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Acknowledgements

• This assessment module was developed with the support and insights of many contributors. We would like to thank:

• Research partners in Brazil, Maldives and Zimbabwe who tested the feasibility of the indicators

• Participants in the design process including government and non-governmental organization representatives from Bangladesh, India, Indonesia, Malawi, Nigeria, South Africa

• Disability and inclusion experts, Shilpa Das and Jacques Lloyd

• Expert committee members who provided overall feedback and expertise

• London School of Hygiene and Tropical Medicine

• Scope Impact
Introduction
People with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

The Missing Billion reports from 2019 and 2022 highlight that people with disabilities experience worse health than others in the population, across the Sustainable Development Goal 3 targets.

Poorer health is due to their underlying impairment and health condition, as well as the more disadvantaged position in society held by many people with disabilities. Moreover, people with disabilities often have difficulties accessing appropriate and quality healthcare services due to wide-ranging barriers and discrimination.

Globally, there are at least one billion people with disabilities, making up 15% of the population. Failure to ensure the right to healthcare of people with disabilities will therefore mean that global targets, such as Universal Health Coverage, will be difficult or impossible to achieve.
The Missing Billion Initiative has thus developed an assessment module – the first module in its toolkit – to evaluate the extent of disability inclusion in the health system. The main purpose of the tool is to allow Ministries of Health to assess their health system and identify where changes are needed.

• The assessment module includes a set of indicators, steps and tools to support actors to identify where there is progress and where gaps remain in order to spark action.

• Repeated use will enable monitoring of trends over time and may also enable assessment of the impact of specific interventions. Consistent use of the tool globally can highlight areas of good practice that could be implemented in other settings.

• The tool was designed to support Ministries of Health but might also be used by disability rights groups use it to identify gaps and advocate for change, researchers, and as part of monitoring in disability inclusion programs.
Objectives of the Assessment Module

- Collate data about the health system in order to set a benchmark for disability inclusion in the health sector.
- Identify the ways in which the health system could be more inclusive of people with disabilities.
- Continue to monitor progress over time using the indicators.
The team at the Missing Billion Initiative developed a draft of the framework and the indicators inspired by the work of PHCPI and Levesque’s framework on patient-centered access to healthcare. The framework was then tested with research partners in Brazil, Maldives and Zimbabwe, and amended subsequently.

A design process to develop the steps and tools was then led by Scope Impact. It included a validation workshop with an expert committee, followed by remote individual sessions with representatives from Ministries of Health and their technical partners. Two rounds of consultations were held to understand use cases for the module and suggestions for how to conduct the assessment, including advocacy, financial considerations, potential users of the module, and ways to use the toolkit. Several experts in disability inclusion, including persons with disabilities, served as advisors throughout the process.
Development of the assessment module v.1

2020
- Initial development
  - Development of framework and indicators, building on the work of PHCPI and Levesque’s framework on patient-centered access to healthcare.

2021
- Pilot-testing
  - Pilot-testing of framework and indicators with research partners in Brazil, Maldives and Zimbabwe.

2022
- Process design and tool
  - Definition of application process and tools.
  - Consultations with expert committee.
  - Individual sessions with representatives from ministries of health and their technical partners.

2023
- Further revisions
  - V.2 upcoming in 2023/2024 after application by ministries of health.
  - Application in Uganda, Chile, South Africa
The assessment module and indicators were developed based on the health system framework. The framework identifies key leverage points in the health system for moving towards greater disability inclusion. It also includes expected changes in outcomes and health status to monitor whether health system improvements are having the intended impact.
# Missing Billion Health Systems Framework

<table>
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<tr>
<th>System</th>
<th>Service Delivery</th>
<th>Outputs</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Governance</td>
<td>Demand</td>
<td>5 Autonomy and Awareness</td>
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<td>2 Leadership</td>
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<td>3 Health Financing</td>
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<tr>
<td>4 Data &amp; Evidence</td>
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<td>8 Health Facilities</td>
<td></td>
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<td></td>
<td></td>
<td>9 Rehabilitation Services &amp; AT</td>
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### Social Determinants and Context
Assessment process

The overall process should take about two to three months including the steps of inception, conducting the assessment, and strategic planning. The indicator set has been developed to be drawn from existing sources to help keep the process streamlined.
Missing Billion Assessment Process

1. Identify leadership and establish task team
2. Inception
3. Conducting the assessment
4. Sharing and strategic planning
### ASSESSMENT LEAD

Ideally the disability focal point or disability inclusion unit in the Ministry of Health (MOH) will lead the process. If such a unit does not exist, then it may be led by the unit responsible for primary care, equity or vulnerable populations for example.

The lead will establish a task team and consult with other stakeholders throughout the process.

The process could also be led by an NGO or an OPD in coordination with the MOH.

### MEANINGFUL PARTICIPATION OF PERSONS WITH DISABILITIES

Throughout the assessment, it will be important to ensure the active involvement of people with disabilities in the planning, decision-making and monitoring related to the assessment.

### TASK TEAM

A task team should be established, led by the assessment lead.

The team should include representatives from relevant departments in the Ministry of Health, persons with disabilities and organizations of persons with disabilities, technical and NGO partners and donor representatives.
The task team should organize a kick-off meeting where key facts about disability and health are shared and the team develops a terms of reference to be clear about how they will work together over the course of the assessment. Suggested activities for the task team in the inception phase include the following:
Identify organizations and influential people who should be involved in and/or informed about the assessment and at what points in the process they should engaged.

Meet with key decision makers and financial partners to sensitize them about the need for disability inclusion in the health sector and to mobilize the political will and financial report needed to conduct the assessment and implement recommendations from the assessment findings.
If possible, organize a meeting or workshop with a broader array of stakeholders to begin sensitizing them to disability inclusion in the health sector and engage them in the process. Earlier engagement may assist with ensuring their participation and support in planning and implementing actions based on findings from the assessment. The meeting might take two possible forms:

- a brief one-to-two-hour event with sensitization activities and information sharing
- a half-day workshop that involves stakeholders in some of the planning for the assessment, such as identifying data sources and other stakeholders to involve.

You should provide time for a person with disabilities or a caregiver to share their experience.

**TOOLS:**

1.1 [Stakeholder mapping tool](#)
1.2 [1-page crib sheet on terminology for disability inclusion](#)
Conducting the assessment

Once all the political and financial support has been mobilized, the task team can then focus on conducting the assessment. The following are suggested activities in this phase:
It is suggested to organize a one-day workshop of the task team to develop the following:

- Workplan with timelines assigning roles and responsibilities
- Initial mapping of data sources for each of the indicators

If a workshop is not feasible due to resource or member availability constraints, then these activities could be completed over a series of several meetings.
COLLECTING AND ANALYSING DATA

The task team will need to do the following to ensure the data is collected in a timely manner:

- Identify person(s) or institutions that are responsible for collecting the data. It might be an expert consultant, consultant team or research institution that is responsible.

  OR

- Assign different members of the task team to collect different aspects of the data for the team.

Periodic meetings to review progress can help to keep the data collection on track and troubleshoot any problems that arise.

TOOLS:

1.3 Matrix to enter the source, findings and notes for each indicator
Sharing and Strategic Planning

After the data collection is completed, the task team should come together again to put together and/or review the report and plan for dissemination and strategic planning. The following are proposed activities for this stage:
ASSEMBLING & REVIEWING THE REPORT

The task team members assigned or contracted consultants or institutions should produce a draft report of the findings. Once the report is developed, bring the task team together for a one-day workshop to review and discuss the report.

DISSEMINATION EVENT

If feasible with the funding available, hold a dissemination meeting with a broad set of stakeholders. The meeting would include the following:

- Presentation of the findings
- Opportunities to provide feedback and comments on the findings
- Discussions to elicit initial thoughts about follow-on plans

The participants would be similar to the sensitization/inception meetings and could either be a brief event to mainly share findings or slightly longer to include some interactivity.
A meeting should be organized with key senior leaders in the Ministry of Health to translate the findings to strategic plans and actions. During the meeting, the task team should be present as well as any other government, multilateral or non-governmental partners who will be essential to move from assessment to action. In the meeting:

- Prioritize three to four essential actions across different elements rather than producing an elaborate, comprehensive plan. If the country is just embarking on disability inclusion, these might focus on foundational policy and systems needs.
- Determine a plan for costing the activities, who is responsible for implementing them, and how they will be monitored.
- Identify sources of funding for the costed activities, either through government resources or donors.
- The country might consider making the task team a permanent committee or creating a committee for oversight. The plan can then be reviewed each year and new actions added as the previous ones are achieved, enabling an evolution of progress.

**TOOLS:**

1.4 Outline for final report
1.5 Prioritization approach for strategic planning
The indicators

The indicators are arranged according to the framework which includes three main domains:

- Systems
- Service Delivery
- Outputs & Outcomes
Missing Billion Health Systems Framework

1. Governance
2. Leadership
3. Health Financing
4. Data & Evidence

System

Service Delivery

- Demand
  - 5. Autonomy and Awareness
  - 6. Affordability

- Supply
  - 7. Human Resources
  - 8. Health Facilities
  - 9. Specialized Services & AT

Outputs

- Effective Service Coverage

Outcomes

- Health Status

Social Determinants and Context
Governance

**Overall objective (“must have”)**
- International regulations must be matched by appropriate in-country laws and policies that protect the right to healthcare for people with disabilities and outlaw discrimination on the basis of disability; accountability mechanisms must be in place to enforce this right

### Potential Indicator

<table>
<thead>
<tr>
<th>Metric</th>
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<tbody>
<tr>
<td>UNCRPD – Ratification of UNCRPD by country</td>
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<tr>
<td>National law – Existence of a national law protecting the rights of persons with disabilities to health</td>
</tr>
<tr>
<td>National health policy – Existence of a national policy or decree on health for persons with disabilities</td>
</tr>
<tr>
<td>National Health Sector Plan(s) – Inclusion of people with disabilities in National Health Sector Plan(s)</td>
</tr>
<tr>
<td>National HIV plan – Inclusion of people with disabilities in National HIV plan</td>
</tr>
</tbody>
</table>

### Metric

- Yes/No and description of whether law prohibits discrimination, whether the law requires reasonable accommodation and whether the law is disability-focused on health focused
- Yes/No and description of how policy ensures access to specialist (rehabilitation services, AT) and general healthcare services for persons with disabilities, and whether the policy includes measures to implement that
- Yes/No & description; **Description to include:**
  1. Includes actions & targets for specialist health services for persons with disabilities
  2. Includes actions and targets for general health care for persons with disabilities (not only prevention of disability)
  3. Includes basic statistics about persons with disabilities and health
  4. Includes monitoring and evaluation indicators on disability as part of overall framework for the health sector
- Yes/No & description; **Description to include:**
  1. Includes actions and targets for specialist HIV health services for persons with disabilities
  2. Includes actions and targets for general HIV health care for persons with disabilities (not only prevention of disability)
  3. Includes basic statistics about persons with disabilities and HIV
  4. Includes monitoring and evaluation indicators on HIV amongst persons with disabilities as part of overall framework for the health sector

### Context
- International regulation stipulates the right of people with disabilities for health care, including the UNCRPD (articles 25 and 26)
- Many countries do have policies and laws in place, but these must be improved & extended (e.g., discrimination in insurance)
- Clearer & enforceable accountability needed
Leadership

Overall objective (“must have”)

• Issues around disability are clearly represented in the MoH and health sector structures and coordination mechanisms. Dedicated structures and leadership should also kick-in in times of crisis or disasters.

Potential Indicator | Metric
---|---
MoH leadership – Existence of a focal point/team/directorate in MoH that's responsible for ensuring health access for people with disabilities | • Yes, responsibility for disability inclusion, and title of role/team
• Yes, responsibility for rehabilitation, and title of role/team
• No, neither

National health sector coordination – Formal representation of persons with disabilities (individual, or OPDs) in highest-level health sector coordination structure | • Yes, and title of structure/group
• No

Global Fund CCM – Representation of person with disabilities in Global Fund CCM | • Yes/No

Pandemic preparedness structures – formal representation of people with disabilities (individuals are representing OPD) in national COVID-taskforce | • Yes/No

Context

• Improvement in national laws, policies and plans depend on the existence of responsible leadership on disability-inclusion in the healthcare system.
• Most coordination structures should have representation of people with disabilities to ensure expertise and experience on the issues to be addressed.
### Health Financing

#### Overall objective (“must have”)
- Health financing and/or health insurance coverage is available to support access to health for people with disabilities, including assistive technologies, specialized services, and any adaptations/improvements of routine services; health financing mechanisms allow adjustments to support effective service delivery.

#### Potential Indicator

<table>
<thead>
<tr>
<th>Metric</th>
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<tbody>
<tr>
<td>% of annual MoH budget, or absolute amount contributed from other Ministries as % MoH budget</td>
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</table>

<table>
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<tr>
<th>Context</th>
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<tbody>
<tr>
<td>Available budgets and health insurance benefits packages must exist to provide disability-inclusive services, specifically for: assistive technologies, specialized services &amp; any adaptations/improvements of routine services.</td>
</tr>
<tr>
<td>Additional budget lines may be needed to cover expenses for provision of rehabilitation and assistive technologies if they are not included in the essential medicines and supplies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric</th>
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<tbody>
<tr>
<td>Yes, at the federal and indication of $ amount Yes, at the decentralized level and indication of $ amount for one example location No, neither</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Metric</th>
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<tbody>
<tr>
<td>Yes, there is a national health insurance and reimbursement for at least certain conditions/treatments to health providers is adjusted for disabilities Yes, there are private insurances and reimbursement for at least certain conditions / treatments to health providers is adjusted for disabilities Yes, there is a national taxation-based budget and any capitation rates for devolved levels is adjusted for disabilities No adjustments (with whatever financing mechanism)</td>
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<th>Metric</th>
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</tr>
</tbody>
</table>
**Data & Evidence**

**Overall objective** (**“must have”**)  
- Routine data is available to show what the health situation of people with disabilities and how to improve it; evidence is generated to understand and improve delivery of health services

<table>
<thead>
<tr>
<th>Potential Indicator</th>
<th>Metric</th>
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</thead>
<tbody>
<tr>
<td>Prevalence of disability – Existence of national data on prevalence of disability (from within last 10 years)</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Routine health data – Existence of routine health data disaggregated by disability</td>
<td>Yes/No</td>
</tr>
<tr>
<td>AT coverage – Existence of data for coverage (% of need covered) of assistive technologies</td>
<td>Yes and list of products for which there is data No</td>
</tr>
<tr>
<td>Population-based data on disability and health – National disability survey done in last 10 years (including health data)</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

**Context**  
- Health information systems should generate data to describe the access to healthcare of people with disabilities in comparison to others  
- There are three potential sources of information  
  - Household surveys on health (including disability)  
  - Routine health information systems (with disability identifiers)  
  - Disability-specific surveys
Missing Billion Health Systems Framework

System
1. Governance
2. Leadership
3. Health Financing
4. Data & Evidence

Service Delivery

Demand
5. Autonomy and Awareness
6. Affordability

Supply
7. Human Resources
8. Health Facilities
9. Specialized Services & AT

Outputs
10. Effective Service Coverage

Outcomes
11. Health Status

Social Determinants and Context
## Autonomy & Awareness

### Overall objective (“must have”)
- People with disabilities make their own decisions about health care and are aware of their rights and options

<table>
<thead>
<tr>
<th>Potential Indicator</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPD advocacy – OPDs advocate on the right to health for persons with disabilities with government and NGO delivery partners</td>
<td>Yes - website of 1-3 national leading OPDs describe priorities/programs/work on advocacy on health on website</td>
</tr>
<tr>
<td>Autonomy and awareness – People with disabilities report autonomy and awareness about health access</td>
<td>Yes - in a quantitative survey from within the last 10 years persons with disabilities were asked about autonomy and awareness about health (in comparison to people without disabilities) OR Yes - qualitative data published in the last 10 years in a peer-reviewed journal on reported autonomy and awareness about health</td>
</tr>
<tr>
<td>Accessibility of health information – Health information is available in accessible formats</td>
<td>Yes - national COVID information and announcement made available at least in the 2 out of the 4 following alternative formats: simple language, sign interpretation of video/tv messages, braille, information for care givers</td>
</tr>
</tbody>
</table>

### Context
- People with disabilities may lack the autonomy to make decisions about their own healthcare, or the knowledge about when and how to seek care when needed. These fundamental barriers must be addressed, otherwise making changes in the supply side alone is unlikely to equalise healthcare access.
### Affordability

**Overall objective ("must have")**
- People with disabilities must be able to afford health care access

<table>
<thead>
<tr>
<th>Potential Indicator</th>
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</thead>
<tbody>
<tr>
<td>Disability allowance – There is a disability allowance that is available to cover healthcare fees not covered by existing insurance or tax-based systems, e.g. travel to clinics, assistive technologies</td>
<td>Yes and % of population covered, amount per person per time unit in $</td>
</tr>
<tr>
<td>Transport subsidy available for disabled people – Transport subsidy is available</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Health coverage – People with disabilities are fully covered for free healthcare through social health insurance, tax-based system, provision as part of disability allowance or any other stipulations</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Co-pays – Any co-pays for services in either health insurance or taxation based systems are waived for persons with disabilities</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

**Context**
- People with disabilities are on average poorer, yet incur greater healthcare costs. For example, transport may be more expensive since people with disabilities cannot always use public transport.
- Financial coverage for people with disabilities may therefore be needed, which can include provision of health insurance specifically, or enrolment in social protection programmes.
Human Resources

Overall objective ("must have")

- Healthcare workforce is knowledgeable about disability and has the skills and flexibility to provide quality care to people with disabilities

<table>
<thead>
<tr>
<th>Potential Indicator</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare workers</td>
<td>training</td>
</tr>
<tr>
<td>&amp; skills</td>
<td></td>
</tr>
<tr>
<td>Flexibility</td>
<td>to provide quality care</td>
</tr>
<tr>
<td>People with disabilities</td>
<td></td>
</tr>
</tbody>
</table>

Context

- Healthcare workers must have knowledge to provide quality care
- They need information about the healthcare needs people with disabilities may experience, both in terms of specific vulnerabilities (e.g., pressure sores among people with mobility impairments) as well as general needs when accessing general health-care (e.g., challenging false assumptions that people with disabilities are asexual)
- Furthermore, healthcare workers need the skills to be able to communicate with people with different impairment types, such as knowing how to interact with someone with a visual or cognitive impairment.
Health Facilities

**Overall objective (“must have”)**
- Healthcare facility infrastructure is accessible for people with disabilities

**Potential Indicator**
- National accessibility standards – Existence of national accessibility standards
- Accessibility of facilities – Accessibility audit of health facilities has been undertaken in the last 10 years

**Metric**
- Yes/No
- Yes - results of audit report in published government report/documents or peer-reviewed journal No

**Context**
- Healthcare facilities must be accessible for people with disabilities
- There are a number of accessibility standards that can guide the features that are needed.
- It will be most cost-efficient for the facilities to be built to these standards, rather than retrofit them at a later date.
- Appointing a responsible person in each health facility can help to ensure that these accessibility features are in place, & maintained.
- Consulting locally with people with disabilities will help to highlight the specific local accessibility barriers and how they can be overcome.
- Additionally, routine monitoring of health facilities to check accessibility is recommended, with consequences for those who fail accessibility standards
Rehabilitation services / AT

Overall objective (“must have”)

- Rehabilitation health services (e.g. rehabilitation and assistive technology) are available, affordable and of good quality for people with disabilities

Potential Indicator

- National assessments – National assessment on AT or rehabilitation (e.g. STAR or RATA) done in the last 10 years

- Coordination – Coordination mechanism cross-Ministry for rehabilitation services and AT where more than 1 ministries involved

- Trained workforce available to provide rehabilitation services and AT

Metric

- Yes/No

Context

- People with disabilities may require specialist health services, including rehabilitation & assistive technology.
- In many countries, need far outstrips supply
- The WHO has launched Rehabilitation 2030. In its “Guide to Action”/ Countries are encouraged to strengthen the capacity and performance of rehabilitation in their health system, through a 4-step process, starting with an assessment
- ATscale and its partners supports governments with capacity assessments on AT specifically.
Missing Billion Health Systems Framework

System:
1. Governance
2. Leadership
3. Health Financing
4. Data & Evidence

Service Delivery:
Demand:
- 5. Autonomy and Awareness
- 6. Affordability
Supply:
- 7. Human Resources
- 8. Health Facilities
- 9. Specialized Services & AT

Outputs:
10. Effective Service Coverage

Outcomes:
11. Health Status

Social Determinants and Context
### Overall objective ("must have")
- The coverage of services for people with disabilities must be equal to people without disabilities

<table>
<thead>
<tr>
<th>Potential Indicator</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modern contraception coverage – Women whose demand is satisfied with a modern method of contraception, disaggregated by disability</td>
<td>% of women with disabilities, compared to % of overall women</td>
</tr>
<tr>
<td>ARTs coverage – People with HIV receiving ART, disaggregated by disability</td>
<td>% of people with disabilities that have coverage, compared to coverage of people without disabilities</td>
</tr>
<tr>
<td>DTP 3 coverage – Children aged 12-23 months who have received diphtheria-tetanus-pertussis vaccine (DTP3), disaggregated by disability</td>
<td>% of children with disabilities, compared to % of overall children</td>
</tr>
<tr>
<td>Refractive error coverage – People with refractive error have coverage of glasses</td>
<td>% of those with need who have glasses (e.g. from RAAB survey)</td>
</tr>
<tr>
<td>NCD coverage – People with diabetes on treatment OR people with hypertension on treatment, disaggregated by disability</td>
<td>% of people with disabilities, compared to people without disabilities</td>
</tr>
</tbody>
</table>

### Context
### Health Status

**Overall objective**

- People with disabilities have the best possible health status, and don’t experience any difference in outcomes to people without disabilities (unless an underlying impairment would explain that)

<table>
<thead>
<tr>
<th>Potential Indicator</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality – Overall mortality rate, disaggregated by disability</td>
<td>Deaths per 100 000 population; people with disabilities compared to people without disabilities</td>
</tr>
<tr>
<td>Diabetes – Prevalence of diabetes OR hypertension among persons aged 18+ years, disaggregated by disability (Global Monitoring Framework NCDs; indicator #12, indicator #11, WHO)</td>
<td>People with disabilities, compared to people without disabilities</td>
</tr>
<tr>
<td>HIV – Prevalence of HIV, disaggregated by disability</td>
<td>% of people living with HIV among adults aged 15–49; people with disabilities compared to people without disabilities</td>
</tr>
<tr>
<td>Overweight and obesity – Prevalence of overweight and obesity among persons aged 18+ years, disaggregated by disability (Global Monitoring Framework NCDs; indicator #13, WHO)</td>
<td>% of all population with disabilities, compared to population without</td>
</tr>
<tr>
<td>Wasting – Prevalence of children wasted (moderate and severe), 0-59 months of age, disaggregated by disability; WHO Child Growth Standards median</td>
<td>% of children with disabilities, compared to % of overall children</td>
</tr>
</tbody>
</table>

**Context**
Potential sources of data

• Government policy documents and reports
• Scientific publications
• Other “grey” literature (e.g., NGO reports)
• Interviews with key informants (e.g., Government, OPDs, health sector)
• Publicly available data
Compendium of Good Practices

2022 evidence report: Reimaging health systems that expect, accept and connect 1 billion people with disabilities

2019 evidence report: Access to health services for 1 billion people with disabilities
Appendix
1.1 **Stakeholder mapping tool**

**Likely partners**
List the key stakeholders to consider on the left. Draw a circle and write the name inside for each, placing them on the map in the location that represents their likely support and role in disability inclusion. Change the size of the circles, with larger circles representing more power or authority.
1.2 1-page crib sheet on terminology for disability inclusion

Definitions (from World Report on Disability)

Accessibility: Accessibility describes the degree to which an environment, service, or product allows access by as many people as possible, in particular people with disabilities.

Accessibility standards: A standard is a level of quality accepted as the norm. The principle of accessibility may be mandated in law or treaty, and then specified in detail according to international or national regulations, standards, or codes, which may be compulsory or voluntary.

Assistive devices; also assistive technology: Any device designed, made or adapted to help a person perform a particular task. Products may be specially produced or generally available for people with a disability.

Disability: In the ICF, an umbrella term for impairments, activity limitations, and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual’s contextual factors (environmental and personal factors).

Disability discrimination: Any distinction, exclusion, or restriction on the basis of disability that has the purpose or effect of impairing or nullifying the recognition, enjoyment, or exercise on an equal basis with others, of all human rights and fundamental freedoms, includes denial of reasonable accommodation.

Health: A state of well-being, achieved through the interaction of an individual’s physical, mental, emotional, and social states.

Health system: An organization of people, institutions and resources that delivers health care services to meet the health needs of target population.

Inclusive society: One that freely accommodates any person with a disability without restrictions or limitations.

Organization of Persons with Disabilities: Organizations or assemblies established to promote the human rights of disabled people, where most the members as well as the governing body are persons with disabilities.

Reasonable accommodation: Necessary and appropriate modification and adjustment not imposing a disproportionate or undue burden, where needed in a particular case, to ensure that persons with disabilities enjoy or exercise, on an equal basis with others, all human rights and fundamental freedoms.

Rehabilitation: A set of measures that assists individuals who experience or are likely to experience disability to achieve and maintain optimal functioning in interaction with their environment.

Social protection: Programmes to reduce deprivation arising from conditions such as poverty, unemployment, old age, and disability.

Universal design: The design of products, environments, programmes, and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.

1 Definition not from World Report on Disability
### 1.3 Matrix to enter the source, findings and notes for each indicator

<table>
<thead>
<tr>
<th>Indicator of interest</th>
<th>Source</th>
<th>Method</th>
<th>Finding</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3</td>
<td>Document</td>
<td>Review of documents (published and from April 2019).</td>
<td>Review with key informants.</td>
<td>Tools</td>
</tr>
<tr>
<td>Component</td>
<td>Indicator</td>
<td>INDICATOR LO</td>
<td>Metric</td>
<td>Potential data sources</td>
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<tr>
<td>Service delivery</td>
<td>OSF advocacy</td>
<td>OSF advocates on the right to health for persons with disabilities</td>
<td>Yes - observation of 1-3 key primary healthcare providers on advocacy for health in community</td>
<td>Search of websites of key OSFs, key informant interviews</td>
</tr>
<tr>
<td></td>
<td>Autonomy and awareness</td>
<td>People with disabilities report autonomy and awareness about health care decisions</td>
<td>Yes - quantitative survey (involves at least 10% of patients with disabilities in the area)</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
</tr>
<tr>
<td></td>
<td>Accessibility of health information</td>
<td>Health information is accessible to persons with disabilities</td>
<td>Yes - qualitative data published in the last 10 years</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
</tr>
<tr>
<td></td>
<td>Affordability</td>
<td>There is a disability allowance that is accessible to persons who need it according to their needs</td>
<td>Yes - qualitative data published in the last 10 years</td>
<td>Search of disability allowances documents (e.g., social or government)</td>
</tr>
<tr>
<td></td>
<td>Transport subsidy available for disabled people</td>
<td>Yes/No</td>
<td>Interview with key informants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health coverage</td>
<td>People with disabilities are covered by health insurance or other health systems in the health system</td>
<td>Yes/No</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
</tr>
<tr>
<td></td>
<td>Co-pay</td>
<td>Any co-pay for services in other health insurance or taxation based systems are covered for persons with disabilities</td>
<td>Yes/No</td>
<td>Key informant interviews</td>
</tr>
<tr>
<td>Human Resource</td>
<td>Training of medical doctors</td>
<td>Information about disability delivered at the medical school curriculum for medical students</td>
<td>Yes - number of hours training</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
</tr>
<tr>
<td></td>
<td>Training of nurses</td>
<td>Information about disability delivered at the medical school curriculum for nursing college students</td>
<td>Yes - number of hours training</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
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<tr>
<td></td>
<td>Training of OHRs</td>
<td>Information about disability delivered at the medical school curriculum for OHRs</td>
<td>Yes - number of hours training</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
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<tr>
<td></td>
<td>Representation in health workforce</td>
<td>People with disabilities are represented in the health workforce</td>
<td>% of medical doctors that have disability</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
</tr>
<tr>
<td></td>
<td>Satisfaction</td>
<td>People with disabilities report that they are satisfied with health workers</td>
<td>Yes - qualitative data published in the last 10 years</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
</tr>
<tr>
<td>Health facilities</td>
<td>National accessibility standards</td>
<td>Evidence of national accessibility standards</td>
<td>Yes/No</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
</tr>
<tr>
<td></td>
<td>Accessibility of facilities</td>
<td>Health facilities for persons with disabilities are located in the last 10 years</td>
<td>Yes - results of a report published government reports (disabilities or persons with disabilities)</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
</tr>
<tr>
<td></td>
<td>National assessments</td>
<td>National report on DF or disability (e.g., SDMC in A4)</td>
<td>Yes/No</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
</tr>
<tr>
<td></td>
<td>Coordination</td>
<td>Coordination mechanisms are in place for rehabilitation service at and below the local level</td>
<td>No</td>
<td>Key informant interviews</td>
</tr>
<tr>
<td></td>
<td>Trained workforce available for rehabilitation services and above</td>
<td>% of Physiotherapy/10,000 population</td>
<td>Search of academic and grey literature (e.g., census reports, NGO reports)</td>
<td></td>
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<tr>
<td>Component</td>
<td>Indicator</td>
<td>Definition</td>
<td>Metric</td>
<td>Potential data sources</td>
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<tr>
<td>Resources</td>
<td>Modern contraception coverage</td>
<td>Women whose demand is satisfied with a package of modern contraception or sterilization</td>
<td>% of women with disabilities, compared to % of overall women</td>
<td>Search of academic and grey literature (e.g., census reports, WHO reports)</td>
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<td></td>
<td>ARTs coverage</td>
<td>People with HIV receiving ART</td>
<td>% of people with disabilities in the population who receive ART</td>
<td>Search of academic and grey literature (e.g., census reports, WHO reports)</td>
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<td></td>
<td>STI coverage</td>
<td>People aged 15-49 years who have been tested for STI in the last year</td>
<td>% of people with disabilities, compared to % of overall people without disabilities</td>
<td>Search of academic and grey literature (e.g., census reports, WHO reports)</td>
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<td></td>
<td>Referral area coverage</td>
<td>People with HIV/AIDS who have a referral area</td>
<td>% of people with disabilities, compared to % of overall population</td>
<td>Search of academic and grey literature (e.g., census reports, WHO reports)</td>
</tr>
<tr>
<td></td>
<td>AIDS coverage</td>
<td>People with HIV/AIDS who have access to care</td>
<td>% of people with disabilities, compared to % of overall population</td>
<td>Search of academic and grey literature (e.g., census reports, WHO reports)</td>
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</tbody>
</table>

| Outcomes | Health status | Overall mortality rate, disaggregated by age, sex, and disability status | Deaths per 1000 population people with disabilities, compared to people without disabilities | Search of academic and grey literature (e.g., census reports, WHO reports) | Source | Source | Source | Description |
|          | Diabetes | Prevalence of diabetes (HbA1c > 6.5%) | People with disabilities, compared to people without disabilities | Search of academic and grey literature (e.g., census reports, WHO reports) | Source | Source | Source | Description |
|          | HIV | Prevalence of HIV| % of people living with HIV among adults aged 15-49 years, people with disabilities, compared to people without disabilities | Search of academic and grey literature (e.g., census reports, WHO reports) | Source | Source | Source | Description |
|          | Overweight and obesity | Prevalence of overweight and obesity, age, sex, and disability status | % of population with disabilities, compared to population without disabilities | Search of academic and grey literature (e.g., census reports, WHO reports) | Source | Source | Source | Description |
|          | Wasting | Prevalence of children wasted (low weight for height) | % of children with disabilities, compared to % of overall children | Search of academic and grey literature (e.g., census reports, WHO reports) | Source | Source | Source | Description |
1.4 Outline for final report

Missing Billion Disability Inclusion Assessment

Report outline
The following provides a suggested outline for the report to present the findings from the Disability Inclusion Assessment. It can be adapted as needed for your context.

1. BACKGROUND
- Describe the reasons for conducting the review and the importance of disability inclusion
- Provide a brief description of the country’s health system and the overall status of disability inclusion in the country

2. METHODS
- Describe the indicators
- Describe the task team, including membership and their role in conducting the assessment
- Describe the process of collecting data on the indicators, including sources

3. FINDINGS
A. System
   - Governance
     o Briefly describe the findings across the indicators for leadership and their implications
   - Leadership
     o Briefly describe the findings across the indicators for leadership and their implications
   - Financing
     o Briefly describe the findings across the indicators for financing and their implications
   - Data & Evidence
     o Briefly describe the findings across the indicators for data & evidence and their implications

B. Service delivery
   - Autonomy and awareness
     o Briefly describe the findings across the indicators for autonomy and awareness and their implications
   - Affordability
     o Briefly describe the findings across the indicators for affordability and their implications
   - Human resources
     o Briefly describe the findings across the indicators for human resources and their implications
   - Health facilities
     o Briefly describe the findings across the indicators for health facilities and their implications

C. Effective service coverage
   - Provide a brief description of the findings and implications for these indicators

D. Health status
   - Provide a brief description of the findings and implications for these indicators

4. CONCLUSIONS
- Drawing from findings across the different indicators, identify some conclusions about the status of disability inclusion within the country’s health system

5. RECOMMENDATIONS
- Based on the findings, identify a few key recommendations to make progress on disability inclusion within the health system
- Identify the top 3 costed actions that you would suggest the Ministry of Health and stakeholders take on in the coming 18 months

6. ANNEXES
- Completed worksheet with the indicators, their source, and findings
- TOR and membership of the task team
1.5 Prioritization approach for strategic planning

**Prioritizing activities**

List the proposed activities on the left. Then agree where each should be placed on the two-by-two table. Draw a circle for each when you place it and change the size of the circles based on cost estimates, with larger circles representing higher cost.

<table>
<thead>
<tr>
<th>LIST OF ACTIVITIES</th>
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<thead>
<tr>
<th>FOUNDATIONAL IMPORTANCE</th>
<th>IMPACT</th>
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<tbody>
<tr>
<td></td>
<td>Important, and may lead to incremental changes</td>
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<tr>
<td></td>
<td>Impaactful and important to set foundations for future actions</td>
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<tr>
<td></td>
<td>Not impactful nor important</td>
</tr>
<tr>
<td></td>
<td>Less impactful but important for setting foundations for future actions</td>
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</tbody>
</table>
Thank you!