Good practices

Compendium of good practice examples to improve health services for people with disabilities

2020-2023

MISSING BILLION

System functions	Governance	• National Clinical Programme for People with Disability in Ireland • Improving access to health care among people with disabilities in Uruguay • National Roadmap for Improving the Health of People with Intellectual Disability in Australia
	Leadership	• COVID-19 Disability Advisory Group (CDAG) in Canada • Advisory Committee for the COVID-19 Response for People with Disability in Australia
	Health Financing	• Dental health reimbursement for people with disabilities in Germany • National Disability Insurance Scheme in Australia • Coverage of disability-related services for children with disabilities in The Philippines
	Data & Evidence	• Learning Disabilities Mortality Review (LeDeR) in the UK • Learning Disability Registers in the UK

Service delivery	Autonomy and Awareness	• Active Rehabilitation Services by and for people with disabilities in Poland • Peer educator training on sexual and reproductive health and rights of people with disabilities in Burundi • Autism and Mental Health Literacy Project (AM-HeLP) in Canada
	Affordability	• Accessible COVID-19 Vaccination Transportation in Toronto, Canada • Disability allowance for people with disabilities in Vietnam
	Human Resources	• Community Health Worker Training in India • Disability-inclusive Nursing Practice Handbook in Germany • Eye care capacity building in low- and middle-income countries • Learning Disability and Autism Training for Health and Care Staff in the UK • Health worker handbook on sexual and reproductive health in Ecuador • Disability and inclusion training for health care workers in Tanzania • Future Learn: Improving Health Assessments for People with Intellectual Disabilities • Disability Training for Community Health Assistants in Zambia • Inclusive family planning and sexual reproductive health services in Kenya

Service delivery

Health Facilities

- Home Testing for COVID-19 in the United Arab Emirates
- Accessible primary health services for Deaf and hard of hearing in Montevideo, Uruguay
- Primary Healthcare Unit for Deaf people in Chile
- Accessibility standards for health facilities in low and middle-income settings
- National Accessibility Audit of Primary Health Care Facilities in Brazil

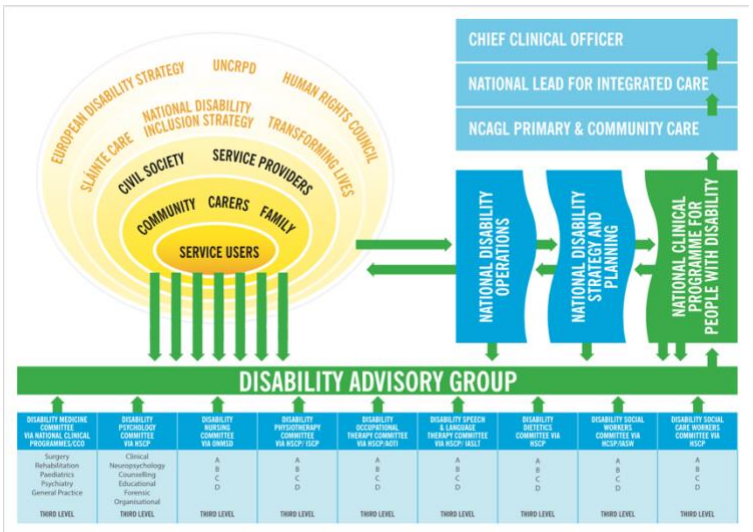
Specialized Services & AT

- Annual Health Checks for people with learning disabilities in the UK
- Wheelchair user training in El Salvador, India, Kenya, Nicaragua, and Romania
- Comprehensive community-based rehabilitation in Tanzania
- National Rehabilitation Plan in Ukraine

SYSTEM ❶ Governance

National Clinical Programme for People with Disability in Ireland

Geography and scale:	Ireland; national
Type of disability:	People with physical, sensory, cognitive, intellectual and psychosocial disabilities; persons with chronic illnesses or frailty and those with transitory impairment.
Involved actors:	Health Service Executive (HSE)



Click on the diagram for larger view.

Best practice description

Housed within the Ministry of Health, the National Clinical Programme for People with Disability (NCPPD) seeks to support the provision of effective and efficient health and social care for people with disabilities.[1,2] Created in March 2020 and composed of three members and a number of associated Disability Specialists, the programme aims to design clinical services that are evidence-informed, context-appropriate, and based in the social and rights model of disability. The NCPPD is advised by the Disability Advisory Group (DAG), consisting of 20 members drawn from each of the nine disciplines which each have a unidisciplinary sub-committee, a range of disability-stakeholders (e.g., service users, carers' associations, service providers, etc.) and representatives of the National Disability Operations and Strategy and Planning programmes. The NCPPD also works closely with other specialized clinical programmes such as mental health, rehabilitation, older persons, etc.

Origin / impetus for best practice

- Ireland's ratification of the United Nations Convention on the Rights of Persons with Disability in 2018 committed it to the inclusion of people with disability in decision making structures.
- Increasing recognition that governance structures dominated by a single profession are sub-optimal for designing integrated clinical services.
- Existing commitment to enhancing the role of other professions through the Health and Social Care Professions Office.
- Promotion by NCPPD personnel of equity of esteem, interdisciplinarity and co-leadership across professions.
- Opportunity to rapidly progress establishment of the new NCPPD due to the exigencies of Covid-19 pandemic.[3]

Impact / results of implementing best practice

- Development of suite of national guidance documents to support health and social care delivery during the COVID-19 pandemic resulting in lower morbidity and mortality by international comparison.[4,5]
- Supporting health workers training to adapt disability assessments and interventions during COVID-19, thereby ensuring continuity of safe and essential services.
- A survey on digital and assistive technology for disability services recognized good practice and scalable projects for acceptable and safe services, supports and opportunities beyond COVID-19 pandemic.
- Changing expectations of people with disability and health and social care professions through co-design, parity of input and integrated approach.

Critical success factors for best practice

- Leveraging ratification of UNCRPD
- Political and clinical window of opportunity for disability related agenda-setting.
- People with disabilities and/or their representatives are centred in the programme.
- Strong backing from health and social care leadership

Impact statement

"The NCPPD has bridged the gap between social care and healthcare in Ireland. The programme has created a fit-for-purpose governance structure which will ensure that integrated health and social care services are co-designed with people with disability, civil society, clinical and care practitioners; is rights-based and determined by person and family-centred needs." – *NCPPD team*

Lessons learned

- The relevance of the UNCRPD to clinical contexts has to be claimed and demonstrated.
- The principle of participation has to be embedded for service providers as well as service users.
- Conventional practices need to be challenged by credible people with credible alternatives.
- Senior allies open to change must be identified and engaged.

Sources	[1] National Clinical Programme for People with Disability [2] NCPPD Programme Governance [3] The Impact of COVID-19 on People with Disabilities [4] COVID-19 posters and resources [5] COVID-19 HSE Clinical Guidance and Evidence
Further links & information	• Guidance on Conducting Assessments in Disability Services • Survey on Digital and Assistive Technology use in Disability Services

Date: March 2021

SYSTEM 1 Governance

Improving access to health care among people with disabilities in Uruguay

MISSING BILLION

Geography and scale: Uruguay; National
Type of disability: All types of disabilities

Involved actors:
- Ministry of Health
- Ministry of Social Development
- PAHO/WHO
- OPDs
- UN Women
- UNPF

"Right to equality and non-discrimination of persons with disabilities"
Click on the image to visit the official website, all information in Spanish.

Best practice description

In 2018, the project "Right to equality and non-discrimination of persons with disabilities" was launched in Uruguay to improve access to health care among people with disabilities. Based on a human rights framework, people with disabilities, institutional actors and civil society established the minimum requirements to guarantee access to health care:

1. Health service providers use the Washington Group's set of questions to identify people with disabilities.
2. Health care workers are trained about disability-inclusive health care with a human rights approach.
3. Each health facility has a focal person that provides all disability-related information.
4. Inclusive health care facilities and services are widely advertised in the population.
5. Diverse communication and information supports (e.g. braille, sign language interpreters, etc.).
6. Wait-times and appointments lengths are altered according to specific needs.
7. Direct and indirect disability-related costs are supported.
8. Universal design of health facilities.

Origin / impetus for best practice

- In 2016, an investigation found multiple forms of discrimination in Uruguay. This led the Committee on the Rights of Persons with Disabilities and the Committee on the Elimination of Discrimination against Women of Uruguay to call on the state to guarantee the rights to equality and non-discrimination of people with disabilities.

Impact / results of implementing best practice

- Training of 300 health care workers in different regions of the country and in both public and private health providers.
- Training of 50 institutions on the Washington Group questions to systematise data on disability.
- Production of accessible free online sexual and reproductive health resources.

Critical success factors for best practice

- Funding by the United Nations Partnership on the Rights of Persons with Disabilities Multi Partner Trust Fund.
- Direct participation of people with disabilities.
- Intersectoral approach including civil society and institutional actors.

Impact statement

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Lessons learned

- Permanent collaboration between actors from different institutions improves the quality of products.
- The participation of people with disabilities in the design, elaboration and validation of products is essential.
- Involvement of people with disabilities is key during training, agreement and negotiation processes.
- The shift towards a social and human rights model of disability is a gradual process.

Sources	• Official project's website • Minimum requirements to guarantee health care access among people with disabilities [in Spanish] • Accessible resources about sexual and reproductive health [in Spanish]
Further links & information	• The United Nations Partnership on the Rights of Persons with Disabilities Multi Partner Trust Fund, 2019 Annual Report

Date: March 2021

SYSTEM

1 Governance

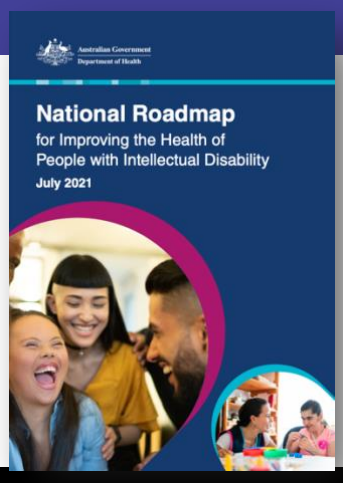
National Roadmap for Improving the Health of People with Intellectual Disability in Australia

MISSING BILLION

Geography and scale: Australia; national

Type of disability: People with intellectual disability

Involved actors:
- Australian Government Department of Health
- People with intellectual disability, family members and carers
- Advocacy organisations
- Clinical and academic experts
- Disability service provider organisations
- Additional Commonwealth agencies and state and territory governments.



Best practice description

The National Roadmap for Improving the Health of People with Intellectual Disability (the Roadmap) was launched in August 2021 after an extensive consultation process. The Roadmap is a landmark document that sets out a comprehensive range of actions to improve the health of people with intellectual disability. Key objectives include:

1. Improve support for people with intellectual disability, their families and carers (e.g., health literacy resources, disability liaison officers in health services).
2. Develop better models of care that are person-centred, trauma-informed, and with reasonable adjustments (e.g., toolkits, best practice guidelines and clinical standards).
3. Provide support for health professionals, including training to provide quality, appropriate and disability informed health care.
4. Improve oral health by integrating it into general health care and by promoting access to existing dental services.
5. Strengthen research, data and measurement of health outcomes.
6. Improve emergency preparedness and response to meet the needs of people with intellectual disability.

Specific programs will implement these objectives over the next 10 years. The Roadmap Implementation Governance Group (RIGG) will oversee implementation of the Roadmap. Membership of the RIGG includes people with intellectual disability, family members and carers; health and disability sector representatives; academic experts; Commonwealth, and state and territory government representatives.

Origin / impetus for best practice

- Around 450,000 people have intellectual disability in Australia (1.8% of the Australian population).
- Compared to the general population, Australians with intellectual disability have higher rates of avoidable deaths, hospitalisations and health conditions.
- In 2019, the Australian Council for Intellectual Disability, in collaboration with Inclusion Australia, launched the "Our Health Counts" campaign to end deadly disability discrimination across Australia.
- A Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability was established in April 2019 in response to widespread concern from the community.
- The Roadmap was approved by the Australian Government Minister for Health and Aged Care, the Hon. Greg Hunt MP, in July 2021.

Impact / results of implementing best practice

- Establishing the RIGG and its sub-committees (Intellectual Disability Focus Group, Education and Training Expert Advisory Group, and National Centre of Excellence Expert Advisory Group) to oversee projects.
- To date, $19.26 million in Australian Government funding:
  - $6.6 million to develop a Primary Care Enhancement Program for people with intellectual disability
  - $6.7 million to improve the uptake and implementation of Annual Health Assessments
  - $4.7 million for curriculum development in intellectual disability health, and
  - $1.4 million to scope and co-design a National Centre of Excellence in Intellectual Disability Health.

Critical success factors for best practice

- Including people with lived experience of intellectual disability when developing and implementing the Roadmap.
- Use of best available evidence to highlight the need to take action.
- Powerful disability advocacy and strong political commitment.
- Cooperation and commitment from a wide range of actors, including Commonwealth and state and territory governments, private and not-for-profit providers, universities and health professional bodies.

Impact statement

The Roadmap aims to address serious health inequities faced by people with intellectual disability. It outlines how Australia can create a health system where people with intellectual disability are valued, respected and have access to high quality, timely and comprehensive health care.

Lessons learned

- Robust governance arrangements need to be established early and sustained.
- Meetings need to be accessible for people with intellectual disability (providing materials in Easy Read, asking presenters to speak slowly, and offering pre-meeting briefing).
- Progress reports and communiques are made publicly available to ensure all parties are held accountable for action.
- Strong advocacy from disability and health organisations is needed to ensure continued implementation and funding of projects.

Sources

[1] National Roadmap for Improving the Health of People with Intellectual Disability
[2] Roadmap Implementation Governance Group (RIGG)
[3] RIGG Meeting communiques

Further links & information

- Commit to the National Roadmap for action! End Deadly Disability Discrimination
- The road to the Roadmap - Council for Intellectual Disability
- How will the Roadmap help people with intellectual disability - video

Date: May 2022

SYSTEM 2 LEADERSHIP

COVID-19 Disability Advisory Group (CDAG) in Canada

MISSING BILLION

Title:	Canadian COVID-19 Disability Advisory Group (CDAG)
Geography and scale:	National; across Canada
Type of disability:	All types of impairments

Involved actors

- Minister of Employment, Workforce Development and Disability Inclusion
- Employment and Social Development Canada
- Health Canada
- Senior Government of Canada Officials and other Ministers
- Disability advocacy groups
- Committee Members (persons with disabilities, allies, academics, and CSO leaders)

Best practice description

Recognizing the profound impact the COVID-19 pandemic has had on persons with disabilities, the Government of Canada created a COVID-19 Disability Advisory Group (CDAG). The Advisory Group is made up of persons with disabilities, allies, academics, and leaders of civil society organizations who work on disability rights and empowerment. Housed within the Ministry of Employment and Social Development, the CDAG meets bi-monthly to advise the Minister, Carla Qualtrough, on the specific issues persons with disabilities are facing during the pandemic. Members of the CDAG have formed several informal working groups who also meet regularly to discuss how persons with disabiltiies can be included in their respective pandemic response activities and report back to the broader CDAG, the Minister, and other Ministers across the Government of Canada when appropriate. Overall, this machinery has helped to make Canada's COVID-19 response more inclusive to persons with disabilities.

Origin / impetus for best

- Government of Canada's commitment to diversity and inclusion, and its appointment of a Minister responsible for persons with disabilities.
- Minister Qualtrough's personal experiences with disability, and lifelong advocacy work on disability issues, informed need for representation of persons with disabilities in pandemic response.
- Disability community aligned behind key principles for an inclusive pandemic response, which provided room to create a committee.
- The implementation of the Accessible Canada Act (2019) has raised awareness of issues facing persons with disabilities, meaning that other ministries are aware that the "nothing about us, without us" approach to policymaking.

Impact / results of implementing best practice

- Specific guidelines on disability considerations for the COVID-19 pandemic
- Inclusive and disability-informed triage protocols
- Communication guidelines for inclusive information dissemination

Critical success factors for best practice

- Whole of government approach and collaboration
- Representation of persons with disabilities in parliament (i.e. Minister Qualtrough)
- Political will for collaboration and senior leadership drive
- Strong disability community advocacy
- Diverse and intersectional representation of the disability community, particularly Indigenous groups

Impact statement

"We know Canadians with disabilities have been disproportionately affected by COVID-19, and are at greater risk due to health, economic, and social conditions. This is why it was essential for the federal Government to get expert advice on the lived experiences of persons with disabilities in real-time. The COVID-19 Disability Advisory Group provided valuable advice and greatly contributed to ensuring our pandemic response was inclusive from the start. I am grateful for their views and commitment." – *The Honourable Carla Qualtrough, Minister of Empolyment, Workforce Development, and Disability Inclusion*

Lessons learned

- Juristictional challenges prevent full implementation of guidelines, as health is a provincial/territorial issue in Canada and similar structures were not always implemented on these levels.
- Cross-cutting approach to emergency response allowed for greater representation of persons with disabilities.

Sources

1. Government of Canada. Accessible Canada Act [Internet]. S.C. 2019, c.10 Justice Laws Website; 2019. Available from: https://laws-lois.justice.gc.ca/eng/acts/A-0.6/
2. Employment and Social Development Canada. Backgrounder : COVID-19 Disability Advisory Group [Internet]. 2020 [cited 2020 Nov 26]. Available from: https://www.canada.ca/en/employment-social-development/news/2020/04/backgrounder--covid-19-disability-advisory-group.html

Further links & information

- COVID-19 and people with disabilities in Canada
- Backgrounder on Members of the COVID-19 Disability Advisory Group
- Statistics Canada: Impacts of COVID-19 on Persons with Disabilities

Date: Nov 2020

MISSING BILLION

SYSTEM 2 LEADERSHIP

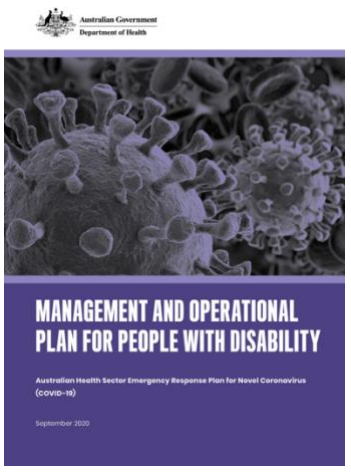
Advisory Committee for the COVID-19 Response for People with Disability in Australia

MISSING BILLION

Geography and scale:	Australia; national
Type of disability:	All types of disability

Involved actors

- People with disability, family members and carers
- Disability organisations
- Disability service sector
- Research sector
- Health care sector (medical practitioners, allied health professionals and nursing)
- Australian Government officials
- State and territory government officials



Best practice description

The Advisory Committee for the COVID-19 Response for People with Disability (Advisory Committee) was established in April 2020 to inform the Australian Government's response to COVID-19 for people with disability. The Advisory Committee includes people with disability, parents and carers, Australian Government officials, state and territory government officials, experts from the health and research sectors, and major disability advocacy groups. Their role is to provide expert advice on the health care needs of people with disability, their families and the disability service sector, including access to COVID-19 screening, prevention and health care.

The Advisory Committee reports to Australia's Chief Medical Officer and regularly informs the Australian Health Protection Principal Committee and Communicable Diseases Network Australia. The Advisory Committee meets regularly (fortnightly in April 2022), and oversees implementation of the Management and Operational Plan for People with Disability under the Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19). Each meeting begins with people with lived experience sharing any relevant updates to the committee for discussion or further action.

Origin / impetus for best practice

- The Australian Government recognised that many people with disability were at greater risk of contracting SARS-CoV-2 and adverse outcomes of COVID-19.
- The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability called on Australian governments to take all necessary measures to ensure protection and safety of people with disability during the pandemic.
- In line with its commitment to ensure that people with disability have equitable access to health care, the Government took early action between March and April 2020 to develop a targeted COVID-19 response plan for people with disability, including the formation of the Advisory Committee.

Impact / results of implementing best practice

- Developed one of the world's first dedicated plans focusing on people with disability.
- Prioritising people with disability in residential settings during vaccine roll-out.
- Among National Disability Insurance Scheme beneficiaries, 87.7% of those aged 16 and over are fully vaccinated as at 14 April 2022.
- Recognition of people with disability within Australia's Primary Health Care 10 Year Plan 2022-2032(launched 25 March 2022).

Critical success factors for best practice

- Powerful disability community advocacy.
- Government officials commitment to considering lived experience of disability in decision-making processes.
- Strong inter-agency collaboration.
- Cooperation across Commonwealth and state and territory governments.

Impact statement

The Australian Government, government agencies, and state and territory governments are working together to coordinate an evidence-based response to a respiratory illness outbreak caused by a novel (new) coronavirus (COVID-19).

Lessons learned

- Importance of disability representatives sharing their lived experience during committee meetings has personalised the challenges and spurred action.
- The need to consider people with disability proactively in health emergency preparedness plans, rather than reactively in response.
- The Advisory Committee has helped enable cross-agency collaboration, which is critical for effective emergency responses.
- Dedicated team needed to do liaison and ensure collaboration within and across governments.
- Publish meeting communiques online to ensure governments are accountable.

Sources	• Advisory Committee for the COVID-19 response for People with Disability • Management and Operational Plan for People with Disability • Advisory Committee meeting communiques • Australian COVID-19 vaccination daily rollout update
Further links & infor-mation	• The impact of and responses to the Omicron wave of the COVID-19 pandemic for people with disability • CDNA national guidelines for the prevention and management of COVID-19 outbreaks in disability residential services - The Disability Supplement • Australia's Primary Health Care 10 Year Plan 2022-2032.

Date: May 2022

MISSING BILLION

SYSTEM 3 Health Financing

Dental Health reimbursement for people with disabilities in Germany

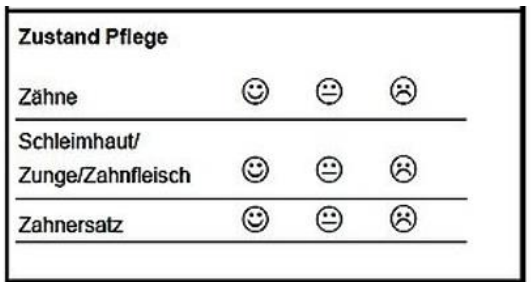
MISSING BILLION

Geography and scale: Germany, nation-wide

Type of disability: All persons with disabilities insured by the public health insurance and entitled to integration assistance and care support.

Involved actors

- German Federal Ministry of Health
- Federal Joint Committee (G-BA)
- National Association of Statutory Health Insurance Dentists (KZBV)
- German Dental Association (BZÄK)
- German Society of Geriatric Dentistry (DGAZ)
- Working group dentistry for patients with disabilities (AG ZMB)
- Public health insurance companies.



Oral health status assessment of teeth, tongue, gums and dentures with a smiley face rating scale.

Best practice description

Special regulations apply for people with disabilities already since 2012; simple dental care procedures provided at home and travel costs to outpatient dental facilities covered for persons with severe disabilities. However, in 2018, a new directive was stablished to further change the reimbursement for insured persons with disabilities. Four main benefits apply: **(1)** Oral health status assessed and registered on a form with an accessible format; **(2)** dental calculus removal available and offered; **(3)** individual oral health plans developed with measures and means to promote dental care and **(4)** oral health education tailored to the specific needs of each person, for instance with demonstrations and practical instructions. Carers are considered in oral health education and individual health plans when needed. All benefits are provided every six months (once per year for the general population).

Origin / impetus for best practice

- Scientific studies had shown that some adults with disabilities have worse oral health (more decayed and missing teeth) than the general population [1,2,3]. Main reasons are financial barriers, physical inaccessibility, and lack of knowledgeable health workers.
- The social law stipulates that health insurances need to consider specific needs. Advocates used that to convene stakeholders and develop the "Oral health for elderly and people with disabilities" report, published in 2010.
- Advocates used this report to enforce the new 2018 directive that changed the reimbursement.

Impact / results of implementing best practice

- Further regulations are being discussed e.g., life-long fluoridation, additional time for dental treatments, in-patient dental treatments, interventions with general anesthesia.

Critical success factors for best practice

- Advocacy (e.g., Special Olympics outreach activities)
- Data collection and evidence building.
- Collaboration among stakeholders.
- Reimbursement of dental services.

Impact statement

"…After decades of struggling to improve dental and oral health for patients who still belong to the high-risk group for caries and periodontal disease, this is a great success. For the beneficiaries themselves, but also for the dentists, who have often carried out preventive measures for their patients free of charge". Dr. med. Imke Kaschke MPH (Head of Health, Special Olympics Germany, 2nd chairperson of AG ZMB).

Lessons learned

- Evidence-based data is essential to successfully implement further requirements.
- Training of health workers is necessary, and this may expand the number of actors involved in the field.

Sources

[1] Kaschke, Liere & Jahn (2004) Spec Care Dentist.

[2] Schnorrenberg (2010) Universität Witten-Herdecke.

[3] Schulte, Freyer & Bissar (2012) Community Dental Health.

Further links & information

- G-BA
- German Dental Association
- KZBV

*All in German language.

Date: Nov 2020

SYSTEM 3 Health Financing

National Disability Insurance Scheme in Australia

MISSING BILLION

Geography and scale:	Australia
Type of disability:	All people with disability

Involved actors

- Australian state and participating territory governments

Best practice description

Since July 2016, the National Disability insurance Scheme (NDIS) has provided individualized support to people with disability, their families and carers.[1] The main objectives are to support the independence, autonomy, and social and economic participation of people with disability, and to provide reasonable, necessary, high quality and innovative supports, that are chosen and planned by people with disability. The program will provide support for education, employment, social participation, independence, living arrangements and health and wellbeing. Disability-related health support cover for instance: continence, diabetic management, dysphagia, epilepsy, nutrition, podiatry, respiratory and wound and pressure care supports. To be eligible, individuals must:

1. Reside in Australia, be an Australian citizen, permanent resident or Protected Special Category Visa holder
2. Meet the disability or early intervention requirements
3. Be under 65 years of age when the access request is made

Origin / impetus for best practice

- Around 4.4 million people in Australia have a disability, or 17.6% of the Australian population.[2]
- The needs of people with disability had been overlooked and support programs were inconsistent across different states and territories across Australia.
- The disability and care sectors in Australia campaigned for a new mechanism to fund support for people with disability because the existing system was "fragmented, underfunded, and inneficient"[3], and gave differential treatment based on the cause or origin of disability.
- The NDIS, a new disability care and support scheme, was stablished under the National Disability Insurance Scheme Act 2013 and the National Disability Insurance Agency (NDIA) was created to administer the scheme.

Impact / results of implementing best practice

- Under full implementation, the NDIS is expected to cover 500,000 Australians by 2023.

Critical success factors for best practice

- Universal health coverage and high-performing health system.
- DPO advocacy, who drive the political agenda, and have funding available to support their work.
- Disability representation in the Australian national parliament.
- $21.6 billion fund in 2019-20 for the scheme; half covered by the Australian government.

Impact statement

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Lessons learned

- High burden of proof and cost of significant medical assessments make it difficult for people with disability to meet NDIS requirements.
- NDIA assessors require more training about disability and the scheme.
- The next National Disability Strategy requires further monitoring, implementation support, and disability-disaggregated data collection.
- How to address the needs of those not eligible for the NDIS still need to be decided.

Sources	[1]The National Disability Insurance Scheme: a quick guide [2]People with disability in Australia [3]National Disability Insurance Scheme Bill 2012
Further links & infor-mation	NDIS Website

Date: August 2021

SYSTEM

3 Health Financing

Coverage of disability-related services for children with disabilities in The Philippines

MISSING BILLION

Geography and scale:	The Philippines – Nationwide
Type of disability:	Children with disabilities

Involved actors

- Philippine Health Insurance Corporation (PhilHealth)
- UNICEF Philippines

PhilHealth – Your Partner in Health

UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

Best practice description

PhilHealth provides benefit packages covering children below 18 years with developmental disabilities, mobility impairments, visual disabilities, and hearing impairments in The Philippines. These packages include various interventions, ranging from:

1. Assessments by medical specialists
2. Assessments by allied health specialists
3. Rehabilitation therapy
4. Assistive devices (prosthesis, orthosis, spinal bracing, seating devices, wheelchairs, hearing aids, optical aids, electric aid and white cane); including yearly services and replacement of devices,

Currently, these services are provided by a few government health care institutions in the country.

Origin / impetus for best practice

- Around five million children have disabilities in the Philippines and only 5% have access to assistive technology.
- Households caring for children with disabilities face a triple financial burden. These are additional costs of accessing general health services, disability specific goods and services, and limited employment opportunities.
- In 2015, PhilHealth began financing packages for adult persons with disabilities. Benefit packages cover assistive devices such as upper and lower limb prothesis, lower limb orthosis and spinal orthosis, and rehabilitation sessions in four government facilities and three private facilities.
- The Philippines has undertaken a series of reforms since 2019 towards the realization of universal health coverage for people with disabilities, most recently extending it to children with disabilities.

Impact / results of implementing best practice

- Other government and private institutions will be contracted to increase availability of assessments.

Critical success factors for best practice

- Country commitment with Universal Health Care
- Increasing the budget allocation for the National Health Insurance Program
- Increased tax on alcohol and tobacco as a source of funding

Impact statement

"We are introducing this Z benefit package which is an improved, rationalized and relevant benefit for children with disabilities mainly to prevent the catastrophic spending of the poor and marginalized who are enrolled in the National Health Insurance Program (NHIP) while ensuring quality healthcare services"
Dr. Celestina Ma. Jude P. de la Serna, Interim/OIC, PhilHealth President and CEO (March 2nd, 2018).

Lessons learned

- This program is expected to trigger supply-side investments by the private sector and local government. In addition to reforms in health professional education to respond to the health human resource gap, with the leadership of the ministries of health and education.

Sources	• PhilHealth Benefits package • RA 11228 – An Act Providing For The Mandatory Philhealth Coverage For All Persons With Disability (PWDs) • Implementing rules and regulations of RA 11228
Further links & information	• Philhealth website

Date: March 2022

SYSTEM 4 Data & Evidence

Learning Disabilities Mortality Review (LeDeR) in the UK

MISSING BILLION

Geography and scale:	England, national.
Type of disability:	Children and adults with learning disabilities

Involved actors

- Department of Health
- National Health Service (NHS) England
- Health Quality Improvement Partnership
- University of Bristol

Best practice description

Established in 2015, the LeDeR programme is a novel program to help reduce premature mortality and health inequalities among people with learning disabilities, as well as to improve the quality of health and social care delivery. Its key components are:

- Every person with learning disabilities who dies has a local review of their case notes and cause of mortality to write a report. The report reviews potentially modifiable factors of their death, such as the level of care received, involving other agencies to contribute to the investigation whenever necessary.
- All local reviews are submitted to the programme and analysed at a national level. Reports include main causes of death and good practices, which are compiled into an annual report with recommendations. This report is also translated into an easy-to-read format.

Origin / impetus for best practice

- Mencap's report, Death by indifference, 2007, described cases of institutional discrimination and avoidable deaths of persons with learning disabilities, and called for an urgent independent inquiry.[1]
- The Michael report (2008) revealed that people with learning disabilities had higher levels of unmet needs, received less effective care and had higher risks of avoidable deaths than the general population.[2]
- Findings of the Confidential Inquiry (2013) showed that avoidable deaths of people with learning disabilities were related to quality of care and service provision. Recommendations included the review of deaths, routine collection of mortality data, and the establishment of a national review board.[3,4]
- See related good practice description in our compendium: Learning Disability Registries.

Impact / results of implementing best practice

The findings from the annual reports have led already to significant changes in practice:

- NHS England set out a long term plan to implement national learning disability improvement standards.
- Health and care staff will receive learning disability and autism training.
- Health system changes in local areas are analysed and shared in action from learning reports.

Critical success factors for best practice

- Mencap's initial data on early deaths.
- Strong advocacy from the learning disability community.
- Political will for collaboration.
- Dedicated funding from NHS England.

Impact statement

"The disparity between people with learning disabilities and the general population in relation to average age at death, causes of death, and avoidable causes of death remains substantial and urgent action is needed"

Professor Pauline Heslop; LeDeR Programme Lead. 16th July 2020 on this link.

Lessons learned

- Reviews have to be high quality and completed in a timely fashion.
- Reviews are not mandatory and reporting rates vary by area; commitment to implementation should be strengthened.
- Mortality trends (cause, geographic location,etc.) can be used to inform policy and research.

Sources

[1] Mencap's report 2007
[2] Healthcare for all, Michael Report 2008
[3] Confidential Inquiry 2013
[4] Heslop P, Blair PS, Fleming P, et al. The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study. Lancet (London, England) [Internet]. 2014 Mar 8;383(9920):889–95. Available from: http://www.ncbi.nlm.nih.gov/pubmed/24332307

Further links & information

- LeDeR programme - University of Bristol
- Action from learning – NHS
- Learning disability improvement standards

Date: Dec 2020

SYSTEM 4 Data & Evidence

Learning Disability Registers at Primary Care Level in the UK

MISSING BILLION

Geography and scale:	England, national.
Type of disability:	People with learning disabilities of all ages

Involved actors

- Department of Health
- National Health Service (NHS) England
- Public Health England

Best practice description

In order to reduce health inequalities and improve primary care, learning disability registers were established in 2006 and now cover nearly 285,000 patients. People with learning disabilities are identified and diagnosed by general practitioners (GPs) and then included in a register. This information is coded and added to the patients' electronic health records. In addition, persons with coded clinical diagnoses associated with a learning disability are automatically added to the register e.g., Down's Syndrome. The NHS and Public Health England collect annual data for specific health and healthcare indicators from registers of all participating GP practices; similar data is also aggregated from a group of people without learning disabilities. Data is analysed at a national level and findings from comparative analysis are published in annual summary reports, which are also translated into easy to read formats.

Origin / impetus for best practice

- Mencap advocated for the creation of a registry of people with learning disabilities ("Treat me Right!" report, 2004).[1]
- The Independent Inquiry report (2008) revealed that people with learning disabilities experience higher levels of unmet need and receive less effective treatments than the general population.[2]

Impact / results of implementing best practice

- Registers facilitate identification of patients who are eligible for an annual learning disability health check and seasonal flu vaccination.
- New clinical codes associated to learning disabilities available after expert review.
- Projects derived from data collection e.g., national project to stop over medication (STOMP).

Critical success factors for best practice

- Financial incentives for GPs who keep learning disability registers.
- Strong advocacy from the learning disability community.

Impact statement

Lessons learned

- Coding of clinical diagnoses should be standardized and consistent across datasets from practices.
- Coverage currently varies across the country and around 75% of people with learning disabilities remain invisible to data collection.[3]

Sources	[1] Mencap report 2004 Treat me right [2] Michael Report 2008 [3] Learning Disabilities Observatory 2016
Further links & information	• NHS – Learning Disabilities and Autism • Learning Disability Data • NHS – Health and Care of People with Learning Disabilities, Experimental Statistics

Date: Nov 2020

SERVICE DELIVERY

5 Autonomy and Awareness

Active Rehabilitation Services by and for people with disabilities in Poland

MISSING BILLION

Geography and scale: National; Poland

Type of Disability Spinal cord injury/disorder (SCI/D), wheelchair users

Involved actors

- Foundation for Active Rehabilitation (FAR)
- State Fund for the Rehabilitation of the Disabled
- Ministry of Family, Labour, and Social Policy

Best practice description

FAR is an organization of persons with disabilities run and supported by persons with SCI/D that offers social and vocational activation programs to persons with SCI/D. FAR works with acute rehabilitation facilities to identify potential program participants and provides:

- Training camps where participants acquire practical daily skills (e.g. wheelchair training, activities of daily living, using transportation)
- Information about living with SCI/D
- Free wheelchair rental for the first year after hospital discharge
- Vocational skills training
- Vocational, social, and psychological counseling.
- Support to the family of persons with SCI/D.

FAR also supports inclusive healthcare by training health professionals on disability issues related to SCI/D from the perspective of persons living with SCI/D and advocacy work. In addition to financing through the State Fund for the Rehabilitation of the Disabled (under the auspices of the Minister of Family, Labour and Social Policy), selected projects are financed by regional governments (e.g. Lodz), the European Union and the business community (e.g. Toyota).

Origin / impetus for best practice

- The concept of active rehabilitation for person with SCI/D stems from the idea that returning to society was a matter of self-determination of persons with SCI/D and can be achieved through sports and skills training.
- Despite existing guidelines on the healthcare for persons with SCI/D, no national programs for SCI care existed, especially long-term care and for community integration. FAR fills the gap between professional-run healthcare and life in the community.

Impact / results of implementing best practice

- Improved motor function.
- Increased independence.
- Improved quality of life.
- Enhanced social integration and job opportunities with FAR.

Critical success factors for best practice

- Having persons with SCI/D as the program facilitators, staff, and leaders of the organization.
- Collaborating with different sectors for programs, donations, etc.
- Strong connection with rehabilitation hospitals

Impact statement

"Persons with permanent SCI do not require continuous care for the rest of their lives, and do not have to be released from any responsibilities. They need skills which will allow them to regain their self-reliance, self-esteem, and a place in the society. This is where the Foundation for Active Rehabilitation steps in. It teaches people with spinal cord injury how to lead a normal life in a wheelchair, how to fulfil their dreams and achieve the goals they had before the accident."

Lessons learned

- Need to have community-based and funded rehabilitation services.
- Critical connections between acute hospitals and post-rehabilitation programs.

Sources

- Tederko et al. 2017. People with SCI in Poland
- Kaminska-Gwozdz et al., 2018. Effect of FAR camps on the QoL of Individuals with SCI.

Further links & information

- Divanoglou, A., Tasiemski, T., Augutis, M. et al. Active Rehabilitation—a community peer-based approach for persons with spinal cord injury: international utilisation of key elements. Spinal Cord 55, 545–552 (2017). https://doi.org/10.1038/sc.2017.28
- EU Resources on People with Disabilities

March 2021

SERVICE DELIVERY

5 Autonomy and awareness

Peer educator training on sexual and reproductive health and rights of people with disabilities in Burundi

MISSING BILLION

Geography and scale: Burundi; provinces of Mwaro, Muramvya and Gitega

Type of disability: All persons with disabilities with a focus on youth (10-24 years old)

Involved actors
- National Program for Reproductive Health, Ministry of Health of Burundi
- National Union of Burundi for people with disabilities (UPHB)
- Deustche Gesellschaft für Internationale Zusammenarbeit (GIZ)
- Local health centres (14) and associations for people with disabilities
- Province and district health management teams
- Specialized educators for people with disabilities
- Youth with disabilities

Best practice description

Youth with disabilities were trained to become peer educators in sexual and reproductive health and rights (SRHR) of people with disabilities. The training was implemented in 2021 by UPHB in collaboration with GIZ. Peer educators then hold informative sessions for youth with disabilities in specialized centres and inclusive schools. SRHR are promoted among youth of different faiths and settings, depending on their specific needs and age groups. Key contents include SRHR, sexually transmitted diseases, contraception, body changes, physical, psychological and sexual violence, etc. Healthcare providers and other partners in the project area also participated in trainings about inclusive health for people with disabilities.

Origin / impetus for best practice

- In 2020, centres and associations for people with disabilities were identified in the provinces of Mwaro, Muramvya and Gitega to assess SRHR needs regarding health information and access to health services. This mapping and assessment was conducted by GIZ in collaboration with UPHB.
- People with disabilities in Burundi have poor access to SRHR education and are exposed to abuse. The specific needs of people with disabilities are not taken into account in health structures. There is a lack of health worker training on disability and SRHR, as well as a lack of adequate educational materials. In addition, health facilities have poor physical accessibility and health care providers tend to have discriminatory behaviour towards people with disabilities.

Impact / results of implementing best practice

- Improved knowledge of SHRH among youth.
- Training of 90 peer educators on SRHR.
- 52 information sessions on SRHR held by peer educators, reaching over 1500 youth with disabilities.
- Training of 43 healthcare workers and 2 partners on inclusive health for people with disabilities.

Critical success factors for best practice

- Youth with disabilities as peer educators on SRHR.
- Topics covered and training methodology.
- Follow-up of peer educators after training and management of peer educators' turn-over.
- Collaboration with religious leaders, as they are the main support of organizations for people with disabilities.
- Funding from an international organization for SRHR and disability inclusion.

Impact statement

- A course on SRH was organised involving people with disabilities. Their participation is a first. Thanks to the training and contacts with the specialised structures, we are thinking of involving people with disabilities in our awareness-raising activities on SRH", Gaudence (caregiver, Fota)

Lessons learned

- Collaboration with SRH stakeholder networks will help to reach people with disabilities in the community.
- Commitments made during training should be implemented and awareness raising activities monitored.
- Future needs include provision of accessible equipment, refresher trainings, and experience sharing between stakeholders and other actors.

Sources	• Training guide for providers in inclusive approaches, 2021, UPHB (Internal use) • A Victorious Youth, Sexual Health and Reproductive Rights Education Guide, 2017, GIZ

Further links & information	

Date: Feb 2022

SERVICE DELIVERY

5 Autonomy and Awareness

Autism and Mental Health Literacy Project (AM-HeLP) in Canada

MISSING BILLION

Geography and scale:	Canada (but available online)
Type of Disability	Autism Spectrum Disorder (ASD)

Involved actors

- Centre for Addiction and Mental Health (CAMH)
- York University Developmental Disabilities and Mental Health Lab
- Autistic people and their families
- Spectrum Productions
- Public Health Agency of Canada

Best practice description

The Mental Health Literacy Guide was developed to increase autistic adults' awareness, knowledge, and acceptance of mental health. The guide has nine sections that focus on building awareness of mental health, particular mental health concerns and coping strategies for autistic people, and resources for support. The guide is targeted primarily at autistic adults and quotations throughout the document showcase the lived experiences of autistic adults to provide the most appropriate, relevant, and valid information. The guide follows two years of consultation with 29 autistic adults and family members of autistic adults from across Canada who spoke about their personal lived experiences. The advisers informed the structure, topics and content of the guide, including chapters on the definition of mental health, what it's like to grow up autistic in Canada, strategies to maintain good mental health, appropriate identity-first language to use to talk about autism, signs of mental health problems and ways to promote well-being. The guide also includes information on the pandemic's impact on autistic people and resources for families and others.

Origin / impetus for best practice

- Lack of information about autistic people's experience of mental health and mental health needs.
- No mental health literacy materials that talk about the intersection between well-being, mental health problems, and autism.
- Limited mental health resources that specifically incorporate autistic peoples perspectives.
- High rates of mental health or substance use disorders among autistic adults (~50%).
- Desire to create a more friendly, welcoming, and accepting environment of autistic mental health, as well as develop more autistic-informed mental health supports in Canada.

Impact / results of implementing best practice

- A program evaluation is underway: researchers are interviewing autistic advisors to understand the experience of co-creating the guide and to develop lessons learned for the future.

Critical success factors for best practice

- Involvement of autistic adults in designing and producing the guide's content.
- Funding from government agencies for autistic mental health research.
- Plain-language summaries and accompanying videos/transcripts make it more accessible to all individuals.
- Specific sections focused on intersectionality.

Impact statement

"One of the biggest myths we try to dispel in this guide is that autism is a mental health problem. Autism is not a mental health problem; it is a different way of being," Dr. Jonathan Weiss, associate professor in the Faculty of Health and York Research Chair in Autism and Neurodevelopmental Disability Mental Health at York University and project lead on the guide (News@York)

Lessons learned

- Importance of consulting and highlighting individuals with lived experience in guidelines.
- While action is important, individual awareness and autonomy can be critical to starting conversations on under-researched or underrepresented topics.

Sources	Autism Mental Health Literacy Project (AM-HeLP) Group. (2021). Mental Health Literacy Guide for Autism. Link.
Further links & infor-mation	The guide has been turned into an animated video series, which can be found on YouTube.

Date: May 2022

SERVICE DELIVERY

6 Affordability

Accessible COVID-19 Vaccination Transportation in Toronto, Canada

MISSING BILLION

Geography and scale:	Residents of the city of Toronto, Canada.
Type of disability:	Any type of disability

Involved actors

- City of Toronto
- Toronto Public Health
- Community Organizations (Toronto Ride, iRide, Scarborough Ride)
- Toronto's Accessibility Task Force on COVID-19 Vaccines
- Uber

Best practice description

The Accessible COVID-19 Vaccination program allows people with disabilities and those over 75 years of age to request free, accessible transportation to COVID-19 vaccination clinics. Individuals are eligible if they "are frail or have underlying conditions which make them at greater risk from COVID-19 and/or unable to safely access other modes of public transportation". The program is available to residents of Toronto if they meet the criteria and have an appointment at a city-run or health partner clinic. Community partners have been selected to ensure those who need to be vaccinated will be reached and Uber has donated $150,000 CAD of vouchers to community organizations. Metro and bus passes were also given to those who could take public transport but could not afford it.

Origin / impetus for best practice

- Limited accessible transport options in Toronto city.
- Recognition that some individuals may not be comfortable using public transport because of their risk status, but need accessible and affordable transport to and from the vaccination centres.
- Input from people with disabilities on Toronto's Accessibility Task Force on COVID-19 Vaccines and their desire to remove barriers to vaccination.

Impact / results of implementing best practice

- Increased accessibility of vaccination.
- Reduced financial barriers to vaccination.

Critical success factors for best practice

- Political will to remove barriers to vaccination.
- Involvement of community organizations.
- Strong disability involvement and dedicated accessibility task-force.
- Health equity considerations that included disability.

Impact statement

"At the City of Toronto, we are committed to ensuring that every resident in every area of in this city can easily access a COVID-19 vaccine when it's their turn. To make this possible, we have adopted a Team Toronto approach that builds on partnerships and active collaborations and delivers on-the-ground support. The Vaccine Equity Transportation Plan is a great example of working together to help our community and remove barriers to accessing vaccines."– Councillor Joe Cressy (Spadina-Fort York), Chair of the Toronto Board of Health

Lessons learned

- Importance of disability representation on task forces and equitable, accessible approaches to COVID-19 response programs.
- Incorporating multiple accessible modalities of transport (i.e. public, private) and partnerships are key to reach individuals with disabilities.

Sources	• Ontario Extending Free Rides to Vaccination Sites for People with Mobility Issues
Further links & information	• Toronto's Vaccine Equity Program • Backgrounder on Toronto's Accessibility Task Force on COVID-19 Vaccination

Date: April 2022

Disability allowance for people with disabilities in Vietnam

Location & scale

Vietnam, National

Type of disability

All people with disabilities

Involved actors

- Ministry of Labour, War Invalids and Social Affairs
- Ministry of Health
- Ministry of Education and Training
- Department of Labour, Invalids and Social Affairs (Provincial level)
- Labour, Invalids and Social Affairs Division, District People Committee (District level)
- Disability Degree Determination Council
- Heads of Cultural and Social issues (Commune level)

1. Description

People with disabilities in Vietnam are entitled to an unconditional cash transfer to cover for daily life expenses. To be eligible, people must have "severe and very severe disabilities" certified by the Disability Degree Determination Council. As of July 2021, people with disabilities can receive a standard social support of about US$17 (VND 360.000) per month. Depending on age and level of severity, larger cash transfers may apply. For instance:

- Adults with severe disabilities: ~ US$25,5
- Children or elderly with severe disabilities, or adults with **very** severe disabilities: ~ US$34
- Children or elderly with **very** severe disabilities: ~ US$42,5

Each allotment is given at the commune level at the local state administrative agency by the responsible civil servant and can be collected in person by the applicant or an individual designated on their behalf.

2. Origin

- In Vietnam, about 7% of the population have disabilities.
- Compared with the general population, people with disabilities in Vietnam:
  - often live in rural areas
  - are two times more likely to be poor
  - have extra living costs due to higher expenses (e.g. in medical care, personal assistance, assistive technology, etc.)
  - more often use health services (medical examination, treatment and rehabilitation)
- In 2012 a social protection program was introduced, including a disability allowance
- About 40% of people with disability receive a monthly disability allowance, which is mainly used to cover basic needs (food, clothing), household expenses and access to general health services.
- Implementation challenges include coordination of services, adequacy of evaluation tools and accessibility of disability assessments.
- Therefore, in 2021 the government decided to reform the social protection program for people with disabilities.

3. Impact

- Expanded coverage of the disability allowance: 395.000 beneficiaries in 2011 to 1,1 million in 2021
- Increased rate along the years (from US$12.75 to US$17)
- Improved accessibility for disability assessments
- Improved household ability to meet basic needs or access healthcare

4. Impact statement

"Social support policies are implemented promptly, fairly, publicly and transparently; on the basis of level of disadvantage and priority in family and community where beneficiaries live" – The Government of the Socialist Republic of Vietnam (Clause 1, Article 3 Decree No. 20/2021/ND-CP)

5. Critical success factors

- Existence of a disability law (2010) promoting the right to access to healthcare, education, transportation, vocational training, and employment
- Disability being on the government's agenda
- Effective local organizational structure with focal points addressing the needs of people with disabilities

6. Lessons learned

- Cash payments could be extended to better cover the needs of people with disabilities.
- Disability Degree Determination Councils need further training on disability and assessment tools to improve consistency across the country.
- There is a need to improve the participation of organizations of people with disabilities in the council.
- It is important to clarify procedures related to the responsibilities of district and commune-level People's Committees in implementing social protection policies.

Sources & links

- Disability-inclusive social protection research in Vietnam (Link here)
- National Disability Survey Vietnam 2016 (Link here)
- Action to the Community Development Institute, Vietnam: "Some innovations in the social assistance policy in Decree No. 20/2021/NĐ-CP of the Government, related to people with disabilities" (Link here)

Acknowledgments

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SERVICE DELIVERY

7 Human Resources

Community Health Worker training in India

MISSING BILLION

Geography and scale:	Dehradun District, Uttarakhand, India
Type of Disability	Developmental Disabilities

Involved actors

- Latika Roy Foundation
- Sight Savers
- Accredited Social Health Activists (ASHAs)

Best practice description

Through a Sight Savers Innovation Grant, the Latika Roy Foundation trained Accredited Social Health Activist (ASHA) in four blocks of the Dehradun district (population: 754,753) on early intervention for children with developmental disabilities. As the Community Health Workers who visit homes for immunisation and maternal health programs, ASHAs also check on young infants. This program taught them to use the WHO tool to identify children with developmental disabilities or delays and refer them to the nearest early intervention centre. Over four months (February to May 2013), 18 ASHA facilitators were trained as master trainers by parents of children with developmental disabilities. From June onwards, these facilitators trained their own ASHA workers under supervision (320 total). Once these were completed by August 2013, follow up workshops were conducted on a monthly basis to understand current knowledge, application in the field and clarifications around understanding and implementation. Thereafter, each home visit would be accompanied by a short interview and assessment with the parents help to assess the development of infants and young children. Those who have been identified with potential delays are referred to the primary health center for further assessment and treatment.

Origin / impetus for best practice

- Despite the high prevalence of disabilities, children were not being referred to early intervention services as much as they should and as early as they should.
- Limited access to community-based services in the rural, mountainous state of Uttarakhand, meant the best feasible option seemed to train the community health workers who visited homes in far and remote areas as part of their national program agenda.
- Families' could not travel long distances for assessments and identification, limiting their ability to access local referrals for therapy for their children
- Limited funding and acute scarcity of professionals to support children with disabilities

Impact / results of implementing best practice

- The program helped with identification of hundreds of children with developmental disabilities who received early intervention.
- Health care workers received new skills, which will also benefit the typical children in their caseloads. Beneficiaries included 560 children; 560 parents; 18 ASHA facilitators, and 320 ASHAs.

Critical success factors for best practice

- Permission for training and implementation, as CHWs are over burdened with multiple government schemes.
- Salary for ASHA facilitators travel and time.
- Supervision and faith that tool would be implemented.
- Connecting with and motivating families to participate in an early childhood developmental evaluation.

Impact statement

"Since the program commenced in January 2013, 133 children have been followed up. A total of 46 follow up programs have been conducted as of July 2013." – Dr. Shubha Nagesh, Latika Roy Foundation

Lessons learned

- Local level health workers can be trained effectively to identify children with disabilities and facilitate early intervention.
- Most interventions are simple for CHWs to learn, teach, and transfer to families of all literacy levels.
- Early intervention is critical, but sustained funding is necessary to ensure these programs continue.

Sources

Census of India (2011). Government of India Census of India https://www.census2011.co.in/census/district/578-dehradun.html

Dunst, C. J., & Bruder, M. B. (2006). Early intervention service coordination models and service coordinator practices. Journal of Early Intervention, 28(3), 155-165.

World Health Organization. Disability and rehabilitation: WHO action plan 2006- 2011. Geneva: World Health Organization. http://www.who.int/entity/disabilities/publications/dar_action_plan_2006to2011.pdf.

Further links & information

- Mont D. Measuring Disability Prevalence. Disability and Development Team. The World Bank Human Development Network Social Protection. 2007. Available at http://worldbank.org/DISABILITY/Resources/Data/20070606DMont.ppt
- World Bank Report. People with disabilities in India: from commitments to outcomes. Washington DC: Human Development Unit, South Asia Region, World Bank, 2007.

SERVICE DELIVERY

7 Human Resources

Disability-inclusive Nursing Practice Handbook in Germany

Geography and scale:	Primarily the German state of North Rhine-Westphalia
Type of Disability	All types

Involved actors

- Compentence Centres Self-determine Life (KSL) [Kompentenzzentren Selbstbestimmt Leben]
- Ministry of Employment, Health and Social Welfare [Ministerium für Arbeit, Gesundheit und Soziales des Landes Nordrhein-Westfalen],
- Bochum Centre for Disability Studies (BODYS), Protestant University of Applied Sciences Rheinland-Westfalen-Lippe

Best practice description

As part of the campaign of North Rhine-Westphalia (NRW) to implement the UNCRPD's stipulations for equal access to healthcare for persons with disability (PwD), the "Competence Centres Self-determine Life (KSL)" in NRW developed a nursing practice handbook entitled "KSL-Concrete #4 Nursing Diversity" [KSL-Konkret #4 Vielfalt Pflegen]. This handbook was written to enhance nursing training with a compact reference guide on effective communication and interaction with PwD in routine practice, on recognizing the needs of PwD and acting accordingly. It aims to lend the nurse confidence in treating patients with disability by building skills and sensitizing the nurse to potential situations (case examples) in clinical routine. This is essential, since the nurse is often the first point of contact in the healthcare facilities and a person of trust. The KSL and their work are financed by the European Commission Social Fund and KSL Ministry of Employment, Health and Social Welfare.

Origin/impetus for best practice

To implement the idea that sustained improvement of life of PwD is a societal responsibility, NRW developed an action plan in 2012 "A society for all – NRW inclusive". As part of this action plan, six competence centres (KSL) were created to ensure the self-determination of PwD and inclusive healthcare in NRW. These KSLs run diverse projects to meet these objectives, especially in the area of knowledge transfer and training. One of these projects was the development of this nursing practice handbook.

Impact / results of implementing best practice

The handbook has only been around since November 2020, but it will sensitize nurses and the public to inclusive health care issues.

Critical success factors for best practice

- Government leadership.
- Training methodology.

Impact statement

" The knowledge acquired through this practical manual will give you confidence in communicating and in interacting with PwD. [By understanding what PwD need], you will save precious time and can focus on providing care. PwD will benefit, and so will you." - Claudia Middendorf, NRW parliamentarian responsible for PwD.

Lessons learned

- Need to reinforce handbooks with training and other supports for people with disabilities.
- Essential to target nurses with training, given they are usually the first point of contact in care.

Sources	KSL-Concrete #4 Nursing Diversity (German)
Further links & infor-mation	• Inclusive health official website in German language • Video: Trailer of practice handbook in German language

July 2022

SERVICE DELIVERY

7 Human Resources

Eye care capacity building in low- and middle-income countries

MISSING BILLION

Geography and scale:	Worldwide; focus on sub-Saharan Africa
Type of Disability	Visual impairment

Involved actors

- Light for the World
- University Hospitals in Jimma and Gondar, Ethiopia
- Ministry of Health, Uganda
- Ministry of Foreign trade and Development Co-operation, Netherlands

Best practice description

To meet the aim of WHO's and the International Agency for the Prevention of Blindness VISION 2020 global initiative to eliminate avoidable blindness, Light for the World with partners have offered cataract operations, distribute medication, train ophthalmologists, build and support hospitals, and provide mobile services that offer eye care in remote areas of low- and middle-income countries, especially in sub-Saharan Africa. Through this program, they set up several residency, optometry, ophthalmic technician, and eye care nursing programs to increase the number of eye-care workers domestically across sub-Saharan Africa. This has also created enough staff for mobile teams to support remote communities.

Origin/impetus for best practice

Over 2 billion people in the world have lost all or some of their sight. At least 1 billion of them have a visual impairment that could have been prevented or treated. Loss of sight severely affects their participation in daily life, e.g. not being able to attend school or work.

Impact / results of implementing best practice

- 63 doctors are pursuing ophthalmology studies in African countries.
- Increase number of eye care staff through two residency programs at Univ. hospitals in Jimma and Gondar.
- 50 students were trained in clinical optometry, and nurses start with ophthalmology or further training.
- Eye clinic of Arba Minch has mobile teams that travel to remote areas.
- Burkina Faso established the country's first national ophthalmology training program in the capital city.
- Mozambique supported the training of ophthalmic technicians and ophthalmologists.
- Partnership with the Ugandan Ministry of Health in the National Intervention on Uncorrected Refractive Errors project.

Critical success factors for best practice

- Successful coordination and engagement with multiple governments and stakeholders.
- Sustainable approach to providing services and increasing capacity.
- Mixed approaches (formal education, training, mobile teams) to have a large impact.

Impact statement

"We strive for effective solutions and high quality. We focus on sustainable and systematic changes, but at the same time also on direct impact and better living conditions for people with disabilities. Our first projects were focused on eye-care and inclusive education…Over the years, the breadth and diversity of the work have grown, and we direct more attention to the rights of persons with disabilities and the importance of inclusive societies."

Lessons learned

- Importance of collaborative effort.
- Sustainable approach is necessary for long-term success.

Sources	Light for the World
Further links & infor-mation	Light for the World Annual Report

March 2021

SERVICE DELIVERY

7 Human Resources

Learning Disability and Autism Training for Health and Care Staff in the UK

Geography and scale:	National, across the United Kingdom
Type of disability:	Learning disabilities and autism

Involved actors

- LeDeR Mortality Review
- NHS (UK health system)
- Department of Health and Social Care
- NHS Health Education England
- British Institute
- British Institute of Learning Disabilities (BILD)
- Gloucestershire Health and Care NHS Foundation Trust
- Mencap
- Pathways Associates Community Interest Group

Best practice description

Starting in April 2021, the NHS has mandated that all health and social care staff participate in mandatory training programs to meet the needs of people with learning disabilities and autism. The program is based on the 2019 Capabilities Frameworks that provide guidance for supporting people with learning disabilities and autism. As part of a pre-service training and professional development program, health and social care workers will be exposed to a curriculum that looks at:

i) Understanding learning disabilities and autism
ii) Personalized support
iii) Physical and mental health
iv) Risk, legislation, and safeguarding
v) Leadership and management, education and research.

The program was designed in collaboration with people with disabilities and will be delivered by individuals with lived experience through face-to-face delivery and blended learning approaches. The program is administered to different tiers of health workers in either two half-day sessions or two full-day sessions (or both).

Origin / impetus for best practice

- LeDeR mortality review and Mencap reports demonstrated the need for better training to improve knowledge, skills and awareness of learning disabilities and autism among health and care professionals.
- The UK Government decided to consult people with learning disabilities and autism to implement a mandatory training for health workers.

Impact / results of implementing best practice

- Over 5,000 people participated in the consultation process to develop the training.
- 1.2 million NHS staff and 1.5 million adult social care staff in England are expected to take part in the training, when it is fully implemented.

Critical success factors for best practice

- Consultation process with people with disabilities, their families, and carers.
- Government responded to mortality reviews and developed action plan for improving health outcomes .

Impact statement

Lessons learned

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Sources	'Right to be heard': The Government's response to the consultation on learning disability and autism training for health and care staff. Department of Health and Social Care. 5 November 2019. Oliver McGowan Mandatory Training in Learning Disability and Autism. NHS Health Education England. Accessed 8 February 2021 Learning Disability and Autism Training for health and Care Staff: A Consultation. Department of Health and Social Care. February 2019
Further links & infor-mation	• Capabilities Framework for Supporting Autistic People • Supporting Autistic people and/or people with a learning disability

Date: March 2021

SERVICE DELIVERY

7 Human Resources

Health worker handbook on sexual and reproductive health care for people with disabilities in Ecuador

MISSING BILLION

Geography and scale:	Ecuador; National
Type of disability:	All types

Involved actors

- Ministry of Public Health, Ecuador
- National Council for Disability Equality, Ecuador
- United Nations Population Fund

"Comprehensive sexual and reproductive health for people with disabilities; Handbook, 2017" Click on the imagine for more information in Spanish.

Best practice description

In 2017, a handbook on sexual and reproductive health services for people with disabilities was developed and distributed to health care professionals in Ecuador's national health system. With a special focus in primary care, it aims to ensure there are quality services that respond to the particular needs of people with disabilities. Based in a human-rights framework, it also aims to strengthen sexual and reproductive health information and counselling for people with disabilities, as well as the exercise of their rights. The handbook provides technical guidance, general recommendations and specific advice by type of disability on: attitudinal, communicational and physical accommodations; autonomy, independence and informed consent; use of contraceptives; pregnancy, childbirth, postpartum and new-born care; and prevention of sexual violence.

Origin / impetus for best practice

- Ecuador subscribes to a human rights framework to address disability and acknowledges at the constitutional level that persons with disabilities are a priority group with recognized rights of access to specialized health care, free medications, comprehensive rehabilitation, and assistive technology.
- The Ministry of Health's National Plan for Sexual and Reproductive Health 2017– 2021 promotes inclusion, equality and respect for human rights within the framework of sexual and reproductive health.
- Ecuador was involved in the "We Decide" programme led by the United Nations Population Fund that promotes the human rights and social inclusion of women and young persons with disabilities.
- Gender-based and sexual violence was found to be higher among women with disabilities than those without in Ecuador.

Impact / results of implementing best practice

- First national workshop of 2019 strengthened inter-sectoral coordination and plans further implementation of the handbook, including the correct use of the contraceptive methods booklet in Braille language.

Critical success factors for best practice

- Technical support of international organizations.
- Participation of a broad range of stakeholders, including people with disabilities.
- Disability-inclusion in the country's political agenda.

Impact statement

- . . .
- . . .
- . . .

Lessons learned

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- . . .
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Sources	• Comprehensive sexual and reproductive health for people with disabilities; Handbook, 2017 [in Spanish] • State party report 2018 UNCRPD • Workshop on Handbook, 2019, UNFPA, Ecuador [In Spanish]
Further links & infor-mation	• Young persons with disabilities: Global study on ending gender-based violence, and realising sexual and reproductive health and rights, 2018, UNFPA

Date: April 2021

SERVICE DELIVERY

7 Human Resources

Disability and inclusion training for health care workers in Tanzania

MISSING BILLION

Geography and scale: Dar es Salaam, Tanzania

Type of disability: All types

Involved actors
- Comprehensive Community Based Rehabilitation in Tanzania (CCBRT)
- Ministry of Health, Community development, Gender, Elderly and Children, Tanzania
- Tanzanian Nursing and Midwifery Council
- Kupona Foundation

Best practice description

CCBRT is the largest provider of disability and rehabilitation services in Tanzania. Through its academy, it offers specialist training for health care professionals on disability inclusion in health care services. A two-day training course aims to provide trainees with an understanding of the concept of disability-inclusive health services and the barriers and benefits of such services for people with disabilities. It is directed at CCBRT staff and representatives of development organizations. The course is based on a human-rights framework and it is delivered through lessons and workshops. After completion, participants receive certificates of attendance and six CCBRT credits.

Origin / impetus for best practice

- The CCBRT Academy started offering external trainings in 2018 in a response to the shortages in human resources for health and limited access to continuing professional training, as well as a sustainability strategy for the organisation.
- The disability inclusion in health care services training is part of a disability and inclusion program that offers courses on the general concept of disability, advocacy, Kiswahili sign language, accessibility, and disability inclusion in the workplace and schools.

Impact / results of implementing best practice

- In 2019, 1,044 people were trained through the academy.
- Increasing number of persons with disabilities who are coming to health facilities to access health care services.
- Improved access of physical infrastructure of the newly constructed health facilities (ramps, toilets, elevators, etc.).
- There has been some initiatives by the Ministry of Health and some partners to produce information on health in accessible formats (Braille and sign language).

Critical success factors for best practice

- Long-standing experience in capacity building and education.
- Sustainable approach.
- Strategic partnerships with academic institutions, philanthropists, sponsors and health care providers.

Impact statement

Lessons learned

- Continuous learning of healthcare providers on disability inclusive approaches is crucial to ensure sustainability.
- Capacity building to health care providers has to go hand in hand with development and dissemination of National Guidelines on Disability Inclusive Health Care Services.
- People with disabilities need to be empowered on their rights to healthcare services and be informed on availability of those services in their localities.

Sources	• CCBRT official webpage • CCBRT Academy
Further links & information	• CCBRT Academy Training Catalog 2019-2020

Date: July 2021

SERVICE DELIVERY

7 Human Resources

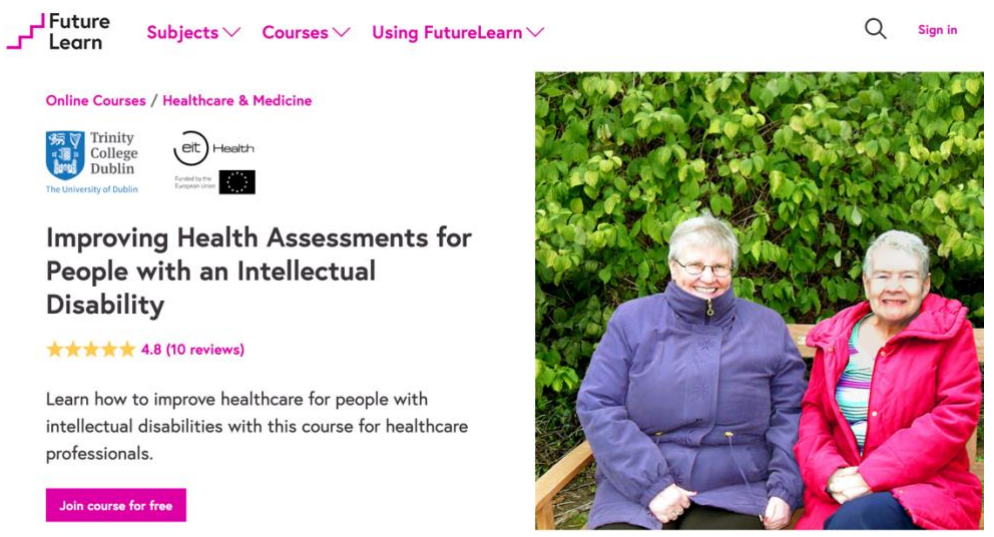
Future Learn: Improving Health Assessments for People with Intellectual Disabilities

MISSING BILLION

Geography and scale:	Internationally accessible, online
Type of disability:	Intellectual Disabilities

Involved actors

- Future Learn
- Trinity College Dublin (TCD)
- EiT Health



Best practice description

The FutureLearn platform provides free and open online courses, including "Improving Health Assessments for People with Intellectual Disability". The aim is to provide healthcare practitioners the knowledge to improve practice and include reasonable adjustment when engaging individuals with intellectual disability in health assessments. The course is taught through a partnership between Trinity College Dublin and EIT Health and was co-developed by people with intellectual disabilities to train health workers on improving care. The content focuses on health inequity, the healthcare landscape for people with intellectual disabilities, communication skills, reasonable adjustments, and best practices for assessing patients with intellectual disabilities. The course is accredited by the Nursing and Midwifery Board of Ireland and can be used as continuing professional development, in some jurisdictions. It provides two hours of content per week over three weeks.

Origin / impetus for best practice

- A previously developed comprehensive health assessment demonstrated the need for more implementation support and health worker training.
- Deinstitutionalization resulted in increased involvement of primary care doctors in health care for people with intellectual disabilities
- Higher prevalence of health conditions, health inequity, and lack of reasonable adjustments to ensure they actually are invited to health assessments, which contributed to high rates of undiagnosed or untreated health conditions among people with intellectual disabilities

Impact / results of implementing best practice

- Over 7,000 healthcare professionals have enrolled in the course in over 100 countries.
- The MOOC is now integrated as part of a module on the intellectual disability nursing programme of TCD Dublin.
- Expansion to post graduate programming in intellectual disability for healthcare professionals at TCD Dublin.
- 87.5% of participants noted a change in perspective about assessing people with ID, 83% noted a change in their approach to communication and 79.1% noted it contributed to their day to day work to make health assessment possible.

Critical success factors for best practice

- Online, flexible, and free materials continuously available
- Course was co-designed with people with intellectual disabilities
- Ability to use the course hours for Continuing Professional Development and courses' accreditation
- Course provides practical techniques for adapting clinical practice
- Integrated into the undergraduate nursing curriculum at TCD Dublin

Impact statement

"The program has been absolutely fabulous, it is so needed and a great boost to everyone, promoting better practice when dealing with people with ID".

Dr Eilish Burke, Ussher Assistant Professor at TCD Dublin. The creator also noted that this course provides targeted education in a convenient way for the learner promoting education and improvement to healthcare delivery for people with intellectual disability.

Lessons learned

- Wide reach and impact of a short course that is widely available.
- Importance of providing practical technique alongside clinical background.
- Need for robust research to inform evidenced based practice.

Sources & Useful Links	• Future Learn Website • Making Reasonable Adjustments to Support People with Intellectual Disabilities in Health Assessments • Health Assessment Impact Video

Date: April 2021

SERVICE DELIVERY

7 Human Resources

Disability Training for Community Health Assistants in Zambia

MISSING BILLION

Geography and scale:	Zambia, National
Type of Disability	All types

Involved actors
- Ministry of Health (MoH)
- Zambia Institute for Special Education
- Clinton Health Access Initiative (CHAI)
- United States Agency for International Development (USAID)

Best practice description

In 2019, the Clinton Health Access Initiative (CHAI) worked with the Government of Zambia in facilitating a 5-day training aimed at improving Community Health Assistants' (CHAs) skills and capabilities for inclusive patient focused healthcare to persons with disabilities. The program trained Ministry of Health (MoH) staff, and tutors and clinical instructors at the two main CHA training schools. By focusing on the teachers and liaisons who work daily with CHAs, the objective was to determine together ways to incorporate greater understanding of the health needs of people with disabilities, and the barriers they face when seeking healthcare, into the education and assessment of CHAs going forward. The training focused on:

1) The unique health system experience of people with disabilities
2) Communication skills (e.g., engagement and communication with children with autism), and introductory sign language
3) Teaching skills in orientation and mobility content to students with visual impairment
4) Use of assistive devices, and other neurological disorders

Origin / impetus for best practice

- In Zambia, CHAs play an important role by filling the gap and increasing access to basic health services for rural communities.
- In 2016, the Zambian MoH conducted a curriculum review of the CHA training program and found that CHAs were not being trained on disability inclusiveness. Questions arose as to whether tutors had the required skills and knowledge to teach students disability inclusiveness.
- CHAI, in partnership with the MoH, and USAID under the Community Health Assistants Support Activity, developed this pilot initiative to improve tutors' understanding and comfort around teaching disability inclusiveness.

Impact / results of implementing best practice

- Training of 19 tutors (most were nurses and others were environmental health technologists).
- Trainees acquired skills in Zambian sign language and other modes of communication.
- Disability modules will be developed and included in all CHA training schools.

Critical success factors for best practice

- Curriculum review of the CHA training program.
- Early involvement and commitment of the MoH.
- Training conducted by a disability specialist hired by the MoH.
- Sufficient time provided for each trainee to familiarize themselves with the training materials and the inclusion of practical sessions.

Impact statement

"I see a great improvement in health services, as most clinics and hospitals have trained health workers in sign language. More awareness and training in disability is needed so that in the next three years disabled people in Zambia are assured of better health"

IMukuma Chiwata, deaf lecturer at the Zambia Institute of Special Education.

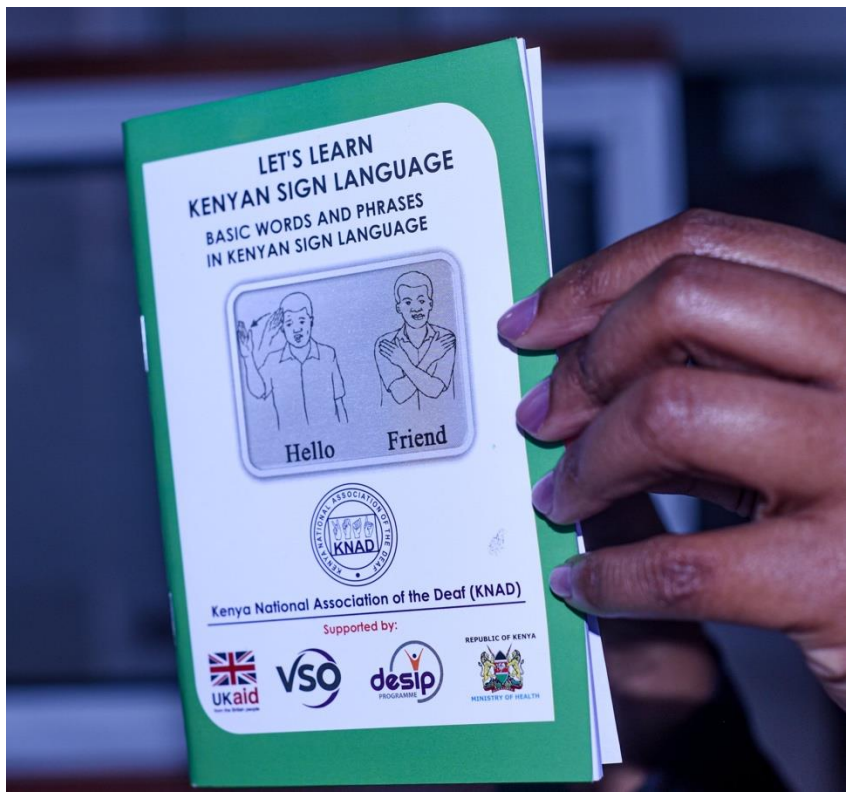
Lessons learned

- Trainees were more receptive to content on sign language and neurological disorders than deafness or blindness. Therefore, more practical sessions and videos about this topic would be ideal.
- Advanced medical terms in sign language should be taught.
- Certified health training schools need a comprehensive disability inclusion curriculum and the MoH should extend disability training to frontline staff.

Sources	
Further links & infor-mation	1 USAID/Zambia Health - Community Health Assistants Support About: The Community Health Assistants Support Activity ran from March 2019 to June 2021. The overall purpose of the activity was to improve access to cost effective, quality basic health and nutrition services at community level and in health posts across eight provinces (Central, Copperbelt, Eastern, Luapula, Muchinga, Northern, North-Western, and Western).

Date: March 2022

Inclusive family planning and sexual and reproductive health services in Kenya



Location and scale

Kenya; 19 counties (Wajir, Garissa, Mandera, Samburu, Isiolo, Marsabit, Kilifi, Lamu, Kwale, Tana River, Mombasa, Baringo, Narok, Kajiado, West Pokot, Elgeyo Marakwet, Turkana, Migori and Homa Bay).

Target population

Women, with special focus on poor rural women, adolescents and people with disabilities

Involved actors

- Foreign, Commonwealth and Development Office (FCDO)
- Ministry of Health, Republic of Kenya
- Population Services Kenya (PS Kenya)
- AMREF Kenya
- Health Right International
- Faith to Action Network
- Voluntary Service Overseas Kenya
- Options Consultancy Services
- Population Services International (PSI)

1. Description

The Delivering Sustainable and Equitable Increases in Family Planning (DESIP) programme aims to ensure that women can plan their pregnancies safely, in line with sexual and reproductive health rights, and to increase access to and use of modern contraceptives. The programme will contribute to reduced maternal, new-born and child mortality in Kenya. DESIP's implementation approach is systems strengthening at policy and service delivery levels to ensure sustainability, and works with public, private and faith-based health facilities. The project integrates social inclusion with a focus on people with disabilities at all levels of implementation:

1) **At national level:** advocacy for disability-inclusive health policies and tools (e.g., inclusive indicators and support for the development of disability mainstreaming guidelines).
2) **At county level:** sensitization of county health management teams; encouraging changes in clinical infrastructures; increasing health funding (e.g., additional disability inclusive budget); and having disability champions.
3) **At health centre level:** training of health staff (e.g., on gender perspective and the use of Braille, sign language, and the Washington Group's set of questions to identify people with disabilities).
4) **At the community level:** sensitization of community health workers (e.g., awareness raising on family planning needs, integration of people with disabilities in outreach and in reach activities, and collaboration with organizations of people with disabilities to promote uptake of family planning services).

This programme is planned for 2019-2024 and also develops educational materials for use at health facilities and in the community.

2. Origin

- There are more than 1.3 million people with disabilities in Kenya.
- Young women with disabilities have difficulty accessing sexual and reproductive health services.
- Access barriers include: structural factors; low awareness of family planning among persons with disabilities; physical inaccessibility of health facilities; inaccessible health information; and low disability-related knowledge and skills of health professionals.
- Modern contraceptive use remains low in some counties and among the poorest populations.
- The DESIP programme was designed and aligned with FCDO's commitment to "leave no one behind".

3. Impact

- 272 health providers trained in disability now attend to people with disabilities.
- 263 health providers received on-the-job guidance on strategies for embedding social, gender and disability inclusion into sexual and reproductive health and family planning programmes, as well as support in self-assessing the inclusive accessibility of health care services.
- Production of health information in Braille formats and sign language posters.
- Disability friendly infrastructure enhanced in some facilities, e.g., ramps and purchase of wheelchairs.
- Data collection in the family planning registers at health centres; previously not included in the registers.
- Community mobilized for people with disabilities.
- Inclusion of people with disabilities and indicators in national level policies.
- Resource allocation for inclusive health in health facilities.

4. Critical success factors

- Initial survey of healthcare providers and health facilities on the current situation of people with disabilities.
- Participation of disability champions in health facilities ensures continuous training of health care workers and advocacy for people with disabilities at facility and county level.
- Operationalization of social inclusion for people with disabilities integrated into the various components of the programme.
- Project funding by FCDO.

5. Lessons learned

- To facilitate disability and family planning data collection, policies need to be disability-inclusive and have indicators for people with disabilities within government tools. Therefore, this programme is collecting data from the beginning of its implementation.
- Trained staff realized that people with disabilities need services just like any other person. However, there is a low awareness and sensitization of health workers in health centres.
- Disability and health equity remain low on the sector's agenda.
- Employing people with disabilities as part of the programme is crucial and increases its impact.
- It is expected that counties will continue to drive the interventions and, if other implementing partners mainstream disability inclusion, more donors will be able to fund the components under the programmes they fund.

Sources & links

- DESIP programme factsheet (link)
- DESIP Learning Conference Report "Leaving no one behind; Expanding sustainable access to contraceptive for all during COVID-19 pandemic" (link)
- VSO Health champion: Truphosah Fridah Monah (link)

Acknowledgments

We thank PS Kenya and VSO for sharing their experience and collaborating in the development of this good practice example sheet.

SERVICE DELIVERY

8 Health Facilities

Home Testing for COVID-19 in the United Arab Emirates

MISSING BILLION

Geography and scale:	National
Type of Disability	Those who have difficulty reaching testing facilities, particularly those with communication and mobility disabilities

Involved actors

- Ministry of Community Development
- Ministry of Health
- Crown Prince of Abu Dhabi Sheikh Mohamed bin Zayed Al-Nahyan

Best practice description

To ensure universal access to COVID-19 testing, the United Arab Emirates launched home testing for residents with disabilities* who may otherwise not be able to access a COVID-19 testing facility. In particular, the program targets individuals with mobility and communication disabilities for whom travelling to a testing centre or communicating with health workers is challenging. Individuals or their families can call a number to book an appointment when a specialized team will come by the home to do the test. The program also expands drive-through testing facilities, which has also increased access for some people with disabilities.

Origin / impetus for best practice

- Desire to ensure all citizens and residents had access to preventative and diagnostic measures, such as testing
- Government's priority to include people with disabilities in mainstream programs, as well as targeted programs to ensure health and safety

Impact / results of implementing best practice

- Reduced barriers to getting tested for COVID-19
- Enhanced accessibility for people with disabilities

Critical success factors for best practice

- Government effort to identify barriers and address them through targeted programs
- Sufficient resources (Human resources for health, personal protective equipment, tests, etc.) to provide at-home testing

Impact statement

Lessons learned

- Two-tracked approaches (universal access and targeted programs) are critical to meeting the health needs of people with disabilities
- Governments need to identify and find innovative ways to address gaps in services for people with disabilities, such as home-based services where feasible

Sources	United Arab Emirates National Home Testing Program for People of Determination
Further links & infor-mation	• Mohamed bin Zayed launches 'National Home Testing Programme for People of Determination' • Coronavirus: UAE launches home testing option for 'people of determination'

* People with disabilities are referred to as "people with determination" in the UAE

March 2021

SERVICE DELIVERY

8 Health Facilities

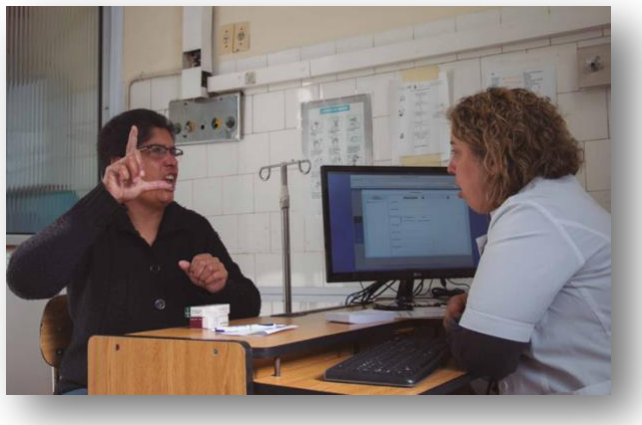
Accessible primary health services for Deaf and hard of hearing in Montevideo, Uruguay

MISSING BILLION

Geography and scale:	Montevideo, Uruguay; Regional
Type of Disability	Deaf and hard of hearing

Involved actors

- Ministry of Health, Uruguay
- State Health Services Administration
- Municipal Government
- National Disability Programme
- National Federation of the Deaf of Uruguay



Best practice description

Four primary healthcare units in Uruguay provide accessible services for the Deaf and hard of hearing. General health services are offered in Uruguayan sign language by a multidisciplinary team including general practitioners, psychologists, social workers, sign language interpreters and deaf mediators. Hearing team members have good knowledge of sign language and patients are accompanied to secondary care referral services by interpreters and mediators. These units opened in 2012 as one of the first of their kind in Latin America to improve health equity and reduce barriers to healthcare access for this population group. Specific objectives include:

1. Training health teams in Uruguayan sign language and in the inclusion of the Deaf community.
2. Defining the role of sign language interpreters and deaf mediators as new members of the healthcare team.
3. Facilitating access to health prevention and promotion for the Deaf community and developing strategies for referrals to secondary care.
4. Achieving comprehensive services appropriate to the needs, autonomy, and independence of patients.

Origin / impetus for best practice

- Uruguay has a population of five million inhabitants. Around 30,000 persons have hearing impairments and 15,000 of them use sign language, which is the country's second official language.
- Deaf and hard of hearing often have worse health outcomes such as higher prevalence of chronic diseases. They also face several communicational barriers that have resulted in poor access to health information and high quality services.
- To address these issues, the first healthcare units for this population were based on a French model of care and Uruguayan health teams were trained through cross-country collaboration and continuous professional development.

Impact / results of implementing best practice

- About 700 persons use the service regularly, resulting in 1000 health visits per year (Year 2019).

Critical success factors for best practice

- Uruguay pledged to universal health coverage, through the Integrated National Health System.
- Cross-country collaboration facilitated the development of the service.
- Powerful disability advocacy.

Impact statement

"In Uruguay, deaf culture was an invisible culture. People didn't see it, they were isolated. Today they are among all of us. I think we have changed the way we think, the way we act and the way we communicate"

Gustavo Milano, General Practitioner at the health unit (Source 2019: Access to health care, a universal right?)

Lessons learned

- Many medical terms still cannot be translated into sign language, so concepts such as viral aetiology, hormonal imbalance, and some sexually transmitted diseases remain unspecific.
- It is an ongoing challenge to fund interpreters and mediators who are not part of the general health budget.
- It is necessary to systematise and record these activities for the elaboration of health statistics.

Sources	• Benia W, Moresino S, coord. Buenas prácticas en capacidad resolutiva. Primer nivel de atención del SNIS. 2018 - Montevideo: Ministerio de Salud Pública, junio de 2019. 336 p.

Further links & information	• Health Service for Deaf persons (in Spanish) • Video of the health service in Spanish, French and sign language

June 2022

SERVICE DELIVERY

8 Health Facilities

Primary Healthcare Unit for Deaf people in Chile

MISSING BILLION

Geography and scale

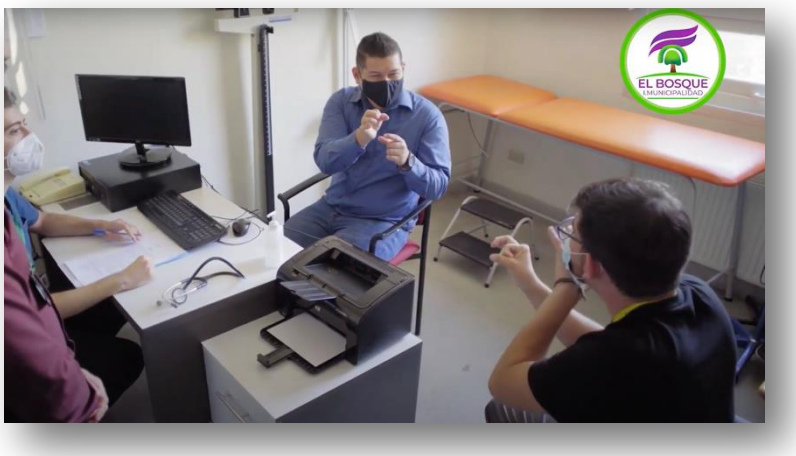
Santiago, Chile; communal

Type of disability

People with hearing impairments

Involved actors

- Santa Laura primary health care center
- Municipal health department, El Bosque Municipality
- Deaf Chileans Foundation
- Deaf Chilean community



Best practice description

A health unit of Santa Laura primary healthcare center offers accessible and integral health services in sign language for people with hearing impairments. The team, consisting of a deaf mediator, a sign language interpreter and a service coordinator, receives between 5 to 6 people per day. The main services offered include:

1. Linguistic and cultural interpretation and mediation.
2. Patient education through workshops on health promotion and prevention.
3. Basic training of health professionals in sign language and inclusive health.
4. Research to identify and develop vocabulary in sign language about medical and health terms.

People must be enrolled at the healthcare center and registered in the unit. Appointments can be scheduled in person, by message or video call. Support is offered throughout the whole primary healthcare journey, as well as referrals and emergencies. The health unit is funded by the local government, through the El Bosque Municipal Health Directorate, which has an agreement with the Deaf Chileans Foundation for the provision of services.

Origin / impetus for best practice

- About 712,005 people (3.7% of the population) have some degree of hearing loss in Chile according to the National Disability Survey of 2015.
- Deaf people often have worse health outcomes than the general population and face communication barriers that prevent them from accessing health information and equal care.
- In 2017, the Deaf Chileans Foundation was trained in the French healthcare model for deaf people by doctors Alexis Karacostas and Jean Dragon. Moreover, the Foundation completed an internship at the Health Unit for the Deaf in Uruguay, who have been implementing the French model in Latin America since 2012.
- The Foundation promotes the right to health among the deaf community and in 2018 launched the first healthcare unit for deaf people in Chile in a primary care center covering a territory of more than 29,000 people in Santiago.
- Since 2021, sign language has been recognized by law as a natural, native language and intangible heritage of deaf people.

Impact / results of implementing best practice

- Reduction of gaps in access to information and communication, seeking to restore the right to health.
- Opening of a job field for deaf people as mediators in health care.
- Health personnel with basic training in sign language perform independent procedures (e.g. taking samples or blood pressure tests).
- About 170 people from different parts of the country regularly visit the unit.

Critical success factors for best practice

- Strong communication strategy and advocacy of the deaf community.
- Legitimisation of the initiative by an organisation of and for deaf people.
- International collaboration for training in the model of healthcare for deaf people.
- Political will and funding from local government through a public-private partnership.

Impact statement

"The unit addresses the global phenomenon of health as a fundamental human right from an initiative that arises from the community, therefore legitimate, and that requires scaling up".
Sebastián Quiñones
Coordinator of the Unit, social worker and Chilean sign language interpreter.

Lessons learned

- It is essential to scale up and transform the initiative into an official service with greater coverage and scope of services.
- The initiative needs visibility at national level and greater political will from stakeholders, giving priority to the leadership and legitimisation of the Chilean deaf community.
- Reliable statistical data and a communal census of deaf people are needed to facilitate the measurement of project impact.
- Mediators have had a stronger role in education and a code of ethics is being developed to strengthen their role in the direct provision of healthcare.

Sources

- Cesfam Santa Laura opens the first health care unit for deaf people in the country [Link, in Spanish]
- **Lissi, M. R., et al.** (2021). The exclusion of the deaf community from the mental health care system [Link, in Spanish]
- What is the Health Care Unit for Deaf People? [Video in Spanish]
- Linguistic - Cultural Mediation in Health [Video in Spanish]
- Sign Language Interpretation in Health Care [Video in Spanish]

Further links & information

- "Ceremony for the agreement signing between Cesfam Santa Laura and the Chilean Deaf Foundation" El Bosque TV [Video in Spanish]
- "Mediators help deaf patients at Cesfam San Laura del Bosque", MINSAL TV [Video in Spanish]
- Instagram USSChile / Facebook USSChile

September 2022

Accessibility standards for health facilities in low and middle-income settings

Location and scale

Worldwide; focus on low and middle-income settings

Type of disability

All people with disabilities

Actors involved

- Sightsavers (headquarters and regional offices)
- Organizations of people with disabilities (OPDs) in Mozambique, Bangladesh, Malawi and Pakistan
- Nampula Central Hospital, Mozambique
- Health and social welfare government institutions, Mozambique

1. Description

The Sightsavers' Accessibility Standards and Audit pack aims to improve hospitals and clinics to ensure that people with disabilities access the services they need. This toolkit can be used to:

- Assess the accessibility of existing infrastructure and make recommendations for improvement.
- Develop or revise national accessibility standards.
- Guide the development of new health infrastructure, ensuring accessibility is embedded throughout from the design phase.

The Accessibility Standards and Audit pack includes:

1. Accessibility guidelines
2. Accessibility audit checklist
3. Training materials
4. Bespoke tape measure
5. Accessibility audit report, scoring and costing templates

The accessibility standards include 12 infrastructure components with their standards and pictures/diagrams. For instance: Minimum width of doors and ramps.

This toolkit is aimed at governments, healthcare providers and development organisations. It is recommended that audit teams include people with disabilities and their representative organisations.

2. Origin

- According to Article 9 of the UN CRPD, equal access to the physical environment, transportation and communications is critical for people with disabilities.
- Physical and communication barriers can prevent people with disabilities from accessing the services they need.
- Governments, health service providers and OPDs often lack the necessary tools and knowledge to address accessibility barriers in health facilities.
- Based on international standards and universal design principles, Sightsavers launched this toolkit in 2018 in collaboration with OPDs and governments.

3. Impact

- Training of more than 200 members of OPDs, governments and the private sector.
- Accessibility audits in 50 hospitals in eight countries in Asia and sub-Saharan Africa.
- Accessibility renovations in 16 health facilities by September 2021.
- Over 1000 downloads of the online toolkit.

4. Impact statement

"...Our hope is that the toolkit will enable the development community – from small community-based organisations to large multilateral donors – to incorporate accessibility into their work, and promote equitable access to healthcare for people with disabilities around the world"

Andrea Pregel, Global Technical Lead for Inclusive Health, Sightsavers

5. Critical success factors

- Participatory process involving people with disabilities and health service providers.

MARCH 2023

- Resource available free of charge online and in accessible formats.

6. Lessons learned

- The toolkit is an effective instrument for assessing the accessibility of health facilities.
- Adaptation was required to address also the wider built environment.
- Free online training on the accessibility auditing methodology will be explored.
- Common barriers include inaccessible counters, lack of accessible toilets, steep ramps, poor colour contrast, and lack of information materials in accessible formats.

Sources and links

- Pregel, A., Smith, K. and Bridger, K. (2019). Accessibility standards and audit pack. Haywards Heath: Sightsavers (website link)
- Introduction to Sightsavers' accessibility standards and audit pack – YouTube (link)
- People with disabilities in Mozambique tell us their top tips for making health services accessible – YouTube (link)
- Sightsavers wins Zero Project award for accessibility audit pack (link)

National Accessibility Audit of Primary Health Care Facilities in Brazil

Location & scale

Brazil; National

Type of disability

All type of disabilities

Involved actors

- Brazilian Ministry of Health
- Researchers from 11 universities
- Primary health care facilities

1. Description

In 2012, Brazil undertook the first national assessment of the accessibility of 38 812 primary healthcare centres of the public health system across 5.543 cities (99% of Brazilian municipalities).

The Ministry of Health (MoH) designed an accessibility questionnaire in consultation with experts. The questionnaire was based on the National Policy for Persons with Disabilities, the Primary Care Policy and the principles of the Unified Health System.

Researchers from 11 universities received 20 hours of training on primary care, the accessibility questionnaire and fieldwork issues. The trained researchers used the questionnaire on-site to assess the accessibility of healthcare facilities for people with disabilities, including:

- Exterior building accessibility (e.g., sidewalks, carpets, floors, ramps, handrails, entrance doors, etc.)
- Internal building accessibility (e.g., toilets, grab bars, corridors, waiting rooms, etc.)
- Information accessibility (e.g., international disability symbols, Braille, use of signage, etc.)
- Availability of healthcare staff trained in disability issues.

The assessments were repeated in 2015 and 2018 in a subset of health facilities covered in 2012. The data collected are publicly available online.

2. Origin

- Accessibility of healthcare facilities is rarely audited even when it is a major barrier for people with disabilities.
- In 2011, Brazil introduced the National Program for Access and Quality Improvement of Primary Care (PMAQ-AB) under the scope of the National Primary Care Policy.

3. Impact

- Some studies have shown an improvement in the physical infrastructure of primary health units. For example: the accessibility of health facilities for wheelchair users has improved from 34% in 2012 to 54% in 2015 and 68% in 2018.

4. Critical success factors

- Strong political commitment of the Ministry of Health with accessibility, and data collection over the last decades.

5. Lessons learned

- Large-scale accessibility audits are feasible.
- The general accessibility of healthcare facilities needs to be improved, especially for people with visual or hearing impairments.
- The accessibility of healthcare facilities varies according to the size of municipalities and regions in Brazil.
- Remote areas, such as those in the Amazon regions, found it difficult to join and participate in the PMAQ.
- The northern regions have the most precarious primary health units and need more investment than the PMAQ offered.
- Accessibility of equipment and transportation must also be assessed.

6. Limitations

- People with disabilities were not involved in the design and implementation of the accessibility audit.
- Changes in primary care policies and funding mechanisms in the previous federal administration led to the discontinuation of PMAQ in 2018.

Sources & links

Pinto,A.;Köptcke,L.S.; David, R.; Kuper, H. A National Accessibility Audit of Primary Health Care Facilities in Brazil—Are People with Disabilities Being Denied Their Right to Health?. *Int. J. Environ. Res. Public Health* **2021**, *18*, 2953. https:// doi.org/10.3390/ijerph18062953

Lopes et al. Diabetes Mellitus macro-regional inequalities in PHC: comparing the three PMAQ-AB cycles. *Saúde Debate* 2022, 46, 376-391. https://doi.org/10.1590/0103-1104202213309

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SERVICE DELIVERY

9 Specialized Services

Annual Health Checks for people with learning disabilities in the UK

MISSING BILLION

Geography and scale:	England; national.
Type of disability and age group:	People with learning disabilities aged 14 and over.

Involved actors

- National Health Service (NHS) England
- Public Health England
- Mencap

Click on the image to view larger version.

Best practice description

People with learning disabilities 14 and over who are registered with a general practitioner (GP) are entitled to a free annual health check. Established in 2008, this programme aims to prevent, detect and treat new and unmet health needs in a timely fashion. Health checks include:

- Physical examinations the patient consents to (e.g. weight, blood pressure, blood samples, etc.)
- Chronic diseases and mental health exam, emphasizing commonly associated conditions (e.g., epilepsy, constipation, dysphagia, etc.)
- Health promotion and review of immunizations and medications.

Accommodations are made whenever necessary, such as additional time, easy to read information, suitable appointment time and support from companions or carers. All of this information is registered in each patient's profile. The GP should help develop a health action plan after the health check and facilitate referrals to any secondary care.[1,2,3,4] *See previous good example: Learning Disability Registers at Primary Care Level.

Origin / impetus for best practice

- People with learning disabilities face health inequities; they often have poorer physical and mental health than the general population.[1]
- "People with learning disabilities may be unaware of the medical implications of symptoms they experience, have difficulty communicating their symptoms or may be less likely to report them to medical staff".[4]
- The Confidence Inquiry (2013) into the deaths of people with learning disabilities recommended the standardisation of Annual Health Checks and a clear pathway between the Annual Health checks and Health Action Plans.[5]

Impact / results of implementing best practice

- From 2019 to 2020, about 58% of people with a learning disability, who are on their GP's learning disability register, had a health check.

Critical success factors for best practice

- GPs receive financial incentives for completing annual health checks.
- Existence of a National Electronic Health Check clinical template
- Existence of a National Health Check toolkit for general practitioners.

Impact statement

"It helps when you have [an annual health check] because it will tell you where your health is improving and where is not" *Leroy*
"Now I do the annual health checks every year, I also want to keep more healthy because I actually started a running group" *Lorainne*
[Personal experiences with annual health checks described in Mencap's video]

Lessons learned

- Not all GPs do health checks but the number is increasing.
- Not all GPs report giving health action plans.
- Coverage of annual health checks varies considerably across the country.

Sources

[1] Learning and Autism – Annual Health checks - NHS
[2] Annual Health Checks NHS
[3] People with learning disabilities in England - Public Health England (2020)
[4] Guidance Annual health checks and people with learning disabilities.
[5] Confidential Inquiry, 2013

Further links & information

- Annual Health Check film by NHS
- Mencap's Don't Miss out! video campaign
- Mencap Don't Miss out! website

Date: March 2021

SERVICE DELIVERY

9 Specialized Services and Assistive Technology

Wheelchair user training in El Salvador, India, Kenya, Nicaragua, and Romania

MISSING BILLION

Geography and scale:	El Salvador, India, Kenya, Nicaragua, and Romania
Type of Disability	Wheelchair users

Involved actors

- World Vision
- Citizen and Voice Action (CVA)
- Motivation UK
- Motivation Romania
- UCP – Wheels for Humanity

Best practice description

With the goal of strengthening the wheelchair service sector through enhanced service capacity, provision of diverse range of wheelchairs, engagement with national and local governments and increased participation of wheelchair users, World Vision implemented the USAID funded ACCESS project in five countries (El Salvador, India, Kenya, Nicaragua, and Romania) from 2014 to 2017 following WHO's 8+ model. The programme helped provide wheelchairs and train users and technicians to increase wheelchair user's independence, knowledge about disability rights, and engagement with other people with disabilities. The program partnered with local organizations of persons with disabilities to ensure the sustainability of the programme at service centres for assistive devices.

Origin / impetus for best practice

"WHO estimates that only 5-15% of the 70 million people relying on wheelchairs for basic mobility have access to appropriate devices. In the absence of appropriate devices, a person with disability cannot be expected to participate in society fully and effectively, and would be excluded from many of the rights granted by national laws and the UN CRPD."[1]

Impact / results of implementing best practice

- 8,019 needs assessments and 7,319 wheelchairs, tricycles, or wheelchair improvements were distributed.
- 911 service providers were trained with wheelchair service skills at 43 service centers.
- 92% of users reported increased accessibility, inclusion, mobility, function, and participation.

Critical success factors for best practice

- Uptake of service provisions and effective capacity building using the Service Assessment Monitoring and Evaluation Tool.
- Qualitative data to assess community participation of wheelchair users.
- Qualitative data on enabling and impeding factors in social participation.

Impact statement

Wheelchair service goes beyond providing the service itself, it extends to "educating communities on appropriate wheelchair service and disability inclusion, facilitating inclusive communities, collaborating with a range of partners, and advocating not only for appropriate service to be mandated in laws and policies but also for disability inclusion at large."[ACCESS project document]

Lessons learned

- Engagement with local/national governments important to address infrastructure accessibility issues.
- Need to strengthen, coordinate, and provide resources for community-based referral network.
- Important to have adequate wheelchair supply, transformation to digitalized databases and combat self-exclusion due to internalized stigma.

Sources	[1] Accelerating Core Competencies for Effective Wheelchair Service and Support (ACCESS) Project
Further links & infor-mation	Wavinya's Wheelchair helps fuel her dream of the skies

SERVICE DELIVERY

9 Specialized Services

Comprehensive community based rehabilitation in Tanzania

MISSING BILLION

Geography and scale:	Dar es Salaam, Tanzania
Type of disability:	All types
Involved actors:	• Comprehensive Community Based Rehabilitation in Tanzania (CCBRT) • Ministry of Health, Community development, Gender, Elderly and Children, Tanzania • Kupona Foundation

Best practice description

CCBRT is the largest health care provider of disability and rehabilitation services in Tanzania. It aims to empower people with disabilities, improve their quality of life and ensure affordable and high quality access to specialized health care. Through an income adjusted fee scheme, services are provided through their four main health facilities: a disability hospital, two private clinics, and one rural rehabilitation centre. Some core services include ophthalmology, physical rehabilitation, orthotics and prosthetics, plastics and reconstruction. In addition, the organization has a Disability Advocacy Unit, an academy, a dedicated Maternal Newborn Wing with an associated capacity building program, and a disability inclusive sexual and reproductive health centre that encourages early diagnostics of birth defects. CCBRT is also the largest provider of fistula surgical care in Tanzania, and a FIGO accredited training site, with over 600 surgeries a year on average. All clinical areas provide specialized surgery and paediatric care, as well as clinical and social support for persons with disabilities and their families/caregivers.

Origin / impetus for best practice

- According to the World Health Organization, there are 10 million people in Tanzania experiencing conditions that could benefit from rehabilitation.
- The country has a shortage of skilled health workers, with only 7 health professionals per 10,000 inhabitants and a third of health facilities are resourced to perform basic service provision.
- CCBRT started providing community based rehabilitation services for children and adults with blindness in 1994 and quickly realized the extended need for comprehensive disability care.
- In addition, CCBRT aims to fill gaps in Dar es Salaam's health system, which was built for a capacity of 750,000 patients, and in the context of a rapidly growing population of 6 million and an estimated disability prevalence of 9%.

Impact / results of implementing best practice

- In 2019, the Orthopaedics and Physical Rehabilitation department of the disability hospital conducted 28,855 consultations (assistive devices, prostheses, orthotics, physical and/or occupational therapy). The rural rehabilitation centre assisted 4,022 patients and provided 580 wheelchairs and assistive devices.

Critical success factors for best practice

- Long-standing experience in specialized care.
- Sustainable approach; the organization is transitioning towards a financially sustainable social enterprise.
- Strategic partnerships with academic institutions, philanthropists, sponsors and health care providers for financial and technical support.

Impact statement

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- . . .
- . . .

Lessons learned

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- . . .

Sources	• CCBRT official webpage • 2018-2022 CCBRT Strategy • CCBRT Annual Report 2019
Further links & information	• World Health Organization Rehabilitation Need Estimator - Tanzania • •

Date: July 2021

SERVICE DELIVERY

9 Specialized services

National Rehabilitation Plan in Ukraine

MISSING BILLION

Geography and scale: Ukraine; national

Type of disability: All types

Involved actors
- Ministry of Public Health of Ukraine
- Professional organizations (e.g. Ukrainian Society for Neurorehabilitation)
- Organizations of people with disabilities (e.g. Coalition for Persons with Intellectual Disabilities)
- Scientific Institutions (e.g. Institute of Emergency Surgery and Rehabilitation)
- Veteran organizations (e.g. Ukrainian Association of Disabled Military Men)
- International Society of Physical and Rehabilitation Medicine
- World Health Organization
- United States Agency for International Development (USAID)
- International NGOs (e.g. UCP Wheels for Humanity; Humanity and Inclusion)

Best practice description

In 2015, Ukraine developed a National Disability, Health and Rehabilitation plan to improve rehabilitation services within the health care system, based in a technical consultation process conducted by a rehabilitation advisory team. Main actions and implementation projects included:

1. Establishment of a new rehabilitation department within the Ministry of Health and an inter-ministerial committee.
2. Translation and local adaption of rehabilitation terminology of the International Classification of Functioning, Disability and Health (ICF) into Ukrainian.
3. Establishment of procedures to conduct a population-based disability survey using internationally recognized methods.
4. Establishment of new curricula and rehabilitation professionals (physical and rehabilitation medicine (PRM) physicians, prosthetist-orthotists, speech and language therapists, physical and occupational therapists).
5. Implementation of model rehabilitation services for acute, post-acute and long-term phases.

Origin / impetus for best practice

- Since 2014 the armed conflict in Eastern Ukraine has resulted in an increased demand for rehabilitation services.
- The Ministry of Health decided to implement principles of the World Health Organization Global Disability Action Plan 2014-2021.
- Ukraine had a rehabilitation system predominantly based on a biomedical model of disability and therapy focused on compensation of functional deficits and different kinds of social support.
- Essential rehabilitation professionals were absent and there was a lack of intersectoral coordination between governing bodies providing rehabilitation services.

Impact / results of implementing best practice

- PRM physicians of the European Society conducted 26 courses (160 hours) to train 26 regular trainers from Ukrainian Medical Universities; in 2020, Ukraine had 283 local PRM physicians.
- The first class of Occupational Therapy Master students enrolled in September 2019.
- Since 2020, three packages of rehabilitation services are included in the national Programs of Medical Guarantees.

Critical success factors for best practice

- Ongoing health care reform of secondary and tertiary levels of care.
- High level of political will and commitment of experts.
- Participation of people with disabilities in the technical consultation process.
- Collaboration with European and internationals partners.
- Raising awareness and information campaigns about the importance of rehabilitation services.

Impact statement

Lessons learned

- Appropriate health care legislation is required for developing modern rehabilitation services.
- Continuing education for rehabilitation professionals is needed.
- ICF and its biopsychosocial approach, should be implemented at a higher pace and at all stages of the rehabilitation process.

Sources

[1] Golyk, V. et al. (2021) Five years after development of the national disability, health and rehabilitation plan for Ukraine: Achievements and challenges. Journal of rehabilitation medicine. [Online] 53 (3), jrm00160-jrm00160.
[2] Gutenbrunner, C. et al. (2018) Responding to the world health organization global disability action plan in Ukraine: Developing a national disability, health and rehabilitation plan. Journal of rehabilitation medicine. [Online] 50 (4), 338-341.

Further links & information

- WHO support for health system development in Ukraine, 2016-2019. Copenhagen: WHO Regional Office for Europe; 2019.
- Strengthening Rehabilitation Services in Health Systems - USAID
- Gutenbrunner, C. et al. (2018) Strengthening health-related rehabilitation services at the national level. Journal of rehabilitation medicine. [Online] 50 (4), 317–325.

Date: May 2021