DRAFT 1 – 31 July 2013

WORLD HEALTH ORGANIZATION ACTION PLAN 2014 – 2021

'BETTER HEALTH FOR PERSONS WITH DISABILITIES'

1. In May 2013 the Sixty-sixth World Health Assembly adopted resolution WHA66.9 on disability endorsing the World Health Organization (WHO) and World Bank 2011 *World report on disability*. The resolution requests the Director-General to prepare a comprehensive WHO action plan based on the evidence in the *World report on disability*, and in line with the CRPD and the report of the High-level Meeting on Disability and Development.

2. WHO recognizes disability as a global public health issue, a human rights issue and a development priority. Disability is a global public health issue because persons with disabilities experience greater unmet needs around health and rehabilitation and poorer health than the general population. Disability is a human rights issue because persons with disabilities experience inequalities, are subject to multiple rights violations including violations of dignity such as violence, abuse, prejudice and disrespect because of their disability, and they are denied autonomy. Disability is a development issue because of higher disability prevalence in lower income countries and because disability and poverty reinforce and perpetuate one another. Poverty increases the likelihood of impairments through malnutrition, poor health care, and dangerous living conditions. Disability may lead to lower living standard and poverty through lack of access to education, employment, earnings, and increased expenditures related to disability.

3. Disability is universal. Everyone will experience limitations in functioning at some point in his or her life. Following the International Classification of Functioning, Disability and Health, this draft action plan uses the term "disability" as an umbrella term for impairments, activity limitations, and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors). Disability is neither simply a biological nor a social phenomenon but arises from the relationship between health condition and context.

4. This action plan is relevant to all persons who experience disability. The beneficiaries are both those persons who have long term impairments – those who are traditionally understood as disabled such as wheelchair users, persons who are blind or deaf or persons with intellectual impairments or mental health conditions - and also the wider group of persons who experience difficulties in functioning due to a wide range of health conditions such as chronic and noncommunicable diseases, infectious diseases, neurological disorders and conditions that result from the ageing process. The term "persons with disabilities", consistent with the terminology used in the CRPD, is used throughout this action plan.

5. While much of the mission of WHO is dedicated to primary prevention – avoiding death and disability - the focus of this action plan is on improved health and well-being for persons with disabilities. Therefore prevention-related activities in this plan focus only on early identification and intervention to prevent the development of secondary or co-morbid

health conditions that are often associated with disability, prevention of the development of new impairments and prevention of existing impairments becoming worse through improving access to health care and population-based public health programmes, and barrier removal.

OVERVIEW OF THE GLOBAL SITUATION

6. More than one billion people currently experience disability, which equates to approximately 15% of the world's population. Of this number between 110 million and 190 million adults experience very significant difficulties in functioning. The number of people who experience disability will continue to increase due to ageing populations, and a global increase in chronic health conditions. National patterns of disability are influenced by trends in health conditions and environmental and other factors – such as road traffic crashes, natural disasters, conflict, diet and substance abuse.

7. Disability disproportionately affects marginalized, disadvantaged or at-risk populations such as women, older people, and people who are poor. Children from poorer households, indigenous populations, and those in ethnic minority groups are also at significantly higher risk of experiencing disability. Lower income countries have a higher prevalence of disability than higher income countries.

8. Persons with disabilities face widespread barriers in accessing services such as those for health care (including rehabilitation), education, employment, social services including housing and transport. These barriers include inadequate legislation, policies and strategies; lack of service provision; problems with the delivery of services; negative attitudes and discrimination; lack of accessibility; inadequate funding; and lack of participation in decisions that directly affect their lives.

9. These barriers contribute to the disadvantages experienced by persons with disabilities. Persons with disabilities, particularly those in developing countries, experience a poorer health status than persons without disabilities, as well as higher rates of poverty, lower rates of educational participation and employment, increased dependency and restricted participation. Many of the barriers experienced by persons with disabilities are avoidable and the disadvantage associated with disability can be overcome.

STRUCTURE OF THE ACTION PLAN 2014-2021

10. The **vision** of the action plan is a world where persons with disabilities and their families enjoy the highest attainable standard of health.

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

12. The action plan has the following three **objectives**:

1) To address barriers and improve access to *health care services and programmes*.
2) To strengthen and extend *habilitation and rehabilitation* services, including *community based rehabilitation*, and *assistive technology*.
3) To support the collection of appropriate and internationally comparable *data on disability*, and promote multi-disciplinary *research on disability*.

13. This plan supports the implementation of the CRPD, in particular Articles 12 (Legal capacity), 19 (Living independently and being included in the community), 20 (Personal mobility), 25 (Health), 26 (Habilitation and rehabilitation), 28 (Adequate standard of living and social protection), 31 (Statistics and data collection) and 32 (International cooperation). It supports actions recommended in the report of the 2013 High-level Meeting on Disability to ensure access for persons with disabilities to healthcare services including rehabilitation and assistive devices, and to improve disability data and promote knowledge and understanding of disability. The plan is based on the findings and recommendations of the *World report on disability*, which synthesizes the best available scientific evidence on the widespread barriers faced by persons with disabilities, and on ways of overcoming these barriers.

14. Internally to WHO the action plan supports the ongoing actions of the WHO Secretariat towards mainstreaming disability in the development agenda, in line with the United Nations General Assembly resolutions[1]. It is aligned with and will support the directions of the WHO General Programme of Work, in particular the new political, economic, social and environmental realities and challenges and evolving health agenda, ensuring that globalization becomes a positive force for all the world's peoples of present and future generations. The action plan complements and supports the implementation of a range of WHO health plans and strategies addressing issues such as healthy ageing, reproductive, maternal and child health, emergency and disasters, and the Comprehensive Mental Health Action Plan 2013–2020, adopted by the World Health Assembly in May 2013, the Action Plan for the Prevention of Avoidable Blindness and Visual Impairment 2014-2019, and the Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013-2020.

15. The design and implementation of the action plan is guided by the following CRPD ***principles***:

- Respect for the inherent dignity, individual autonomy, including the freedom to make one's own choices, and independence of persons;
- Non-discrimination;
- Full and effective participation and inclusion;
- Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
- Equal opportunity;
- Accessibility;
- Equality between men and women, and
- Respect for the evolving capacities of children with disabilities and respect of the right of children with disabilities to preserve their identity.

16. The design and implementation of the action plan is based on the following evidence-based ***approaches***:

- Human-rights based approach;
- Universal health coverage;
- Life course approach, including continuum of care;

[1] Resolutions 66/288, 66/229, 66/124, 65/186 and 64/131.

- Multi-sectoral approach; and
- Person-centered approach, including empowerment of persons with disabilities.

Proposed actions for Member States, the Secretariat, and International and National Partners

17. Specific ***actions***, detailing ***what*** can be done to achieve the plan's three objectives, are proposed for Member States, the Secretariat, and international and national partners. Possible options regarding ***how*** to implement these actions are proposed as ***inputs*** from various actors.

18. This action plan recognizes the considerable variation in contexts and starting points experienced by countries and regions in their efforts to ensure access to health care and provide specific programmes and supports such as rehabilitation for persons with disabilities. The plan is intended to provide structure and guidance but cannot be a '*one-size-fits-all'* plan. Efforts towards achieving the plan's objectives need to align with existing regional and national obligations, policies, plans and targets.

19. Disability is a cross-cutting issue involving all sectors and diverse actors. As such effective implementation of the WHO disability action plan will require strong commitment, resources and actions by a wide range of international, regional and national partners and the development and strengthening of networks on a regional and global basis.

20. OBJECTIVE 1: ADDRESS BARRIERS AND IMPROVE ACCESS TO HEALTH-CARE SERVICES AND PROGRAMMES

21. The WHO Constitution enshrines the highest attainable standard of health as a fundamental right of every human being, including access to timely, acceptable, and affordable health care of appropriate quality. The right to health means that States must generate conditions in which everyone can be as healthy as possible and that health services are provided on the basis of free and informed consent.

22. Good health is a pre-requisite for participation in a wide range of activities including education and employment. However, evidence shows that persons with disabilities have unequal access to health care services, have unmet health care needs and experience poorer levels of health compared to the general population. Persons with disabilities may experience greater vulnerability to preventable secondary conditions, co-morbidities, and age-related conditions and may require specialist health care services. They can be subjected to treatment or other protective measures without their consent, are at greater risk of violence than those without disabilities, and have a higher risk of unintentional injury from road traffic crashes, burns, or falls. Some studies have also indicated that some people with disabilities have higher rates of risky behaviors such as smoking, poor diet and physical inactivity.

23. Health systems frequently fail to respond adequately to both the general and specific health care needs of persons with disabilities. Persons with disabilities have the same general health care needs as everyone else however they encounter a range of attitudinal, physical and systemic barriers when they attempt to access health care. Analysis of the WHO World Health Survey shows that persons with disabilities are twice as likely to find

health care providers skills and facilities inadequate, three times more likely to be denied health care and four times more likely to be treated badly in the health care system. Half of persons with disabilities cannot afford needed health care and they are 50% more likely than persons without disability to suffer catastrophic health expenditure, which pushes them into poverty.

24. Article 25 of the CRPD reinforces the rights of persons with disabilities to attain the highest standard of health care, without discrimination. Given that multiple factors limit access to health care for persons with disabilities actions in all of the components of the health care system are required, including increasing Ministry of Health awareness, knowledge and data to adequately address disability and increase access to services. Within national health care policies, formal acknowledgement that some groups of persons with disabilities experience health inequalities is needed as a key step towards addressing health disparities, together with a commitment to collaboration and a coordinated approach from health-care providers. Community-based rehabilitation is an important strategy for ensuring and improving access to health services particularly in rural and remote areas. Persons with disabilities should be consulted in the development of strategies to eliminate barriers and promote inclusive and accessible health care.

OBJECTIVE 1: Address barriers and improve access to health care services and programmes.	**Evidence of success**	**Means of verification**	**Important assumptions**
Success indicator 1.1 **-** X % of countries have updated their health policies in line with the CRPD. ***Success indicator 1.2*** – X% of countries have universal health coverage inclusive of persons with disabilities	Existence of health policy in line with CRPD. Universal health coverage inclusive of persons with disabilities	Survey of Ministries of Health, administered by WHO Secretariat at baseline, 5 years, 10 years. Surveys	

ACTIONS FOR OBJECTIVE 1	**Proposed inputs for Member States**	**Inputs for the Secretariat**	**Proposed inputs for international and national partners**
1.1 Develop and/or reform health and disability policies, strategies and plans for consistency with the Convention on the Rights of Persons with Disabilities.	• Review and revise existing policies ensuring disability is mainstreamed into health and other sectors. • Mobilize the health sector to contribute to the development of a multisectoral national disability strategy and action plan ensuring clear lines of responsibility and mechanisms for coordination, monitoring and reporting. • Health sector support for monitoring and evaluating the	• Provide technical support; develop guidelines on Disability Inclusive Health Systems Strengthening to help achieve universal coverage. • Provide support and build capacity within Ministries of Health and other relevant sectors for the development, implementation and monitoring of policies, strategies and plans.	• Support opportunities for exchange on effective policies to promote the health of people with disabilities. • Relevant national bodies, including DPOs and other civil society actors to participate and provide technical inputs/support to reform efforts.

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
	implementation of health policies to ensure compliance with the CRPD. • Promote active participation of persons with disabilities and DPOs in the process.		
1.2 Develop leadership and governance for disability inclusive health.	• Identify focal points for disability within Ministries of Health and develop internal action plans that support inclusion and access to mainstream health care. • Ensure participation of the health sector in national disability coordinating bodies. • Ensure participation of Disabled People's Organizations in health policy/making, and quality assurance	• Provide support to Member States to build their leadership capacity; develop and implement a training package in line with Inclusive Health Guidelines... • Host regional workshops on universal health coverage and equity drawing on country experience.	• Provide support to Ministries of Health to build their leadership capacity for ensuring disability inclusive health.
1.3 Address barriers to financing and affordability through options and measures to ensure persons with disabilities can afford and receive the health care they need without extreme out-of-pocket and	• Allocate adequate resources to ensure implementation of the health components of the national disability strategy and plan of action. • Ensure that National health care	• Provide technical assistance to countries for resource planning, budgeting and expenditure.	• Provide technical and financial assistance to Member States to ensure people with disabilities can access mainstream health care services.

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
catastrophic expenditures.	financing schemes include minimum packages, poverty and social protection measures that target and meet the healthcare needs of people with disability. • Reduce or remove out-of-pocket payments for people with disabilities who have no means of financing health care, to achieve Universal Health Coverage. • Provide support to meet the indirect costs related to accessing health care, e.g. transport. • Where private health insurance exists ensure it is affordable and accessible for people with disabilities.		
1.4 Address barriers to service delivery including physical access, information and communication, and coordination.	• Adopt national accessibility standards (in line with Universal Design principles) and ensure compliance within mainstream	• Initially support identification of barriers to particular services through technical assistance to collect disability disaggregated service utilization data**.**	• Support consumer groups to carry out access audits to identify barriers that may exclude people with disabilities from accessing health services.

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
	health settings. • Provide a broad range of reasonable accommodations[2] to overcome barriers to access mainstream health services. • Support mechanisms to improve the continuum of care experienced by people with disabilities including: discharge planning, multidisciplinary team work, development of referral pathways and service directories. • Support CBR programmes to include healthcare referral within activities	• Promote capacity building of CBR programmes especially in the areas related to health.	• Support development of CBR programmes.
1.5 Address specific challenges to the quality of health care experienced by people with disabilities [including, health worker knowledge, attitudes and practices as well as participation of people with disabilities in decisions	• Support education and training by integrating disability into relevant undergraduate curricula and continuing education for service providers.	• Build understanding and promote importance of inclusion of disability issues (including the rights of persons with disabilities) in the curricula of schools of medicine and nursing, and other health related institutions.	• Integrate education on the health and human rights of persons with disability into undergraduate and continuing education for all health-care workers. • Ensure people with disabilities are involved as providers of education

[2] *"Reasonable accommodation"* means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms (*Convention on the Rights of Persons with Disabilities*, Geneva, United Nations, 2006).

ACTIONS FOR OBJECTIVE 1	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
that directly affect them].		• Develop model curricula on disability for health and rehabilitation personnel. • Provide technical support to countries seeking to implement model curricula on disability and health	and training where relevant. • Provide training and support for community workers who assist people with disabilities to access health services.

OBJECTIVE 2: STRENGTHEN AND EXTEND HABILITATION AND REHABILITATION SERVICES, INCLUDING COMMUNITY-BASED REHABILITATION AND ASSISTIVE TECHNOLOGY.

25. Habilitation and rehabilitation are defined as "sets of measures that assist individuals, who experience or are likely to experience disability, to achieve and maintain optimal functioning, in interaction with their environments". A distinction is sometimes made between habilitation which aims to assist those who acquire disability congenitally or early in life to develop maximal functioning; and rehabilitation, which aims to assist those who are experiencing temporary or permanent loss in functioning later in life. In this action plan the term rehabilitation will be used to refer to both types of intervention. It is also inclusive of community-based rehabilitation (CBR) and assistive technology.

26. Community-based rehabilitation (CBR)[3] is used by over 90 countries for rehabilitation, equalization of opportunities, poverty reduction, and social inclusion of persons with disabilities. In many instances it has played a key role in making health and rehabilitation services available in countries with limited resources. CBR is provided by health or non-health care professionals and other appropriately trained informal care givers. Assistive technology[4] includes eye glasses, magnifying glasses, hearing aids, augmentative and alternative communication (AAC), walking sticks, crutches, walking frames, walkers, wheelchairs (manual and powered), seating and positioning systems, tricycles, scooters, orthoses such as calipers, braces and splints, and prostheses such as artificial legs. Assistive technology also encompasses information and communication technology such as computers, screen reading software and customized telephones.

27. Habilitation and rehabilitation, including peer support, CBR and the provision of assistive technology are good investments because they build human capacity and are can be instrumental in enabling people with limitations in functioning to remain in or return to their home or community, live independently, and participate in education, the labour market and civic life. They can reduce the need for formal support services as well as reduce the time and physical burden for caregivers.

28. Global data on the need for habilitation and rehabilitation and related services, the type and quality of measures provided and estimates of unmet need do not exist. However, national-level data reveals large gaps in the provision of and access to services in many low and middle-income countries. Data from four Southern African countries found for example that only 26-55% of people received the medical rehabilitation they needed. Hearing aid production currently meets less than 10% of global need, and less that 3% of the hearing aid needs in developing countries are met annually.

29. Barriers to the provision of habilitation, rehabilitation, assistive technology and community services are significant and include the lack of prioritization in health systems; lack of governance and leadership, policies and plans; high costs and lack of or inadequate funding mechanisms; insufficient appropriately trained professionals, facilities and

[3] Community-based rehabilitation (CBR) offers an operational methodology to realize human rights and development objectives at the community level, based on a comprehensive multi-sectoral approach, which can achieve empowerment for persons with disabilities and their families.

[4] Assistive technology "is any piece of equipment, or product, whether acquired commercially, modified or customized, that is used to increase, maintain or improve the functional capabilities of individuals with disabilities".

equipment; lack of integration and decentralization of rehabilitation services within primary and secondary health settings and ineffective service models. Major rehabilitation centers are usually located in urban areas and even basic therapeutic services are often not available in rural areas. Travelling to secondary or tertiary rehabilitation services can be costly and time-consuming, and public transport is often not adapted for people with mobility difficulties. Lack of research and data on needs, unmet needs, type and quality of services provided, costs and benefits also constrains the development of effective rehabilitation services. Finally, there is insufficient consultation with and involvement of persons with disabilities in the provision of rehabilitation services.

30. Some people with disabilities have complex rehabilitation needs requiring intensive or expert management in tertiary care settings. However the majority of people require fairly low-cost, modest rehabilitation and related services that can be provided in primary and secondary health-care settings or in the community. Article 26 (Habilitation and rehabilitation) of the CRPD outlines the need for States Parties to undertake appropriate measures to organize, strengthen and extend habilitation and rehabilitation services and programmes particularly in the area of health. Article 26 also emphasizes the need for States Parties to promote the availability, knowledge and use of assistive devices and technologies as they relate to habilitation and rehabilitation. In addition, Article 4 (General obligations), Article 20 (Personal mobility), and Article 32 (International cooperation) require Member States and the international community to invest in facilitating access to quality assistive technology, including by making them available at affordable cost.

31. Whilst Ministries of Health will have a critical role in ensuring access to appropriate, timely, affordable and high-quality rehabilitation services, it is important to also recognize and articulate the linkages with other Ministries, for example Social Welfare that may provide services such as the provision of assistive devices or subsidies for services and equipment and Ministries of Labour involved in the provision of vocational rehabilitation etc. Given that non-government actors including faith-based organizations, civil society organizations, and the private sector often play important roles in the provision of rehabilitation services, these must also be included in plans of action.

32. Rehabilitation is always voluntary and some individuals may require support with decision-making about rehabilitation choices. In all cases rehabilitation and community services and supports should empower persons with disabilities and their family members.

OBJECTIVE 2: Strengthen and extend habilitation and rehabilitation services, including integrated community-based rehabilitation, and assistive technology.	**Evidence of success**	**Means of verification**	**Important assumptions**
Success indicator 2.1 **-** X% of countries have developed or updated legislation, policies, and regulations on rehabilitation and community services in line with CRPD.	Existence of rehabilitation and community services law, policy and regulation compatible with CRPD.		

ACTIONS FOR OBJECTIVE 2	**Proposed inputs for Member States**	**Inputs for the Secretariat**	**Proposed inputs for international and national partners**
2.1 Provide leadership and governance for developing and strengthening policies, strategies and plans on habilitation and rehabilitation.	• Develop or revise legislation, policies, standards and regulatory mechanisms for rehabilitation. • Develop or revise national rehabilitation plans in accord with situation analysis. • Develop mechanisms for national rehabilitation sector coordination and planning.	• Provide technical guidance; finalize and disseminate evidence-based Guidelines on health-related. • Provide support and build capacity within Ministries of Health and other relevant sectors for the development, implementation and monitoring of legislation, policies, strategies and plans.	• Participate directly in the development of policies, strategies and plans. • Provide technical inputs and support to countries that are introducing and expanding rehabilitation services.

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
		• Host regional events on developing/strengthening regional action plans on rehabilitation	
2.2 Provide adequate financial resources to ensure the provision of appropriate habilitation and rehabilitation programmes and services.	• Develop funding mechanisms to increase coverage and access to affordable rehabilitation services. • Where needed redistribute existing resources to ensure funding is available for rehabilitation services. • Where appropriate to the country context promote equitable access to rehabilitation services through health insurance.	• Provide evidence based guidance for Ministries of Health, and other relevant sectors and stakeholders on appropriate funding mechanisms for rehabilitation.	• Advocate national leadership for increased resource allocation for rehabilitation. • Provide financial support through international cooperation including in humanitarian crises.
2.3 Develop and maintain a sustainable workforce for habilitation and rehabilitation as part of a broader health strategy.	• Develop and implement national health and rehabilitation plans to increase the numbers and capacity of human resources for rehabilitation. • Improve working conditions, remuneration and career progression opportunities in order to attract and retain rehabilitation personnel.	• Provide evidence-based guidance for Ministries of Health, and other relevant sectors and stakeholders on the recruitment, training and retention of rehabilitation personnel. • Provide technical assistance to support Ministries of Health, and other relevant sectors and stakeholders to build the capacity of training providers, and develop	• Develop training standards for different types and levels of specialist rehabilitation personnel. • Build training capacity in accord with national health and rehabilitation plans. • Implement measures to improve recruitment and retention of specialist rehabilitation personnel particularly in rural and remote areas.

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
		standards for training. • Develop CBR online training package to strengthen CBR workforce particularly at the community level.	• Train non-specialist health personnel on disability and rehabilitation relevant to their roles and responsibilities.
2.4 Expand and strengthen habilitation and rehabilitation services ensuring integration into primary (including community), secondary and tertiary levels of the health care system, and equitable access	• Review existing rehabilitation programmes and services and make necessary changes to improve coverage, effectiveness and efficiency. • Integrate basic rehabilitation services within existing health infrastructure particularly in countries where there are few services available. • Utilize CBR as a strategy to complement and strengthen existing rehabilitation service provision particularly in countries where there are few services available. • Establish mechanisms for effective coordination between different rehabilitation service providers and levels of the health	• Support countries to integrate rehabilitation services into the health system with a focus on decentralization of services at the primary/community level. • Develop relevant tools and training packages to develop and strengthen habilitation and rehabilitation services. • Provide technical guidance for countries that wish to develop or strengthen CBR programmes. • Support the development of a global database on CBR programmes and the CBR Global Network.	• Work with Ministries of Health to expand and strengthen the provision of rehabilitation services in line with national rehabilitation plans. • Promote CBR as an effective strategy to support people with disabilities and facilitate their access to rehabilitation services. • Provide technical and financial support to ensure the delivery of quality CBR programmes, and to maintain existing CBR networks at the global, regional and country levels. • Work with relevant stakeholders to establish and streamline referral systems to ensure people with disabilities have access to the modes of service delivery they

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
	care system.		require at each level of the health system.
2.5 Promote the need for and access to a range of community support services which complement habilitation and rehabilitation services, and support independent living and full inclusion in the community.	• Contribute to the development of policy frameworks for the provision of community support services in line with the CRPD. • Contribute to the development of transition plans for closure of residential institutions, where relevant. • Strengthen referral mechanisms between rehabilitation services and community support services	• Provide technical guidance on designing and implementing appropriate policy frameworks. • Support capacity building in the area of independent living and personal assistance.	• Advocate for the development of policy frameworks to ensure the effective provision of community support services. • Support national leadership in identifying and securing technical and financial resources required for community support services. • Provide technical inputs/supports to ensure persons with disabilities and their family members/informal caregivers have access to community supports.
2.6 Make assistive technologies of appropriate quality available and accessible.	• Include the provision of assistive technologies in health, rehabilitation and other relevant sectoral policies, strategies and plans accompanied by the necessary budgetary support.	• Develop and disseminate evidence-based guidance on the provision of assistive technology. • Provide technical assistance to Member States to build capacity to develop and strengthen provision of assistive technology.	• Provide technical and financial assistance to Member States to build capacity to develop and strengthen provision of assistive technology.
2.7 Engage, support and build the capacity of persons with	• Include persons with disabilities and their family members /	• Promote awareness and understanding about the rights of	• Advocate the inclusion of persons with disabilities and their family

ACTIONS FOR OBJECTIVE 2	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
disabilities, and their family members / informal caregivers to support independent living and full inclusion in the community.	informal caregivers in all aspects of developing and strengthening rehabilitation services. • Collaborate with other sectors to ensure appropriate support services are provided for informal caregivers.	persons with disabilities and the role of families/informal caregivers. • Maintain and strengthen partnerships with organizations and associations representing persons with disabilities and their family members/caregivers.	members / caregivers in all aspects of developing and strengthening rehabilitation services. • Advocate the importance of informal caregivers in the lives of people with disabilities, and the importance of promoting their health and wellbeing.

<u>OBJECTIVE 3:</u> STRENGTHEN COLLECTION OF NATIONALLY RELEVANT AND INTERNATIONALLY COMPARABLE DATA ON DISABILITY, AND SUPPORT RESEARCH ON DISABILITY,

33. Good quality disability data and research are essential for informing policy and programmes and efficiently allocating resources. They are also important for strengthening understanding about disability and what works in overcoming barriers and ensuring that persons with disabilities can participate and contribute equally.

34. There is however a lack of rigorous and comparable data and research related to disability and health care systems nationally and globally. While data are collected on mortality, policy-relevant data on functioning and disability are lacking. Surveillance systems do not often disaggregate data based on disability, and persons with disabilities are often excluded from trials that seek scientific evidence for the outcomes of a health intervention. The lack of evidence is a significant barrier for decision-making and in turn impacts on access to mainstream health care and specialized services for persons with disabilities.

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

36. Internationally, methodologies for collecting data on disability need to be developed, tested cross-culturally, and applied consistently. Tools are required for disaggregating data relating to persons with disabilities. Data need to be standardized and internationally comparable to benchmark and monitor national and international progress on disability policies and on the implementation of the CRPD. Nationally, disability should be included in data collection. Uniform definitions of disability, based on the International Classification of Functioning (ICF), can allow for internationally comparable data. Dedicated disability surveys, or disaggregating data from other data collection efforts by disability status, can provide information on disability characteristics, such as prevalence, health conditions associated with disability, use of and need for services, quality of life, opportunities, and rehabilitation needs.

37. Priority areas for health-related research include measurement of disability and its determinants; identification of barriers in health care and strategies for overcoming barriers; success factors for health promotion interventions for persons with disabilities; prevention of secondary conditions; and early detection and referral of health problems through primary health care. Health-related research on disability should be inclusive of persons with disabilities and research agendas should be developed with the active participation of persons with disabilities or their representative organizations.

OBJECTIVE 3: Strengthen collection of nationally relevant and internationally comparable data on disability, and support research on disability	**Evidence of success**	**Means of verification**	**Important assumptions**
Success indicator 3.1 **-** % of countries which have capacity to monitor routinely the situation of persons with disabilities. ***Success indicator*** **3.2 -** % of countries including disability within priorities of national research funding agencies	Number of countries with valid, reliable monitoring tool providing international comparable data on health and social situation of persons with disabilities. Research funding programmes which explicitly mention disability as a priority for research.	Government responses. National reporting from Ministry of Education, National Science Foundation or equivalent.	

ACTIONS FOR OBJECTIVE 3	**Proposed inputs for Member States**	**Inputs for the Secretariat**	**Proposed inputs for international and national partners**
3.1 Improve disability data collection through the development and application of a standardized model disability survey (MDS)	• Implement valid and reliable tools to enable and improve the collection of data on disability.	• Develop evidence-based tools to assist and strengthen collection of data on disability, including a Model Disability Survey. • Provide technical support to Member States to build capacity for disability related data collection and research through development and implementation of Training of Trainer programmes on disability data collection.	• Provide technical and financial support to the Secretariat to assist with the development of tools to collect data on disability. • Provide technical and financial support to Member States to improve their capacity to collect data of disability.

ACTIONS FOR OBJECTIVE 3	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
		• Convene regional events to systematically review data by area, demonstrate analysis options and application of results to policy development.	
3.2 Reform national data collection systems, including health information systems, to routinely include sex and age-disaggregated disability data based on ICF.	• Include disability in national data collection systems and provide disability disaggregated data wherever possible.	• Provide technical guidance to support Member States developing and/or reforming national data collection systems, including health information systems to strengthen the disability component.	• Provide technical and financial support to Member States developing and/or reforming national data collection systems to strengthen the disability component.
3.3 Invest in and strengthen research on priority disability issues focusing particularly on the key objectives of this action plan	• Work with research funding agencies to ensure that disability is included as a priority issue • Support research on priority disability issues including needs and unmet needs for services, barriers to service delivery, and health and rehabilitation outcomes.	• Develop, publish and disseminate evidence-based guidelines for Member States and partners on priority disability issues. • Collaborate with research partners to conduct and steward research on priority disability issues, for eg. Noncommunicable disease-related disability.	• Support Member States and the Secretariat in conducting research on priority disability issues.
3.4 Strengthen capacity and build a critical mass of disability-trained researchers in a range of disciplines including	• Develop and implement a strategy for strengthening and building human resource capacity in the area of disability research,	• Collaborate with Member States and key national and international partners to develop strategies to strengthen and build human	• Provide technical and financial support to Member States to develop and implement strategies to strengthen and build human

ACTIONS FOR OBJECTIVE 3	Proposed inputs for Member States	Inputs for the Secretariat	Proposed inputs for international and national partners
epidemiology, disability studies, health and rehabilitation, special education, economics, sociology, and public policy.	including for DPOs • Collaborate with key education and training institutions (both national and international) to strengthen and build human resource capacity in the area of disability research. • Ensure people with disabilities get access to the training needed to become researchers.	resource capacity in the area of disability research.	resource capacity in the area of disability research. • Provide learning and research opportunities by linking universities in developing countries with those in high-income and middle-income countries.