	Patient surveys Facility surveys (exit interviews)
		(b) Percentage of complaints from persons with disabilities, disaggregated by sex, age and type of complaint	Health service delivery – Outputs	Tier 2	N/A	Complaints mechanisms (with disability disaggregation)

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
Improved determinants of health and risk factors for persons with disabilities						
22	Poverty	Percentage of persons with disabilities living below the international poverty line	Determinants of health and risk factors	Tier 1 & Global	Proportion of the population living below the international poverty line, by sex, age, employment status and geographical location (urban/rural) [SDG 1.1.1]	Demographic and Health Surveys (with disability disaggregation)
23	Social protection	Percentage of persons with severe disabilities receiving cash benefits, by sex	Determinants of health and risk factors	Tier 1	Proportion of population covered by social protection floors/systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims, poor and vulnerable populations [SDG 1.3.1]	SDG indicators database (ILO)

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
24	Education	Percentage of persons with disabilities accessing different levels of education, disaggregated by sex and age	Determinants of health and risk factors	Tier 1	Parity indices (female/male, rural/urban, bottom/top wealth quintile, and others such as disability status, Indigenous peoples and conflict-affected peoples, as data become available) for all education indicators on this list that can be disaggregated [SDG 4.5.1]	Multiple Indicator Cluster Survey and Demographic and Health Surveys (with disability disaggregation)
25	Employment	Percentage of persons with disabilities who are unemployed, disaggregated by sex and age	Determinants of health and risk factors	Tier 2	Unemployment rate, by sex, age, and persons with disabilities [SDG 8.5.2]	Demographic and Health Surveys (with disability disaggregation)
26	Health risk factors	Percentage of persons with disabilities who have tracer risk factors for poor health	Determinants of health and risk factors	Tier 2	Tracer risk factors: Child stunting/wasting/overweight [SDG 2.2.1/2.2.2] Tobacco use [SDG 3.a.1] Prevalence of hypertension Prevalence of diabetes Obesity (adults and children)	Demographic and Health Surveys (with disability disaggregation)

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
Persons with disabilities have effective health service coverage						
27	Health service coverage for persons with disabilities	Percentage of persons with disabilities receiving tracer health service interventions, disaggregated by sex and age	Health system objectives – Outcomes	Tier 1 & Global	Service intervention coverage for:	Household surveys Health information management systems
Tracer	Timing and number of antenatal care visits	Percentage of women with disabilities who had a live birth and/or stillbirth in the 2 years preceding the survey who received antenatal care 4 or more times	Health system objectives – Outcomes	Tier 2	Antenatal care (ANC) coverage, at least 4 visits (ANC4)	Demographic and Health Surveys (with disability disaggregation)
Tracer	Skilled birth attendance	Percentage of women with disabilities who had live births and/or stillbirths in the 2 years preceding the survey and delivered by a skilled provider	Health system objectives – Outcomes	Tier 1 & Global	Skilled birth attendance [SDG 3.1.2]	Demographic and Health Surveys (with disability disaggregation)
Tracer	Modern family planning methods	Percentage of women with disabilities who have their demand for family planning satisfied by modern methods	Health system objectives – Outcomes	Tier 1 & Global	Family planning demand satisfied with modern methods [SDG 3.7.1]	Demographic and Health Surveys (with disability disaggregation)

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
Tracer	Childhood vaccination	Percentage of children with disabilities who were fully vaccinated (according to national schedule), disaggregated by sex and age	Health system objectives – Outcomes	Tier 1 & Global	Child immunization coverage [SDG 3.b.1]	Demographic and Health Surveys (with disability disaggregation)
Tracer	HIV testing	Percentage of persons with disabilities who report having been tested for HIV and received the test results, disaggregated by sex and age	Health system objectives – Outcomes	Tier 2	Not in PHC or SDG framework but is in Demographic and Health Survey	Demographic and Health Surveys (with disability disaggregation)
Tracer	Antiretroviral (ART) coverage	ART coverage among persons with disabilities living with HIV, with viral load suppression, disaggregated by sex and age	Health system objectives – Outcomes	Tier 2	HIV ART	National AIDS control programme
Tracer	Cervical cancer screening	Percentage of women with disabilities tested by a doctor or health care worker for cervical cancer	Health system objectives – Outcomes	Tier 2	Cervical cancer screening	Demographic and Health Surveys (with disability disaggregation)
Tracer	Hypertension screening and treatment	(a) Percentage of persons with disabilities who have had their blood pressure measured by a doctor or other health-care worker, disaggregated by sex and age	Health system objectives – Outcomes	Tier 2	Not in PHC or SDG framework but is in Demographic and Health Survey	Demographic and Health Surveys (with disability disaggregation)

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
Tracer		(b) Percentage of persons with disabilities who have been told by a doctor or other health worker that they have high blood pressure or hypertension and are prescribed medication to control the condition, disaggregated by sex and age	Health system objectives – Outcomes	Tier 2	Hypertension treatment coverage	Demographic and Health Surveys (with disability disaggregation)
Persons with disabilities have financial protection						
28	Catastrophic health expenditure	Percentage of persons with disabilities who live in households with catastrophic health expenditure and/ or impoverishing health spending compared to those without disabilities	Health system objectives – Outcomes	Tier 1 & Global	Proportion of population with large/impoverishing household expenditure on health as share of total household expenditure of income [SDG 3.8.2]	Household budget surveys Household income and expenditure surveys Household socioeconomic and living standards surveys
Persons with disabilities are protected in health emergencies						
29	Emergency vaccination	Percentage of persons with disabilities who receive routine and emergency vaccines, compared to those without disabilities	Health system objectives – Outcomes	Tier 1 & Global	Routine/emergency vaccine coverage [SDG 3.b.1]	Routine health information systems (with disability disaggregation)

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
30	Emergency health interventions	Percentage of persons with disabilities who receive emergency-related interventions compared to those without disabilities	Health system objectives – Outcomes	Tier 2	N/A	Routine health information systems (with disability disaggregation)
Public health interventions are inclusive						
31	Public health intervention coverage for persons with disabilities	Percentage of persons with disabilities who receive tracer public health interventions, disaggregated by sex and age	Health system objectives – Outcomes	Tier 2	Tracer public health interventions: • Use of insecticide-treated nets • Population with basic-drinking water services	Demographic and Health Surveys (with disability disaggregation)
Reduced premature mortality of persons with disabilities						
32	Life expectancy at birth	Life expectancy at birth in years for women and men with disabilities	Health system objectives – Impact	Tier 1	Life expectancy	Civil registration\ medical certification of cause of death (with disability disaggregation) Routine health information systems (with disability disaggregation) Household and population surveys (with disability disaggregation)

No	Indicator	Definition	Results chain level	Indicator tier	Alignment with primary health care (PHC)/Sustainable Development Goal (SDG) indicators	Potential data source
33	Maternal mortality ratio	Number of maternal deaths during a given time period per 100,000 live births during the same time period	Health system objectives – Impact	Tier 1	Maternal mortality rate [SDG 3.1.1]	Needs changes to census or Demographic and Health Survey questionnaires or Maternal Death Surveillance and Reporting system
34	Mortality due to noncommunicable diseases (NCDs)	Number of maternal deaths during a given time period per 100,000 live births during the same time period	Health system objectives – Impact	Tier 1	Probability of premature death from NCDs [SDG 3.4.1]	Civil registration\ medical certification of cause of death (with disability disaggregation) Routine health information systems (with disability disaggregation)
Reduced morbidity for persons with disabilities						
35	Health conditions due to avoidable causes	Percentage of persons with disabilities who acquire tracer avoidable conditions, disaggregated by sex and age	Health system objectives – Impact	Tier 1 & Global	Tracer avoidable conditions: New HIV infections [SDG 3.3.1] TB incidence [SDG 3.3.2] Malaria incidence [SDG 3.3.3] Hepatitis B infections [SDG 3.3.4]	Surveillance systems (with disability disaggregation)

[a] *Note: The numbers of the indicators correspond to the* PHC measurement framework *indicator number*

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