**Questionnaire on** **the right of persons with disabilities to the highest attainable standard of health**

*N.b.: The responses to these questions were derived from Light for the World programmes in countries such as Ethiopia, Bosnia and Herzegovina, Mozambique and Rwanda as well as from a literature review on access to health for persons with disabilities.*

1. **Please provide information on existing or planned legislation and policies to ensure the realization of the right to health of persons with disabilities, including current challenges and good practices.**

In many countries, there are no specific regulations pertaining to the right to accessible health care for persons with disabilities. While in theory persons with disabilities have the same right to health care as anybody else, in practice their access to this right is hampered by inaccessible services, financial issues, lack of information on services, inadequately trained health care staff, challenges with transport etc.

**Examples from partner countries of Light for the World:**

In **Bosnia Herzegovina**, healthcare and health insurance are not the responsibility of the central (national) institutions because jurisdiction resides in the so-called entities (the regions). For example, in the entity of the Federation of Bosnia and Herzegovina, it is a shared competence between the regional level and the district level (the cantons).

Laws on the regional level on healthcare explicitly ban discrimination on the basis of disability and contain a principle declaring the highest standard and equality of opportunity in availing of healthcare. Current laws do not ensure, however, equal choice or access for persons with disabilities, any more than equal quality and standards of healthcare services, whether sexual and reproductive health services or general health programmes.

In **Mozambique**, the Ministry of Health is responsible for the design and implementation of policies that give persons with disabilities access to health care, rehabilitation and assistive devices. Rehabilitation services fall under the responsibility of the Physical Medicine and Rehabilitation Department which is responsible for the rehabilitation centres on provincial level. These are often inaccessible to the country’s rural population.

In **Rwanda**, the government is willing to include disability issues in its policies, but lacks the financial and technical resources to implement them. In 2009, the Ministry of Health adopted Guidelines on “Mainstreaming Disability into the Health System at Community Level”. In practice, access to healthcare is still limited by long distances to the nearest health facility, insufficient number of health workers, negative attitudes and costs. Specific attention is given to sexual and reproductive health services; youth and health centres offering such services receive government funding. Still, women with disabilities report problems in getting SRHR services.

Also, some efforts have been noted on tailoring HIV/AIDS awareness programmes to persons with disabilities, but no data exists on the prevalence in this group.

In **Ethiopia**, the Ministry of Health has developed a strategy on how to better include persons with disabilities in all health services (available in Amharic). In practice, while the Ministry of Health is responsible for providing general health services to persons with disabilities along with the rest of the population, little specific focus is put on disability within general health policies. Disability is mentioned in the health sector transformation plan which states the issues and needs of persons with disabilities, but does not strategically address those needs. The Ministry of Health, with the technical support of ECDD (Ethiopian Center for Disability and Development) and selected DPOs produced a manual “Disability Mainstreaming Manual in the Health Sector”. The infrastructure directorate of the Ministry also just finalized new service centre construction guidelines to ensure physical accessibility of new health centres, health posts and hospitals. Existing buildings and their adaptation, however, are not mentioned. Some other directorates such as the youth and women’s affairs directorate have included reporting on reaching persons with disabilities in their plans.

The implementation of all these policies has not progressed very far. While the Ministry has started to train some health professionals in disability-inclusive health service provision and some in sign language, there is still a resource challenge with limited capacity towards systematically addressing the existing gaps. A major problem is the lack of disability disaggregated data regarding service provision to persons with disabilities. The national Health Monitoring Information System doesn’t have disability inclusive/specific indicators. Another challenge is the weak capacity and structure of DPOs towards monitoring the implementation of existing inclusive policies and negotiating for more. Civil society and international partners are still playing a major role in the financing and delivering of services for persons with disabilities within all areas of healthcare and social services.

1. **Please provide any information and statistical data (including surveys, censuses, administrative data, literature, reports, and studies) related to the exercise of the right to health of persons with disabilities in general, as well as with particular focus in the following areas:**

In low and middle-income countries, quite often NGOs fill gaps in health care services which are not provided by government or they support the public health care providers to run services and ensure health care for the community. According to a survey by the African Child Policy Forum, specialised health care services for children with disabilities in Ethiopia, including rehabilitation, were predominantly offered by NGOs. For example, NGOs provided **87% of community-based rehabilitation (CBR) services**, **65% of specialised rehabilitation services**, and **88% of occupational therapist services**.

CBR projects, often funded and supported by NGOs, play an important role in ensuring access to health for persons with disabilities. Especially in rural and remote areas, people often do not know about available services or do not have the means to travel to healthcare providers and get the required services. Consequently, linking people to services and making sure that they get the treatment and medical support they need is an important task of CBR programmes.

In **Ethiopia**, some progress in health care and rehabilitation can be noted over the past few years. Provision of training in physiotherapy, and more recently also in speech therapy, has started and is slowly becoming part of the services in the health sector. Orthopaedic technicians are also trained, with ICRC support. Although there are still major gaps, there is a growing understanding from both the public and the health service providers on the need of rehabilitation and its importance for personal wellbeing. Major problems are lack of early detection and interventions and lack of understanding among healthcare services about the general health needs of persons with disabilities.

In **Burkina Faso**, there is a serious lack of rehabilitation services. Physiotherapists in the country are not officially acknowledged by the Ministry of Health. Also, medical specialisations which are needed to support people with disabling health conditions are only trained outside of the country. People in Burkina usually have to go abroad for these services (if they can afford it) or depend on visiting physicians within health campaigns.

**Findings from Bosnia and Herzegovina**: Within a programme focusing on the CRPD’s provisions on the right to health, run by the organisation MyRight and funding from Light for the World and the Austrian Development Cooperation, the participating DPO coalitions conducted an assessment on the accessibility of health care institutions in 5 regions of the country. Monitoring teams visited 64 healthcare facilities, of which not one was fully accessible to persons with disabilities.

The monitoring questionnaire included questions covering every form of accessibility in line with Article 9 of the Convention, from external, environmental and physical aspects to internal accessibility and accessibility of information, communication and other services. This included the physical entrance, parking, wheelchair ramps installed in accordance with building code, lifts or platforms to provide access to upper storeys, toilets adapted for use by persons with disabilities, and the use of universal or inclusive design within the facility, public signage in Braille and in easy-to-read-and-understand forms, as well as the provision of live assistance and intermediaries. The questionnaire also contained questions about access to specific services intended for persons with disabilities, such as gynaecological services for women with disabilities or dental services for children with intellectual disabilities. Nine health centres in Sarajevo were found which had adjustable tables, but six of the tables were on higher levels in buildings without elevators. Dental services for children and persons with disabilities could be provided only in hospitals where surgical procedures could be performed.

The assessment revealed that, while **76% of institutions had access ramps for wheelchair users, 55% of those ramps failed to meet basic accessibility regulations** (e.g. an inappropriate gradient, insufficiently wide, insufficient space for turning around).

76% of facilities provided no vertical access (i.e. elevators) within the building, so that wheelchair-users could not access many specialist services. 72% had no accessible bathrooms.

Information on services provided by public health facilities was not available in accessible format (i.e. Braille, larger print, contrasts etc.)

Quality of the healthcare was insufficient:

* poor physical accessibility in most primary healthcare facilities in both urban and rural environments;
* a lack of diagnostic and other instruments and equipment, or failure to adapt them to requirements of persons with multiple or more “severe” impairments;
* low use of specific, less-well known drugs to prevent either the incidence or the progress of disabling conditions (i.e. Multiple Sclerosis) , lack of specialised nutritional programmes aimed at the same;
* lack of access to services for specific groups – i.e. gynaecological services, reproductive health counselling for women with disabilities, or adapted dental and other health services for children and adults with intellectual disabilities;
* lack of training programmes for medical and paramedical staff in working with persons with disabilities;
* insufficient access to medical rehabilitation programmes;
* absence of programmes to properly assess needs for orthopaedic and other aids, tailored to the individual needs of persons with disabilities, and of programmes providing hygienic and sanitary materials and guidance on their use.

The law on health insurance in the Federation of Bosnia Herzegovina contains an entitlement to orthopaedic and other aids but the needs assessment is based on specific medical indicators. The same applies to the entitlement to medicines, the list of which is approved by the cantonal health insurance institutes. Linking this entitlement to medical indicators considerably limits the scope of providing appropriate individually-adjusted aids of the sort actually required by persons with disabilities in their day-to-day lives. Also, the cantonal ministries of health determine the entitlement to such aids and medicines, resulting in uneven coverage, with very different entitlements provided in different cantons, placing persons with disabilities in a highly disadvantaged position.

The budgets of the health ministries and the health insurance institutes do not include any clear allocation of resources for purchasing orthopaedic or other aids, in particular those whose use would increase the level of inclusion for individuals with multiple or so called “more severe degrees of” disability, nor are resources earmarked for the adaptation of facilities and medical equipment to make them more accessible to persons with multiple disabilities.

The entity laws on healthcare do not provide the right to health insurance for persons with disabilities on the basis of their disability, deriving it instead from other bases (through another insurer, a welfare beneficiary status, etc.). As a result, persons with disabilities often do not get health insurance, leading to their exclusion from healthcare services.

Certain local authorities (for example Sarajevo Canton) do provide health insurance on the basis of disability in their regulations. This, however, results in discrimination between persons with disabilities based on location. From an overall perspective, the possibility that a person with disabilities might end up without health insurance coverage and consequently without the right to access healthcare services brings into question the constitutionally declared right to healthcare.

The question of early habilitation and rehabilitation is not dealt with in any detail under any particular law, nor is the need recognised for access to preschool education particularly for children with multiple and specific or rare disabilities or those living in rural areas. Certain forms of rehabilitation, most often professional ones, are dealt with in special schools, both primary and secondary, and therefore are open only to children and youth with disabilities attending those schools.

The issue of rehabilitation, beyond primary medical rehabilitation, of persons whose impairment arose in the course of their life is not regulated by law at all.

Regardless of the progress made, persons with disabilities are not in a position to fully meet their needs for healthcare, habilitation and rehabilitation, which has a negative impact on their quality-of-life, potential for employment and active inclusion in the community.

Based on interviews with persons with disabilities conducted within the three-year programme “Every Life Matters” in Ethiopia, Rwanda and Mozambique[[1]](#footnote-1) and on a literature review on studies of barriers to health care[[2]](#footnote-2), we collected information on the various barriers and challenges which persons with disabilities experienced:

* standing in the long queues for a long time,
* not being offered priority or accommodation when asking for medical services,
* lack of inclusive communication when medical staff does not know basic sign language or have basic understanding of how to communicate with persons with different types of disabilities
* persons with disabilities reported infrastructural barriers that lead to more limitations regarding the access to health care, inter alia, lack of accessible transport and roads and no proper equipment and facilities to accommodate persons with disabilities at health centres.

1. **Barriers on the demand side**

**Lack of accessible information about available services:**   
Available research suggests that persons with disabilities are often unaware that they can access healthcare services in general health centres. Even though persons with disabilities often have a higher need for healthcare, there is a significant difference between persons with and without a disability in whether they know where to go for treatment. For example, persons with disabilities report that there is only a limited amount of information in accessible formats about HIV and the importance of testing, and that they therefore do not know that they can go for HIV testing and services. In Cambodia, a survey showed that only 18% of persons with disabilities knew how best to treat cataract, as compared to over half of all other respondents. Persons with leprosy did not receive information about the cause, transmission and contagiousness of the disease, which led to increased prevalence of the disease and disabling conditions that could otherwise have been prevented or treated at an early stage.    
Low literacy rate among persons with disabilities which in turn stems from lack of access to education hinders access to information. Illiteracy prevents access to commonly used print materials such as newspapers, leaflets or billboards. Deaf persons who had little to no literacy would find it difficult to understand information from sources other than sign language. This would be similar for persons with visual impairments, who could not get information in the absence of alternative formats to printed sources.

**Lack of awareness** is also a barrier to attending healthcare services as families or caretakers may not know that persons with disabilities can use general health care centres. Because persons with disabilities are often not able to access information themselves, they are reliant on friends and family for health information, rather than on messages and information from health professionals.     
  
**Additional expenses to access health care**  
The cost associated with getting to and receiving health care were regularly named as one of the main obstacles to accessing healthcare services by persons with different disabilities. Persons with disabilities and their caretakers often struggle with poverty due to limited access to employment, and are also less likely to access subsidies and insurance programmes which can mitigate health care costs. Yet, persons with disabilities often have higher health care needs related to their impairments, and therefore higher costs.    
In addition, persons with disabilities report high (public) transportation costs to get to the health facility because often they also have to pay transport costs for their assisting person, may need to give a financial incentive to the person accompanying them, and/or have to hire specialized means of transport that can, for example, accommodate them and their wheelchair.

**Barriers to mobility**   
Transportation and other mobility issues are frequently named as a barrier to healthcare. Mobility related barriers revolve around lack of support from family members to go to health facilities and services. Persons with visual and physical disabilities reported that they often had difficulty to access a health centre unaccompanied, a situation which is extra worrying for women seeking antenatal or maternal health care services, as they are additionally vulnerable due to both their gender and pregnant status.

In Uganda, it is reported that persons with disabilities are rejected or made fun of by taxi drivers or other passengers in public transport. A study in Uganda, Zambia and Ghana highlights that persons with disabilities often need to travel with an assistant to help them manoeuvre around obstacles they encounter on the way. This brings additional complications due to the difficulty of finding someone prepared to give up their time, but also prepared to be publicly seen with a disabled person. Health centres are often a long distance from where persons with disabilities live, and public transport is often inaccessible, meaning alternative modes of transportation need to be found and paid for. Similarly, roads may be poor and sidewalks and ramps missing, terrains may be mountainous or flooded and thus make it difficult for persons with disabilities to navigate.

**Social barriers**  
Stigmatization and marginalization are significant barriers in accessing healthcare services. These are largely imbedded in negative attitudes towards persons with disabilities, leading to feelings of rejection, shyness and lack of confidence. This in turn translates to negative health outcomes, not only because persons with disabilities report increased levels of stress and psychological strainand but also because if persons with disabilities are seen as worthless, their families or support persons are less likely to take them to hospital.

Negative family attitudes might also manifest in a lack of practical support for their relatives with disabilities, for example related to to sexual and reproductive health, as persons with disabilities are often seen as asexual beings not in need of such services.

Low self-esteem, shyness and shame can also lead persons with disabilities to excluding themselves from health services. The impact of internalized negative feelings about themselves and their disabilities is that many are too ashamed to leave the house to attend healthcare. Persons with disabilities reported not attending the health centre or asking questions for fear of appearing ignorant about their own health conditions. Deaf women reported not utilizing health services when needed because they felt ashamed for not being able to ask questions.   

1. **Barriers on the supply side: healthcare service providers**

**Staff attitude**s   
Negative attitudes of healthcare staff and service providers have been extensively reported. Healthcare providers appear to be insensitive, whether on purpose or because of a lack of knowledge about the needs of persons with disabilities. Verbal, physical and mental abuses characterize the negative attitudes reported.

Studies report how

* health workers refuse to shake hands with or treat a person affected by leprosy;
* blind persons being ridiculed by health workers for requesting HIV/AIDS testing;
* women with disabilities are forced to undergo sterilization;
* physical restraints are used during labour
* derogatory terms such as 'crazy' are used by staff to describe women with psychosocial disabilities and mental health problems.

Other studies mentioned that healthcare providers would ignore patients with disabilities and give priority to other patients, in anticipation of communication problems.

Negative attitudes are also related to assumptions such as that persons with disabilities are a-sexual, or simply seen as incapable of having children.

Staff attitudes were found to make a big difference in how clients would experience a visit to a healthcare facility. Two interviewees in the baseline study of the programme “Every Life Matters” reported that they experienced positive treatment because the health care professional also had a disability.

Other positive experiences mentioned were friendly respectful treatment at the health centres, lab technicians who came directly to explain test results to the patients when they knew that they had a disability, staff at the reception who gave good support and orientation to patients with disabilities, one person in Mozambique reporting that he received free treatment when showing his disability card from his DPO, some interviewees recognizing that they were given priority when waiting for services. Choosing a certain health care facility over others was also due to the friendliness of and trust in staff, a deaf woman in Rwanda shared that she would always go to a certain centre where one of the nurses was her friend and understood her, others shared that they relied on health care staff who already knew their needs and conditions.

**Communication barriers**   
Communication barriers between health centre staff and patients with disabilities are a big challenge.

A study with deaf persons indicated negative attitudes were a result of frustration, as health care staff and deaf persons were not able to communicate with each other, and staff did not give deaf persons enough time to explain their situation.

Many healthcare providers at health facilities can neither understand nor communicate in sign language, nor are sign language interpreters available.

For pregnant women with disabilities, these barriers have resulted in life-threatening situations for both the mothers and unborn babies, with reports stating that deaf women have lost their babies because they could not understand the instructions of midwives without sign language.

Other women experienced challenges with doctors’ inability to take a patient’s medical history. The doctors end up making estimations of what patients say and give wrong prescriptions.  
Other reports show that health providers do not understand the explanations of deaf people’s health conditions, which has resulted in wrong prescription of medicines. A woman with this experience, for example, reported having received just paracetamol for a very complicated situation of her pregnancy that the midwife could not understand.

In situations where persons with disabilities do have access to a sign language interpreters, an additional challenge is that they might mistrust the interpreter, who they perceive as giving them wrong information on their health status, or feel uncomfortable with the violation of privacy, particularly when it comes to sensitive information regarding to sexual and reproductive health, such as HIV status. Similarly, those who come to the health centre with the support of an assistant or family member, report difficulty in maintaining confidentiality.

Barriers are not only found in the direct communication between health care staff and patients, but also in the indirect communication, such as brochures and prevention or awareness campaigns. Persons with visual impairments, for example, need information in accessible format instead of pictures or charts. (Health information) messages given on the radio, likewise, are inaccessible for persons who are hard-of-hearing or deaf.  

**Infrastructural barriers: Inaccessible buildings and equipment**  
Inaccessible health facilities and equipment at the health centres were identified as one of the biggest barriers in the literature review. This is particularly so for persons with physical and visual impairments. Specific barriers cited under this category include that health centre buildings have no ramps, toilets or latrines are inaccessible, there is a lack of sidewalks, and elevators are non-existent or non-functional. As a result, persons with physical disabilities who use wheelchairs are denied access to such buildings or access them with difficulty and inconvenience, especially if they are unaccompanied.

For example, people had to get out of their wheelchairs and move on the ground. A woman in Ghana reports how she almost fell off the stairs during an unaccompanied hospital visit.

A woman in Uganda described how she could not access the delivery ward of a major referral hospital, as it was located on the 6th floor.  In as far as sexual and reproductive health services and maternal healthcare is concerned, the same sources highlight insufficient or absence of equipment such as adjustable delivery beds for women giving birth, wheelchairs and personnel to assist women to climb delivery beds and examination tables.

Interviewees in Mozambique shared that also the lack of available medication was a big problem. One interviewee shared that for her/his diabetes check-ups she/he was sent to a health centre 3-4 hours away because the local hospital did not have the equipment.

Accessibility was recognized as a deciding factor where to go for treatment, this also included close distance to the person’s home, thereby not needing to take a bus. Accessibility and close distance were even then deciding factors to use these health centres when the quality of service was lower than elsewhere.

1. **Please provide information on discrimination against persons with disabilities in the provision of healthcare, health insurance and/or life insurance by public or private service providers.**

The following information is from a 3-year programme of Light for the World called “Every Life Matters”[[3]](#footnote-3) in Mozambique, Ethiopia and Rwanda. It explores how healthcare can become accessible for persons with disabilities and which collects and develops good practices to draw from. The programmatic focus is on eye health, neglected tropical diseases and sexual and reproductive health services.

Discriminatory behaviour and treatment was reported in many different instances:

* Long wait for services, i.e. a man with albinism in a region in Rwanda reported that he had to wait in a queue for a long time in direct sunlight which was very dangerous to his eyes and skin.
* Difference between regulations and practice: i.e. a lady in a region in Rwanda described that she saw a sign in the waiting area which said that priority would be given to persons with severe disabilities, but when she pointed this out to the staff, the regulation was ignored.
* Demanding bribes to get treatment: Interview partners described how they were informed that the health centre had already reached the maximum number of patients with community health insurance. If they wanted to get treatment that day, they were asked to pay a “VIP fee”.

Advice to health centres from persons with disabilities in the interviews:

* Setting up a focal person for disability at the centre
* Reducing financial costs, both for general health care and for specialised services
* Consulting persons with disabilities when developing plans
* Having proper facilities: accessible facilities, reliable equipment (to go to a hospital and then finding that the necessary machines are not working is a complete waste of transport money, as one interviewee in Mozambique explained), clean and accessible toilets (interviewees described how they had to return home to use the bathroom because the ones at the hospital were inaccessible and/or not clean).
* Speeding up services and explaining what is going on, i.e. to blind persons who don’t know when the queue is moving or where to go
* Training of health care staff: disability awareness, sign language, how to adapt services to fit the needs of persons with disabilities
* Improving medication stock and availability of medicine, equipment, assistive devices, ensuring that pharmacies are close to the health care centre and actually carry the medication which is prescribed.

Information from partner organisations in Ethiopia:

Persons with disabilities indicated that deep rooted discrimination against persons with disabilities, lack of awareness on disability among healthcare professionals and the community, coupled with communication, accessibility and policy barriers were major causes of their exclusion from adequate healthcare. Counselling services were often found to be biased, for example when counsellors pressured a woman with a disability to keep her pregnancy although she was there for an abortion. The counsellors would argue that the child could serve as her guide in the future. In other cases, women who came for antenatal care were advised to terminate the pregnancy based on the assumption that the woman could not afford to raise a child. In the same project, interviewees mentioned that healthcare products imported from abroad are often inaccessible to persons with disabilities due to costs, for example Braille inscribed medicine packages or adjustable beds. Interview partners also raised affordability of the health services, especially in the private sector, as discriminatory. Also, public outreach services were reported to not reach persons with disabilities and referral systems between DPOs and the health systems were noted as poor.

1. **Please provide information on the observance of the right to free and informed consent of persons with disabilities regarding healthcare, including sexual and reproductive health and mental health services.**

In a research Light for the World did among deaf women about their access to reproductive health services we found that many women struggle to access health services[[4]](#footnote-4). A main finding was that women are often denied services, or treated disrespectfully. They are at risk of not getting clear information on how give birth in a safe way and also lack access to information to what is going to happen during labour. There were various stories of unsafe abortions due to lack of information on abortion and contraceptives. The women interviewed also shared that they did not receive proper information about their treatment.

The study “Her Body her Rights”[[5]](#footnote-5) discusses the access of women with intellectual disabilities to sexual and reproductive health and rights information and lists recommendations for improvement of communication and services.

On SRHR services, a woman in Mozambique who went to the health centre to give birth was asked by the staff whether she was married. She felt that the staff judged her and expected that she could not be married because of her disability.

On a positive note, in an Ethiopian health centre the doctor informed a woman that she could conceive, whereas before she had always been told that this was impossible due to her impairment.

A partner organisation from Ethiopia shared: During the project implementation, we met women with different types of disabilities, particularly women with intellectual disabilities stating that they had been sterilized without their consent. But as an NGO registered as and working on development issues, not on rights, we weren’t able to refer those complaints to the legal aids. Some girls with intellectual disabilities also indicated that they had been forcibly provided with long term contraceptives without their consent. This is because the parents of these girls insisted to prevent their children from becoming pregnant. In most cases, service providers would respect the wish of the parents over the rights of the affected persons. Their argument would be “not to add another burden by having a new-born baby in a family with a disabled family member”.

1. **Please describe to what extent and how are persons with disabilities and their representative organizations involved in the design, planning, implementation and evaluation of health policies, programmes and services.**

In Bosnia and Herzegovina, cooperation started in 2014 between five DPO coalitions working together in the MyRight capacity building programme, the Agency for Quality Assurance and Accreditation in Healthcare of the Federation of Bosnia and Herzegovina and the Agency for Certification, Accreditation and Health Care Improvement of the Republic Srpska.

Its main aim was to improve the quality of standards for different medical practices through the inclusion of persons with disabilities in the revision process. Persons with disabilities actively participated in the process and gave their comments and suggestions, i.e. on standards for family medicine doctors, centres for mental health and outpatient clinics.

MyRight also contributed to the creation of inclusive standards for hospitals which are the first standards designed to establish a higher level of accessibility of healthcare institutions and provide comprehensive services in relation to patients who have disabilities.

The greatest value of these standards is that during their development, persons with disabilities were strongly involved and had the opportunity to improve them with their professional knowledge and personal experience. In most segments, the application of these standards also ensures better quality services for other vulnerable groups of patients such as pregnant women, older people, obese people, so that the benefits of these standards are multiple.

As a result of the cooperation, a brochure for healthcare personnel was developed with guidance on how to ensure good services for persons with disabilities. The brochure is now used in trainings by the Agency for continuous professional development of staff in the field of quality improvement, safety and accreditation in healthcare.

The brochure was also presented at the Faculty of Medicine in a seminar called "The Importance of Quality Approach to (Future) Health Workers towards Persons with Disabilities". The training of students of medical faculties on the specifics of communication and accessibility for persons with disabilities is of great importance to their future work in healthcare. The Medical Faculty in Sarajevo is among the first higher education institutions in Bosnia and Herzegovina that has raised the issue of inclusion of persons with disabilities in healthcare in the system of educating their students from a human rights perspective.

In Ethiopia, some progress was observed by partner organisations. Inclusion is getting on the agenda of the Ministry of Health and some big non-governmental service providers. The Ministry has now established a technical working group to oversee the inclusion of persons with disabilities in the health sector and hence involves the task force team to monitor and evaluate the plan, implementation and intended outcomes of the different directorates within the Ministry. It has also made DPOs part of the ‘Public Wing’, along with representatives from different segments of the population. In these platforms, the performance of the Ministry is evaluated bi-annually and recommendations are given for better service provision. DPOs use this platform to raise their concerns about accessibility of health services. But similar platforms in the regions do not yet include DPOs among the stakeholders involved.

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1. Findings come from a baseline study conducted within the programme, can be obtained from Light for the World [↑](#footnote-ref-1)
2. <http://lab.light-for-the-world.org/wp-content/uploads/2018/01/Literature-review-barriers-health-care-20-07-2017.pdf> [↑](#footnote-ref-2)
3. A baseline study with focus group interviews was conducted. The study is unpublished but will be shared with the Special Rapporteur for informal reference. [↑](#footnote-ref-3)
4. The research is not published yet, but an article about the main findings will be available soon and shared with the Special Rapporteur. [↑](#footnote-ref-4)
5. See literature list below [↑](#footnote-ref-5)