

## **Disability**

### **Report by the Secretariat**

1. The attached document EB132/10 was considered by the Executive Board at its 132nd session.<sup>1</sup> The Board also adopted resolution EB132.R5.<sup>2</sup> It should be noted that the information provided in paragraphs 10, 19 and 25 of the report has been updated.

#### **ACTION BY THE HEALTH ASSEMBLY**

2. The Health Assembly is invited to adopt the draft resolution recommended by the Executive Board in resolution EB132.R5.

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<sup>1</sup> See the summary records of the third meeting; the fourth meeting, section 2; and the ninth meeting, section 2.

<sup>2</sup> See document EB132/2013/REC/1 for the resolution, and for the financial and administrative implications for the Secretariat of the adoption of the resolution.



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# Disability

## Report by the Secretariat

1. Disability is neither purely a biological nor a social construct but the result of interactions between health conditions and environmental and personal factors (WHO, 2001).<sup>1</sup> Disability can occur at three levels: an impairment in body function or structure; a limitation in activity, such as the inability to read or move around; a restriction in participation, such as exclusion from school or work. As such, people with disabilities include those who are traditionally understood as disabled (for example wheelchair users, people who are blind or deaf or people with intellectual impairments), and people who experience difficulties in functioning due to a wide range of health conditions such as chronic diseases, severe mental disorders, multiple sclerosis and old age.

2. There are more than 1000 million people with disabilities in the world, of whom between 110 million and 190 million experience significant difficulties. The total corresponds to about 15% of the world's population and is higher than WHO's previous estimates, which date from the 1970s and suggested a figure of around 10%. Furthermore, the prevalence of disability is growing because of ageing populations and the global increase in chronic health conditions. National patterns of disability are influenced by trends in health conditions and environmental and other factors – such as road traffic crashes, natural disasters, conflict, diet and substance abuse. Disability disproportionately affects vulnerable populations, in particular, women, older people and people that are poor. Low-income countries have a higher prevalence of disability than high-income countries.

3. People with disabilities face widespread barriers in accessing services, such as those for health care (including rehabilitation), education, transport and employment. These barriers include inadequate policies and standards, negative attitudes, lack of service provision, inadequate funding, lack of accessibility, inappropriate technologies and formats for information and communication, and lack of participation in decisions that directly affect their lives.

### HEALTH AND SOCIOECONOMIC OUTCOMES

4. Across the world people with disabilities have worse health and socioeconomic outcomes, as outlined below.

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<sup>1</sup> *The International Classification of Functioning, Disability and Health*. Geneva, World Health Organization, 2001.

5. **Poorer health than the general population.** Depending on the group and the setting, people with disabilities may experience greater vulnerability to preventable secondary conditions, co-morbidities and age-related conditions. Some studies have also shown that they exhibit higher rates of risky behaviours such as smoking, poor dietary practices and habits, and physical inactivity. People with disabilities also have a higher risk of being exposed to violence. Analysis of the WHO's World Health Survey reveals that half of all disabled people cannot afford health care in contrast to a third of non-disabled people.<sup>1</sup> People with disabilities are more than twice as likely to report finding that health-care providers' skills are inadequate to meet their needs. They are three times more likely to report being denied the health care they need and four times more likely to report being treated badly. There are extensive unmet needs for rehabilitation services. For example, data from four southern African countries found that only 26% to 55% of people received the medical rehabilitation they needed; 17% to 37% received the assistive devices they needed; and 5% to 24% received the welfare services they needed. These unmet service needs (including the provision of assistive devices) can result in poor outcomes for people with disabilities, including deterioration in general health status, problems in executing tasks or actions, difficulties in participating in normal activities, longer stays in and repeated admissions to hospital, and reduced quality of life.

6. **Higher rates of poverty than people without disabilities.** On average, people with disabilities and households with a disabled member experience higher rates of deprivation – including food insecurity, poor housing, lack of access to safe drinking-water and basic sanitation, and inadequate access to health care – and have fewer assets than people without disabilities and households without a disabled member. People with disabilities may face extra indirect and direct costs, for example for personal support or for medical care or assistive devices. Because of these higher costs, people with disabilities and their households are likely to be poorer than non-disabled people with similar income. Disabled people in low-income countries are 50% more likely to experience catastrophic health expenditure than non-disabled people.

7. **Low educational achievement.** Children with disabilities are less likely to start school than their peers without disabilities, and have lower rates of staying in schools. Gaps in completing education are found across all age groups in both low-income and high-income countries, with the pattern being more pronounced in poorer countries.

8. **Reduced economic participation.** People with disabilities are more likely to be unemployed and generally earn less even when they are employed. A recent study from the Organisation for Economic Co-operation and Development showed that, on average, their employment rate (44%) was slightly more than half the rate for persons without disability (75%).<sup>2</sup>

9. **Increased dependency and restricted participation.** Reliance on institutional solutions, lack of community living and inadequate services leave people with disabilities isolated and dependent on others. Living in residential institutions is reported to be responsible for people with disabilities lacking autonomy, being segregated from the wider community, and at greater risk of violence, abuse and other human rights violations. Generally, most support for people with disabilities comes from family members or social networks, but exclusive reliance on informal support can have adverse

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<sup>1</sup> World Health Organization and World Bank, *World report on disability*. Geneva, World Health Organization, 2011. For further information on the World Health Survey see Technical appendix C and <http://www.who.int/healthinfo/survey/en/> (accessed 19 November 2012).

<sup>2</sup> *Sickness, disability and work: breaking the barriers. A synthesis of findings across OECD countries*. Paris, Organisation for Economic Co-operation and Development, 2010.

consequences for the carers, including stress, isolation and lost socioeconomic opportunities. These difficulties increase as family members age.

## RESPONSES AND RECOMMENDATIONS

10. The Convention on the Rights of Persons with Disabilities, which was adopted in 2006 and came into force in May 2008, has been signed by 155 countries or regional integration organizations and been ratified by 127, establishes disability as a human rights and development issue. It also calls upon States Parties to the Convention to treat disability not as a supplementary issue but as an integral part of their work.

11. The *World report on disability*, published in 2011 by WHO and the World Bank has subsequently been translated into several languages including all the official United Nations languages and issued in a broad range of alternative formats.<sup>1</sup> It shows that many of the barriers people with disabilities face are avoidable and that the disadvantage associated with disability can be overcome. The report recommends that governments and their development partners cover the following areas.

12. **Enable access to all mainstream policies, systems and services intended for the general public.** People with disabilities need better access to free and affordable health care at all levels of the health-care system (with a specific focus on primary and community health), broader health insurance coverage, appropriately trained health-care workers, and the empowerment of people with disabilities to manage their health needs better. Measures to promote the health of people with disabilities and their inclusion in society through general care (such as immunization, reproductive and maternal health services, advice on physical activity and diet, screening for cancer and other conditions) and specialized health care are as important as measures to prevent people developing health conditions associated with disability. Mainstreaming not only fulfils the human rights of persons with disabilities, it is also more cost-effective.

13. **Invest in specific programmes and services for people with disabilities.** Some people with disabilities require access to specific measures, such as rehabilitation and support services, which can improve functioning and independence and foster participation in society. They also need integrated and decentralized rehabilitation services, and improved provision of assistive technologies, for example wheelchairs, hearing aids, low vision devices, and related services. Rehabilitation workers need to be trained in order to ensure a sufficient supply of personnel who can enable people with disabilities to achieve their potential and have the same opportunities to participate fully in society. Investment should be made in a range of well-regulated and responsive support services such as respite care, personal assistants, sign-language provision among others that can ensure dignity and well-being for people with disabilities and their families.

14. **Adopt a national disability strategy and plan of action.** Such strategies should set out a comprehensive long-term vision that covers both mainstream programme areas and specific services for people with disabilities and will help improve coordination between sectors and services.

15. **Provision of adequate and sustainable funding and improved affordability.** Adequate and sustainable funding of publicly provided services outlined in the strategy and plan of action is needed in order to remove barriers to access and ensure that good quality services are provided.

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<sup>1</sup> World Health Organization and World Bank. *World report on disability*. Geneva, World Health Organization, 2011.

16. **Improve data collection.** Data (as well as definitions and methods) need to be standardized and internationally comparable in order to facilitate benchmarking and monitoring of progress on disability policies. At the national level, disability questions – or a disability module – should be included in existing surveys. Dedicated surveys related to disability can also be carried out in order to gain more comprehensive information.

17. The other recommendations focus on **increasing public awareness and understanding of disability, supporting and strengthening further research, improving human resource capacity (including training of health professionals), and consulting and involving people with disabilities** in the design and implementation of these efforts.

## ACTIVITIES OF THE SECRETARIAT

18. In April 2008, the Director-General established a Task Force on Disability, with representation from all clusters and regional offices. The Task Force has made significant progress, in both raising awareness of disability as a cross-cutting issue in technical work (for example, sexual and reproductive health, and emergency risk management) and removing barriers, be they physical, lack of information or reasonable accommodation<sup>1</sup> or policies, to the participation of people with disabilities in WHO's work.

19. Since the launch of the *World report on disability*, the Secretariat has provided support for 55 national policy dialogues and events. It has also jointly published guidelines on the provision of wheelchair services<sup>2</sup> and, in partnership with UNESCO, ILO and the International Disability and Development Consortium, guidelines on community-based rehabilitation,<sup>3</sup> which contribute to promoting and strengthening community-based rehabilitation programmes that empower all persons with disabilities to have access to and benefit from education, employment, health and social services. It has issued practical information and tools for assessing and improving the quality of care and human rights in mental health and social care facilities,<sup>4</sup> and, in partnership with UNICEF, a discussion paper on early childhood development and disability.<sup>5</sup> The Secretariat is in the process of writing guidelines on rehabilitation.

20. At the country level the Secretariat is providing support on disability to Member States requesting guidance in the areas of policy development and strategic planning, capacity-building and technical assistance, in particular in order to improve data, make health system strengthening inclusive, strengthen rehabilitation services (including provision of assistive technology), extend services (for example, for people with mental health conditions), and expand community-based rehabilitation.

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<sup>1</sup> "Reasonable accommodation" means necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms. Source: Article 2 *Definitions*, Convention on the Rights of Persons with Disabilities, United Nations, 2006.

<sup>2</sup> WHO, ISPO, USAID. *Guidelines on the provision of manual wheelchairs in less resourced settings*, Geneva, World Health Organization, 2008.

<sup>3</sup> WHO, UNESCO, ILO. International Disability and Development Consortium. *Community-based rehabilitation: CBR guidelines*. Geneva, World Health Organization, 2010.

<sup>4</sup> WHO *QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities*. Geneva, World Health Organization, 2012.

<sup>5</sup> WHO, UNICEF. *Early childhood development and disability: discussion paper*. Geneva, World Health Organization, 2012.

21. In line with the *Guidelines on the provision of manual wheelchairs in less resourced settings*, the Secretariat has created basic and intermediary training modules. Under development are a human rights-based curriculum on disability for health and rehabilitation personnel, a training package on community-based rehabilitation for programme managers, and guidance on training human resources for rehabilitation.

22. In response to the urgent need to improve the collection, analysis, synthesis and dissemination of data on disability in a manner that is accurate and comparable across different settings, countries and populations, the Secretariat in partnership with the World Bank is working on a model disability survey, which builds on existing initiatives and will result in a standardized survey instrument. The Secretariat has also published an atlas on the resources available globally to prevent and treat mental health conditions and to help protect the human rights of people living with these conditions.<sup>1</sup>

23. Recognizing that disability is a cross-cutting issue involving all sectors and diverse actors, the Secretariat works with a broad range of partners across all its areas of work. For example, it leads the development of community-based rehabilitation, by building capacity and fostering networks on a regional and global basis.

#### **HIGH LEVEL MEETING OF THE UNITED NATIONS GENERAL ASSEMBLY**

24. The United Nations General Assembly has called for the mainstreaming of disability in the development agenda in several resolutions.<sup>2</sup> In resolution 66/124 on the High-level Meeting of the General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities it decided to convene a one-day meeting, at the level of Heads of State and Government, on 23 September 2013 on the theme “The way forward: a disability-inclusive development agenda towards 2015 and beyond”.

#### **ACTION BY THE EXECUTIVE BOARD**

25. [This paragraph contained a draft resolution, which was adopted by the Board as resolution EB132.R5.]

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<sup>1</sup> WHO. *Mental health atlas 2011*. Geneva, World Health Organization, 2011.

<sup>2</sup> Resolutions 66/288, 66/229, 66/124, 65/186 and 64/131.