Good practices

Compendium of good practice examples to improve health services

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### 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.1-4 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.

### 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.1,5
- Supporting health workers training to adopt 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.

  ~ NCPDD team

### 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 NCPDD personnel of equity of esteem, interdisciplinarity and co-leadership across professions.
- Opportunity to rapidly progress establishment of the new NCPDD due to the exigencies of Covid-19 pandemic.

### Sources

1. National Clinical Programme for People with Disability
2. NCPDD 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

### 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.

### Further links & information

- Guidance on Conducting Assessments in Disability Services
- Survey on Digital and Assistive Technology use in Disability Services

Date: March 2021
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.

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.
LEADERSHIP

CANADIAN COVID-19 DISABILITY ADVISORY GROUP (CDAG)

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 disabilities 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

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

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

Lessons learned
- Jurisdictional 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

Further links & information
- COVID-19 and people with disabilities in Canada
- Background on Members of the COVID-19 Disability Advisory Group
- Statistics Canada: Impacts of COVID-19 on Persons with Disabilities

Date: Nov 2020
### Health Financing

#### Health insurance reimbursement for oral health and dental care for people with disabilities

**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.

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

### Impact / results of implementing best practice

- 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.

### 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).

### Sources


### 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.

### Further links & information

- G-BA
- German Dental Association
- KZBV

*All in German language.
## Australian National Disability Insurance Scheme

### 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. 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.
- 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 inefficient", and gave differential treatment based on the cause or origin of disability.
- The NDIS, a new disability care and support scheme, was established 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:
- . . .

### 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

### Further links & information:
- NDIS Website

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**Date: August 2021**
## Learning Disabilities Mortality Review (LeDeR)

### 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.
- 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.
- 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.
- 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.

### Sources
- [Confidential Inquiry 2013](http://www.ncbi.nlm.nih.gov/pubmed/24332307)

### 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.

### Further links & information
- LeDeR programme - University of Bristol
- Action from learning - NHS
- Learning disability improvement standards
Learning Disability Registers

**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 the 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 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
### 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 fulfill 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.
- EU Resources on People with Disabilities
Human Resources

Community Health Worker training to identify children with development disabilities

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<tr>
<th>Geography and scale:</th>
<th>Dehradun District, Uttarakhand, India</th>
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<td>Developmental Disabilities</td>
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**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 Activists (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.
- Additional knowledge helps parents and CHWs understand disability beyond observable features and improve evaluation of developmental milestones for all children.

**Sources**

**Further links & information**
German Disability-inclusive Nursing Practice Handbook

**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.

**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.

**Geography and scale:** Primarily the German state of North Rhine-Westphalia

**Type of Disability:** All types

**Involved actors**

- Competence Centres Self-determine Life (KSL) [Kompetenzzentren Selbstbestimmt Leben]
- Bochum Centre for Disability Studies (BODYS), Protestant University of Applied Sciences Rheinland-Westfalen-Lippe

**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.

**Sources**

KSL-Concrete #4 Nursing Diversity (German)
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.

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.

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. 

Light for the World

Import / results of implementing 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 variety of the work have grown, and we direct more attention to the rights of persons with disabilities and the importance of inclusive societies.”

Critical success factors for best practice
- Importance of collaborative effort.
- Sustainable approach is necessary for long-term success.
**Learning Disability and Autism Training for Health and Care Staff**

<table>
<thead>
<tr>
<th>Geographical and scale:</th>
<th>National, across the United Kingdom</th>
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<td>Type of disability:</td>
<td>Learning disabilities and autism</td>
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**Involved actors**
- LeDeR Mortality Review
- NHS (UK health system)
- Department of Health and Social Care
- NHS Health Education England
- 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).

**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

**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, carers, and other stakeholders.
- Government responded to mortality reviews and developed action plan for improving health outcomes.

**Impact statement**

**Lessons learned**

**Further links & information**
- Capabilities Framework for Supporting Autistic People
- Supporting Autistic people and/or people with a learning disability

Date: March 2021
### Human Resources

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

<table>
<thead>
<tr>
<th>Geography and scale:</th>
<th>Ecuador; National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of disability:</td>
<td>All types</td>
</tr>
</tbody>
</table>

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

#### 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
- Young persons with disabilities; Global study on ending gender-based violence, and realising sexual and reproductive health and rights, 2018, UNFPA

#### Sources
- State party report 2018 UNCRPD
Disability and inclusion training for health care workers in Tanzania

**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**
- 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
# Health Facilities

## Home Testing for COVID-19 in the United Arab Emirates

### 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 & information
- 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*
### Annual Health Checks for people with learning disabilities in the UK

<table>
<thead>
<tr>
<th>Geography and scale:</th>
<th>England; national.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of disability and age group:</td>
<td>People with learning disabilities aged 14 and over.</td>
</tr>
</tbody>
</table>

**Involved actors**
- National Health Service (NHS) England
- Public Health England
- Mencap

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**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.\(^1\) See previous good example: Learning Disability Registers at Primary Care Level.

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**Origin / impetus for best practice**

- People with learning disabilities face health inequalities; 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.\(^5\)

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**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.

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**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.

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**Impact statement**

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**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.

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**Sources**

- Learning and Autism – Annual Health checks – NHS
- Annual Health Checks NHS
- Guidance Annual health checks and people with learning disabilities.
- Confidential Inquiry, 2013

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**Further links & information**

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

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Date: March 2021
### Specialized Services and Assistive Technology

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

<table>
<thead>
<tr>
<th>Geography and scale:</th>
<th>El Salvador, India, Kenya, Nicaragua, and Romania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Disability</td>
<td>Wheelchair users</td>
</tr>
</tbody>
</table>

| 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 & information

- Wavinya’s Wheelchair helps fuel her dream of the skies
## 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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## Geography and scale:

<table>
<thead>
<tr>
<th>Geography and scale:</th>
<th>Dar es Salaam, Tanzania</th>
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<tbody>
<tr>
<td>Type of disability:</td>
<td>All types</td>
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</tbody>
</table>

### Involved actors:

- Comprehensive Community Based Rehabilitation in Tanzania (CCBRT)
- Ministry of Health, Community development, Gender, Elderly and Children, Tanzania
- Kupona Foundation

### 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