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PLAN OF ACTION ON DISABILITIES AND REHABILITATION

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 (1, 2). 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 (1).

2. This Plan is aligned with the recommendations of the World Report on Disability, published by the World Health Organization and the World Bank (1), the WHO global disability action plan 2014-2021: Better health for all people with disabilities¹ (2), the Strategic Plan of the Pan American Health Organization 2014-2019 (3), the Convention on the Rights of Persons with Disabilities (4), the recommendations of the High-level Meeting of the United Nations General Assembly on Disability and Development (5), and the Program of Action for the Decade of the Americas for the Rights and Dignity of Persons with Disabilities (2006-2016) (6).

Background

3. WHO recognizes disability as a public health issue, since people with disabilities encounter barriers to health and rehabilitation services (1). 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 (1, 2, 7, 8).

¹ The WHO *global disability action plan 2014-2021: Better health for all people with disabilities*, approved by the 67th World Health Assembly, is available on the WHO website:
http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_16-en.pdf?ua=1

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

- a) OAS: Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons With Disabilities, 1999 (10);
- b) WHO: Resolution WHA58.23. Disability, including prevention, management, and rehabilitation, May 2005 (11);
- c) UN: Convention on the Rights of Persons with Disabilities, 2006 (4);
- d) PAHO: Resolution CD47.R1. Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health and Other Related Rights, September 2006 (12);
- e) OAS: Program of Action for the Decade of the Americas for the Rights and Dignity of Persons with Disabilities. 2006 (6);
- f) PAHO: CD49/11. Strategy and Plan of Action on Mental Health, 2009 (13);
- g) PAHO: CD49/19. Plan of Action on the Prevention of Avoidable Blindness and Visual Impairment, 2009 (14);
- h) PAHO: CD49/8. Plan of Action on the Health of Older Persons including Active and Healthy Aging, PAHO 2009 (18);
- i) PAHO: Resolution CD50.R8. Health and Human Rights, 2010 (15);
- j) WHO and World Bank: World Report on Disability, 2011 (1);
- k) PAHO: CD51/10. Strategy and Plan of Action on Epilepsy, 2011 (16);
- l) PAHO: CD51/7. Plan of Action on Road Safety, PAHO 2011 (19);
- m) WHO: EB134/16. Draft WHO global disability action plan 2014-2021: Better health for all people with disabilities (2);
- n) PAHO: Strategic Plan of the Pan American Health Organization 2014-2019 (3);
- o) UN: Recommendations of the United Nations High-level Meeting on Disability and Development, 2013 (5);
- p) PAHO: CD52/7. Plan of Action for the Prevention and Control of Noncommunicable Diseases, PAHO 2013 (17);
- q) WHO: Resolution WHA66.9. Disability, May 2013 (20).

Situation Analysis

5. An estimated 140 million people in our Region have a disability (21), 2-3% of them a significant² functional impairment. Vulnerable groups are those most affected by disability and include women and children victims of violence, older persons, and people

² Functioning can be considered a general term that refers to all bodily functions, activities, and social participation.

living in poverty. Indigenous populations and ethnic minorities are also at significantly higher risk (21, 22, 23). Only 3% of people in the Region of the Americas with some type of disability of varying degrees of severity have access to rehabilitation services, and 3% are highly dependent³ on another person⁴ 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 (22, 23).

6. Despite efforts to improve the capture of disability data in general population censuses, measurement methodologies and criteria still vary widely (23, 24). The most recent results of specialized surveys and the 2010 round of censuses in Latin America and the Caribbean have made it possible to gauge the magnitude of the situation of people living with disabilities. According to these studies and ECLAC estimates,⁵ 12.4% of the Latin American and 5.4% of the Caribbean population, on average, live with at least one disability (24).

7. The findings of the 2010 census rounds 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 (24). 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 (24, 25). When evaluating disabilities by type in Latin America and the Caribbean (2010 census), visual impairments are the most prevalent, followed by mobility and hearing impairments, which increase with age (9, 24).

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 (1). The cost of assistive technology devices is also a barrier for people with disabilities, especially in low-income countries (25).

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 behavior (1, 2). There is a high global incidence of disability from mental and

³ Dependence: a situation in which a person with a disability needs personal assistance or assistive devices to perform (or improve his or her performance of) a particular activity.

⁴ Caregiver: Includes formal, paid caregivers and informal, unpaid caregivers, who in most cases are women who care for someone in the home.

⁵ Economic Commission for Latin America and the Caribbean.

neurological disorders stemming from functional psychoses, dementia, epilepsy, cognitive disabilities, substance abuse disorders, and depression (13).

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 (1, 17). 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 (26, 27, 28).

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 (1).

12. Some countries in the Region have developed good health care and social protection practices to benefit persons with disabilities, especially those with severe disabilities. These countries include: Ecuador, with its *Misión Solidaria Manuela Espejo*;⁶ Venezuela, with its national health program for people with disabilities (PASDIS);⁷ Chile, with its instrument for assessing functioning in the community (IVADEC);⁸ Costa Rica, with its primary care rehabilitation network;⁹ Uruguay, with its *Uruguay sin Barreras* project;¹⁰ Peru, with its *Tumbes y Piura Accesible* project;¹¹ and other countries with interesting projects, among them Argentina, Bolivia, Brazil, Colombia, and Guyana. The countries of the Andean Community, Hipólito Unanue

⁶ Ecuadorian government initiative designed to lend visibility and provide assistance to persons with disabilities and their families, determining their biopsychosocial situation:

<http://www.vicepresidencia.gob.ec/informacion-programas-2/>

⁷ Program of Venezuela's Ministry of Popular Power for Health: <http://pasdis.mpps.gob.ve/pasdis/>

⁸ IVADEC-CIF: Instrument for the Assessment of Functioning in the Community, based on the International Classification of Functioning, Disability, and Health and prepared by Chile's Disability and Rehabilitation Department, Undersecretariat of Public Health, Ministry of Health for implementation of the Networked System for Disability Classification and Certification:

<http://ssviqui.redsalud.gob.cl/?p=2800>

⁹ Initiative of the Costa Rican Social Security Fund to improve primary health care, including basic rehabilitation services:

http://portal.ccss.sa.cr/portal/page/portal/GIT/Foro_Salud_Tics/Tab/Tab/1%20-%20Foro%202010-atenci%F2n%20primaria-equipamiento1.pdf

¹⁰ Initiative of the Ministry of Social Development's National Disability Program and support from the Ministry of Health and PAHO/WHO to promote the inclusion of persons with disabilities:

http://pronadis.mides.gub.uy/innovaportal/v/22299/9/innova.front/artigas_sin_barreras

¹¹ Peruvian government initiative through the National Council for the Inclusion of Persons with Disabilities to create the conditions leading to a better quality of life for persons with disabilities:

http://www.conadisperu.gob.pe/tumbes_accesible/

Agreement, adopted the Andean health policy for disability prevention¹² and comprehensive care of people with disabilities.

Plan of Action (2014-2019)

13. A 5-year Plan of Action (2014-2019) is proposed, based on the experiences of the Member States and considering the shared responsibilities of those states that have a federal political structure (federal states). This Plan is aligned and linked with the indicators and targets of the Strategic Plan of the Pan American Health Organization 2014-2019¹³ 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) inclusion and participation; f) respect for people's dignity and nondiscrimination;¹⁴ and g) universal accessibility (1, 2, 4, 5, 10, 13).

15. The Plan of Action rests on four cross-cutting approaches aligned with the PAHO 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 health¹⁵ and the habilitation 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.

¹² The countries of the Hipólito Unanue Agreement are: Bolivia, Chile, Colombia, Ecuador, Peru, and Venezuela.

http://www.orasconhu.org/sites/default/files/Libro%20Politica%20Andina%20de%20Discapacidad_0.pdf

¹³ Under Category 2 of the Strategic Plan of the Pan American Health Organization 2014-2019 (Noncommunicable Diseases and Risk Factors), it is stated that PAHO will contribute to the improvement of health and living conditions for people with disabilities and that this will include generating synergies between related health programs for health promotion and prevention of disabilities, strengthening capacity of health human resources, providing social protection for people with disabilities, and improving information on disabilities within health information systems.

¹⁴ Pursuant to the Convention on the Rights of Persons with Disabilities and other applicable international human rights instruments.

¹⁵ This includes affordably providing these people with free programs and health care, including sexual and reproductive health services, of the same type and quality as those provided to other people.

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, habilitation 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 habilitation 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 interprogrammatic approach coupled with intersectoral coordination. Disability calls for an integrated, coordinated response that includes partnerships between the health sector and the social protection, education, labor, human rights protection, and other sectors. People with disabilities, their families, and caregivers should play an active role (1, 2, 4, 5). 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 PAHO/WHO 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 2013: 6. Target 2019: 14)

Objective 1.2. Take measures to ensure that international human rights standards and PAHO/WHO 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 PAHO/WHO.
(Baseline 2013: 6. 2019: 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 2013: 1. Target 2019: 9)

Strategic Line of Action 2: Strengthen the health sector's habilitation 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 habilitation and rehabilitation services, and to link with other health programs and services and other ministries and government entities (1). Habilitation and rehabilitation¹⁶ mitigate the impact of highly diverse health issues by

¹⁶ Rehabilitation: Understood as the coordinated use of medical, social, educational, and vocational measures for training or retraining individuals to the highest attainable level of functional ability. Habilitation: Assistance to individuals with a congenital disability who have not yet acquired sufficient capacity or ability to participate in educational, work, and social life. Source: Technical Information Series 419. WHO, 1969. Convention on the Rights of Persons with Disabilities.

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 (1).

23. The Community-based Rehabilitation Strategy (CBR) (30) 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 (31, 32).

24. Some people with disabilities have complex rehabilitation needs that must be addressed in specialized centers. However, most people need habilitation 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 habilitation 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 habilitation and rehabilitation services (30, 31).

25. Investing in habilitation, 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 habilitation 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, habilitation, 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.

¹⁷ WHO Disability and Rehabilitation Team; visit: www.who.int

¹⁸ Idem 17.

- d) Formulate standards and protocols for habilitation, 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 habilitation and rehabilitation services and social services for persons with disabilities.
(Baseline 2013: 0. Target 2019: 16)
- 2.1.2 Percentage of countries that include the Community-based Rehabilitation Strategy (CBR) in national rehabilitation programs in accordance with the PAHO/WHO matrix.
(Baseline 2013: 3. Target 2019: 19)
- 2.1.3 Percentage of countries that include assistive technology devices for persons with disabilities as part of their service delivery systems.
(Baseline 2013: 6. Target 2019: 20)

Objective 2.2. Formulate habilitation and rehabilitation regulations.*

Indicator:

- 2.2.1 Number of countries that have formulated or updated habilitation and rehabilitation regulations.*
(Baseline 2013: 3. Target 2019: 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 (1). 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; habilitation and rehabilitation needs; quality of life;

* Pursuant to the recommendations of the World Report on Disability and the High-level Meeting of the United Nations General Assembly on Disability and Development, and to the Convention on the Rights of Persons with Disabilities and the technical guidelines of PAHO/WHO.

¹⁹ Disaggregated by sex, age, ethnic origin, socioeconomic status, etc.

cost-effectiveness of rehabilitation interventions; service delivery models; and the human resources training (1).

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 2013: 6. Target 2019: 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 2013: 6. Target 2019: 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 2013: 2. Target 2019: 16)

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

Indicator:

- 3.3.1 Number of countries that subsidize at least 2 research projects per year on disability, habilitation, or rehabilitation.
(Baseline 2013: 0. Target 2019: 14)

Monitoring, Analysis, and Evaluation

30. This Plan contributes to meeting the targets in Category 2 of the PAHO 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 5-year period (2014-2019) will be US\$ 6,222,500. The estimated gap is 56% of the total budgeted. The Plan can be implemented largely with the work of the Organization's Regional Adviser and joint efforts with the network of Collaborating Centers and reference centers, with support from the PAHO Representative Offices in the countries. Forging partnerships and identifying donors to support the plan will be important.

Action by the Directing Council

32. The Directing Council is requested to review this proposed Plan of Action on Disabilities and Rehabilitation, which makes pertinent observations and recommendations, and consider approval of the proposed resolution that appears in Annex A.

Annexes

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53rd DIRECTING COUNCIL

66th SESSION OF THE REGIONAL COMMITTEE OF WHO FOR THE AMERICAS

Washington, D.C., USA, 29 September-3 October 2014

CD53/7, Rev. 1
Annex A
Original: Spanish

PROPOSED RESOLUTION

PLAN OF ACTION ON DISABILITIES AND REHABILITATION

THE 53rd DIRECTING COUNCIL,

Having reviewed the *Plan of Action on Disabilities and Rehabilitation* (Document CD53/7, Rev. 1);

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;

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;

Understanding that investing in habilitation 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;

Considering that Resolution CD47.R1 (2006), *Disability: Prevention and Rehabilitation in the Context of the Right to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health and Other Related Rights* urges the Member States to draft and adopt policies, plans, and laws on health, habilitation, and rehabilitation consistent with the applicable international human rights instruments;

Considering that, in May 2014, the Sixty-seventh World Health Assembly approved the *WHO Global disability action plan 2014-2021: Better health for all people with disabilities* (resolution WHA67.7), the Pan American Health Organization (PAHO), with the consensus of its Member States, drafted this plan of action aligned with the global action plan and the PAHO Strategic Plan 2014-2019;

Observing that this plan of action addresses the objectives essential for meeting the countries' needs, in accordance with their national context,

RESOLVES:

1. To approve the *Plan of Action on Disabilities and Rehabilitation* and its implementation within the context of the particular conditions of each country.
2. To urge the Member States, taking into account the shared responsibilities in federated States, 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 habilitation 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 multisectoral 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.
3. To request the Director to:
- a) strengthen PAHO cooperation with the Member States to promote and protect the quality of life of persons with disabilities and their enjoyment of the highest attainable standard of physical and mental health;
 - b) assist the Member States with the preparation, review, and implementation of national disability and rehabilitation plans and the updating of laws;
 - c) collaborate in evaluations of country habilitation and rehabilitation programs and services, especially by monitoring indicators, to evaluate progress and the impact of the interventions;
 - d) help the Member States improve their health information systems to produce, analyze, and utilize disability data that meet the criteria of quality, timeliness, and reliability;
 - e) foster partnerships with international organizations and other regional and subregional entities to support the multisectoral response needed to implement this plan of action;
 - f) facilitate information dissemination and the sharing of experiences and good practices, in addition to promoting technical cooperation among the Member States;

- g) facilitate the Member States' collaboration with teaching institutions and nongovernmental organizations, especially organizations of persons with disabilities and others that promote protection and respect for persons with disabilities.



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

1. Agenda item: 4.5-Plan of Action on Disabilities and Rehabilitation

2. Linkage to Program and Budget 2014-2015:

a) **Category 2:** Noncommunicable Diseases and Risk Factors

b) **Program area:** Disability and Rehabilitation

Outcome 2.4: Increased access to social and health services for people with disabilities, including prevention.

3. Financial implications

a) **Total estimated cost for implementation over the lifecycle of the resolution (estimated to the nearest US\$ 10,000, including staff and activities):**

Cost of implementing the Plan of Action for the 5-year period (2014-2019):

Staffing: \$1,785,000

Operating expenses/activities: \$4,437,500

Total: \$6,222,500

b) **Estimated cost for the 2014-2015 biennium (estimated to the nearest US\$ 10,000, including staff and activities):**

Biennium 2014-2015 (Biennial Work Plan reduced in 2015, since the Plan will be approved by the Directing Council in September 2014, which means that for practical purposes, implementation begins in 2015)

Staffing: \$495,000

Operating expenses/activities: \$887,500

Subtotal: \$1,382,500

Total: \$ 1,382,500

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

Staffing: \$495,000

Operating expenses/activities: \$100,000

Subtotal: \$595,000

Total: \$595,000

Annual gap: \$787,500

4. Administrative implications

- a) Indicate the levels of the Organization at which the work will be undertaken:**
Planning for the work is centered on the needs of the Member States. The priority countries with less-developed disability and rehabilitation programs are especially important.

The Plan will be implemented at three levels:

- i. Regional: resource mobilization, advocacy, preparation and dissemination of technical, methodological, and training materials; delivery of technical cooperation to the countries for implementation of their national disability and rehabilitation plans.
- ii. Subregional: coordination with subregional integration agencies such as CARICOM, SICA, MERCOSUR, UNASUR, Hipólito Unanue Agreement. Facilitation of cooperation among countries, discussion of mutual problems, and the sharing of experiences.
- iii. National: formulation and implementation of national disability and rehabilitation plans under the direction of the ministries of health, with the participation of other sectors and institutions; this implies support for and supervision of the local levels. PAHO technical cooperation to the countries will be based on the joint identification of needs.

- b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile):**

The Plan can be implemented with the support of the Organization's Regional Adviser on disability and rehabilitation and joint work in a network with the Collaborating Centers and reference centers, the support of the PAHO focal points in the Representative Offices, and linkage with other interprogrammatic and intersectoral activities.

- c) Time frames (indicate broad time frames for the implementation and evaluation):**

2014: Approval of the Plan of Action by the Directing Council.

2015: Implementation of Plan of Action begins.

2016 and 2018: Biennial evaluations.

2020: Final evaluation.



ANALYTICAL FORM TO LINK AGENDA ITEM WITH ORGANIZATIONAL MANDATES

1. Agenda item: 4.5-Plan of Action on Disabilities and Rehabilitation

2. Responsible unit: Noncommunicable Diseases and Disabilities (NMH/ND)

3. Preparing officer: Dr. Armando Vásquez Barrios

4. List of Collaborating Centers and national institutions linked to this Agenda item:

- Instituto Nacional de Rehabilitación de México. PAHO/WHO Collaborating Center for medical and rehabilitation research.
- Instituto Nacional de Rehabilitación JJ. Arvelo–Venezuela.
- Centro de Investigación y Asesoría en Discapacidad, Escuela de Salud Pública, Universidad de Córdoba–Argentina.
- Servicio Nacional de Rehabilitación–Argentina.
- Instituto Nacional de Rehabilitación Adriana Rebas Flores–Lima, Perú.
- Instituto Nacional de Rehabilitación Pedro Aguirre Cerda–Santiago, Chile.
- Comité de Rehabilitación. Medellín–Colombia.
- CBR networks of the Americas (NGOs and government institutions working on the community-based rehabilitation strategy)
- Escuela de Salud Pública de Guadalajara–México.
- Centro Nacional de Rehabilitación–San José, Costa Rica.
- Servicio Nacional de la Discapacidad–Santiago, Chile.
- Hospital de Rehabilitación Julio Díaz–Havana, Cuba.
- American Speech-Language-Hearing Association–Maryland, USA.
- Secretaría Técnica de Discapacidad–Quito, Ecuador.
- Instituto Nacional de Rehabilitación Psicofísica del Sur–Mar del Plata, Argentina.
- Escuela de Salud Pública y Escuela de Terapia Ocupacional de la Universidad de Chile–Santiago, Chile.
- Centro Iberoamericano para la Tercera Edad–Havana, Cuba.
- Centro Mexicano de Clasificación de Enfermedades y el Centro Colaborador para la Familia de Clasificaciones Internacionales de la OMS, Universidad de São Paulo (Collaborative work on application of the ICF).
- Universidad Don Bosco, Facultad de Ciencias de la Rehabilitación–San Salvador, El Salvador.

5. Link between Agenda item and Health Agenda for the Americas 2008-2017:

The following links are particularly relevant:

- Statement of Intent: paragraphs 2, 3, 5, and 6.
- Principles and Values: paragraphs 9, 10, 11, and 12.
- Situation Analysis and Health Trends in the Americas: paragraphs 14, 15, 16, 17, 19, 20, 22, 25, 26, 27, 28, 30, 31, 32, and 33.
- Areas of Action: paragraphs a, b, c, d, g, and h.

6. Link between Agenda item and the PAHO Strategic Plan 2014-2019:

It is linked essentially with Category 2 (Noncommunicable Diseases and Risk Factors).

Program area 2.4. Disability and Rehabilitation: Outcome 2.4, Indicator 2.4.1.

In the PAHO Program and Budget 2014-2015: 2.4.1 is linked to the Outputs (OCM and OPT).

The Disability and Rehabilitation area will require effective interprogrammatic work with the other categories and programs.

7. Best practices in this area and examples from countries within the Region of the Americas:

Some countries with best practices and successful experiences should be mentioned, among them:

- a) Chile: Creation of the Technical-Administrative Management Department of the Ministry of Health Disability and Rehabilitation Program. Development of its instrument for assessing functioning in the community (IVADEC-ICF) for networked classification and certification of disability.
- b) Argentina: Creation of the federal rehabilitation program (strengthening of the rehabilitation service network by levels of complexity). Introduction of the standard disability certificate (CUD).
- c) Ecuador: Misión Solidaria Manuela Espejo: program for ascertaining the bio psychosocial situation of persons with disabilities. Creation of the Technical Administrative Management Unit of the Ministry of Health Disability and Rehabilitation Program.
- d) Venezuela: Creation of the Unit Technical-Administrative Management Unit of the Ministry of Health Disability and Rehabilitation Program and development of the comprehensive health services program for persons with disabilities (PASDIS).
- e) Costa Rica: Initiative of the Costa Rican Social Security Fund for strengthening primary health care, including basic rehabilitation services.
- f) Guyana: Formulation of the health sector's Strategic Plan for Rehabilitation.
- g) Colombia and Bolivia: Development of national regulations for implementing the community-based rehabilitation strategy (CBR).

8. Financial implications of this Agenda item:

Achieving the successful implementation of this Plan of Action has financial implications, which are detailed in Annex B.

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