Special Olympics Health

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SOI Presentation

Why the report now?

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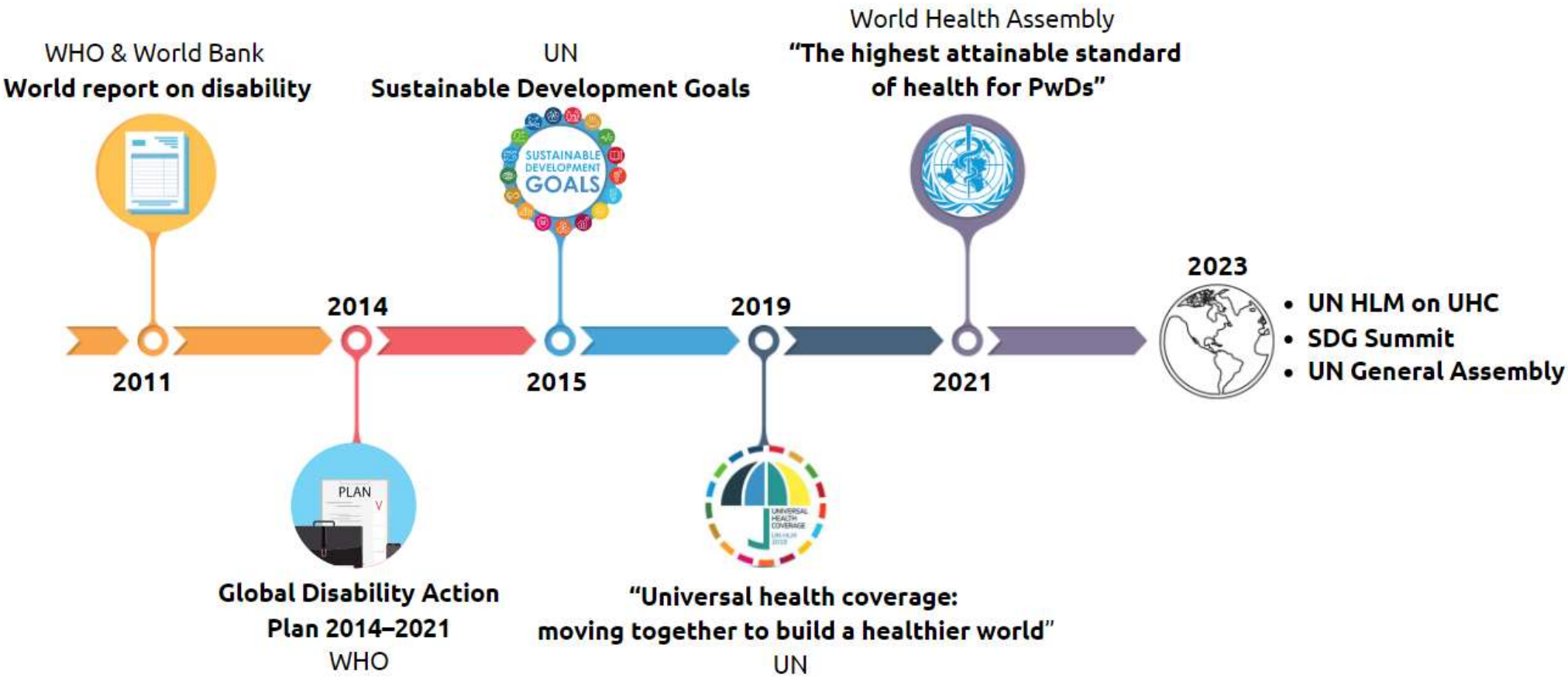

The report: structure

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1. Health equity for persons with disabilities matters

2. Health inequities experienced by persons with disabilities, and their contributing factors

3. Advancing health equity for persons with disabilities in the health sector

4. Recommended principles for implementation

Scenario #1

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Scenario #1

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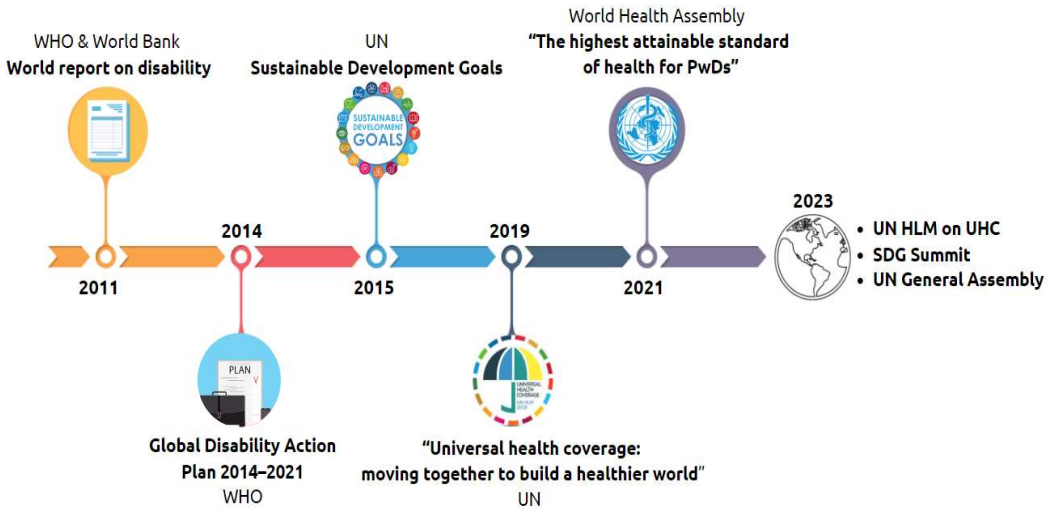
1.3 BILLION
people globally have significant disability

1 in 6 people

80% is the estimated number of persons with disabilities living in **low- and middle-income countries** where access to basic health services are especially limited for persons with disabilities



Scenario #1

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All governments and health sector partners need to commit to **3 recommended principles** when implementing actions

- **Include health equity at the center of all actions**
- **Empower and include persons with disabilities**
- **Monitor the impact of health section actions for persons with disabilities**

WHO/UCN/NCD/SDR/2022.01

World Health Organization

Scenario #1

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Special Olympics:

A Key Partner for Achieving Health Equity for People with Intellectual Disabilities

Scenario #2

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Ministry of Health

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Scenario #2

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US$10 return per US$1 spent

For every US$1 spent on disability-inclusive cancer prevention and control, the return on investment could be US$9

For every US$1 spent on disability-inclusive NCD prevention and care, the return on investment could be US$10

Vaccination and family planning provided in disability-inclusive manner could be highly cost-effective

Scenario #2

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Inequalities experienced by people with ID

- Have poorer health outcomes due to avoidable, unjust, and unfair factors
- Have higher rates of diabetes, asthma, arthritis, cardiac disease, and hypertension
- Die 16-20 years younger
- Are 8 times more likely to die from Covid-19
- Are excluded from consultation processes due to pre-assumptions regarding their contribution

World Health Organization
Global report on health equity for persons with disabilities

Scenario #3

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Scenario #3

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actions to achieve health equity for persons with disabilities

Political commitment, leadership, and governance

1 Prioritize health equity for persons with disabilities

2 Establish a human rights-based approach to health

3 Assume a stewardship role for disability inclusion in the health sector

4 Make international cooperation more effective by increasing funding to address health inequities for persons with disabilities

5 Integrate disability inclusion in national health strategies, including preparedness and response plans for health emergencies

6 Set actions that are specific to the health sector in national disability strategies or plans

7 Establish a committee or a focal point the Ministry of Health for disability inclusion

8 Integrate disability inclusion in the accountability mechanisms of the health sector

9 Create disability networks, partnerships and alliances

10 Ensure the existing mechanisms for social protection support the diverse health needs of persons with disabilities

Health financing

11 Adopt progressive universalism as a core principle, and as a driver of health financing, putting persons with disabilities at the centre

12 Consider health services for specific impairments and health conditions in packages of care for universal health coverage

13 Include into health-care budgets the costs of making facilities and services accessible

Engagement of stakeholders and private sector providers

14 Engage persons with disabilities and their representative organizations in health sector processes

15 Include gender-sensitive actions that target persons with disabilities in the strategies to empower people in their communities

16 Engage the providers of informal support for persons with disabilities

17 Engage persons with disabilities in research and including them in the health research workforce

18 Request that providers in the private sector support the delivery of disability-inclusive health services

Models of care

19 Enable the provision of integrated people-centred care that is accessible and close to where people live

20 Ensure universal access to assistive products

21 Invest more finances in support persons, interpreters, and assistants to meet the health needs of persons with disabilities

22 Consider the full spectrum of health services along a continuum of care for persons with disabilities

23 Strengthen models of care for children with disabilities

24 Promote deinstitutionalization

Health and care workforce

25 Develop competencies for disability inclusion in the education of all health and care workers

26 Provide training in disability inclusion for all health service providers

27 Ensure the availability of a skilled health and care workforce

28 Include persons with disabilities in the health and care workforce

29 Train all non-medical staff working in the health sector on issues related to accessibility and respectful communication

30 Guarantee free and informed consent for persons with disabilities

Physical infrastructure

31 Incorporate a universal design-based approach to the development or refurbishment of health facilities and services

32 Provide appropriate reasonable accommodation for persons with disabilities

Digital technologies for health

33 Adopt a systems-approach to the digital delivery of health services with health equity as a key principle

34 Adopt international standards for accessibility of digital health technologies

Quality of care

35 Integrate the specific needs and priorities of persons with disabilities into existing health safety protocols

36 Ensure disability-inclusive feedback mechanisms for quality of health services

37 Consider the specific needs of persons with disabilities in systems to monitor care pathways

Monitoring and evaluation

38 Create a monitoring and evaluation plan for disability inclusion

39 Integrate indicators for disability inclusion into the monitoring and evaluation frameworks of country health systems

Health policy and systems research

40 Develop a national health policy and systems research agenda on disability

WHO/UCN/NCD/SDR/2022.02

World Health Organization

What other actions do we implement as SO movement?

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40 actions to achieve health equity for persons with disabilities

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World Health Organization

The report: stories

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Personal story

Speaking out on stigma to fight it

When Dr Ahmed Hankir first experienced psychological distress as a medical student in the United Kingdom of Great Britain and Northern Ireland, he delayed seeking help due to the shame and stigmatization associated with having a mental health condition.

Compounding his situation was the stigmatization of being a man of colour, a Muslim and a migrant – a "triple whammy" which contributed towards an "identity crisis" – and the strain of surviving through low-paid jobs and a war in the country of his roots.

He felt the stigmatization of mental health most acutely within his own profession. He was "ridiculed" by fellow medical students and ostracized by his closest companions. When he sought help from the person in charge of student support, he was "psychologically tortured".

"Stigma is rampant in the medical profession. Unless we address it, it will continue," he said. "It takes strength to accept that you might be a source of stigma. There's ignorance and arrogance [from] providers. What we need is humility. I've met inspirational, humble doctors."

As a psychiatrist, he draws from his past. "My lived experience is my superpower. It makes me more insightful, and I can mobilize empathy."

Today, Hankir is renowned for his "Wounded Healer" presentation, which aims to debunk myths about mental illness through blending performing arts and psychiatry. He has won many awards for this, including the World Health Organization Director-General Award for Global Health in 2022.

"Speaking out on stigma challenges it. I try to engage and educate the audience," he explained. More than 100 000 people across 20 countries have heard him speak.

He continues to face negativity from some psychiatrists; some are "suspicious" of his success. "They think I can't function. I was miserable for many years. But now I am not just surviving, I'm thriving," he laughed.

Photo: © Dr Ahmed Hankir

Overview

- As of 2021, an estimated 1.3 billion people – or 16% of global population – experience significant disability. This number is growing driven by increased number of people with noncommunicable diseases, who are also living longer and ageing with limitations in functioning.
- Many of the differences in health outcomes between persons with disabilities and those without cannot be explained by the underlying health condition or impairment and are associated with avoidable unjust or unfair factors. These factors are called "health inequities".
- It is an obligation of the state, through their health sector in coordination with other sectors, to address existing health inequities so that persons with disabilities can enjoy their inherent right to the highest attainable standard of health. The obligation is an international law of human rights.
- Addressing health inequities for persons with disabilities will advance the achievement of global health priorities.
  - Health equity is inherent to the pursuance of UHC.
  - Countries can make faster progress in improving the health and well-being of their population through cross-sectoral public health interventions that are inclusive and provided in an equitable manner.
  - Advancing health equity for persons with disabilities is a central component of all efforts to protect populations in health emergencies.
- Addressing health inequities for persons with disabilities benefits everyone. Older people, persons with noncommunicable diseases, migrants and refugees, or frequently unreached populations, such as those from lower socioeconomic backgrounds can benefit from disability inclusive approaches that target persistent barriers to inclusion in the health sector.
- Advancing health equity for persons with disabilities contributes to their wider participation in society.
- Investing in health equity for persons with disabilities means investing in Health for All, which whilst would likely require additional investments for ensuring equitable access to people with disability still brings high economic and societal dividends. For example, there could be nearly US$ 10 return per US$ 1 spent on implementing disability inclusive prevention and care for noncommunicable diseases. Other population-wide interventions such as family planning and vaccination also remain highly cost-effective when provided in disability inclusive manner, despite the additional cost required.

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For older people with a disability, ageism is an intersecting factor that can result in discrimination and human rights violations. Older persons with disabilities are often denied their autonomy, and their role in the community is dismissed as irrelevant and burdensome *(241)*. They are more at risk for developing NCDs due to underlying health conditions, unmet health needs, greater levels of poverty and exclusion from services. This is an important issue given the anticipated increase in population ageing in the coming decades.

Race is another intersecting factor with racial discrimination affecting health outcomes for persons with disabilities. In the United States, persons with

manifest sometimes in higher levels of obesity *(138, 250)*. Special Olympics has found higher rates of obesity among Special Olympics participants with intellectual disabilities and the general population globally *(251)*.

My right to practice sports, to engage in physical activity, has greatly helped both my physical and mental health."

Special Olympics Athlete at CRPD Conference for States Parties Side Event

communication and cultural barriers *(71, 73, 74)* and a lack of linguistic and cultural training among health and care providers *(73)*, all negatively influence the health-seeking behaviours and quality of care for refugees and migrants with disabilities. They often report a fear of not being understood by health and care professionals *(71)* or feel that they should not ask for health services *(73)*, all of which lead to poorer health outcomes compared to the general population. In addition, refugees, asylum seekers and stateless persons with disabilities are often excluded in national health systems and plans and cannot

receive the rehabilitative services or assistive products they require *(246)*. Conflict-related displacement, when people are forced to flee, has significant effects on access to essential services including food, water, sanitation, shelter and health care during the different phases of the displacement. It is important to note that populations who are more at risk, such as persons with disabilities, may be unable to flee or may choose to stay behind; if on the move, they will struggle to meet their immediate and ongoing needs *(247)*.

2.2.3 Risk factors

tobacco compared to 15% among adults without disabilities *(136)*. Prevalence of tobacco use among women with disabilities is even higher *(9, 10)*. Prevalence rates of alcohol consumption and substance use are also higher among persons with disabilities *(15, 18)*. It is important to note that very often these risk factors are a result of other determinants of health such as economic circumstances and level of education of an individual. For example, greater financial means can allow people to buy healthier food or have the means to exercise *(253, 254)*.

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Take home messages

- Use examples, practices, and case studies
- Use data relevant to your context
- Use data and information to supplement your arguments
- Refer to the report in your work
- Align report's findings & recommendations with your inclusive health work
- Supplement the report's findings with SO data, case studies and stories

Questions?

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Moving forward

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Do you have a story about health system strengthening and policy?

Would a resource be helpful? Please don't hesitate to your RHM