Post-2015 Sustainable Development Goals

Policy brief

For further information contact:
Catherine Naughton, Director of CBM International Advocacy and Alliances, Catherine.Naughton@cbm.org

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CBM is an international Christian development organization, committed to improving the quality of life of people with disabilities in the poorest communities of the world.

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Universal health coverage

Health influences all three dimensions of sustainable development: social, economic and environmental. Fifteen per cent of the world's population are persons with disabilities and one in five of the world's poorest people have disabilities[1]. Persons with disabilities experience poorer levels of health than the general population[2] and often spend more of their income on medical expenses than others[3].

This policy brief puts forward key issues for ensuring that goals and targets on health in the post-2015 development framework are disability-inclusive. The recommendations resonate with the current post-2015 narrative on cross-cutting targets on health, which aim to create synergies between the future sustainable development goals contributing to improved health globally.

Overarching recommendation

Universal health coverage across the whole life span should be a stand-alone goal in the post-2015 framework. The goal should be underpinned by the principle of equity and a rights-based approach to health. This will result in the removal of all barriers to ensure that men, women, boys and girls with disabilities can access healthcare on an equal basis with others.

Recommendations on health and disability in the post-2015 agenda

1. Health systems should deliver **inclusive and accessible services** that are consistent with the Convention on the Rights of Persons with Disabilities (CRPD) and the WHO Action Plan on Disability 2014-2021. This requires the provision of rehabilitation services, and social protection measures that include disability related extra costs such as assistive devices and technology, support services and additional healthcare costs.
2. Measures to accelerate the achievement of the current Millennium Development Goals (MDGs) on health and new targets on Non Communicable Diseases **must include persons with disabilities.**
3. Data systems to collect healthcare outcomes in the post-2015 framework must be **inclusive of data on persons with disabilities.**
4. All health related policies, programs and services need to **address gender inequalities**.
5. **Mental health services** must be properly resourced and seen as an **integral part of mainstream healthcare provision.**
6. Healthcare services provided during emergencies and health planning in disaster risk processes must be inclusive of persons with disabilities.

Mayor Benjamin Maggay of Cervantes local government in the Philippines, is convinced that CBR is one of the best strategies to attain its development agenda – a good entry point for including the whole population: persons with disabilities, indigenous people, children, women, and senior citizens

"Under the law, we have the same rights to be respected. Therefore I must deliver the services that the person with disability need on an equal footing with other persons".

Health – a precondition, an indicator and an outcome of progress

Anybody can, and is likely to, experience disability directly at some point in life. Disability is therefore a global public health issue, a human rights issue and is intrinsically linked to human development. A higher proportion of persons with disabilities live in poorer countries[4] and poverty increases the likelihood for impairment due to malnutrition, dangerous working and transportation conditions and poor healthcare. At the same time, persons with disabilities have less access to education and livelihood opportunities, which can lead to worse living conditions and increased out-of-pocket payments for healthcare, thus increasing their susceptibility to poverty.

Persons with disabilities face several barriers in accessing health services and generally have worse health outcomes than others[5]. These barriers can be architectural, such as inaccessible or inappropriate health facilities and long distances to travel to access them; barriers due to misconceptions and health workers' lack of knowledge of disability, as well as information related, where many persons with disabilities cannot access information or are not adequately informed about health prevention, promotion and treatment.

Therefore, a post-2015 development framework needs to address **universal access to health** in synergy with other development goals and **address the root causes of poverty and ill health**, which affect marginalized groups, such as persons with disabilities to a much greater extent.

Overarching recommendation

Universal health coverage across the whole life span should be a stand-alone goal in the post 2015 agenda. The goal should be underpinned by the principle of equity and a rights-based approach to health. This will result in the removal of all barriers to ensure persons with disabilities can access healthcare on an equal basis with others.

Legal frameworks for inclusive health and rehabilitation systems

The WHO constitution[6] and the International Covenant on Economic, Social and Cultural Rights, state the right for everybody to attain the highest possible state of health and wellbeing, without discrimination. Article 25 of the CRPD reinforces this right and article 26 states that access to rehabilitation and habilitation is important to enable persons with disabilities to be independent through supporting their full physical, mental, social and vocational ability, for inclusion and participation in society.

Disability-inclusive health policies promote services that are **accessible and acceptable, affordable, accountable and are of good quality**[7]. A cross-cutting principle is **participation and free and informed consent**, which ensures that persons with disabilities or their representative organizations are included in the planning, delivery and monitoring of health and rehabilitation services and are not subject to forced or coerced interventions.

"They provided me with a tricycle which is much better for moving around—it lets me visit people and take food for my cows and feed them myself. I can move very far and my son can go to school instead of pushing my trolley…I have to work because I have to run the family. As my son is studying in class 4, I need money to support his education."

Abdul Gafur, Bangladesh

www.endthecycle.org.au/stories/Abdul

"I remember once when a mother came with her disabled son to the center. I didn't even want to look at him; the whole situation frightened me. Today I know what is disability and all these people receive services in the centre. If necessary, I also know where to call in order to refer to more specialized treatment. But, if it is a flu or diarrhea, we can very well treat these children here".

Maria Zeneyda Rugama, nurse in Piedras Grandes, Nicaragua

Inclusive health systems

Within the MDG framework the disease-specific health goals resulted in vertical intervention programs in many developing countries and distorted the health system[8]. An equitable and human rights based approach to health therefore needs to consider the whole person, throughout the life span and within a social and economic environment, and not compartmentalize treatment by disease or stage in life. **Health systems and facilities have to be inclusive and accessible to all persons that need them** and health workers have to be trained in how to interact respectfully with persons with disabilities.

Procurement systems, which are fundamental to health service delivery, should be guided by **Universal Design principles**[9] to make sure that equipment and material, medication and health facilities are inclusive of the needs of all people, including persons with disabilities.

Having access to rehabilitation services and assistive technologies can in many cases improve the chances of persons with disabilities accessing work, education, healthcare, and participating in their community life. In addition it is estimated that 92% of the disease burden in the world is related to causes that require health professionals associated with physical rehabilitation[10]. **Facilitating access to rehabilitation is therefore an important public health issue**. Full access to rehabilitation and assistive technology will be achieved only when governments, through pre-payment and pooling of funds, such as social protection, subsidize these costs and make them available for everyone[11].

Linking primary health care to Community Based Rehabilitation (CBR) programs can help mitigate against these barriers and will also have a double impact, making existing services more inclusive and reaching a higher number of persons with disabilities, especially in rural areas and low-income settlements[12].

Recommendation

Health systems should deliver inclusive and accessible health services that are consistent with the Convention on the Rights of Persons with Disabilities (CRPD) and the WHO Action Plan on Disability 2014 -2021. This requires the provision of rehabilitation services and social protection measures that include disability related extra costs such as assistive devices and technology, support services and additional health care costs.

"Health is a fundamental human right and yet what we have learned through progress reports on the MDGs and the World Report on Disability is that great inequities exist in health systems around the world. One important contribution to overcoming inequity in health systems is Community Based Rehabilitation, which is a cross disability, multisectoral, and rights based strategy for ensuring that persons with disabilities are included in services and opportunities and participate fully in life. A focus on the health sector through the CBR strategy helps in two fundamentally important ways: it supports the health system in reaching people close to home and it unlocks the barriers that have traditionally made it difficult for persons with disabilities to access mainstream and disability specific health services, thus supporting people's self-advocacy as well as supporting health professionals in eliminating systemic and attitudinal barriers in health provision"

Karen Heinicke-Motsch, Director of International Programs CBM USA

The unfinished MDGs, Non Communicable Diseases and measuring progress for all

Evidence and data gathering on the situation of persons with disabilities is slowly improving. Globally 15% of the world's population, or one in seven people have a disability[13]. Moreover, disability disproportionately affects women, older people and poor people, with the UN estimating that 80% of persons with disabilities live in developing countries[14].

Persons with disabilities have the same general health needs as everybody else and therefore require equal access to mainstream health services. Yet, the MDGs specific to health did not include persons with disabilities. While the MDGs succeeded in supporting countries to improve on a number of health outcomes, the aggregated targets of the MDGs hid increasing national inequities and failed to measure progress among the poorest and most marginalized, such as persons with disabilities[15].

In addition, Non-Communicable Diseases are becoming increasingly important public health concerns, and account today for two out of three deaths and half of all disability worldwide[16]. Persons with disabilities have equal risks, or in some cases higher risks, for falling sick but are seldom reached by preventative or curative services. For example, the prevalence of diabetes among people with schizophrenia is as high as 15% compared to the general population of 2-3%[17].

Recommendations

Measures to accelerate the achievement of the current MDGs on health and new targets on Non Communicable Diseases must include persons with disabilities.
Data systems to collect healthcare outcomes in the post- 2015 framework must be inclusive of data on persons with disabilities

"I didn't like to take my daughter to the health center because they always told me that they couldn't attend my daughter, because it was a special case and these cases are only treated in specialized clinics in Managua. Now we have received a visit from a CBR worker and we were referred to doctors in Juigalpa. The nurses of our health center also participated in a training, and now they are providing good services to us in the centre".

Velia Sánchez, mother of a child with disability in Juigalpa, Nicaragua

"The WHO Comprehensive Global Mental Health Action Plan is the latest evidence of a new global recognition of the importance of reversing the historical neglect of mental health. Now we have good tools, backed by strong evidence of efficacy, we have no excuse but to work together to close the scandalous mental health treatment gap that currently exists"

Dr Julian Eaton, Global Advisor on Mental health, CBM

Women with disabilities must have equal access

Women with disabilities have the same risks of developing health problems as other women but in general do not receive the same level of preventative and curative healthcare due to barriers to access and the discriminatory attitudes of healthcare workers. The barriers women with disabilities face include: accessing information enabling them to make informed choices, inaccessible clinics, or programs that are not inclusive of their specific healthcare needs. **One of the biggest obstacles faced by women with disabilities is the discrimination they encounter based on pre-conceived ideas about disability**. These pre-conceived ideas can manifest themselves in decisions about reproduction and family planning often being made by a third party, in some circumstances without the consent of the woman or girl concerned.

As well as these barriers, numerous violations of women's rights have been reported from institutional healthcare settings; women with psychosocial and intellectual disabilities are particularly vulnerable in such deprived settings[18].

Article 17 (Protecting the integrity), Article 23 (Respect for home and family) and Article 25 (Health) of the CRPD protect the rights of women and girls with disabilities to the necessary support and services related to their health and also their right to have a family.

Recommendation

All health-related policies, programs and services need to address gender inequalities.

Mental health is integral to inclusive health policy and practice

Persons with mental health conditions and/or psychosocial disabilities are among the most marginalized in many communities, yet by 2030 depressive disorders alone will be the single greatest contributor to the global burden of disease[19]. Lack of community support and access to adequate healthcare can force many to live their entire life in institutions or in poverty, excluded by their communities. Studies show that between 76% and 85% of persons in developing countries with mental health problems do not receive adequate treatment[20]. The result is a large proportion of the population not being economically active throughout their most productive years.

Improving access to mental health and social services is an effective way to help achieve wider development objectives. Similarly, recognizing the key mental health component of other health sectors and routinely including indicators on mental health in management information

systems will strengthen efforts to achieve targets and reduce the invisibility of persons with psychosocial disabilities. **Clear minimum standards of practice must be enforced in mental health services**, particularly institutions, to reduce the human rights abuse still common in places that should be offering care.

Recommendation

Mental health services must be properly resourced and seen as an integral part of mainstream healthcare provision.

Emergencies and Disaster Risk Reduction

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"When you arrive in a camp with your child and your wife and you have a disability, it is really hard to find the basic things to survive".

Kambinja, in an internally displaced camp near Goma, November 2012

Persons with disabilities remain at high risk in disasters caused by natural hazards and conflicts or by low-severity high-frequency disasters[21]. Disasters and conflicts disproportionately place persons with disabilities and their families in vulnerable situations and they often experience increased problems and difficulties with accessing information. For example, research indicates that the fatality rate among persons with disabilities registered with the government was twice that of the rest of the population during the 2011 Japan earthquake[22].

Emergencies often lead to people acquiring disabilities due to a breakdown of health services that cannot adequately treat injuries that can result in death or impairments. Good governance in health is therefore required before, during and after emergencies to ensure disability-inclusive actions on emergency management on health.

Article 11 of the CRPD[23] requires that persons with disabilities benefit from and participate in disaster risk reduction strategies.

Recommendation

Healthcare services provided during emergencies and health planning in disaster risk processes must be inclusive of persons with disabilities.

Case study

An intervention for Inclusive Primary Healthcare in Charsadda, Pakistan

In 2010, Pakistan experienced one of its most intensive summer monsoons with over 20 million people affected by the floods, most of them in Khyber Pakhtunkhwa Province. Charsadda district was one of the most severely affected districts and the provision of health services in the intervention area was also severely affected. As the floods disrupted the healthcare system, CHEF International and CBM, who had been partners since 2007, agreed a project **to ensure that persons with disabilities had access to a functioning healthcare system and that they were prepared for future disasters.**

From the project's activities, five key areas can be highlighted as important steps to be taken towards inclusive healthcare for persons with disabilities:

1. Trained health workers in prevention of impairment and rehabilitation
Primary health personnel were trained in early identification of impairments as well as disability rights and disaster preparedness.

2. Accessible basic health services
An important aspect of the project was ensuring that persons with disabilities could actually access basic health services. Four Basic Health Units (BHU) were renovated providing accessible waiting room areas and bathrooms. Also house-to-house visits took place to ensure that the BHU was able to reach out to all persons with disabilities living in the community.

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Attended at the renovated Basic Health Unit

3. An empowered and educated disability community
In addition to making services accessible, it was important to raise awareness on the health of persons with disabilities. Education on hygiene and nutrition was provided as well as building capacity on rights and advocacy by supporting the creation of Disabled Persons Organizations.

4. A gender sensitive approach
From the outset, the project ensured that a gender-balanced team was recruited to implement its health activities, including the recruitment of lady health workers in the Basic Health Units. It also involved flexible outreach sessions so that women could fit in attending health sessions on nutrition around their schedules of caring for family and working.

5. A sensitized provincial and district government on inclusive healthcare
The final important step was ensuring that what is being learnt and implemented through this project does not just remain locally owned. With this in mind the project invited district staff into its training on disability rights to improve their knowledge and to help towards the long term sustainability of the project's objectives.

Case study

Working with government and communities to improve access to healthcare in Nicaragua

Community Based Rehabilitation (CBR) programs which link to national health schemes and primary health care in Nicaragua have led to more people with disabilities receiving necessary health services, both through access to municipal health centers and via support in their communities or homes.

A comprehensive CBR program is being implemented in the Chontales and Boaco departments of the country by CBM partner Asociación de Programas Integrales de Educación Comunitaria Astrid Delleman (ASOPIECAD), which itself works in close partnership with local community organizations and Nicaraguan Government institutions. One aspect of the CBR program is to promote equal access to health services for all people with disabilities by using participatory methods at community level. For example, it is using a self-assessment tool to identify individual and community needs, capacities and resources – and in this way involving persons with disabilities and their families directly in all aspects of the programs.

Nicaragua ratified the CRPD in 2007 and since then the Government has put into practice a number of programs to ensure the rights of persons with disabilities, among them the right to health.

Early stimulation and education of children

ASOPIECAD's CBR program works closely with a national Nicaraguan Government program to promote the early stimulation of children of up to six years of age. Called "Amor para los más chiquitos y chiquitas", the program promotes inclusive activities for strengthening the capacities of parents, community volunteers, teachers and community leaders to ensure children's right to education and healthcare and to support their all-round development.

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Training nurses and health teams on disability-inclusive early stimulation techniques

ASOPIECAD is complementing this program by helping to build the capacity of community actors to equally identify children with disabilities. It has trained parents and brought in adapted tools to work with children with disabilities. These included early stimulation techniques, encouraging the conduct of regular health checks and supporting inclusion in pre-school and schools.

Inclusive Family and Community Health

The Family and Community Health model promoted as a holistic approach to improve the health status of families and communities, aims to bring health services closer to the population and strengthen the participation of the people in health prevention and promotion. To ensure that this model of care is equally reaching persons with disabilities, the CBR team at ASOPIECAD has, together with medical specialists and in coordination with the Ministry of Health, provided training on disability and the right to health to CBR workers, community health workers, general practitioners and community leaders.

The result of linking CBR to national health programs and primary healthcare has led to more persons with disabilities accessing the municipal health centers and because they are no longer invisible, they are also supported in their own communities or homes during the visits of specialist health personnel providing services through the health teams. Through the program "Todos con Voz", persons with multiple disabilities that have difficulties leaving their homes receive health checks at their home.

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