World Health Organization

Better health for people with disabilities

ISSUES PAPER

Success Indicators for measuring the WHO action plan 2014-2021: better health for persons with disabilities

Comments due by COB Tuesday 12th November 2013

The extensive consultation process being carried out for the development of the WHO Action Plan 2014 – 2021: better health for persons with disabilities has identified the need to further develop success indicators that can help to measure and monitor progress.

This paper outlines the challenges in framing suitable success indicators and provides additional options for consideration by stakeholders. The Secretariat welcomes comments on the options proposed. Comments should be sent to the email disabilityplan@who.int by Close of Business on Tuesday 12th November.

Developing relatively low-cost and accurate methods to measure progress provides some conceptual and practical challenges especially if stakeholders seek indicators that reflect stronger health and community systems that are responsive to persons with disabilities and hence capture information on outcomes or attainments.

Data on disability related to health, rehabilitation and community services are not currently included in relevant routine data collection methods and therefore would require specific investment for the development or adaption of measurement tools.

The indicators included in the first draft of the plan are largely structural/ rule based. Structural indicators include those at the level of policies and capture a commitment on behalf of States to work on the objective. For example a policy on inclusive health is a means to translate the obligations of signatories to the CRPD into an implementable programme of action. Feedback from the consultation process has called for more process level indicators that for example can attempt to measure progressive realization of the right to health care for persons with disabilities.

One important strength of the draft action plan is that increased investment in objective 3 and a review of the actions for stakeholders could enable the development of relevant measurement tools and would provide service related information relevant to objectives 1 and 2.

The following tables outline possible indicators that could replace or be used in combination with the initial indicators. While both quantitative and qualitative indicators are relevant to the action plan the focus here is principally on quantitative indicators. Baseline and target information to be determined based on a final selection of indicators.

OBJECTIVE 1. TO ADDRESS BARRIERS AND IMPROVE ACCESS TO *HEALTH CARE SERVICES AND PROGRAMMES*.				
Existing indicator	**Other possibilities for consideration**	**Sources of Data**	**Baseline**	**Targets**
Success indicator 1.1 - X % of countries have updated their health policies in line with the CRPD[1]. ***Success indicator 1.2*** – X% of countries have universal health coverage inclusive of persons with disabilities	***Success indicator (structural)*** ***1.1 –*** **Option a: Option a:** X % of countries that have national health policies that **[recognize]** or **[explicitly mention]** that persons with disabilities have the right to the enjoyment of the highest attainable standard of health. **Option b**: X % of countries that have health policies in line with the CRPD[2]. **1.2** - X % of countries that prohibit health insurers from discriminating against pre-existing disability ***Success indicator (process/ outcome)*** ***1.3*** – proportion of persons with disabilities that are covered by health insurance, **1.4** proportion of persons with disabilities that have access to the health care services that they need. **1.5** patients with disabilities incurring out-of-pocket expenditures for obtaining services	***Structural/ rule based indicators*** – data to be collected through surveys of key informant of Ministries of Health and Civil Society/disability persons organizations, administered by WHO Secretariat at baseline, 5 years, 10 years OR expert analysis of national health policies/ insurance obtained from government publications, legal and administrative document departments and official web sites. ***Process/ outcome level indicators*** National disability surveys . – Investing in Objective 3 - notably the implementation of the Model Disability Survey will provide this data and enable comparison between persons with and without disability		

[1] Guidance is needed on what constitutes being in line with the CRPD.

[2] A composite index would need to be developed comprises indicators that cover health policies for people with disabilities. For example each indicator could be given a score of 1 if it exists and 0 if it doesn't or cannot be assessed. For example

a: Existence of an up-to-date (need to be defined) national health strategy linked to national needs and priorities (a).
b. Sexual and reproductive health—reproductive health policy explicitly addresses the needs of persons with disabilities (a)
d. The UNGASS National Composite Policy Index questionnaire for HIV/AIDS covers disability (a)
c. Child health—existence of an updated comprehensive, multiyear plan for childhood immunization that includes strategies for reaching children with disabilities (a)
e. Existence of mechanisms, such as surveys, for obtaining client input on appropriate, timely and effective access to health services which disaggregates data by disability (d, f)

	1.6 proportion of adults with recent health visit who stated their provider was responsive to their expectations (focus on integrated people centred care) 1.7 service availability and readiness of health facilities for persons with disabilities (if this can be modified to include physical access for example). *Related indicators* - % of households with a disabled member that are impoverished annually by out-of-pocket payments, by expenditure quintile	Exit interviews and MDS (1.6) Model Disability Survey (1.4); Other national health surveys as part of UHC monitoring framework and measurement approach Health facility assessments (1.7)		
OBJECTIVE 2. TO STRENGTHEN AND EXTEND *HABILITATION AND REHABILITATION* SERVICES, INCLUDING *COMMUNITY BASED REHABILITATION*, AND *ASSISTIVE TECHNOLOGY.*				
Existing indicator	**Other possibilities for consideration**	**Sources of Data**	**Baseline**	**Targets**
Success indicator 2.1 - X% of countries have developed or updated legislation, policies, and regulations on rehabilitation and community services in line with CRPD.	***Success indicator 2.1* - Option a:** X % of countries that have national policies on rehabilitation and community services related to persons with disabilities. **Option b**: X % of countries that have rehabilitation and community services / CBR policies in line with the CRPD (index would need to be developed). 2.2 Rehabilitation-service readiness for health facilities (would need to be developed)	Health facility assessments (2.2) 2.3 (It would need to be determined if it could be integrated into census) International Standard Classification of Occupations (ISCO) and surveys by professional organizations (2.4) Health facility assessments (2.3	Baseline for professionals per country (see world report for PT and OT per 10 000 population (2.4)	

[4] The International Standard Classification of Occupations (ISCO) belongs to the international family of economic and social classifications and is one of the main international classifications for which ILO is responsible. The last revision ISCO - 08 was adopted in 2007. In the ISCO there are a number of professionals who are likely to play a significant role in the provision of rehabilitation services: generalist medical practitioners, specialists in physical and rehabilitative medicine, physiotherapists, audiologists and speech therapists, medical and dental prosthetic and related technicians (including orthotists and prosthetists), physiotherapy technicians and assistants, other health care professionals such as occupational therapists and recreational therapists other support personnel such as patient care assistants, orthopaedic appliance makers and wheelchair repairers.

	2.3 Number and distribution of rehabilitation facilities per 10 000 Population. 2.4 Number of rehabilitation workers per 10 000 population 2.5 Number of graduates from educational institutions per 100 000 population – by level and field (PT, OT, P&O, PRM, CBR) of education 2.6 Proportion of health facilities offering rehabilitation services[3] 2.7 Proportion of the population covered by CBR 2.8 Proportion of people with disabilities that receive the assistive technologies that they need (for example hearing aids, glasses, prosthetics/ orthotics)	and 2.4) Data to be collected through surveys of key informant of Ministries of Health and Civil Society/disability persons organizations, administered by WHO Secretariat at baseline, 5 years, 10 years (2.7) Disability surveys such as the Model Disability Survey (2.8)		

3 It may also be possible to look at service readiness score – a list of tracer items would need to be compiled to assess availability and functioning of service

OBJECTIVE 3. TO SUPPORT THE COLLECTION OF APPROPRIATE AND INTERNATIONALLY COMPARABLE *DATA ON DISABILITY*, AND PROMOTE MULTI-DISCIPLINARY *RESEARCH ON DISABILITY*.				
Existing indicator	**Other possibilities for consideration**	**Sources of Data**	**Baseline**	**Targets**
***Success indicator 3.1* -** % of countries which have capacity to monitor routinely the situation of persons with disabilities. ***Success indicator* 3.2 -** % of countries including disability within priorities of national research funding agencies	***Success indicator 3.1* -** % of countries, which have collected comprehensive[5] information on disability. ***Success indicator* 3.2 –** further work required	Government responses. National reporting from Ministry of Education, National Science Foundation or equivalent.	55 countries (3.1 alternative formulation)	

[5] Defined as all domains of functioning (Impairments in body function and structure, activities and participation). Note this excludes information on environmental factors. The other option would be to develop an index i.e one point for every domain to a maximum of 4 points.