2030

Africa Disability

AHO PLAN OF ACTION ON DISABILITIES AND REHABILITATION

AFRICA HEALTH ORGANISATION

EQUALITY
FOR ALL

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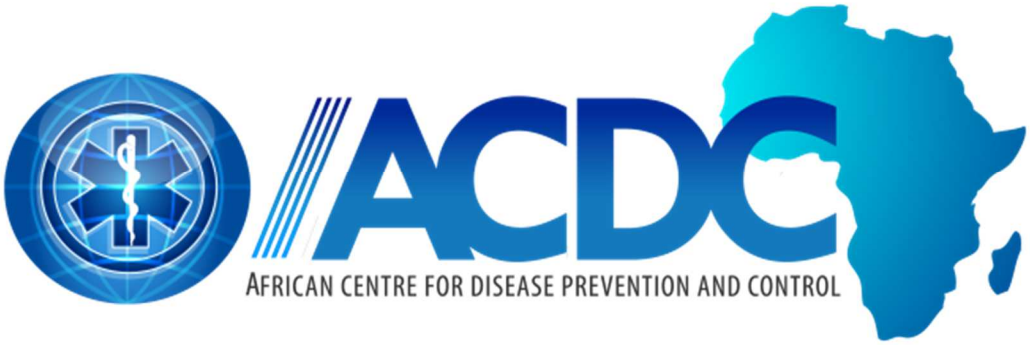
Partners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Africa
Disability


GMF
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FOUNDATION

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Preface

It is estimated that 15% of the world's population, or 1 billion people, live with some degree of disability. Of that figure, 3% have a severe disability. The prevalence of disabilities is growing, due to the aging of the population and the global rise in chronic diseases, violence, accidents of all types, and the use and abuse of alcohol and illicit substances, and it is higher in low-income countries. Health facilities in many countries do not meet the health care needs of persons with disabilities, and the probability of their being denied health care is three times higher, and of their being treated inappropriately, four times higher than for people with no disability.

AHO recognizes disability as a public health issue, since people with disabilities encounter barriers to health and rehabilitation services. This is a human rights issue, because people with disabilities often face stigmatization and discrimination. It is also a development priority, because disability gives rise to poverty and poverty, in turn, gives rise to more disability.

An estimated 340 million people in Africa have a disability, 2-3% of them a significant[2] functional impairment. Vulnerable groups are those most affected by disability and include women and children victims of violence, older persons, and people living in poverty. Ethnic minorities are also at significantly higher risk. Only 3% of people in Africa with some type of disability of varying degrees of severity have access to rehabilitation services, and 3% are highly dependent[3] on another person[4] to assist them with their activities of daily living; only 25% of children with disabilities have access to education and of these children, only 5% finish primary school. Some 3% of newborns have impairments that must be detected and treated with early interventions, because otherwise, these impairments may lead to lifelong disability.

Although some 360 million people worldwide have moderate to profound hearing loss, hearing aid production meets only 10% of global needs and 3% of needs in the developing countries; some 200 million need glasses but do not have access to them; and 70 million need a wheelchair, but only 5-15% obtain one. The cost of assistive technology devices is also a barrier for people with disabilities, especially in low-income countries.

People with disabilities are more vulnerable to preventable secondary diseases, comorbidities, and age-related conditions. They are more exposed to violence, are at greater risk of injuries from accidents of all types, and exhibit higher indexes of risky behaviour. There is a high global incidence of disability from mental and neurological disorders stemming from functional psychoses, dementia, epilepsy, cognitive disabilities, substance abuse disorders, and depression.

10. Occupational and traffic injuries, violence, joint diseases, and degenerative central nervous system disorders all contribute to the disability issue. Some 1.2-1.4 million people die each year as a result of traffic accidents and 20-50 million are injured; however, the number of people who develop a disability in the wake of the accidents is not well documented.

Graciano Upenyu Masauso
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Introduction

1. It is estimated that 15% of the world's population, or 1 billion people, live with some degree of disability. Of that figure, 3% have a severe disability. The prevalence of disabilities is growing, due to the aging of the population and the global rise in chronic diseases, violence, accidents of all types, and the use and abuse of alcohol and illicit substances, and it is higher in low-income countries. Health facilities in many countries do not meet the health care needs of persons with disabilities, and the probability of their being denied health care is three times higher, and of their being treated inappropriately, four times higher than for people with no disability.

2. This Plan is aligned with the recommendations of the World Report on Disability, published by the World Health Organization and the World Bank, the WHO global disability action plan 2014-2021: Better health for all people with disabilities, the Strategic Plan of AHO 2020-2030, the Convention on the Rights of Persons with Disabilities, the recommendations of the High-level Meeting of the United Nations General Assembly on Disability and Development,.

Background

3. AHO recognizes disability as a public health issue, since people with disabilities encounter barriers to health and rehabilitation services. This is a human rights issue, because people with disabilities often face stigmatization and discrimination. It is also a development priority, because disability gives rise to poverty and poverty, in turn, gives rise to more disability.

4. Numerous global and regional program documents and resolutions served as background for the preparation of the Plan of Action, notably:

a) UN: Convention on the Rights of Persons with Disabilities, 2006;

c) WHO and World Bank: World Report on Disability, 2011;

d) WHO: EB134/16. Draft WHO global disability action plan 2014-2021: Better health for all people with disabilities;

e) UN: Recommendations of the United Nations High-level Meeting on Disability and Development, 2013;

Situation Analysis

5. An estimated 340 million people in Africa have a disability, 2-3% of them a significant[2] functional impairment. Vulnerable groups are those most affected by disability and include women and children victims of violence, older persons, and people living in poverty. Ethnic minorities are also at significantly higher risk. Only 3% of people in Africa with some type of disability of varying degrees of severity have access to rehabilitation services, and 3% are highly dependent[3] on another person[4] to assist them with their activities of daily living; only 25% of children with disabilities have access to education and of these children, only 5% finish primary school. Some 3% of newborns have impairments that must be detected and treated with early interventions, because otherwise, these impairments may lead to lifelong disability.

6. Despite efforts to improve the capture of disability data in general population censuses, measurement methodologies and criteria still vary widely. The most recent results of specialized surveys and the 2010 round of censuses have made it possible to gauge the magnitude of the situation of people living with disabilities.

7. The findings of the report show that the disability prevalence rate is higher in women than in men, especially from age 60 onward. Women, moreover, spend more time caring for a family member with a disability and are at greater risk of developing caregiver syndrome. Disability prevalence is higher in the lowest income quintiles as age increases, especially in people aged 60 and over. The lack of resources and the difficulty generating income faced by people with disabilities, their families, and their caregivers exacerbate the negative impact of their condition on their quality of life. When evaluating disabilities by type, visual impairments are the most prevalent, followed by mobility and hearing impairments, which increase with age.

8. Although some 360 million people worldwide have moderate to profound hearing loss, hearing aid production meets only 10% of global needs and 3% of needs in the developing countries; some 200 million need glasses but do not have access to them; and 70 million need a wheelchair, but only 5-15% obtain one. The cost of assistive technology devices is also a barrier for people with disabilities, especially in low-income countries.

9. People with disabilities are more vulnerable to preventable secondary diseases, comorbidities, and age-related conditions. They are more exposed to violence, are at greater risk of injuries from accidents of all types, and exhibit higher indexes of risky behaviour. There is a high global incidence of disability from mental and neurological disorders stemming from functional psychoses, dementia, epilepsy, cognitive disabilities, substance abuse disorders, and depression.

10. Occupational and traffic injuries, violence, joint diseases, and degenerative central nervous system disorders all contribute to the disability issue. Some 1.2-1.4 million people die each year as a result of traffic accidents and 20-50 million are injured; however, the number of people who develop a disability in the wake of the accidents is not well documented. Natural disasters and other emergencies produce morbidity and disability in the affected population and heighten the vulnerability of people with disabilities living where the disaster strikes—people whose particular needs are overlooked in emergency risk management.

11. Knowing the cost of disabilities is important for designing public policies. Estimates of the cost of disabilities are few and fragmented, even in the developed countries. Most countries have some type of social protection program for persons with disabilities; however, in low-income countries, such programs only cover persons with severe disabilities. Disability services account for approximately 10% of public social expenditure in the countries of the Organization for Economic Cooperation and Development (OECD) and only 6% of the working-age population.

Plan of Action (2020-2030)

13. A 10-year Plan of Action (2020-2030) is proposed, based on the experiences of the Member States and considering the shared responsibilities of those states that have a federal political structure. This Plan is aligned and linked with the indicators and targets of the Strategic Plan of AHO 2020-2030 and the WHO global disability action plan 2014-2021: *Better health for all people with disabilities*, and the Convention on the Rights of Persons with Disabilities, and will lead to implementation of the interventions necessary for improving the health, functioning, and quality of life of people with disabilities and their families.

14. *Principles: a)* an independent life; *b)* assistance for dependence, including the protection of caregivers; *c)* respect for the cognitive development of children with disabilities and their right to preserve their identity; *d)* equality of opportunities; *e) i*nclusion and participation; *f)* respect for people's dignity and nondiscrimination;[14] and *g)* universal accessibility.

15. The Plan of Action rests on four cross-cutting approaches aligned with the AHO Strategic Plan: gender, equity, ethnicity, and human rights *(3).* People with disabilities should have access to health sector and social security services and programs that respect and recognize ethnic, cultural, and gender characteristics and differences. Articles 25 and 26 of the Convention on the Rights of Persons with Disabilities stress the right to health[15] and the rehabilitation and rehabilitation of persons with disabilities.

16. *Vision:* People with disabilities living in the Americas have the right to the enjoyment of the highest attainable standard of health and other related human rights, in equality with the rest of the population, and to a better quality of life with a guarantee of appropriate care and the promotion of equal opportunities.

17. *Goal:* Strengthen the integrated health sector response by implementing policies, plans, programs, and laws for the care of persons with disabilities, their families, and caregivers throughout the life course, taking into account the shared responsibilities in federal states. This will be accomplished through health promotion, prevention, treatment, rehabilitation and rehabilitation activities, and access to assistive technology.

Strategic Lines of Action

18. This Plan of Action is based on the following strategic lines of action:

a) promote equity within the framework of the health policies, plans, and legislation on disability to improve governance;

b) strengthen the health sector's rehabilitation and rehabilitation services network, which includes the provision of assistive technology and community-based rehabilitation;

c) promote the production and analysis of data on disabilities and support research.

Strategic Line of Action 1: Promote equity within the framework of the health policies, plans, and legislation on disability to improve governance.

19. In order to tackle the disability issue from the health sector's perspective, it will first be necessary to draw up a national plan aligned with the country's health policy. The plan will require an inter-programmatic approach coupled with inter-sectoral coordination. Disability calls for an integrated, coordinated response that includes partnerships between the health sector and the social protection, education, labour, human rights protection, and other sectors. People with disabilities, their families, and caregivers should play an active role. The main obstacles to accessing the health services that people with disabilities face are physical barriers, transportation issues, lack of competencies among service providers, negative attitudes toward people with disabilities, communication barriers, and lack of information among people with disabilities about their rights and the available services.

20. Plans should consider the prevention of injuries or diseases that may cause or be related to disability with the participation of multiple health programs. Early detection of disabilities is a critical component of any strategy and should be accompanied by early intervention to develop a treatment plan for the affected person and family.

21. National disability and rehabilitation policies, plans, and legislation should consider the following basic actions: ensure that disability legislation conforms to international human rights norms and standards and AHO technical guidelines; develop disability and rehabilitation programs consistent with national health policy and the country's economic and social development plans; adequately fund policies, plans, and legislation; guarantee persons with disabilities access to quality health services, including rehabilitation, that are located near their community (see strategic line 2); provide appropriate care for persons with disabilities in emergencies and disasters.

Objective 1.1. Formulate and implement national disability and rehabilitation plans and policies aligned with regional and global disability plans, as well as the Convention on the Rights of Persons with Disabilities and other related international standards.

Indicator:
1.1.1 Number of countries that have implemented national disability and rehabilitation plans consistent with regional and global plans and the Convention on the Rights of Persons with Disabilities and other related international standards.
(Baseline 2020: 6. Target 2030: 14)

Objective 1.2. Take measures to ensure that international human rights standards and AHO recommendations are reflected, as appropriate, in legislation**,** policies and**/**or programs relevant to persons with disabilities.

Indicator:
1.2.1 Number of countries with specific legislation on disability consistent with international human right instruments and the technical guidelines of AHO.
(Baseline 2020: 6. 2030: 16)

Objective 1.3. Countries include a disability component in their disaster and emergency risk management plans.

Indicator:

1.3.1 Number of countries with the disability component in their disaster and emergency risk management plans.
(Baseline 2020: 1. Target 2030: 9)

Strategic Line of Action 2: Strengthen the health sector's rehabilitation and rehabilitation services network, which includes the provision of assistive technology and community-based rehabilitation.

22. Ministries of health have a responsibility to guarantee access to appropriate, timely, affordable, and good-quality rehabilitation and rehabilitation services, and to link with other health programs and services and other ministries and government entities. Rehabilitation and rehabilitation[16] mitigate the impact of highly diverse health issues by promoting recovery through an individual's interaction with his or her environment. Both processes include medical care, therapy, and auxiliary technologies and should begin as early as feasible; services should also be provided as close as possible to the residence of the affected parties.

23. The Community-based Rehabilitation Strategy (CBR) offers a conceptual and operational model for coordinating the specialized resources of the various care levels and the organized community and facilitates ties with and strengthens the main services, along with access to specific interventions. It is linked with primary health care, which, as the first line of contact with the population, plays a key role in the early identification and treatment of persons with disabilities. To facilitate its work, the primary health care team should have protocols or guidelines, as well as a functioning referral and cross-referral mechanism linked to the health information system.

24. Some people with disabilities have complex rehabilitation needs that must be addressed in specialized centres. However, most people need rehabilitation or rehabilitation services and other related services that can be provided in secondary or primary health care facilities near the community.[17] A common problem in our countries is that second-level facilities, as well as rehabilitation and rehabilitation services, are located in major cities, while rural areas or territories in the interior suffer from an almost complete lack of services. Added to this is the fact that primary health care personnel have very limited skills when it comes to disability and rehabilitation; nonspecialized environments and general hospitals are not prepared to provide basic rehabilitation and rehabilitation services.

25. Investing in rehabilitation, rehabilitation, and assistive technology strengthens personal resources and can be key to enabling persons with disabilities to live an independent life and be reintegrated into their family and community. Assistive devices and technologies such as wheelchairs, prosthetics, mobility aids, hearing aids, visual aid devices, and other equipment can improve the functioning of people with disabilities and better enable them to live independently.18

26. The following actions are recommended:

a) Expand and improve decentralized rehabilitation and rehabilitation services and ensure geographic coverage linked to the health services network. Promote the CBR strategy and its linkage with primary health care.

b) Include prevention, treatment, rehabilitation, and rehabilitation activities in disability plans. Facilitate access to assistive technology.

c) Ensure long-term care for chronically ill and highly dependent people, as well as protection for caregivers.

d) Formulate standards and protocols for rehabilitation, rehabilitation, and primary care services.

Objective 2.1. Increase access to social and health services for persons with disabilities.

Indicator:
2.1.1 Number of countries that have attained at least 12% access to rehabilitation and rehabilitation services and social services for persons with disabilities.
(Baseline 2020: 0. Target 2030: 16)

2.1.2 Percentage of countries that include the Community-based Rehabilitation Strategy (CBR) in national rehabilitation programs in accordance with the AHO matrix.
(Baseline 2020: 3. Target 2030: 19)
2.1.3 Percentage of countries that include assistive technology devices for persons with disabilities as part of their service delivery systems.
(Baseline 2020: 6. Target 2030: 20)

Objective 2.2. Formulate rehabilitation and rehabilitation regulations.

Indicator:
2.2.1 Number of countries that have formulated or updated rehabilitation and rehabilitation regulations.*
(Baseline 2020: 3. Target 2030: 16)

Strategic Line of Action 3: Promote the production and analysis of data on disabilities and support research.

27. The availability of information and scientific evidence will lead to a better understanding of the disability situation in our countries and facilitate decision-making. Better information is needed about the number of people with disabilities,[19] their health status, the extent and nature of their met or unmet health needs, the social and environmental barriers that they face, including discrimination, their use of the health systems, and the receptivity of those systems.

28. Each country should determine its priority areas for research on disabilities, which should include such aspects as health promotion for persons with disabilities; prevention, detection, and early intervention; rehabilitation and rehabilitation needs; quality of life;

cost-effectiveness of rehabilitation interventions; service delivery models; and the human resources training .

29. Specific recommendations:

a) Include disability data in national information systems.

b) Adopt and utilize the International Classification of Functioning, Disability, and Health as a standard for developing instruments and methodologies for harmonizing information in the Region.

c) Develop a set of basic indicators and design a disability surveillance system for integration with the national health surveillance systems.

d) Set priorities and support research.

Objective 3.1. National surveillance systems incorporate the set of indicators used by the International Classification of Functioning, Disability, and Health.

Indicator:
3.1.1 Percentage of countries that have included the International Classification of Functioning, Disability, and Health (ICF) in their disability certification systems.
(Baseline 2020: 6. Target 2030: 19)

3.1.2 Number of countries whose national surveillance systems incorporate the set of indicators used by the International Classification of Functioning, Disability, and Health.
(Baseline 2020: 6. Target 2030: 18)

Objective 3.2. Countries routinely report disability data to the health information system.
Indicator:
3.2.1 Number of countries that systematically include disability data in the health information system, disaggregated by age, sex, and ethnic origin (type of disability, degree of severity, origin, or cause).
(Baseline 2020: 2. Target 2030: 16)

Objective 3.3. Countries subsidize research on disability, rehabilitation, and rehabilitation.

Indicator:
3.3.1 Number of countries that subsidize at least 2 research projects per year on disability, rehabilitation, or rehabilitation.
(Baseline 2020: 0. Target 2030: 14)

Monitoring, Analysis, and Evaluation
30. This Plan contributes to meeting the targets in Category 2 of the AHO Strategic Plan. Monitoring and evaluation will be aligned with the Organization's results-based management framework and its performance management processes. Progress reports will be prepared at the end of every biennium. Mid-term and final evaluations will be conducted to identify strengths and weaknesses in Plan implementation. The sources of the necessary information are: *a)* reports from national ministries of health; *b)* reports of the Noncommunicable Diseases and Disabilities Unit; *c)* the compilation of research; and *d)* country reports monitoring compliance with the Convention on the Rights of Persons with Disabilities.

Financial Implications
31. The estimated cost of implementing the Plan over the 10-year period (2020-2030) will be USD 500,222,500. Forging partnerships and identifying donors to support the plan will be important.

Summary

32 Recognizing that the prevalence and incidence of disabilities are growing, due, among other things, to the aging of the population, the rise in chronic diseases and their risk factors, substance abuse, occupational and traffic injuries, and violence and humanitarian crises;
Recognizing that disability is a public health issue, a human rights issue, and a development priority;

33 Understanding that persons with disabilities have worse health outcomes when compared with the disability-free population, and that they face stigma and barriers to service access;
Recognizing that community-based rehabilitation and the availability of human and material resources contribute to comprehensive, quality care and the protection of the human rights of persons with disabilities;

34 Understanding that investing in rehabilitation and rehabilitation, as well as in social and health services and in the provision of cost-effective assistive technology is important for enabling persons with disabilities to live an independent life and integrate with their families and communities, and that it helps reduce the need for formal support services and relieve the physical and psychological burden on caregivers;

To summarize, taking into account the shared responsibilities, AHO agrees to:

a) make disability a priority in their national health policies to ensure implementation of the respective plans leading to universal, equitable access by persons with disabilities and their families to health services and programs that include rehabilitation and rehabilitation, the provision of assistive technology, and other support throughout the life course;

b) strengthen the legal framework and regulations in the countries and their enforcement to protect the human rights of persons with disabilities, pursuant to the principles of the Convention on the Rights of Persons with Disabilities, the Inter-American Convention for the Elimination of All Forms of Discrimination against Persons with Disabilities, and the applicable international standards;

c) support civil society involvement in activities to promote and protect the health of persons with disabilities, ensuring that they are consulted through their representative organizations and can actively participate in policy-making and the drafting of legislation, as well as the creation of the respective services;

d) strengthen the community-based rehabilitation strategy in integrated service networks by broadening activities for disability prevention and detection, early intervention, access to assistive technology, and other support;

e) continue efforts to shift the hospital-based disability care model to a community-based model in which treatment is provided at the primary health care level and decentralized outpatient rehabilitation services are set up close to the population;

f) ensure a health and social service response suited to the particular characteristics of groups in conditions of vulnerability or with special needs that have disabilities;

g) consider the upgrading and regular training of human resources a key component for improving the health service response;

h) improve the equipment and infrastructure of health care services for persons with disabilities;

i) improve the production, analysis, and use of disability data in national information systems and apply valid tools consistent with the International Classification of Functioning, Disability, and Health;

j) support research and the evaluation of public policies in the field of disability;

k) adopt an effective multi-sectoral approach that includes mechanisms for coordinating ministries, NGOs, academic institutions, and other services for persons with disabilities;

l) protect the health of caregivers who assist persons with disabilities, whether family members or professionals, in the performance of essential duties;

m) promote the sharing of experiences and good practices among countries

Report on the Financial and Administrative Implications of the Proposed Resolution for AHO

1. Agenda item: 5.10 - Plan of Action on Disabilities and Rehabilitation 2020-2030

2. Financial implications:

a) Total estimated cost for implementation over the life cycle of the resolution (including staff and activities):
The estimated cost of this plan is US$615,128,580 (approximately $600,610,000 for activities and $15,128,580 for staff).

b) Estimated cost for the 2020-2021 biennium (including staff and activities):
The estimated cost for the biennium is $50,650,260 (approximately $40,550,000 for activities and $10,100,260 for staff).

c) Of the estimated cost noted in *b),* what can be subsumed under existing programed activities?

3. Administrative implications:

a) Indicate the levels of the Organization at which the work will be undertaken:
The work will be carried out at the country, subregional, and regional levels.

b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):
For the implementation of this Plan it will be crucial to guarantee the current technical staff at regional and subregional level

c) Time frames (indicate broad time frames for the implementation and evaluation):
The proposed plan will cover 2016-2021 and requires support from AHO, partnerships, and Member States. The final evaluation will be completed in 2031 and presented to the Governing Bodies in 2032.

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