Disability Inclusion: Health

"Only healthy people with the support of a functioning health sector can ensure sustainable development of their societies. A loss of health is a loss not only to the person but also to the person's family and society as a whole".[1]

Key facts

- People with a disability have a greater need to access health services and experience higher levels of unmet health needs than people without a disability.[2]

- It is more common for people with a disability to report an inability to afford health services than people without.[3]

- People with a disability report multiple barriers to accessing health services.[4]

- 5–15% of people in low and middle-income countries who require assistive devices/technologies receive relevant equipment.[5]

- Women with a disability are more likely to be infected with HIV or other sexually transmitted diseases.[6]

- It is estimated that 105 million people across the world need an appropriate wheelchair.[7]

- Over 80% of people in Africa with epilepsy go without treatment.[8]

- People with a disability more commonly report selling land and other assets to cover health costs.

- Specialist health services are more commonly needed by people with a disability and these can be scarce and difficult to access.

- Less than 0.1% of people who are Deaf or hard of hearing or who are blind or have a vision impairment receive appropriate support.[9]

Reasons for disability inclusion in health programs

- The CRPD, in particular, Article 25 and 26, confirm the importance of health for all which reinforces the need for people with a disability to have full access to health services.

- MDGs 5 and 6 with a focus on health will not be reached without the inclusion of people with a disability in mainstream health programs.

- Many health services world wide remain inaccessible for people with a disability which inhibits access to health care.

- Many health budgets have no funding allocation to meet the health requirements of people with a disability and in turn, the cost of health services can exacerbate the poverty experienced by some people with a disability.

- Early identification of impairments and appropriate referrals to specialist medical or disability services is lacking in developing countries which in turn increases the rate of disability.

- Good quality, accessible health and disability services enable people with a disability to achieve health outcomes equal to other members of their community.

- People with a disability may rely on family members for transport to health services or translation support, which can create resistance in seeking interventions.

How to include people with a disability in health programs

Mainstreaming disability into health programs will ensure many of the barriers experienced by people with a disability are removed and their right to health is achieved.

The following principles, which adhere to a human-rights approach to disability, are used to demonstrate inclusion of people with a disability in all development programs and sectors.

Awareness of disability and its implications

Participation and active involvement of people with a disability

Comprehensive accessibility through addressing physical, communication, policy and attitudinal barriers

Twin track identifying disability specific actions combined with mainstream approaches

Awareness

- Identify the number of people with a disability within the community. This information can be gathered, for example, through meeting local people with a disability and DPOs, census data, household surveys, Community-Based Rehabilitation (CBR) and disability services and facilities for inclusive education.

- Provide information regarding disability to health professionals to ensure there is up-to-date knowledge on prevalence and impact of disability.

- Use people with a disability in awareness-raising activities.

- Highlight the role played by the health sector in preventing impairment.

- Encourage awareness-raising efforts by disability service providers and Disabled Peoples Organisations (DPOs) with their local health providers.

- Advocate for the inclusion of disability within broader health policies, strategies, programs and monitoring mechanisms.

- Ensure billboards, posters or other health promotion information depicts people with a disability as part of the general population.

Participation

- Build relationships with people with a disability and DPOs to gain their active participation within the program.

- Ensure direct consultation with people with a disability for identification of their health-related barriers.

- Allocate a budget to cover travel and participation expenses along with attendance time for people with a disability and DPOs to actively be involved in consultations.

- Employ someone with a disability within the health service to ensure active participation and representation within the program.

- Promote people with a disability as health care workers to demonstrate their skills and capacity along with improving representation of service recipients.

- Develop strong linkages between health and disability stakeholders.

Comprehensive accessibility

Comprehensive accessibility = physical, communication, policy and attitudinal access

- Hold consultations in physically accessible venues.

- Identify the preferred communication mode for individuals with a disability. Note that not all people who are blind will have been taught Braille, likewise, not all individuals who are Deaf or hard of hearing will have sign language skills.

- Be prepared to source alternative communication options including large print, Braille, pictorial, audio and sign language based on individual requirements. These may be arranged through local partners, inclusive education services, CBR and disability organisations.

- Improve physical access to health services including hospitals, community health services and outreach clinics.

- Build capacity of health care workers in communicating with people with a disability.

- Build capacity of health services in order to meet the basic health requirements of early identification and diagnosis of impairment, with appropriate referrals to specialist medical and disability services.

- Address financial barriers to health services for people with a disability, embedding disability related funding strategies within policies.

- Pay particular attention to women and girls with a disability as they are often severely marginalised, experiencing numerous challenges, including sexual and physical violence.

- Sexual reproductive health programs should be particularly aware and inclusive of the requirements of women with a disability.[10]

- National health plans and strategies, or vertical health programs, may not have considered the specific needs of vulnerable groups. Work towards greater inclusion of a disability perspective in all future plans.

- Address attitudes to improve participation of people with a disability.

- Use people with a disability and engage DPOs for capacity development activities around attitude, access and rights.

Twin track

Twin track enables full inclusion through mainstream access working alongside disability specific supports

Mainstream	Disability specific
Promote disability inclusion in health programs. Ensure all data collected during programs can be disaggregated by disability, age and gender.	Support initiatives that strengthen disability and specialist medical services. Facilitate access to all disability and specialist medical services including the cost of assistive devices or medication.
Adopt universal design principles for all health services. Ensure health facilities are built with accessible features, including	Work closely with local disability organisations to promote health

ramps, widened doorways, accessible toilets, appropriate signage and adjustable height beds which will be useful for a range of purposes. Advocate for the inclusion of disability within broader health policy, programs and monitoring mechanisms. Support initiatives that build disability inclusion into the health training curricula. Engage people with a disability in training efforts. Depict people with a disability as members of the general population in health education and health promotion messages.	services through their networks. Promote the active engagement of people with a disability and DPOs in advocacy efforts with their local health service providers. Map all specialist medical and disability services, including referral processes, and disseminate widely in varied formats. Promote the early identification of disability in childhood and establish appropriate referrals to disability services. Support development and dissemination of clinical guidelines for commonly occurring impairment types (e.g. club foot).

Case study: Uttarakhand Cluster of the Community Health Global Network (CHGN)

Nossal Institute of Global Health

The Uttarakhand Community Health Cluster is a unique network of community health programs based in the Northern India state of Uttarakhand. Launched in 2008 as part of the Community Health Global Network, the cluster now has 40 member organisations covering a catchment area of approximately three million people. The members come together for mutual knowledge sharing and program strengthening.

During a biannual learning and sharing workshop, the Uttarakhand Cluster identified the need for knowledge, skills and resources to address a growing concern that people with a disability were excluded from the benefits of existing health programs. This began the planning of a disability-inclusive development project across the cluster. Supported by the Nossal Institute for Global Health, a disability situational analysis was conducted to identify key stakeholders and areas of gaps and opportunities. Following an initial disability training workshop, representatives from each of the programs collectively agreed upon goals to promote inclusion of people with a disability into existing health programs, including the following:

1. To ensure people with a disability have equal access to and benefit from all health and development activities in the 40 Cluster programs
2. To strengthen the existing disability specific interventions and initiate some further disability specific projects in the Cluster
3. To empower people with a disability to work for the realisation of their rights through the establishment and networking between self-help groups and DPOs.

Outcomes included training programs for project staff and community health volunteers, with a focus on awareness-raising, addressing stigma, early identification and referral to disability services in the region. The community also initiated a collaboratively produced disability awareness DVD.

Three health professionals from the cluster completed an Australian Leadership Award Fellowship. One of these representatives has been appointed as the Cluster Disability Advisor to coordinate the implementation of disability-inclusive actions across the 40 cluster programs using the skills, tools and training programs developed.

Future directions
Activities to be conducted in the next stage of the project include:
- Collecting baseline data to better understand the barriers experienced by people with a disability when accessing health services.
- Training cluster program leaders and appointed disability coordinators from each of the programs to facilitate, lead and review the implementation of disability-inclusion activities across the 40 health programs.
- Facilitating organisational assessments and development of action plans for each health program to identify and implement:

- mainstreaming activities (e.g. addressing physical barriers or skills and attitudes of health workers to ensure that people with a disability have equal access to health services), and
- disability specific programs (e.g. improving capacity for rehabilitation, or the provision of assistive devices such as wheelchairs).
- Establishing, supporting and building the capacity of DPOs.
- Developing new CBR programs in selected health services.

Lessons learned

Despite a commitment by the 40 cluster programs to ensure people with a disability benefit equally from community health programs, the cluster has identified a long list of activities which at first appears to be overwhelming in the context of other competing priorities. However, the Uttarakhand Cluster has identified simple sustainable strategies for action, beginning first with awareness-raising activities, acknowledging that barriers extend beyond simply physical access to health centre buildings. These activities reflect a twin track approach including a variety of disability-specific measures, along with activities that ensure people with a disability are included in existing programs. These strategies will be facilitated by the allocated focal points within the cluster, ensuring that people with a disability are actively involved throughout the planning, implementation and evaluation of programs. One of the project staff reflected on the lesson he learnt about the value of participation for people with a disability when he said, "I have never worked with or had a friend with a disability. I never really understood what barriers they experience. Now I have new friends and I am excited about the changes we can make in our health programs to ensure everyone is included".

Checklist for disability inclusion in health programs

☐ Does the project design make reference to people with a disability and demonstrate awareness of disability specific requirements?

☐ Have people with a disability participated in the project development process?

☐ Are people with a disability and DPOs playing an active role throughout the project?

☐ Is there budget allocation to cover participation expenses and attendance time for consultations with people with a disability and DPOs?

☐ Have current barriers to health services been explored?

☐ Have strategies been identified to address barriers in accessing services?

☐ Have health services addressed the particular needs of women, children and elderly with a disability?

☐ Does the project budget include a line item for disability-related access measures?

☐ What measures are in place to report on disability inclusion?

☐ What systems are in place to record data on disability including type, age and gender?

☐ Has awareness-raising for health professionals been planned?

☐ What awareness-raising activities do you intend to conduct to improve the community's knowledge about disability and health?

☐ Does awareness-raising include dispelling myths about causes of disability?

☐ Has a DPO been identified for disability related awareness raising and training?

☐ Are alternative communication options available based on individual requirements?

☐ Has a person with a disability been employed within the project?

☐ Is there an advocacy plan for broader promotion of disability in government health policy and health programs?

☐ Are people with a disability depicted in health promotion activities as representing part of their broader community?

☐ What systems are in place to support transportation costs to enable people with a disability to have access to health services?

Useful resources for disability inclusion in health programs

Source International Information Support Centre
http://www.asksource.info/about/news_na.htm

Australian Development Gateway, Disability Inclusive Development, Health:
http://www.developmentgateway.com.au/cms/op/preview/sectors/did/page985.html
http://www.who.int/topics/disabilities/en/

Promoting Sexual and Reproductive Health for Persons with Disabilities. (2009). UNFPA/WHO Guidance Note:
http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/srh_for_disabilities.pdf

World Report on Disability.(2011). WHO & World Bank:
http://www.who.int/disabilities/world_report/2011/en/index.html

Maxwell, J., Watts Belser, J. & David, D. (2007). *A Health Handbook for Women with Disabilities.* Hesperian Foundation:
http://hesperian.org/wp-content/uploads/pdf/en_wwd_2008/en_WWD_2008_full%20book.pdf

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