

Technical Note for World Bank Task Teams

Disability-Inclusive Health Care Systems



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Note:

The following document is a Technical Note for Task Teams and Task Team Leaders (TTLs) on disability-inclusive health care systems. The note provides the rationale for disability inclusion, information and examples on disability-inclusive practices and operations, and specific guidance on integrating disability into health system programming supported by the World Bank.

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Contents

List of boxes	ii
List of figures and tables	ii
Executive summary	1
Section 1: Background on disability and technical note.....	9
Section 2: The problem - key issues for persons with disabilities in health systems.....	14
Section 3: A framework for considering disability-inclusive health	24
Section 4: Awareness raising on need for disability inclusion in the health system.....	31
Section 5: Actions for task teams to promote disability inclusion in the health system.....	38
Conclusion	47
Appendix 1: Key terminology.....	48
Appendix 2: Measuring disability and disaggregating data by disability	50
Appendix 3: Missing billion health system assessment	52
Appendix 4: Good practice examples	58
Appendix 5: Monitoring disability-inclusive health.....	60
References	62

List of boxes

Box 1: Health systems that are disability-inclusive work better for all	13
Box 2: Disability inclusion will support the attainment of other health goals. Example HIV/Aids	19
Box 3: Legal and policy context for disability-inclusive health	20
Box 4: How is disability already embedded in the World Bank context?	21
Box 5: Identification of persons with disabilities, including early identification of children with disabilities	29
Box 6: Stakeholder engagement with persons with disabilities	30
Box 7: The World Bank’s Disability Inclusion and Accountability Framework.....	31
Box 8: World Bank specific examples on disability inclusion in health programming.....	36
Box 9: Learning from the Hygiene Behaviour Change Coalition (HBCC) COVID-19 Hygiene Hub projects.....	45

List of figures and tables

Figure 1: Examples of health issues experienced by persons with disabilities across the life course	15
Figure 2: Example health outcomes among persons with disabilities	17
Figure 3: Missing Billion Health Systems Framework	25
Table 1: Approaches for overall health system strengthening for disability-inclusion	27
Table 2: Potential metrics and measures for monitoring	60

Executive Summary

The objective of this Technical Note is to provide task teams and task team leaders (TTLs) with tools for designing and delivering health care services that are inclusive of disability. More specifically, the ambition of this Technical Note is to improve awareness and skills of TTLs and other World Bank employees toward recognizing the rights of persons with disabilities to receive equitable health care from the outset, to help drive demand from governments, and to identify concrete actions to promote disability-inclusion in health service delivery. The guide provides the rationale for disability inclusion, tips for engaging in dialogue, information and examples on disability-inclusive practices and operations, and specific guidance on integrating disability into health service programming and delivery supported by the World Bank.

I. Background on disability

“Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.” (The UN Convention on the Rights of Persons with Disabilities, United Nations 2006).

Disability-inclusive health systems have the capacity to provide physical access, health information, good quality and affordable health care services that meet the needs of persons with disabilities. Strengthening health systems to be inclusive of persons with disabilities makes them work better for all (see Box 1 as well).

Globally, there are at least one billion persons with disabilities – equating to 15 percent of the population. Persons with disabilities are more likely to be poor and face a wide range of exclusions, including from health, education, employment, and social participation (WHO 2011¹, UN 2018²).

II. Key issues for persons with disabilities in health systems

On average, persons with disabilities have worse health because of their exclusion in health services and underlying health conditions/impairments. They experience three broad categories of health care needs to varying extents:

1. **Routine health care services**, including preventive (e.g., vaccination), promotive (e.g., health messaging), and curative care (e.g., emergency services, noncommunicable disease treatment).
2. **Additional general health services** because of their, on average, poorer health status
3. **Specialist services** for impairments, including specialist medical treatment (e.g., ophthalmology), rehabilitation services, and assistive products.

However, persons with disabilities frequently face a range of barriers accessing health care (e.g., accessibility, affordability, and attitudinal). Consequently, persons with disabilities have higher mortality and worse health outcomes than persons without disabilities, including from COVID-19, as demonstrated in the figure below.

Example outcomes...		
Diabetes 3 x more likely	Malnourished and die as a child 2 x more likely	COVID-19 update: “a case in point”
Catastrophic health expenditure 50% more likely	HIV / AIDS 2 x more likely	
Seriously ill as a child 10 x more likely	Health system reason for low life expectancy 40% of cases	Mortality 2-3x more likely

Sources: Missing Billion - access to health services for 1 billion people with disabilities. Report, 2019; M. Bosworth et al. 2021; “Deaths involving COVID-19 by self-reported disability status during the first two waves of the COVID-19 pandemic in England: a retrospective, population-based cohort study” in *The Lancet Public Health*.

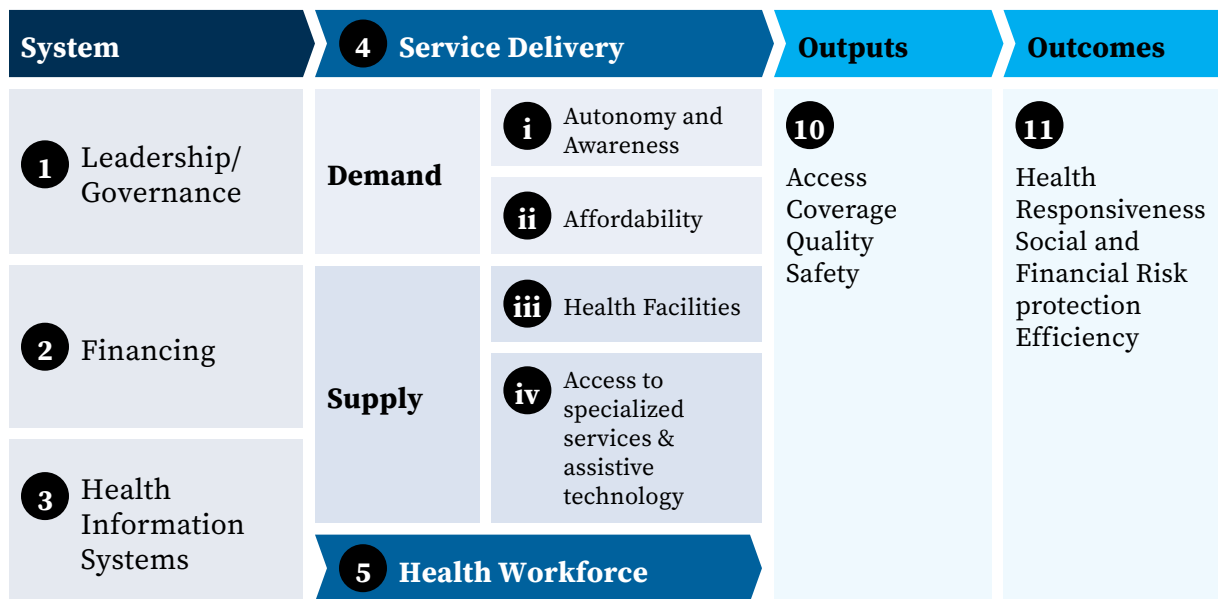
1 WHO and The World Bank. 2011. “World Report on Disability.” World Health Organization, Geneva. <https://www.who.int/teams/noncommunicable-diseases/sensory-functions-disability-and-rehabilitation/world-report-on-disability>

2 UN 2018. “UN Flagship Report on Disability and Sustainable Development Goals.” United Nations, New York. <https://www.un.org/development/desa/disabilities/publication-disability-sdgs.html>

In the World Bank context, the delivery of disability-inclusive health services is therefore important to:

- Maximize the human capital and quality of life of persons with disabilities and their families;
- Support achievement of Sustainable Development Goal 3, Universal Health Coverage (UHC), and other health goals;
- Realize the right to health of persons with disabilities; and
- Produce optimal health services that work better for everyone.

Globally, improvements are needed at the system level, as well as service delivery, considering both the demand side (i.e., persons with disabilities) and supply side (i.e., health services). These improvements will lead to more effective service coverage and ultimately better health status of persons with disabilities. This framework is described in the figure below.



Adapted from the [Missing Billion Health Systems Framework](#) and the WHO’s Health System Framework (“building blocks”)

III. Awareness and capacity building on disability-inclusive health services

To counter limited or lack of awareness, the first step is to build internal and client capacity and generate awareness of the benefits of disability inclusion—two key points here are:

- a. disability-inclusive health services not only enable persons with disabilities access to health care, which gives a boost to their potential for human capital accumulation, and
 - b. disability inclusion helps to strengthen health systems by improving service delivery capacity, quality of services, and accessibility of services.
- 3.1 Task teams should approach** projects from a **disability-inclusive lens** that encompasses disability-inclusive health service strengthening, in alignment with the Environmental and Social Framework (ESF) and the World Bank’s Disability Inclusion and Accountability Framework.

Specifically, task teams should consider the following key principles during the project planning and development stage, here summarized as a “**15%-INCLUDE-List-To-Remember:**”

- **15%:** In any given country approximately 15 percent of the population are persons with disabilities.
- **Investigate:** Be curious and understand the situation of persons with disabilities and their need for and access to health services
- **Nudge:** Instigate discussions with country stakeholders and governments on this topic; ask questions (see lines of argumentation and conversation openers under resources in this document)
- **Consultation:** Consult persons with disabilities on their experiences in the health sector
- **Leverage:** Include persons with disabilities at all steps of project design and implementation, and learn from their input to make the solutions better for all
- **US dollars:** Inclusion needs budget (but investing in disability-inclusive services is likely to produce services that are better for all). Interventions must be identified and costed
- **Design:** A twin-track approach to disability inclusion is considered in designing any interventions (mainstreaming of routine health services and targeted programming for persons with disabilities, for example., specialist services)
- **Evaluation:** Inclusion needs to be monitored and evaluated and ensure that the results framework has appropriate Indicators to measure disability inclusion.

3.2 Task teams can also raise awareness to generate demand in government for disability-inclusive health services

There is often a need for governments to understand both why and how to include disability issues in their planning processes. It can easily be dismissed as being something that is not of priority concern, as being too expensive, and/or a specialist concern.

Potential TTL actions:

- Offer a strong **rationale** for why disability inclusion matters when engaging with government representatives (e.g., arguments on rights and policies, economic impact of exclusion, importance of disability-inclusion to achieve human capital, and other World Bank goals, such as the International Development Association [IDA]20 commitments)³
- Drive a **step-by-step approach** to inclusion: 1) Raise interest (e.g., consult with persons with disabilities); 2) Develop a fact base for the country (e.g., health system assessment for persons with disabilities); and 3) Act (e.g., fund specific projects on disability-inclusion).

3 <https://ida.worldbank.org/en/replenishments/ida20-replenishment>



IV. Actions for TTLs to promote disability inclusion in the delivery of health services

TTLs have a key role to play in supporting the inclusion of disability in World Bank health activities.

Key actions:

Focused on Country Management Unit (CMU) and Global Practice (GP) Management

4.1 Develop a section on disability in Systematic Country Diagnostics (SCDs) and Country Partnership Framework.

Potential TTL and/or CMU actions:

- Include persons with disabilities as an “at risk” population, where appropriate
- Strongly signal the importance of disability inclusion throughout documentation
- Provide key statistics on disability and/or disaggregate data presented by disability
- Reach out to the Global Disability Advisor’s team for review/consultation
- Consult with persons with disabilities in developing the SCD
- Ensure that the procurement of health care supplies is disability-inclusive
- Highlight how disability inclusion fits within the World Bank’s twin goals, Environmental and Social Standard 10 of the ESF, the human capital project, IDA policy, and other disability-related commitments.

4.2 Incorporate disability into health system assessments

Potential TTL and/or GP actions:

- Include disability-inclusive health language in the Terms of Reference
- Incorporate disability into any technical assistance on health system assessments (TTL)
- Initiate assessment of disability inclusiveness of country health systems (through advisory services and analytics)
- Provide technical assistance to conduct assessments that specifically examine disability-inclusion within the health system (e.g., Appendix 3)
- Organize accessible consultations with persons with disabilities/organizations of persons with disabilities about barriers and opportunities to inform health system assessment content

As a best practice, documentation should include:

- Data on the prevalence of disability and additional health needs
- A description of the barriers facing persons with disabilities in accessing health services and how these can be addressed
- The importance of using a twin-track approach in health service delivery

Focused on Project Preparation and Design

4.3 Design health projects that are disability-inclusive and equitable

Using the table below, TTLs can help guide this process at different stages of health project development, with specific examples given for possible actions at each step and a key set of indicators suggested to monitor progress.

Step	Objective	Example of Action
Identification	Raise the topic of disability, analyze and highlight relevant data, and consider specific inclusion of disability in identification document(s)	Encourage inclusion of disability as a major or second order issue (e.g., Togo UHC project – stakeholder engagement recognizes persons with disabilities as a vulnerable group)
Concept note	Promote disability inclusion in the project through the twin-track approach (i.e., ensure access to mainstream services and provide targeted services where needed)	Include key statistics on the health of persons with disabilities. Articulate how interventions support disability inclusion, and/or include a specific intervention on disability inclusion, e.g., wheelchair ramps at health facilities.
Preparation	Refine the project plan to ensure disability inclusion	As per ESS10 on stakeholder engagement, include persons with disabilities in accessible consultations on the project design and implementation plan, covering their costs (e.g., travel, support services, and disclosure of information in appropriate formats)

Implementation	Ensure implementation is inclusive of persons with disabilities and monitor inclusion	<ul style="list-style-type: none"> • Provide staff training and capacity development on inclusion for persons with disabilities • Ensure facilities and equipment are accessible • Include budget line for reasonable accommodations (e.g., Togo UHC project—funding for accessible facilities) • Assess disability in client population to monitor inclusion
Completion and evaluation	Evaluate disability inclusion and distill lessons learned for future projects.	Evaluate project's reach, effectiveness, and impact on persons with disabilities

Good practice examples—ranging from government disability and health strategies to individualized interventions for people with intellectual disabilities—are shared in the document to provide inspiration and ideas for action.

Conclusion

Persons with disabilities make up 15 percent of the global population, or one in seven people worldwide. Evidence clearly shows that they are consistently left behind by health systems leading to the experience of adverse health outcomes. World Bank task teams and TTLs have a transformative role to play in the creation and support of disability-inclusive health systems.

Such systems will:

- improve the human capital and quality of life of individuals
- help realize the rights to health care for persons with disabilities
- support the achievement of World Bank twin goals, as well as global health and other goals
- reduce economic losses to individuals, health systems, and governments
- produce health systems that work better for all

Given the importance of this topic, a critical next step is to develop a monitoring agenda to track progress and developments. While it is challenging to find data on disability-inclusive health metrics, there are proxy indicators and tags that could be defined to start this agenda.

Section 1: Background on Disability and Technical Note

What is disability?

The UN Convention on the Rights of Persons with Disabilities states that “*Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.*” (United Nations 2006). There is, therefore, a distinction between an impairment (e.g., visual loss) and the experience of exclusion (i.e., disability). Persons with disabilities are an extremely diverse group and include people with different genders, ages, income levels, impairment types, and levels of disability.

How common is disability?

Globally, there are approximately one billion persons with disabilities, constituting 15 percent of the world’s population. (World Bank and WHO 2011) The limited available data (from 2004) shows that disability is approximately equally prevalent across World Health Organization (WHO) regions (high income countries: 15 percent; low- and middle-income countries—Africa: 15 percent; Americas: 14 percent; Southeast Asia: 16 percent; Europe: 16 percent; Eastern Mediterranean: 14 percent; Western Pacific: 15 percent). Overall, 80 percent of persons with disabilities live in low- and middle-income countries (World Bank and WHO 2011). The number of persons with disabilities is set to increase in the future because of population aging, unsafe living environments (e.g., car crashes, occupational hazards), and the rising prevalence of noncommunicable conditions, such as diabetes and stroke. This

trend may be further accelerated by climate change (e.g., injuries after extreme climatic events) and the emergence of new infectious diseases (e.g., long COVID-19). Ultimately, almost everyone is likely to experience some form of disability— temporary or permanent— at some point in their lives.

What challenges do persons with disabilities experience?

Persons with disabilities are not a monolith. Do they do face a wide range of barriers across sectors, including in health, education, transportation, social protection, and more, so that they are more likely to be excluded from these domains. For instance, they are 50 percent more likely to experience catastrophic health expenditures (World Bank and WHO 2011). These exclusions are a violation of their rights and hamper efforts to achieve the Sustainable Development Goals (SDG) and other development targets (e.g., UNAIDS' HIV targets). Such exclusions fails to support their human capital potential and contributes to poverty, both for individuals and at the national level (Banks and Polack 2014).

Objectives and Rationale of the Technical Note

The objective of this Technical Note is to provide task teams and task team leaders (TTLs) with tools for designing and delivering health care services that are inclusive of disability. More specifically, the ambition of this Technical Note is to improve awareness and skills of TTLs and World Bank staff toward ensuring that persons with disabilities receive equitable health care from the outset, to help drive demand from governments, and to identify concrete actions to promote disability inclusion in health service delivery. The guide provides the rationale for disability inclusion in health systems, tips for engaging in dialogue, information and examples on disability-inclusive practices and operations, and specific guidance on integrating disability into health service programming and delivery supported by the World Bank.

This Technical Note focuses on the challenges in terms of achieving good health care service delivery. The overarching rationale is that the provision of disability-inclusive health services, including through World Bank projects, is important to:

1. Maximize the human capital and quality of life of persons with disabilities and their families. Access to health is an important part of enhancing people's human capital through better health outcomes and the capacity to participate in society to their fullest potential. Persons with disabilities often lack access to basic services, including appropriate and timely health care, which puts them at a greater disadvantage, especially in lower- and lower-middle-income countries. Ensuring disability-inclusive health systems can

help reduce barriers to health care, allowing persons with disabilities to seek timely and affordable health care and have better health outcomes and greater engagement in other areas (e.g., school and employment) and thereby help to maximize their human capital.

2. Support achievement of [Sustainable Development Goal](#) (SDG) 3, which calls for ‘ensuring healthy lives and promoting well-being for all at all ages’; Universal Health Coverage (UHC), which supports SDG3 through promoting access and affordability of health service; as well as other health goals.
3. Produce optimal health services that work better for everyone (Box 1).

The costs of inclusion are likely to be low; for instance, if disability is incorporated in planning from the start, then the additional costs of accessibility are generally less than 1 percent of total construction costs (Metts 2000; Steinfeld 2005).

What are the challenges identified for disability-inclusive health programs?

Disability inclusion is often implicitly a focus within health programming, such as for UHC or the World Bank’s focus on health equity and the Human Capital Project’s goal of investing in equity and growth for all. However, an explicit focus on disability inclusion remains elusive.



A series of interviews with seven World Bank Group TTLs identified four common reasons that disability inclusion is not mainstreamed into World Bank health projects:

1. Limited or lack of demand for disability inclusion from clients when approaching financing for health or Advisory Services and Analytics (ASA) from the World Bank.
2. Prioritization of other issues, such as gender and climate change, rather than disability in an environment of competing demands for limited development resources.
3. Lack of a strong perceived push or guidance from within the World Bank to focus on disability-inclusion. Lack of clarity on what value-added interventions the World Bank can offer its clients.
4. Perception that disability inclusion is expensive and complex, with a lack of guidance and expertise about how it can be achieved. This Technical Note aims to address these concerns and suggest actions.

Notes on the Scope of this Technical Note:

- The focus of this Technical Note is on inclusion of persons with disabilities in health care interventions financed by the World Bank.
- While health services are the primary focus, it should be noted that:
 - a. Primary prevention of impairments (e.g., road traffic safety programs, quality of maternal health care) is an important priority of many health and nutrition programs, including those supported by the World Bank. However, this is beyond the scope of this Note, except that, persons with disabilities should be included in these services.
 - b. Health care is only one aspect required to maximize the human capital of persons with disabilities. Other programs (e.g., education, employment, social protection, and community-based rehabilitation) are also important. Disability inclusion in these programs is therefore rightly a focus for the World Bank but is beyond the scope of this Note.
- Health systems are commonly defined as the organization of people, institutions, and resources that deliver health care services to meet the health needs of a target population. The focus of this Note is on the components most directly designed/ influenced/controlled by the health sector (e.g., health facilities, health workforce) rather than broader factors (e.g., transport systems, social determinants of health). Many of these other social determinants of health for persons with disabilities (i.e., inclusive education, social protection, etc.) are addressed through the respective Global Practices (GPs) with guidance and coordination from the Social, Sustainability, and Inclusion GP's Disability Inclusion Team.

Box 1: Health systems that are disability-inclusive work better for all

Strengthening health systems to be inclusive of persons with disabilities makes them work better for all. For instance:

- Improving physical accessibility of buildings and equipment will facilitate access of older people, people with short-term impairments or illnesses, pregnant women, etc.
- Improving informational accessibility will help people who do not speak the dominant language.
- Training health professionals to understand disability diversity will increase their knowledge of and sensitivity toward other types of diversity (e.g., ethnicity, sexuality, and gender identity).
- Provision of rehabilitation will be helpful for people with short-term impairments and chronic illnesses.

Strengthening disability inclusion in the health system is likely to be cost-effective. Conversely, there is a cost of doing nothing:

- Most changes are likely to be low-cost. For instance, the cost of accessibility is generally less than 1 percent of total construction costs (Metts, 2000).
- Providing timely and accessible care to persons with disabilities will save money otherwise needed for expensive treatment of later stage conditions. For instance, a study in the UK showed that providing rehabilitation for people with complex neurological disabilities produced substantial savings in ongoing care costs, especially in high-dependency patients (Turner-Stokes et al. 2016). Similar results were obtained in Ireland for people with brain injuries (Cooney and Carroll 2016).
- Persons with disabilities are likely to be more economically productive if they have good access to health care (Banks and Polack 2014).

Section 2: The Problem – Key Issues for Persons with Disabilities in Health Systems

Disability inclusion in health systems is important, since persons with disabilities often have worse health outcomes and higher health care needs, yet face significant barriers to accessing services. Consequently, persons with disabilities have worse health outcomes, on average, including with respect to COVID-19 (Bosworth et al. 2021; Kuper and Heydt 2019; World Bank and WHO 2011).

What are the health care needs of persons with disabilities?

Persons with disabilities have the same health needs as persons without disabilities and may have additional needs that are specific to their impairment. Persons with disabilities experience worse health, on average, for a variety of reasons, including their: i) underlying health conditions and/or impairments; ii) higher levels of poverty, exclusion, and deprivation; and iii) poorer access to and quality of health care (Hashemi et al. 2020; Kuper and Heydt 2019; World Bank and WHO 2011). Many persons with disabilities also require access to specialist services for their impairments (e.g., physiotherapy, audiology).

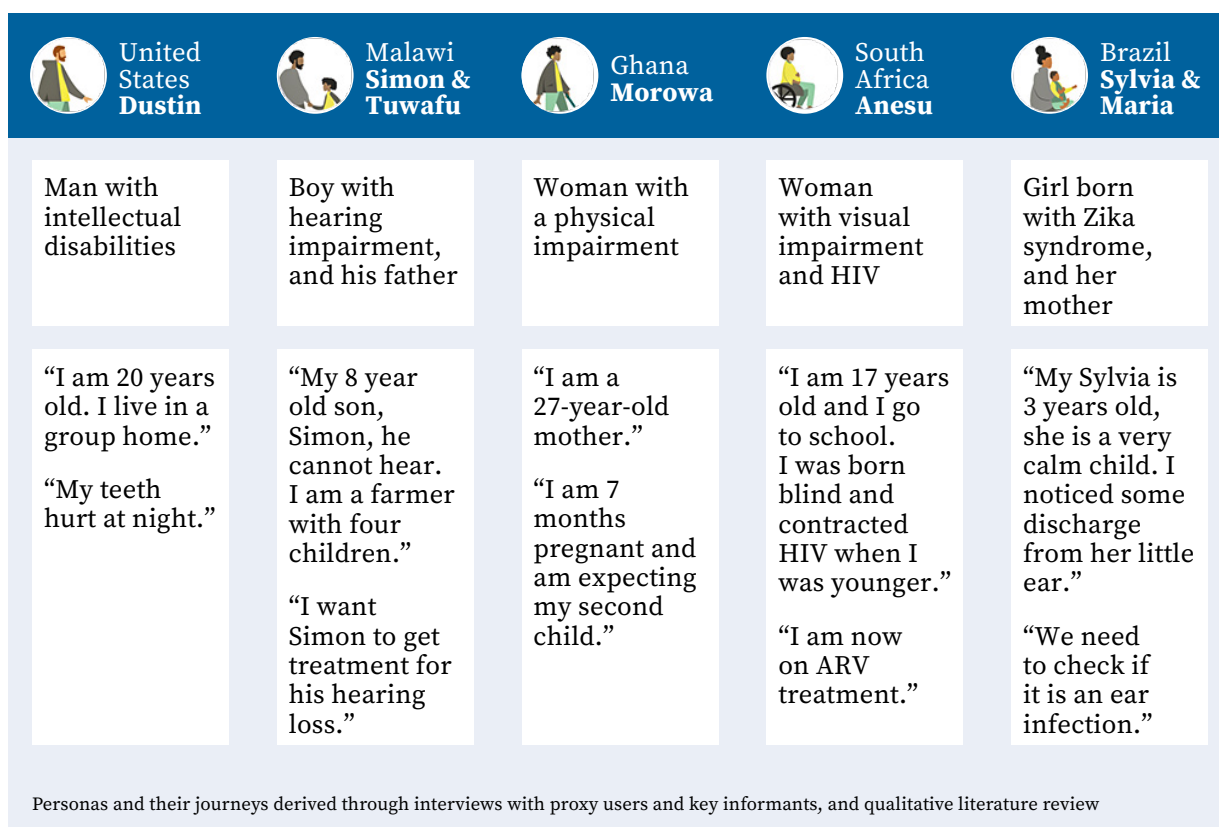
Consequently, persons with disabilities experience three broad categories of health care service needs to varying extents:

1. **Routine health care services**, including preventive (e.g., vaccination), promotive (e.g., health messaging), and curative care (e.g., emergency services, noncommunicable disease treatment).

2. **Additional general health services** because of their, on average, poorer health status
3. **Specialist services** for impairments, including specialist medical treatment (e.g., ophthalmology), rehabilitation services, and assistive products.

Persons with disabilities are not a homogenous group and intersectional variables, such as gender, location, and impairment type, will influence health care needs as exemplified in Figure 1. Moreover, disabilities can arise across the life cycle and the health care needs of children, adolescents, young adults, and older adults with disabilities will vary as demonstrated in these examples.

Figure 1: Examples of health issues experienced by persons with disabilities across the life course



Source: The Missing Billion — access to health services for 1 billion people with disabilities. Report, 2019.

What challenges do persons with disabilities face in accessing health care services?

Persons with disabilities face a range of challenges in accessing health care services (Hashemi et al. 2020; Kuper and Heydt 2019), despite their greater need, including:

- **Accessibility**
 - **Environmental accessibility** — e.g., health facilities and equipment are often not physically accessible.

- **Informational accessibility** — e.g., information and online services may not be accessible (e.g., lack of easy-to-read information, sign language interpretation).
- **Availability** — e.g., frequent lack of rehabilitation service availability.
- **Affordability** — e.g., incur higher out-of-pocket payments (e.g., payment for accessible transport or for expenses of caregiver) (Mitra et al. 2017).
- **Attitudinal barriers** — e.g., face stigma and discrimination by families who may not prioritize their needs and/or health care professionals who may make assumptions about what persons with disabilities need or may consider that they do not need certain services (e.g., sexual and reproductive health services).
- **Quality** — e.g., healthcare workers may have limited information and training about disability.
- **Legal** — e.g., persons with disabilities may be denied the choice of treatment or the legal capacity to make decisions about their care.

Again, intersectional factors will influence the types of barriers people experience. For instance, women with disabilities may face double discrimination both because of being female and disabled, and this may become a “triple” jeopardy if they also live in a low-resource setting (Astbury and Walij 2013). In studies from the United States, Lesotho, and Swaziland, for example, women with disabilities are up to two times more likely to have pre-term birth and low-weight babies (Mitra et al. 2015; Eide and Jele 2011; Kamaleri and Eide 2010). Life course factors are also important; children with disabilities may face particular barriers since they are less able to make their own health care decisions, while older persons with disabilities may be de-prioritized for health care services by themselves, families, or care providers.

Health systems failures are the root cause of barriers persons with disabilities face when accessing services. These include:

- **Governance:** Laws, policies, and national plans are not always: 1) in place to protect the rights of persons with disabilities; 2) developed in collaboration with persons with disabilities, or with persons with disabilities in mind; and/or 3) implemented, monitored, and enforced.
- **Leadership:** Lack of dedicated roles and responsibilities at national and local levels in the health sector (e.g., dedicated responsibility for disability, representation of disability in national coordination bodies), as well as awareness and skills to address disability inclusion in existing leadership structures.
- **Health financing:** Lack of funding or financing (e.g., insufficient funding available for adjustments and specific services such as assistive technology (AT), lack of mechanisms to address affordability issues).

- **Data and evidence:** Lack of disaggregated routine health data and operational evidence (e.g., monitoring indicators).

What are the implications for health outcomes of persons with disabilities?

As a result of these (aforementioned) health systems limitations, persons with disabilities experience poorer health outcomes. These are summarized in Figure 2.

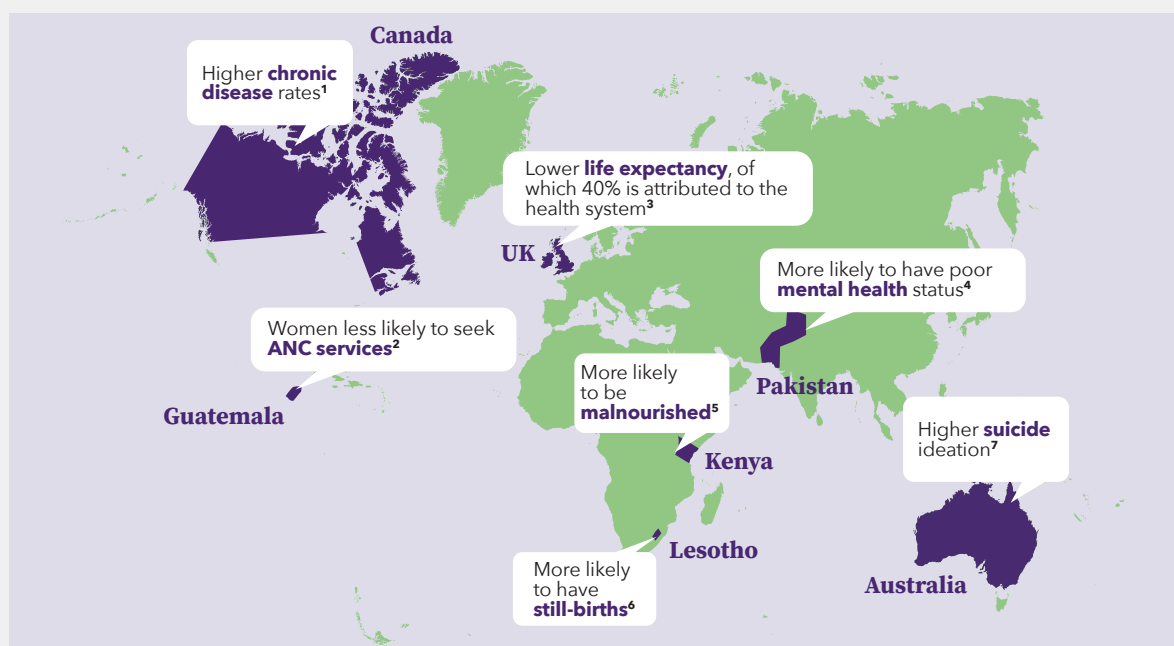
Figure 2: Example health outcomes among persons with disabilities

Example outcomes...		
Diabetes 3 x more likely ¹	Malnourished and die as a child 2 x more likely ²	COVID-19 update: “a case in point” ⁷
Catastrophic health expenditure 50% more likely ³	HIV / AIDS 2 x more likely ⁴	
Seriously ill as a child 10 x more likely ⁵	Health system reason for low life expectancy 40% of cases ⁶	
		Cases 2-3x more likely
		Mortality 2-3x more likely

Sources: Missing Billion - access to health services for 1 billion people with disabilities. Report, 2019; M. Bosworth et al. 2021; “Deaths involving COVID-19 by self-reported disability status during the first two waves of the COVID-19 pandemic in England: a retrospective, population-based cohort study” in *The Lancet Public Health*.

- 1 A. Reichard, H. et al, “Health disparities among adults with physical disabilities or cognitive limitations compared to individuals with no disabilities in the United States”, *Disability and Health Journal*: WHO, “ Model Disability Survey: General Results Ziarat District, Balochistan Province, Pakistan.” Geneva: 2018, WHO. “Model Disability Survey: General Results Sri Lanka. Geneva: 2019.
- 2 M. Kerac et al, “Follow Up of Past - Discharge Growth and Mortality after Treatment for Severed Acute Malnutrition: A Prospective Cohort Study”, *PLoS One*; H. Kuper et al, “Malnutrition and Childhood Disability in Turkana, Kenya: Results from a Case - Control Study: *PLoSOne*
- 3 World Health Organization, “World Report on Disability”, 2011
- 4 P. DeBeaudrop et al, “Disability and HIV: a systematic review and a meta analysis of the risk of HIV infection among adults with disabilities in SSA”, *AIDS Care*
- 5 H. Kuper, A. et al. “The Impact of Disability on the Lives of Children: Cross- Sectional Data Including 8,900 Childrn with Disabilities and 898,834 Children without Disabilities across 30 Countries”, *PLoS One*
- 6 University of Bristol, Annual Report, the Learning Disabilities Mortality Review Programme
- 7 For example: M. Bosworth et al. 2021; “Deaths involving COVID-19 by self-reported disability status during the first two waves of the COVID-19 pandemic in England: a retrospective, population-based cohort study” in *The Lancet Public Health*.

... from all parts of the world



Sources: Missing Billion - access to health services for 1 billion people with disabilities. Report, 2019; M. Bosworth et al. 2021; “Deaths involving COVID-19 by self-reported disability status during the first two waves of the COVID-19 pandemic in England: a retrospective, population-based cohort study” in *The Lancet Public Health*.

- 1 A. Reichard, H. et al, “Health disparities among adults with physical disabilities or cognitive limitations compared to individuals with no disabilities in the United States”, *Disability and Health Journal*
- 2 Kuper H. et al, “Can we achieve universal health coverage without a focus on disability? Results from a national case-control study in Guatemala”, *PLoS One*
- 3 University of Bristol, Annual Report, the Learning Disabilities Mortality Review Programme
- 4 World Health Organization, Model Disability Survey Pakistan
- 5 Kuper H et al, “Malnutrition and Childhood Disability in Turkana, Kenya: Results from a Case-Control Study”, *PLoS One*
- 6 Kamaleri Y et al “Living Conditions among People with Disabilities in Lesotho A National Representative Study”, *SINTEF Technology and Society: Global Health and Welfare*
- 7 Australian Institute of Health and Welfare, “Health of Australians with disability, health status and risk factors”

The consequences of poor health and lack of health care for persons with disabilities are:

1. Failure to maximize the human capital and quality of life of persons with disabilities and their families, since good health is a precursor to many areas of engagement (e.g., school, employment, community life)
2. Sub-optimal health services for all (Box 1, p. 13)
3. Difficulties in achieving SDG 3 and other health goals (Box 2, p. 19)

4. Lack of compliance in domestic law and achievement of fundamental human rights (Box 3, p. 20)

For these reasons, the importance of disability inclusion in health is supported by World Bank documentation and policies (Box 4, p. 21).

Box 2: Health goals cannot be achieved without disability inclusion: the case of HIV/AIDS in Zimbabwe

Zimbabwe has made remarkable progress in its fight against HIV, making UN 95:95:95 target appear achievable (see Table below). However, without ensuring persons with disabilities have improved access to, and can afford healthcare, Zimbabwe will not be able to achieve its target. On average, 25 percent of people with HIV have disabilities (L. M. Banks et al. 2015). This means that for a hypothetical group of 1,000 people with HIV, 250 will have disabilities. Assuming conservatively that persons with disabilities in Zimbabwe are 10 percent less likely to be tested, access treatment, or continue antiretroviral therapies (ARTs) to allow viral suppression, outcomes are consistently worse for persons with disabilities. For each indicator, persons with disabilities make up at least one in three people for whom the target is not met. The closer the goal is to being met (e.g., the percent of people on HIV treatment), the greater the proportion of persons with disabilities among those for whom the target is not met. This example illustrates how HIV-related goals will be difficult to reach without a focus on disability. However, a similar argument could be made with respect to malaria, COVID-19 vaccination, cancer screening, or other health targets.

Table: HIV, disability and the achievement of the UNAIDS 95:95:95 goals

Population Group	Number	Know HIV status	On HIV treatment	Virally suppressed
Total (current Zimbabwe estimates)	1000	900 (90%)	846 (94%)	728 (86%)
Disabled	250	209 (84%)	182 (87%)	145 (80%)
Not disabled	750	691 (92%)	664 (96%)	583 (88%)
Target not met		100	54	118
Percent disabled		41%	50%	31%

Box 3: Legal and policy context for disability-inclusive health

Four important documents outline the legal and international policy context for disability-inclusive health:

- [*UN Convention on the Rights of Persons with Disabilities*](#): Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD) sets out parameters for disability-inclusive health and the right to the highest attainable standard of health without discrimination. Article 26 of the UNCRPD confirms the right to rehabilitation and assistive technologies. Other relevant articles include Article 5 (Equality and non-discrimination), Article 9 (Accessibility), Article 12 (Equal recognition before the law), and Article 14 (Liberty and security of person). One hundred eighty-six states have ratified the CRPD, and many have national, regional, and/or local laws to implement these articles.
- The **Sustainable Development Goals (SDGs)**: SDG 3 aims to “Ensure healthy lives and promote well-being for all at all ages” (emphasis added) and is therefore clearly relevant to persons with disabilities. Moreover, it includes the target to achieve Universal Health Coverage (UHC), meaning that the full range of necessary quality health services (including rehabilitation) are available for the whole population, without incurring financial risk. The 2019 [political declaration](#) of the high-level meeting on UHC explicitly acknowledges the need to include persons with disabilities in efforts toward UHC.
- The **World Health Assembly (WHA)** Resolution [EB148.R6](#) advances “The highest attainable standard of health for persons with disabilities” and was adopted by the 74th World Health Assembly in 2021. It prioritizes: 1) ensuring access to health services; 2) protection during health emergencies; 3) access to public health interventions; and 4) disability data.
- The **Declaration on UHC following the UN High-level Meeting** in September 2020 includes the requirement to “increase access to health services for all persons with disabilities, remove physical, attitudinal, social, structural and financial barriers, provide quality standard of care and scale up efforts for their empowerment and inclusion, noting that persons with disabilities... continue to experience unmet health needs.”

Box 4. How is disability already embedded into the World Bank context?

The World Bank's overall twin goals to end extreme poverty and boost shared prosperity will ultimately have transformative impacts on persons with disabilities around the world, who often experience higher rates of poverty; social exclusion; limited access to affordable, accessible, and quality health care; and poor health outcomes.

Key World Bank documents that address disability inclusion:

- The [World Bank Directive on Addressing Risks and Impacts on Disadvantaged or Vulnerable Individuals or Groups](#) outlines directions to minimize risks and impacts for disadvantaged or vulnerable individuals or groups under the ESF, including persons with disabilities.
- [World Bank Group Commitments on Disability-Inclusive Development](#) describes the World Bank Group's 10 commitments on disability inclusion.
- [Disability Inclusion and Accountability Framework](#) provides a roadmap for disability inclusion and elaborates principles for inclusion, including health-sector-specific activities.
- [Environmental and Social Framework \(ESF\)](#) is a risk-mitigation tool that includes disability as a cross-cutting theme. Disability inclusion is particularly important under the following Environmental and Social Standards (ESSs): ESS1, ESS2, ESS4, and ESS10.
- Numerous tools and guidance notes that exist to support the implementation of the Disability Inclusion and Accountability Framework and ESF:
 - [Good Practice Note on Non-Discrimination and Disability \(GPN\)](#), which outlines key steps across the project cycle to make sure World Bank projects are accessible to persons with disabilities.
 - [Human Capital and Disability](#), a publication that describes why disability inclusion is key to achieving human capital, emphasizing the role of health.

Importance of Disability Inclusion to Human Capital:

Human capital—the knowledge, skills, and health that people accumulate over their lives—is a central driver of sustainable growth and poverty reduction. The Human Capital Project is a global effort and World Bank flagship agenda to accelerate more and better investments in people for greater equity and economic growth. Health systems have a particular role to play in human capital attainment for persons with disabilities, since responsive, equitable, and inclusive health systems ensure adequate care for primary impairments and co-morbidities that can improve the quality of life of individuals. Barriers to health care may have a direct impact on the capacity of a person with a disability to attend school, work, and fulfil their potential. By tackling inclusion in the health sector, these barriers can be reduced to allow persons with disabilities the opportunity to attain the highest possible human capital.

Disability Inclusion under IDA in Health, Nutrition, and Population work:

- In recent years there has been growing recognition of disability Inclusion within the International Development Association (IDA). Both the IDA 19 and IDA 20 funding cycles Include policy commitments toward disability Inclusion.
 - Under IDA 19, Policy Commitment 3 reads “support improvements in social sector service delivery with a focus on addressing the differential constraints faced by men and women, boys and girls, and by people with disabilities.”
 - The IDA 20 policy commitment aims “to promote inclusive societies, support at least 18 IDA countries to meet the needs of persons with disabilities by implementing the principles of non-discrimination, inclusion, and universal access as per the ESF, through projects in education, health, social protection, water, urban, digital development and/or transport.”
- The Health, Nutrition, and Population Global Practice has developed brief Technical Notes on Disability inclusion to guide staff on implementing and measuring these commitments.
- [Disability Inclusion and Accountability Framework](#) Section 9 looks at disability-inclusive health care and specific health projects that are disability-inclusive.

Walking the Talk—Reimagining Primary Health Care After COVID-19:

The World Bank released a new agenda-setting document to stress that a robust and reimagined Primary Health Care (PHC) agenda, as part of a broader reinvigoration of UHC, must be part of the post-COVID story. It calls for four structural shifts in how PHC is designed, financed, and delivered: 1) From dysfunctional gatekeeping to quality, comprehensive care for all; 2) From fragmentation to person-centered integration; 3) From inequities to fairness and accountability; and 4) From fragility to resilience. Not considering persons with disabilities and their experienced barriers in the health sector will, by definition, lead to a failure to deliver on any of these shifts. World Bank disability-specific projects:

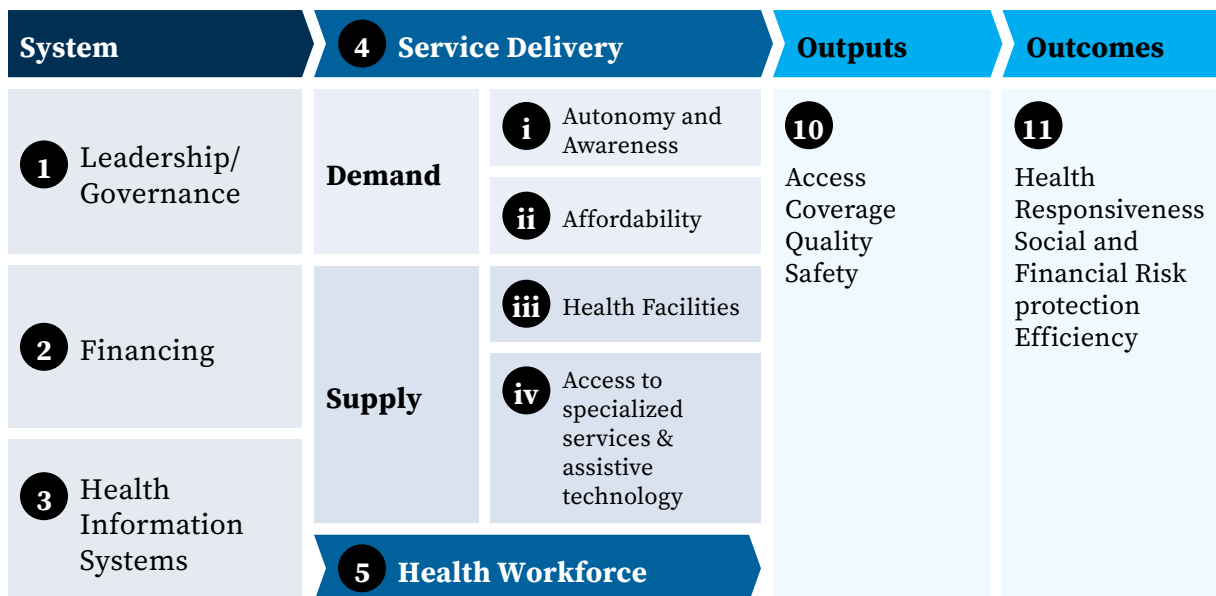
The World Bank has an existing track record in focusing projects on persons with disabilities. Some examples are:

- [Treating River Blindness](#): World Bank, WHO, African governments, pharmaceutical firms, and development partners protected 100 million people per year from river blindness in 31 African countries during a 40-year partnership, which is now closed.
- [Emergency demobilization and transitional reintegration project](#) (P113506) in Burundi included a specific focus on disability.
- [Tamil Nadu Empowerment and Poverty Reduction Project](#) (P150395) in India included a specific mental disability project implemented in 578 villages.

Section 3: A Framework for Considering Disability-Inclusive Health

Health care systems need to adapt to better meet the needs of persons with disabilities, and the World Bank has an important role in supporting this change. Improvements are needed at the system level, as well as in service delivery, considering both the demand side (i.e., persons with disabilities) and the supply side (i.e., health services) that will lead to more effective service coverage and better health status of persons with disabilities. The Missing Billion Framework is one such framework that provides key entry points for disability inclusion in the health system. The framework is aligned with the WHO's Health Systems Framework using the building blocks of health care. This framework is described in Figure 3.

Figure 3: Missing Billion Health Systems Framework



Adapted from the [Missing Billion Health Systems Framework](#) and the WHO’s Health System Framework (“building blocks”)

These health system improvements can be achieved through a **“twin-track approach”**:

- ensuring persons with disabilities are included in mainstream services by removing barriers on the demand and supply side; and
- provision of specific services to meet the unique health needs of persons with disabilities.

Table 1 provides example interventions for overall health system strengthening towards disability-inclusion. Making these changes will contribute to building health systems that work better for all, not just persons with disabilities (as discussed earlier in Box 1, p. 13).



Table 1: Example interventions for overall health system strengthening for disability-inclusion

Health System Aspect	Overall objective	Actions at different health system levels			
		Mainstream interventions	Disability-specific and specialised services	Disease-specific example: HIV	Disease-specific example: COVID-19
Governance/ leadership	Policies and laws support the right to health care for persons with disabilities	Disability included in health-related policies and plans	Rehabilitation specified as essential health service	Disability included in National Strategic Plan on HIV and AIDS	Planning for persons with disabilities for COVID-19 vaccination and other action plans
Health Financing	Budgets are available for disability inclusion (e.g. accessibility) and provision of rehabilitation and specialist services	MoH budget lines to support disability inclusion	MoH budget for rehabilitation and assistive technology (AT)	Budget included for HIV-related rehabilitation	Budget for disability inclusion in COVID-19 funding
Data and Evidence	Data is available on inequities in relation to disability and service availability	National disability survey undertaken (e.g., UNICEF MICS)	National assessment of assistive technology and/or rehabilitation capacity Rehabilitation metrics in HMIS	Data on disability prevalence among people living with HIV	COVID-19 mortality/hospitalization data disaggregated by disability

Autonomy and Awareness	Persons with disabilities are identified, provided with accessible health information and supported to seek care needed	Health information provided in alternative formats (e.g., braille, sign language) Early identification and referral of persons with disabilities	Advocacy on right to rehabilitation Provision of referrals to rehabilitation services	Peer counselling on HIV to persons with disabilities Linking people with HIV to mental health and rehabilitation services, as needed	Support to caregivers on preventing COVID-19 infection Identification and referral of people with long COVID
Human Resources	Health workers have awareness and skills to treat persons with disabilities. Rehabilitation/ specialist workforce is available	Disability awareness and skills training for health care workers	Rehabilitation workforce available	HIV health care workers trained on disability	Care home staff trained on COVID-19 prevention
Health Facilities	Health facilities and equipment are accessible, and outreach services are provided as needed	Health facilities are accessible to people with a range of impairments	Outreach services are provided for rehabilitation	Home based rehabilitation for people with HIV	COVID-19 vaccination sites are accessible

Throughout the project cycle, consideration needs to be given towards the identification of persons with disabilities to include them in health services, in particular children with disabilities who can most benefit from early intervention (Box 5). Furthermore, it is vital to consult with persons with disabilities, which can be through working with national and international organizations of persons with disabilities (OPDs) (Box 6).

Box 5: Identification of persons with disabilities, including early identification of children

The identification of persons with disabilities is a key concern for health care providers focused on better serving and including this group. Children with disabilities, or children at high risk of disability, are often a priority, since early identification will support early intervention and consequently better developmental outcomes. Different strategies can be used to support self-referral to health services:

Strategy for identification	Examples
School/pre-school screening	School-based hearing and vision screening of children
Routine health service screening	Neonatal hearing screening at birth Early years developmental checks of children
Disease-specific screening	Regular screening of people with diabetes (e.g., for visual or physical impairments)
Case finding	Key Informant Method to identify children with disabilities Screening camps (e.g., for people with visual impairment)
Household surveys	Large-scale surveys of vision, hearing, or other impairments
Routine data sources	Disability allowance beneficiaries, children registered with special learning needs, diagnosis of specific conditions in medical records, or health insurance form (e.g., Down's Syndrome).

Register	Register of people with specific impairments (e.g., learning disability register in the UK).
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It is essential that projects that identify persons with disabilities also provide appropriate health care or referrals to ensure the continuity of care.

Box 6: Stakeholder engagement with persons with disabilities

Persons with disabilities are a key population that are required to be part of stakeholder engagement processes, as they are best placed to advise on the challenges and barriers that they face in accessing services.

Several practical points to consider for consultations:

1. Persons with disabilities are not a homogenous group. They include people with diverse impairment types, genders, ages, and so on. It is important, therefore, to consult with a broad range of persons with disabilities.
2. Organizations of persons with disabilities are in place in most client countries and at the international level. They can assist in making consultations more disability inclusive. Good practice is to bring them on as consultants.
3. Persons with disabilities should be consulted about disability-related issues but also included in more general discussions.
4. Engaging and establishing relationships with organizations of persons with disability from the onset is very important. For example, health sector projects in the Philippines and Ghana sought out meaningful inputs during COVID-19 from local disability organizations (Box 8). These consultations were facilitated by the well-established relationships in place prior to the emergency.
5. Disability-inclusive budgeting and planning are needed for these consultations. Venues for the consultations and the process must be accessible to ensure the participation of persons with disabilities. This requires advance planning to ensure there is sufficient budget available to cover transportation costs, accessible venues, and the use of communication support (such as sign interpreters, large print materials, etc.).

Section 4: Awareness Raising for Disability Inclusion in the Health System

Interviews with TTLs highlighted that a common reason for lack of disability inclusion in health projects is lack of awareness of the issue or of actions needed. Raising awareness in task teams and governments is therefore important, not least to generate demand.

- I. **Raise awareness for task teams to approach projects from a disability-inclusive lens** that encompasses disability-inclusive health systems strengthening, in alignment with the World Bank's Disability Inclusion and Accountability Framework (Box 7, p. 31).

Box 7: Six key steps for disability inclusion

The World Bank's Disability Inclusion and Accountability Framework includes six key steps that provide overall guidance for facilitating disability-inclusive operations:

1. Apply a twin-track approach: including persons with disabilities among the beneficiaries of all projects while carrying out specific projects to address the main gaps to their inclusion.
2. Adopt explicit references to disability in general policies, guidelines, and procedures that shape the World Bank's activities.
3. Identify focus areas for disability-inclusive projects and advisory services.

4. Collect data to improve the evidence base on the situation of persons with disabilities.
5. Build staff capacity and organizational knowledge on disability inclusion.
6. Develop external partnerships for implementing the disability-inclusion agenda.

A first step to promoting disability Inclusion in Health, Nutrition, and Population (HNP) projects is to ensure that task teams themselves are aware of the needs and challenges of persons with disabilities and the entry points for addressing these issues within the context of the World Bank’s commitments. The resources shared earlier in this document provide a starting point to improve awareness and skills. Box 7 presents the key points of the World Bank’s Disability Inclusion and Accountability Framework, which provides the broader context for this work.

Within this framework, task teams are encouraged to adopt an equitable approach that considers disability inclusion to be intrinsic to all health projects and activities (i.e., not something that is additional). In applying these to World Bank operations (ASA or lending), it is critical that task teams adopt a disability lens from project inception. Persons with disabilities need to be considered at the outset of any project, in the context of the project scope⁵, making sure that they can:

- Be included in mainstream services (e.g., address barriers and discrimination in health service delivery, address accessibility).
- Receive the additional services they may require because of their impairment (e.g., physiotherapy, audiology).

Specifically, task teams should consider the following key principles during the project planning and development stage, here summarized as a “**15%-INCLUDE-List-To-Remember**”:

- **15%:** In any given country, approximately 15 percent of the population are persons with disabilities
- **Investigate:** Be curious and understand the situation of persons with disabilities in the health system
- **Nudge:** Instigate discussions with country stakeholders and governments on this topic; ask questions (see lines of argumentation and conversation openers under resources in this document)
- **Consultation:** Consult persons with disabilities on their experiences in the health sector (Box 6, p. 30)

5 In-line with ESF risk-mitigation requirements

- **Leverage:** Include persons with disabilities at all steps of project design and implementation, and learn from their input to make the solutions better for all
- **US dollars:** Inclusion needs budget (but investing in disability-inclusive services is likely to produce services that are better for all—Box 1). Interventions must be identified and costed
- **Design:** A twin-track approach to disability inclusion is considered in designing any interventions (mainstreaming of routine health services and targeted programming for persons with disabilities, for example, specialist services, where required)
- **Evaluation:** Inclusion needs to be monitored and evaluated and ensure that the results framework has appropriate Indicators to measure disability inclusion.

II. Create buy-in with governments for disability-inclusive health

Government officials may have low awareness, skills, or experience ensuring that the health system is accessible and inclusive of persons with disabilities. Often there is a need to help governments understand both why and how to include disability issues in their planning processes. Moreover, there may be resistance to disability-inclusion if this is not viewed as a priority, is considered expensive to address, and/or a specialist concern. Task teams are often in a position to a) offer a strong **rationale** for why disability inclusion matters when engaging with government representatives, and b) drive a **step-by-step approach** to inclusion.

- a) **Rationale:** Task teams/TTLs can use different (not mutually exclusive) evidence, including:



- Rights and policies – points for dialogue:
 - i) International Conventions and policies (Box 3): Has the country ratified international treaties (likely) and how is the implementation going? What does this mean for the health sector? How has the country implemented Article 25 of the UN CRPD, which specifically focuses on the right to health? (United Nations 2006)
 - ii) National and local laws: Does the country have national laws on disabilities (likely)? How are they applied in the health sector? Is the country compliant with its own regulations?
 - iii) Equity policies and plans: Are there policies and plans for improving equity, highlighting the rights of persons with disabilities as a disadvantaged group? If not, is that something the country is considering, and what should be the work in the health sector?

- Economic impact and human capital related points for dialogue:
 - i) Societal cost: People who have better health are more likely to gain an education, work, and be economically productive and building their human capital. Their family members are more likely to work as their caregivers' responsibilities will be reduced. (Banks and Polack 2014)
 - ii) Health sector cost: Delays in seeking needed treatment due to lack of availability of quality care leads to higher medical costs and productivity losses.
 - iii) [Universal Design Approach](#) (Box 1): Health systems that work better for persons with disabilities will work better for all (e.g., older people, minority language speakers).
 - iv) Planning for disability-inclusion at project identification stage (e.g., building accessible facilities, training health care workers about disability) should incur few additional costs.

- Achievement of health/disease plans – points for dialogue:
 - i) UHC and SDG3: Highlight disability prevalence, that is, approximately 15 percent of the population are persons with disabilities. Furthermore, persons with disabilities have greater health care needs but face many barriers to accessing services. What is the availability of information

on the health care needs and barriers facing persons with disabilities? How does their inclusion/exclusion affect UHC, or any other specific health goals for the country?

- Inclusion in disability-specific or vertical plans may also be relevant, for example with HIV. Highlight that HIV and disability are strongly linked and about 25 percent of all people that are HIV-positive have disabilities (Lena Morgon Banks et al. 2015). Explain that models have shown that HIV targets are not attainable if persons with disabilities continue to have lower levels of testing and medication adherence (Kuper 2022). Then ask questions to consider disability-inclusive HIV projects. How are persons with disabilities considered in HIV plans, given they are more likely to contract HIV and less likely to be compliant with HIV treatment? What data exists on this population group, and what is its impact on 95-95-95 (Box 2) and/or any other country-specific goals?
- ii) “Vulnerable” groups: Do any plans to improve inclusion for “vulnerable” groups include an intersectional approach to including persons with disabilities? If so, how does this look operationally?
- iii) COVID-19: Did you know that persons with disabilities are more likely to die from COVID-19? What plans are made to ensure that COVID-19 responses are inclusive? What provisions are in place to ensure persons with disabilities have access to COVID-19 testing and vaccinations?

Additional entry points for discussions are highlighted in Appendix 3.

b) A step-by-step approach: Disaggregated data on disability is often unavailable in most countries.⁶ However, some programs have begun collecting data to measure inequities, such as Sightsavers Inclusive Eye Health Programme and the Learning Disability Register in the UK (see Appendix 4: Good Practice Examples). There are also good practice examples from the World Bank (Box 8). Possible first steps and tactics could include:

- **Raise interest on the importance of disability-inclusion**, for instance by suggesting a specific consultation with persons with disabilities on health services,

⁶ Data is often available on the health status and needs of persons with disabilities but has not been analyzed. Here is a resource for disability data: <http://ghdx.healthdata.org/keyword/disability>

- **Develop a data driven approach to the health situation of persons with disabilities**, for instance, by including disability in the next DHS, middle-income country, or population-based survey, or providing a technical assistance for a health system assessment, which includes a focus on persons with disabilities.
- **Act to promote disability inclusion**, for instance by funding targeted projects on disability or funding to mainstream disability into other health projects.

Box 8: World Bank-specific examples on disability inclusion in health projects

Raise awareness: [Consultation with Persons with Disabilities in the Philippines](#)⁷ (P173877)

During the COVID-19 pandemic, the World Bank's response in the Philippines included consultation and feedback from persons with disabilities. Throughout the project development cycle, persons with disabilities were identified as a critical group to engage with and organizations of persons with disabilities (OPDs) were consulted. For example, the [Environmental and Social Management Framework](#) helped to identify barriers to COVID-19 information and hospitals and formulated possible responses, such as training more health staff, highlighting where accessible services are available, and conducting further assessments to improve accessibility. By pinpointing particular barriers facing persons with disabilities and consulting with them on possible responses, the Philippines COVID-19 response has been more inclusive of persons with disabilities. The [COVID-19 Household Surveys](#) also included measures of disability, allowing disaggregation of data.

This collaborative engagement demonstrated the potential for inclusion in health projects beyond COVID-19. Subsequently, the team has included persons with disabilities in the government's health facility assessment surveys for vulnerable groups. With the results of this survey, there will be an action plan on improving health for persons with disabilities to improve health outcomes.

Act: [Ghana COVID-19 Emergency Preparedness and Response Project](#) (P173788)

Persons with disabilities have been included and consulted in Ghana's response to COVID-19. Seven OPDs were consulted in the development of the project and

approximately 20,000 people have been reached through direct support. By explicitly focusing on OPD engagement within targeting vulnerable populations, the team has been able to conduct key activities toward including persons with disabilities. For example, through the networks of OPDs, there has been information in sign language and Braille to ensure COVID-19 information, including details about COVID-19 vaccination, is accessible and specific supplies distributed to support persons with disabilities during lockdowns. By December 2020, over 10,000 persons with disabilities received 56,000 liters of detergents, 10,100 liters of hand sanitizer, and 150,000 packets of tissue paper to protect them from infection. About 1,900 persons with disabilities received medical and psychosocial care for COVID-19-related illnesses and 48,000 nose masks to prevent infection. The project also procured 10,000 dormitory mattresses and 20,000 wheelchairs for persons with disabilities to improve their mobility and reduce stigma. By including persons with disabilities in the consultations and project documents, there was meaningful inclusion and measurement of impact for persons with disabilities.

Section 5: Actions for Task Teams to Promote Disability Inclusion in the Health System

Task Teams and TTLs have a key role to play in supporting the inclusion of disability in World Bank health projects.

Key actions are:

a) For CMU and GP management:

- Prepare/develop content on disability inclusion and health for SCDs and Country Partnership Frameworks (CPFs).
- Incorporate disability into health assessments, as per the ESF.

b) For Project preparation and design:

- Design health projects that are disability-inclusive and equitable.

Specifically, this may entail the following actions:

Encourage the inclusion of a section on disability in SCDs

The situation and needs of persons with disabilities should be considered as part of the SCD and CPFs. Consequently, task teams working on SCDs may consider the inclusion of key statistics and high-level analysis on living situation and experienced barriers of persons with disabilities in these documents/processes as they relate to inclusive health care services. Examples could include disaggregating data by disability (e.g., comparing family planning

coverage between women with and without disabilities) or including disability-specific statistics (e.g., the gaps in need for wheelchair services, or numbers of physiotherapists/audiologists per head of the population).

a) Potential actions for Task Team and/or CMU:

- Include persons with disabilities as a population “at risk,” where appropriate
- Strongly signal on the importance of disability inclusion throughout documentation
- Provide key statistics on disability and/or disaggregate data presented by disability
- Reach out to the Global Disability Advisor’s team for review/consultation
- Consult with persons with disabilities in developing the SCD
- Highlight how disability inclusion fits within the World Bank’s twin goals and other disability-related commitments

b) Key questions the TTL should ask:

- What data are available on the prevalence and predictors of disability (e.g., census data)
- What data are available on health access for persons with disabilities? For instance, has there been a disability survey in the last 10 years? (e.g., UNICEF MICS)?
- Which OPD should be consulted with when developing the SCD?
- Does the country have any disability-inclusive health strategies/action plans/targets?
- Does the most recent health system assessment mention disability?
- Does the country have health-related social protection and are provisions made for persons with disabilities?

c) Additional action for Task Team/TTL:

- Incorporate evidence on/importance of persons with disabilities and health access in any input provided to the CMU

d) Tips and resources: Recently, several countries have included disability in their SCDs:

- **Namibia** — data on social services are disaggregated by disability status and persons with disabilities are mentioned as a group that faces particular barriers in accessing employment. While there are no mentions of disability in the health section, expanding barriers could help ensure that persons with disabilities are included across sectors.
- **Nigeria** — this 2019 SCD highlights the population of persons with disabilities and particular barriers they face, such as inadequate accessible infrastructure

and barriers to publicly-provided social supports. It would have been helpful if the health section of the SCD had also mention persons with disabilities as a vulnerable group and highlighted particular barriers persons with disabilities face in accessing health care. A separate 2018 World Bank report “Disability Inclusion in Nigeria: A Rapid Assessment” presents data on the barriers facing persons with disabilities in accessing health services and the gaps in programming.

- **Sierra Leone** — employment data are disaggregated by disability status. Other data collections and specific barriers to inclusion for persons with disabilities could be further highlighted throughout the document.

Incorporate disability in health systems assessments

Integrating disability within health systems assessments is an important step to disability inclusion in health sector work. In Brazil, the government monitors the accessibility of health facilities as part of its Program for Improving Primary Care Access and Quality (PMAQ). (Macinko et al. 2017)

a) Potential actions for Task Team/TTL and/or GP:

- Include disability-inclusive health language in the Terms of Reference for the agency or organization conducting the assessment
- Incorporate disability into any technical assistance on health system assessments (TTL)



- Initiate assessment of disability inclusiveness of country health systems (through ASAs) focused on GP management (GP)
- Provide technical assistance to conduct health systems assessments that is specifically examining disability-inclusion within the health system (e.g., Appendix 3)
- Organize accessible consultations with persons with disabilities/OPDs about barriers and opportunities to inform health system assessment content

b) Key questions the TTL/GP should ask:

- Which disability-specific metrics could be included in the health system assessments? (For examples, see Appendix 5).

Ideally, documentation should include:

- Data on the prevalence of disability and additional health needs
- Description of barriers facing persons with disabilities in the health system, and how these can be addressed
- Importance of using a twin-track approach in health systems

Where SCDs have been conducted recently, ASA can offer suggestions for including disability-specific metrics and encourage disability disaggregated data, while Health Systems Assessments that are being planned can be an important entry point into disability inclusion. If neither a SCD nor a health systems assessment are planned, a specific inclusive health system assessment could be done (e.g., Appendix 2).



Design health projects that are disability-inclusive and equitable

Task Teams/TTLs can also support disability inclusion in the different stages of health project development (Example given in Box 8).

a) Identification:

- **Objective:** Raise the topic of disability, analyze and highlight relevant data (Kuper and Heydt 2019; World Bank and WHO 2011), and consider specific inclusion of disability in identification document(s).
- **Example actions:** Encourage the inclusion of disability as a major or second order issue (e.g., importance of provision of accessible health facilities)
- **Tips and resources:** See resources above on talking points with the government on why disability matters

Key questions the TTL should ask:

- Are you aware that persons with disabilities are a potential at-risk group for this health issue/project?

b) Concept Note:

- **Objective:** Promote disability inclusion in the project through the twin-track approach (i.e., ensure access to mainstream services and provide targeted services where needed).
- **Example actions:**
 - i) Promote disability inclusion in the project through the twin-track approach (i.e., ensure access to mainstream services and provide targeted services where needed).
 - ii) Discuss the importance of including disability in the project design
 - iii) Identify persons with disabilities specifically when listing vulnerable groups (e.g., done by the [Global Fund to Fight HIV/AIDS, TB and Malaria](#)) (The Global Fund 2021)
 - iv) Include key statistics on the health of persons with disabilities
 - v) For any described major health interventions, describe how it will reach persons with disabilities (and other vulnerable groups)
- **Tips and resources:**
 - i) Look for the country's health sector disability inclusion plan/strategy, general disability inclusion plan/strategy, or laws to suggest areas for inclusion within already identified country-specific goals
 - ii) Undertake disability-inclusive health system assessment (e.g., Missing Billion Appendix 3)

Key questions the TTL should ask:

- Can we make specific mention of disability in the Concept Note? If so, how?
- How does disability interface with the particular area of project focus (e.g., if building new facilities, will they be accessible?)
- Will the project fund accessible facilities/equipment?
- Will there be collaboration with other sectors (e.g., transport) to improve access for persons with disabilities?
- In terms of financing, what arrangements can be made to reduce catastrophic out of pocket expenditure for persons with disabilities?
- Is there need for SBCC-type campaigns to reduce stigma/improve household demand for health care for persons with disabilities?
 - i) Are there best practice examples of SBCC we can tap into?
 - ii) Which local representative organizations can we work with to develop the campaign?

b) Preparation:

- **Objective:** Refine the project plan to ensure disability inclusion.
- **Example actions:**
 - i) As per ESS10 on stakeholder engagement, include persons with disabilities during consultations on the project design and implementation plan by ensuring accessibility and if required covering accommodations such as costs for, travel, sign language Interpreters
 - ii) Identify potential risks and challenges facing persons with disabilities, and mitigation strategies in the health sector
 - iii) Develop disability-inclusive indicators and/or support disability-disaggregated data
 - iv) Provide specific budget lines for disability inclusion (e.g., consultation with persons with disabilities, production of accessible information, reasonable accommodations to ensure mainstream services are disability-inclusive, provision of targeted services).
- **Tips and resources:**
 - i) Box 6 on stakeholder engagement provides some useful insights on stakeholder engagement

Key questions the TTL should ask:

- What additional actions/resources are needed to support the inclusion of persons with disabilities?
- What indicator related to disability could be included in the monitoring and evaluation (M&E) framework? (e.g., percentage of beneficiaries that are persons with disabilities, percentage of health facilities with wheelchair ramps).

c) Implementation:

- **Objective:** Ensure implementation is inclusive of persons with disabilities and monitor inclusion.
- **Example actions:**
 - i) Provide staff training and capacity development on inclusion for persons with disabilities
 - ii) Continue to engage with persons with disabilities to refine accessibility and disability inclusion (e.g., training staff on disability awareness, accessible facilities, partnerships with OPDs)
 - iii) Support cross-coordination between the Ministry of Health and ministries responsible for disability issues
 - iv) During supervision, revise targets and indicators where there are opportunities for greater disability inclusion

Key questions the TTL should ask:

- Is the project facing issues in the inclusion of persons with disabilities? If so, are further actions needed?
- Are there gaps in planned project intervention/PAD and implementation specifically related to disability inclusion?
- Has there been training for project teams on disability-inclusive project design and M&E?

d) Completion and evaluation:

- **Objective:** Evaluate disability-inclusion and distill lessons learned for future projects.



- **Example actions:**
 - i) Evaluate project's reach, effectiveness, and impact on the health care needs of persons with disabilities
 - ii) Analyze indicators to demonstrate project impact on persons with disabilities
 - iii) Suggest further entry-points for disability inclusion in health sector projects based on findings
 - iv) Ensure process for integrating learning around disability inclusion to other projects and contexts
 - v) Review project portfolio and see where to integrate disability inclusion in future work
- **Tips and resources:**
 - i) Suggested indicators to monitor disability inclusion at the program level (process and outcome) and at the national level are given in Appendix 5 (Table 2).
 - ii) Appendix 2 on measuring disability and disaggregating data and Box 9 on learning about disability inclusion from the Hygiene and Behaviour Change Coalition present useful examples.

Key questions the TTL should ask:

- Is there evidence that the project was also effective (e.g., showed positive impact) for persons with disabilities?

Box 9: Learning from the Hygiene Behaviour Change Coalition (HBCC) COVID-19 Hygiene Hub projects

The Hygiene Behaviour Change Coalition was set up in early 2020 by Unilever and the UK's Foreign, Commonwealth, and Development Office (FCDO) with the aim of providing a rapid response to help contain and limit the spread of COVID-19 in low- and middle-income countries. In total, 74 projects were funded across 21 organizations working in 37 countries and included a range of activities from distribution of hygiene products like hand soap, sanitizers through to behavior change messaging. A small research study was conducted in late 2020 to investigate the extent to which HBCC grantees were including considerations around disability and aging in their hygiene promotion programs. The researchers developed a COVID-19-Inclusive water, sanitation, and hygiene (WASH) checklist against which to measure projects. This checklist, which utilized many features from the *EquiFrame* framework, contains 15 core concepts of human rights designed to spotlight a range of interventions which, if implemented, work to ensure persons with disabilities, older adults, and caregivers can achieve equal access to WASH services.

The research found that while most projects mentioned persons with disabilities as being a key group for targeting, fewer mentioned older adults, and caregivers were the least likely to be targeted. But while most projects acknowledged persons with disabilities, few designed activities that would specifically address their COVID-19 related needs. The rapid nature of the needs-assessments conducted in response to the COVID-19 crisis had the effect of excluding persons with disabilities and older adults from project planning consultations. A key learning point is that having established mechanisms for engaging representative organizations and caregivers enables even rapid assessments to be conducted inclusively, leading to a better range of project responses. The research also highlighted the need for targeted information to be provided to some groups for whom generalized messaging was insufficient, even if they were communicated in accessible formats. Again, which can be generated in consultation with representative groups. It also highlighted the need to regularly collect disability and aging disaggregated data using standardized methods so that gaps in the distribution of services can be rapidly resolved.

Conclusion

Persons with disabilities make up 15 percent of the global population, or one in seven people worldwide. Evidence clearly shows that they are consistently left behind by health systems and experience adverse health outcomes as a result. World Bank task teams and TTLs have a transformative role to play in the creation and support of disability-inclusive health systems.

Such systems will:

- improve the human capital and quality of life of individuals
- help realize the rights to health care for persons with disabilities
- support the achievement of World Bank twin goals, as well as global health and other goals
- reduce economic losses to individuals, health systems, and governments
- produce health systems that work better for all

Given the importance of this topic, a critical next step is to develop a monitoring agenda to track progress and developments. While it is challenging to find data for disability-inclusive health metrics, there are proxy indicators and tags that could be defined to start this agenda.

Appendix 1: Key Terminology

Disability

The most acceptable terminology is “persons with disabilities.” In some countries, such as the UK, “disabled person” is commonly used. It is important to refrain from using terminology that has negative connotations to refer to persons with disabilities, including “handicapped” or “invalid,” or negative phrases associated with particular impairment types (e.g., “retardation”). Additionally, avoid using the phrase “the disabled,” or similar terminology for impairment groups (e.g., “the blind”).

Accessibility

The World Bank Environmental and Social Framework defines accessibility as “the degree to which the physical and social environment, transportation, information and communications, and services that are open and available to the public can be accessed by persons with disabilities.”⁸

Universal Design

According to the World Bank Environmental and Social Framework, Universal Design is the composition and design of an environment that meets the needs of all people so it can be accessed and used by all, regardless of their age, size, ability, or disability. By considering the diverse needs and abilities of all throughout the design process, universal design creates products, services, and environments that meet peoples’ diverse needs.⁸

⁸ World Bank. 2018. “Good Practice Note on Non-Discrimination and Disability. Environment and Social Framework for IPF Operations.” World Bank, Washington, DC.

The concept of universal access is viewed primarily as accessibility of the **built environment**, which includes housing and private buildings, as well as public spaces or buildings, and to the social environment, particularly in services and government offices. Universal access can also relate **to access to information and communication** through channels and in formats that allow persons with disabilities to participate in stakeholder engagement (ESF Good Practice Note: Non-discrimination and Disability, 2018 and Guidance Note on ESS4).

For further Information on accessibility, kindly refer to the [Technical Note on Accessibility](#) (World Bank 2022)

The difference between prevention of impairments, inclusive health and provision of rehabilitation

- Disability-inclusive health seeks to achieve equitable access to health care regardless of an individual's disability. This means making sure that services are accessible and affordable to persons with disabilities, and that health professionals are skilled to meet their needs.
- Health services also, of course, serve to treat and prevent the development of impairments. However, refrain should be used in describing this process as “preventing disability,” but rather focus on “preventing health conditions or impairment.”
- Many persons with disabilities may benefit from rehabilitation to optimize functioning, such as through physiotherapy or the provision of assistive devices. Rehabilitation is an essential part of a health system and so the principles of inclusive health also apply to rehabilitation.

8 World Bank. 2018. “Good Practice Note on Non-Discrimination and Disability. Environment and Social Framework for IPF Operations.” World Bank, Washington, DC.

Appendix 2: Measuring Disability and Disaggregating Data by Disability

The Washington Group (WG) Short Set is frequently used to measure disability and is endorsed by the World Bank and other UN agencies. This set consists of six questions on functioning, namely, do you have difficulty:

1. Seeing, even if wearing glasses?
2. Hearing, even if using a hearing aid?
3. Walking or climbing steps?
4. Remembering or concentrating?
5. With self-care, such as washing all over or dressing?
6. Communicating, for example understanding or being understood?

For each question, the response options are: “No difficulty,” “Some difficulty,” “A lot of difficulty,” or “Cannot do at all.”

A person is classified as disabled if they answer “A lot of difficulty” or “Cannot do at all” in at least one of the six domains

More information about this tool, and translations, is available here: <https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/>. Other questions sets are also available, including the Washington/UNICEF Child Functioning

Module for children 2-17 and more extended question sets (<https://www.washingtongroup-disability.com/question-sets/>). Furthermore, World Bank has recently launched an E-course on “[Collecting Data on Disability Inclusion](#)”.

This self-paced E-course provides technical knowledge to World Bank staff and development partners on disability disaggregated data to support more robust activities towards inclusive development. The course includes an introduction to the WG question sets.

Data can be disaggregated by disability once a measure of disability is available (whether through the WG or another tool). This means that key outcomes are compared for people with and without disabilities, such as the presence of health problems, barriers to accessing health care, or health care coverage. Disaggregating data allows examination of whether certain issues are greater for persons with disabilities.

Example: In a study in Guatemala, 38 percent of adults surveyed reported that they had experienced a serious health problem in the past 12 months. When disaggregated by disability, this figure was 47 percent among persons with disabilities and 23 percent among people without disabilities, showing a strong association between disability and experiencing a serious health problem.

Disaggregation by type of disability (e.g., hearing, vision) may be possible if datasets are large enough to reach a meaningful conclusion. Disaggregation of data may be possible either in data generated through World Bank mechanisms or from existing sources. A large amount of data already exists and is openly available that includes measures of disability. For instance, The Global Health Data Exchange includes more than 1800 surveys from around the world that include measures of disability. This database can be searched to identify datasets in the country of interest: <http://ghdx.healthdata.org/keyword/disability>.

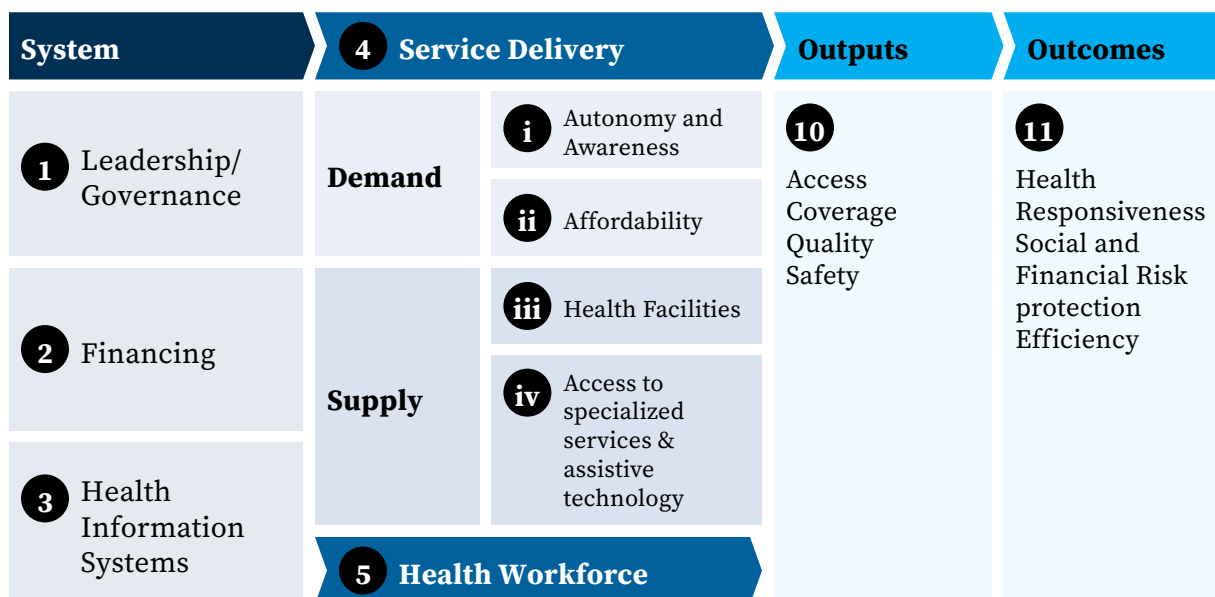
Appendix 3: Missing Billion Health System Assessment

Building on existing other health systems frameworks and in recognition of the particular issues around health access for persons with disabilities, the following framework for review has been established. This framework is aligned fully with the structure of the conceptual framework of the Primary Health Care Performance Initiative (PHCPI).⁹

As part of the preparation phase for a project, a disability-specific health system assessment could be commissioned or conducted using this structure. Or, depending on the focus of the health project, these provide the guiding questions to review with the government partners on specific subjects, e.g., health facilities.

⁹ PHCPI is a partnership of country policymakers, health systems managers, advocates trying to catalyze primary health care improvements in low- and middle-income countries. PHCPI has developed a conceptual framework to describe critical components of a strong primary health care system. The framework is the basis for any PHC assessment, indicator definition and progression models.

Inclusive Health Systems Framework



Adapted from the [Missing Billion Health Systems Framework](#) and the WHO's Health System Framework ("building blocks")

1. Leadership/Governance

The overall objective ("must-ensure"): international regulations must be matched by appropriate in-country laws and policies that protect the right to access health care services for persons with disabilities and outlaw discrimination based on disability; accountability mechanisms must be in place to enforce this right. Issues around inclusion are clearly represented in the MoH and health sector structures and coordination mechanisms. Dedicated structures and leadership should also kick-in in times of crisis or disasters.

Talking points

- Has the country ratified the UNCPRD? Has the government submitted an initial country report to the Committee? Are there concluding observations on access to health care services?
- Is there a national law that addresses persons with disabilities?
- What provisions does the national policy on disability have for health?
- Is there a specific national policy or action plan on the health of persons with disabilities?
- Does the national law prohibit discrimination against persons with disabilities (e.g., health insurance, COVID-19 services and vaccinations)? Does it have considerations to address the needs of persons with disabilities (i.e., assistive device funding, specialized services, accessible transportation cost coverage, etc.)?

- What is the situation in relation to informed consent and guardianship for persons with disabilities, especially in relation to enforced institutionalization and medical procedures, such as forced sterilization?
- Does the Health Sector Plan address the particular access barriers of persons with disabilities?
- Is there an accountability mechanism in place to ensure that actions are taken so that health care is inclusive of persons with disabilities?
- Are there Grievance Redress Mechanisms (GRM) in place to report issues in accessing health care services, as per the ESF?
- Is there a focal point or division within the Ministry of Health responsible for disability inclusion? Where does the focal point sit?
- Which ministry/department/agency within the government houses disability inclusion? Are there individuals responsible for health in this ministry? How do they collaborate with the Ministry of Health?
- Is information on health care services available in accessible formats?
- Which other ministries work on disability or support the Ministry of Health in disability-inclusion?
- Do coordination structures, e.g., the Global Fund CCM, HIV and AIDS Councils have representation of persons with disabilities?
- Are there any ad-hoc committee, taskforces, or other dedicated capacity that responsible for addressing disability issues as part of pandemic preparedness plans?
- How many health professionals in leadership positions are persons with disabilities? How many persons with disabilities work in the Ministry of Health?

2. Financing

The overall objective (“must-ensure”): **Health financing and/or health insurance coverage is available to support assistive technologies, specialized services, and any adaptations/improvements of routine services; health financing mechanisms allow adjustments to support effective service delivery**

Talking points

- Are there any particular budget items in the health budget for disability-related services or adjustments?
- Are national health insurance benefit packages including disability-related services (e.g., for rehabilitation or Assistive Technologies)?
- If a reimbursement-based system: Are specific reimbursement rates available for routine services that may need longer for persons with disabilities (e.g., dental care for a person with intellectual disabilities)?
- If a budget-based system: are capitation rates or budgets adjusted by the needs of the population/catchment area, including disability?

3. Health Information Systems

The overall objective (“must-ensure”): **Health financing and/or health insurance coverage is available to support assistive technologies, specialized services, and any adaptations/improvements of routine services; health financing mechanisms allow adjustments to support effective service delivery**

Talking points

- Does reliable data exist on the number of persons with disabilities and type of impairment?
- Is it possible to disaggregate MICS, DHS, or other household health data by disability?
- Has there been a survey on health access for persons with disabilities in the last 10 years? E.g., the WHO Model Disability Survey?
- Are there any operational research projects or pilots underway that address particular access challenges for persons with disabilities?
- Has there been any mapping done of the human experience of persons with disabilities as a basis for designing interventions/adaptations? Has qualitative data been collected on the needs and preferences of persons with disabilities as a basis for designing interventions/adaptations?

4. Service Delivery

a) Demand: Autonomy & Awareness

The overall objective (“must-ensure”): **Persons with disabilities make their own decisions about health care and are aware of their rights and options**

Talking points

- Is key health information for the general public (e.g., radio messages on HIV, or general information about COVID-19 on TV) accessible? Does this include alternative formats (braille, videos with captions, easy-to-read, etc.) for persons with vision impairments, d/Deaf and hard of hearing individuals, or persons with intellectual and developmental disabilities?
- Are there education materials available for persons with intellectual disabilities about “going to the doctor” or available in plain language?
- Are there any peer education programs for persons with disabilities on their rights to health and for particular disease areas?

b) Demand: Affordability

The overall objective (“must-ensure”): **Persons with disabilities must be able to afford health care access**

Talking points

- Is there a social protection program or a disability allowance for persons with disabilities? How much is it? Does it have stipulations on what services/supports are covered?
- Is there any financial support for accessing health services, i.e., transport vouchers?
- Is there a program to support personal assistants for persons with disabilities to access health care?
- Is there a fund to support the purchase of assistive devices and necessary adaptations?

c) Supply: Health facilities

The overall objective (“must-ensure”): **Health care facility infrastructure is accessible for persons with disabilities**

Talking points

- Are there any national accessibility standards for health care facilities?
- Are there any local institutions that have developed/adapted practical guides/tools that are available for the use of accessibility audits?
- Has an accessibility audit of clinics been conducted?
- Are clinics and hospitals required to purchase accessible and disability friendly medical equipment?

d) Supply: Access to essential medicines, specialized services and assistive technology

The overall objective (“must-ensure”): **Essential medicines, Specialist health services (e.g., rehabilitation and assistive technology) are available, affordable and of good quality for persons with disabilities.**

Talking points

- Are there any national rehabilitation and/or Assistive Technology plans or committees?
- Has there been any assessments of rehabilitation services and capacity in the country (e.g., the WHO Systematic Assessment of Rehabilitation Situation- STARS?)
- Are there any prioritized activities to improve rehabilitation (including Assistive Technology) in the health sector national plan?
- Is there a national rehabilitation policy?

5. Health workforce

The overall objective (“must-ensure”): **Health care workforce is knowledgeable about disability and has the skills and flexibility to provide quality care to persons with disabilities**

Talking points

- Does the curriculum or licensing requirements for doctors, nurses and community health workers include training on disability-inclusive health care? Are there core competencies nationally, or some standardization of curriculum? How much training do health workers receive on disability?
- Have doctors, nurses and community health workers received any in-service or professional development training about disability-inclusive health care?
- Are persons with disabilities leading and/or involved in the training of health workers?
- What proportion of the health workforce has a disability themselves?
- Are there university courses on disability and community health care?

Appendix 4: Good Practice Examples

Below, there is an index of good practice examples of inclusion from the Missing Billion Initiative. For examples 1)-8) there are one-pagers in the appendix as well as brief descriptions of other good practices from around the world.

Health System Aspect	Good Practice Example	Country	Related other best practice
Governance	1. Framework and action plan for improving health	Uruguay	<ul style="list-style-type: none"> • Brazil Health Care Laws • Philippines, the “Magna Carta for Disabled Persons” Act
Leadership	2. COVID-19 Disability Advisory Group (CDAG)	Canada	<ul style="list-style-type: none"> • Brazil’s technical health units for persons with disabilities • Morocco MOH disability focal points
Health Financing	3. Dental Health Reimbursement for Persons with disabilities	Germany	<ul style="list-style-type: none"> • Maldives National Health Insurance Scheme

Data and Evidence	4. Learning Disability Registers	UK	<ul style="list-style-type: none"> • Malawi DHS survey • WHO Model Disability Survey • UNICEF MICS Child and Adult Functioning Modules (available in over 30 countries) • South Africa Household Survey on Disability
Autonomy and Awareness	5. Active Rehabilitation Services By and For Persons with Disabilities	Poland	<ul style="list-style-type: none"> • Kenya Peer Education for HIV prevention and treatment in the Deaf Community • International Disability Alliance public health guidance on the COVID-19 pandemic
Human Resources	6. Community Health Worker Training to identify children with developmental disabilities	India	<ul style="list-style-type: none"> • UK's Oliver McGowan Mandatory Training in Learning Disability and Autism • Special Olympics online training portal
Health Facilities	7. Home Testing for COVID-19	UAE	<ul style="list-style-type: none"> • Brazil National Accessibility Audit of primary health care facilities
Specialized Services and Assistive Technology	8. Annual Health Checks for people with learning disabilities	UK	<ul style="list-style-type: none"> • Assistive technology country capacity assessment in seven African countries • Solomon Islands STARS assessment • Rapid Assistive Technology Assessment

Appendix 5: Monitoring Disability-Inclusive Health

Monitoring disability-inclusive health is challenging given the lack of general data on persons with disabilities and a lack of disaggregated data by disability. However, given the need to invest and monitor the progress, it is important to Identify some metrics that can be tracked as proxies for ultimate outcomes.

Table 2: Potential metrics and measures for monitoring

Program process monitoring	Measure	Source
<ul style="list-style-type: none"> Persons with disabilities mentioned as a high risk/focal group in program plans 	Yes/No, description	Program document review
<ul style="list-style-type: none"> Budget line included for disability-inclusion and/or disability-specific services 	Yes/No, amount	Program budget review
<ul style="list-style-type: none"> Consultation with persons with disabilities during program preparation 	Yes/No, description	Interview program managers
<ul style="list-style-type: none"> Reach of persons with disabilities in program 	% participants with disabilities	Baseline/midline/endline survey

Program impact assessment		
• Outcome data disaggregated by disability	Outcome disabled vs non-disabled	Endline survey
• Disability-specific outcomes	Disability-specific indicators	Endline survey
Country/regional monitoring		
a) Leadership/governance		
• Health policy in place on disability and health	Yes/No, description	Key informant interview
• Leadership role on disability in health sector	Yes/No, description	Key informant interview
b) Financing		
• Ministry of Health budget line for disability inclusion and/or rehabilitation	Yes/No, description	Key informant interview
c) Data		
• Disability survey undertaken in last 10 years. If so, disaggregation of health-related measures by disability	Yes/No	Search for: MICS, DHS, Model Disability or other surveys
• If data available, disaggregate key available indicators by disability	Outcome disabled vs non-disabled	Survey data

Source: The Missing Billion Initiative Diagnostic Toolkit

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