The WHO European Framework for action to achieve the highest attainable standard of health for persons with disabilities 2022–2030

Information document

Access to good-quality, timely and affordable health care services is a human right. Health is a crucial aspect of well-being. Accordingly, disability discrimination and barriers of any type that hinder access to and utilization of health care services by persons with disabilities must be eliminated. The proposed WHO European Framework for action to achieve the highest attainable standard of health for persons with disabilities 2022–2030 has been developed in consultation with Member States of the WHO European Region and reaffirmed through multiple stakeholder consultations with Member States and organizations of persons with disabilities.

The Framework envisages that, by 2030, persons with disabilities and their needs will be fully included and considered in all health care planning, delivery and leadership across the Region. The Framework includes targets and specific actions for Member States, the WHO Regional Office for Europe, and national and international stakeholders, as well as a detailed monitoring and evaluation framework, to ensure that the right to health for persons with disabilities is fully realized.

This information document is submitted for consideration and adoption by the 72nd session of the WHO Regional Committee for Europe, together with the related resolution, working document and background document.
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OVERVIEW AND MAIN ELEMENTS OF THE FRAMEWORK

Vision

1. The WHO European Framework for action to achieve the highest attainable standard of health for persons with disabilities 2022–2030 envisions that, by 2030, persons with disabilities will be fully included and considered in all health care planning, delivery and leadership across the WHO European Region, leading to a disability-inclusive health sector and the promotion of the health and well-being of all persons, in order to achieve the highest attainable standard of health for persons with disabilities of all ages and across all contexts in the Region.

Objectives

2. The objectives of the framework are as follows:

(a) Objective 1: Ensure that all persons with disabilities receive quality health services on an equal basis with others.

(b) Objective 2: Promote the health and well-being of persons with disabilities.

(c) Objective 3: Ensure that all health policies and programming, as well as resilience-building and recovery plans during public health emergencies, are disability inclusive.

(d) Objective 4: Build an evidence base on disability and health.

Approaches

3. The approaches suggested by the framework are as follows:

(a) Human rights: Persons with disabilities should enjoy the same rights to health, employment, education and all other areas of life on an equal basis with others.

(b) Universal design: The built environment, health care equipment and products, and all health services need to be accessible and usable by all people.

(c) Life course: The needs of persons with disabilities should be fully considered across the life course.

(d) Health systems: Actions need to be developed to ensure that disability inclusivity is integrated in the six building blocks of health systems: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership and governance.

INTRODUCTION

4. There are currently 135 million persons with disabilities in the WHO European Region. Persons with disabilities experience structural disadvantage, exemplified through increased poverty rates, lower literacy levels and lower employment compared with the general population. They also experience greater risk factors for poor health, which – combined with limited service delivery – contribute to poor health outcomes.

5. Persons with disabilities often have increased needs for health care: they need to access general health care services as well as disability-related health care services. However, evidence – both globally and 1 Following the United Nations Convention on the Rights of Persons with Disabilities, the term “persons with disabilities”, as used in this framework, refers to people who have long-term physical, mental, intellectual or sensory impairments that, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others. Disability is a fluid concept and is highly connected to the environment where people live.
in the European Region – shows that, on average, persons with disabilities face more barriers to accessing and using health care and have greater unmet health care needs than persons without disabilities.

6. Unmet health care needs can have detrimental effects on the health and well-being of persons with disabilities and can be associated with worse health outcomes, including mortality rates that are two to three times higher than the rest of the population across all ages. Unmet health care needs can also lead to unnecesarily high health care costs, as persons with disabilities are more likely to experience delayed access to health care, which can lead to more difficult and expensive treatments.

7. In the European Region, only 50% of persons with disabilities can afford health care, including rehabilitation services, while only 10% have access to assistive devices; these barriers can have a negative impact on the health and well-being of both persons with disabilities and their carers. Furthermore, persons with disabilities in the Region report lower levels of use of cancer screening services.

**Barriers to accessing and using health care services**

8. The observed disparities in access to health care and in health outcomes are the product of both direct and indirect discrimination that, combined, lead to compromised access to health care systems and to living conditions associated with poor health. Persons with disabilities across the Region are faced with a multitude of barriers to accessing and using timely, relevant and good-quality health care services.

9. These barriers do not affect solely persons with disabilities but, more widely, people who experience discrimination, including – but not limited to – people belonging to marginalized or minority groups (sexual, racial, ethnic, linguistic, among others), older people and people on low incomes. Policy actions aimed at addressing such barriers can have a multiplier effect, benefiting a range of health service users.

10. Barriers to health care services are often due to failures in systems and service delivery. Examples of such barriers are given in the sections that follow.

**Attitudinal barriers**

11. Persons with disabilities face several attitudinal barriers to health care, which include health care professionals not always treating them with dignity and not respecting their autonomy. These barriers are related to disablism, which refers to environments, policies, procedures, behaviours and attitudes that disadvantage persons with disabilities. Disablism can have important effects on access to health care, contributing to the provision of low-quality or inappropriate services, underutilization of services (including low rates of participation in cancer screening) and poor experiences of health care utilization. Furthermore, intersectionality needs to be acknowledged; intersectionality refers to the combined barriers and discrimination that persons with disabilities may face if they are also a member of another marginalized group due to their race, sexual orientation, gender, age or other identity.

**Physical barriers**

12. Persons with disabilities are often faced with physical barriers in their effort to access and use health care services. These barriers include the absence of the following: auditory and visual cues, working elevators or ramps, automatic doors, hallways or doors wide enough to accommodate people using mobility devices, handrails, accessible parking, appropriate signage, adapted bathrooms or adjustable-height furniture (such as examination beds, chairs or equipment). Even when accessible features, such as ramps, are present, they may often be blocked owing to a lack of awareness of disability.

**Communication barriers**

13. Persons with disabilities face several communication-related barriers that affect their access to and use of health care, including lack of accessible information, lack of training of health care professionals in
appropriate and respectful communication with people with disabilities of all ages, and inaccessible digital health environments. Poor communication can have wide-ranging effects and may result in violations of the rights of persons with disabilities, including descriptions of pain being ignored, parents’ expertise in their children’s medical condition being dismissed, and persons with disabilities not being told how long they will have to wait or even what procedure (ranging in severity from changes in medication to surgery) will be performed. Poor communication in health care can lead to reduced adherence to treatment, reduced decision-making power and reduced autonomy among service users, as the lack of complete and appropriate information reduces their chance to make informed decisions. It can also result in poorer health outcomes, including delayed diagnosis.

**Transportation and geographical barriers**

14. Persons with disabilities face geographical and transportation-related barriers in accessing and using health care services. These barriers may be related to the availability of services, the distance to health centres and a lack of transport. The physical distance to a health centre can be a significant barrier for persons with disabilities, since they often require reliable, affordable and accessible transport. Particularly in rural areas, the lack of health care facilities and pharmacies can either lead to unmet health care needs, when persons with disabilities do not access the services they need, or to high personal expenses, when persons with disabilities need to arrange private transport services to access health services, especially if local transport is inaccessible or unreliable.

**Policy barriers**

15. Policies that are not disability inclusive can pose significant barriers to health. Even when legal frameworks prohibiting discrimination on the basis of disability exist (for example, either the United Nations Convention on the Rights of Persons with Disabilities – UNCRPD – or domestic laws), health policies are not always disability inclusive. Policies can affect the health of persons with disabilities both directly and indirectly. Direct policies are the ones that directly target persons with disabilities and impact their access to health care, for instance, policies changing social assistance and social benefits, and policies enabling forced treatments and administration of drugs and involuntary detention and institutionalization, to which persons with psychosocial and intellectual disabilities are particularly vulnerable. Policies that indirectly target persons with disabilities are policies that involve the entire population but that often affect persons with disabilities disproportionately, for example co-payments or budget cuts in health.

**Financial barriers**

16. Low income can affect health in various ways: (a) directly, for example, through reduced ability to pay for the medication, therapies or rehabilitation services necessary to manage one’s health conditions, such as alleviation of pain, or through reduced ability to make out-of-pocket payments, and (b) indirectly through, for instance, reduced ability to afford heating or food. Persons with disabilities are often excluded from the job market and have higher daily living costs (for instance, increased heating costs if they spend more time at home or personal assistance costs), resulting in increased vulnerability to impoverishing or catastrophic costs. This situation is further exacerbated by the fact that persons with disabilities are often faced with increased out-of-pocket payments for various aspects of their care, including assistive technology. Financial barriers, indeed most barriers, also have a gender dimension, with women with disabilities reporting higher unmet health care needs due to cost.
WHO EUROPEAN FRAMEWORK FOR ACTION TO ACHIEVE THE HIGHEST ATTAINABLE STANDARD OF HEALTH FOR PERSONS WITH DISABILITIES 2022–2030

17. This framework represents the culmination of a long-standing strategic engagement of WHO and organizations of persons with disabilities to realize the right to good-quality health care for all persons with disabilities (including persons living in the community, institutional settings or any other arrangements) and to eliminate all disability-based discrimination in the health sector. The framework is a response to resolution WHA74.8 (2021) on the highest attainable standard of health for persons with disabilities and reflects the determination of the WHO Regional Office for Europe (WHO/Europe), as expressed in the European Programme of Work, 2020–2025 – “United Action for Better Health in Europe” (EPW), to “leave no one behind”. The core principles of the framework are that it is equity based, people focused and data enabled. It is also aligned with the core priorities of the EPW, which aims at achieving universal health coverage, protecting against health emergencies and promoting health and well-being.

18. Through specific targets as well as associated measurable indicators and actions for Member States, WHO/Europe, and national and international stakeholders, this framework will help Member States achieve the highest attainable standard of health for persons with disabilities.

Developing the Framework

19. The framework was developed in a co-production process with Member States and non-State actors, and included the following activities:

(a) Three online consultation meetings with Member States and non-State actors, including representatives of organizations of persons with disabilities. These meetings were co-led by a core group of Member States, which spearheaded the development of the framework in the Region, with support from WHO/Europe.

(b) One online consultation event with representatives of organizations of persons with disabilities from countries across the Region, co-led by the European Disability Forum.

(c) Member States were encouraged to hold their own consultation events, involving representatives of organizations of persons with disabilities, and to provide feedback to the framework development team.

20. The consultations were accessible through the use of International Sign Language interpretation, live captioning and other accommodations, as required. Participants received drafts of all relevant documents, including a consultative document, the working document, the resolution, the information document and the background document. Participants had the opportunity to provide input either during the meeting or at a later stage, giving them time to consult with local stakeholders.

21. Links were established to ensure the objectives of this framework were consistent with the WHO Global report on health equity for persons with disabilities (as decided by resolution WHA74.8, to be launched in December 2022), and with the WHO Global Disability Action Plan 2014–2021.

Objectives and corresponding action areas

22. Given the complexity of health care and the diversity of disability, and acknowledging the huge diversity of the health landscape, including health systems, across the Region, the framework is flexible enough to be actionable across different settings, yet specific enough to monitor and measure progress and evaluate success. The following lists of targets and actions are to serve as guidelines and inspiration for action to Member States and stakeholders.
23. The framework consists of four objectives, aligned with the three core priorities of the EPW. Each objective is accompanied by corresponding action areas, targets and indicators (see Fig. 1). The complete sets of actions for each objective are included in the background document, along with the complete monitoring and evaluation framework (with 20 indicators, accompanying measures of progress, and data sources).

**Fig. 1. Framework outline**

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Principles</th>
<th>Approaches</th>
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<tbody>
<tr>
<td>✓ Ensure equitable access to services</td>
<td>• Equity based</td>
<td>• Human rights</td>
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<tr>
<td>✓ Promote health and well-being</td>
<td>• People focused</td>
<td>• Universal design</td>
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<tr>
<td>✓ Elaborate disability-inclusive policies and plans</td>
<td>• Data enabled</td>
<td>• Life course</td>
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<tr>
<td>✓ Build evidence base on disability and health</td>
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<td>• Health systems</td>
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**Objective 1. Ensure that all persons with disabilities receive quality health services on an equal basis with others**

24. WHO/Europe is committed to achieving universal health coverage and ensuring that people of all ages across the Region have access to health care, as outlined in the EPW. The accomplishment of this objective will ensure that persons with disabilities have access to and can use affordable, timely, relevant and good-quality general and specialist health services in primary, secondary and tertiary care, including community and at-home service delivery.

25. Disability discrimination is a major impediment to achieving universal health coverage in the Region. According to Article 2 of the UNCRPD:

“Discrimination on the basis of disability” means any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation.

26. In health care, disability discrimination can take many forms and can refer to policies, attitudes and/or systems that directly or indirectly disadvantage persons with disabilities. It is exemplified by compromised accessibility of health services, increased barriers to access and use of services, and a disregard for the fundamental right to health care and for the autonomy of persons with disabilities.

27. Strategic priorities:

(a) Ensure that persons with disabilities and their families are treated with respect and dignity and that they are fully informed and empowered (including legally) to consent before any decisions about their health are taken.

(b) Eliminate disability discrimination by removing all barriers to access and use of health care services across the life course and provide reasonable accommodations when needed.
(c) Strengthen health systems to deliver or coordinate rehabilitation, habilitation, assistive technology, assistance and support services (including peer support), and community-based rehabilitation.

(d) Develop and/or reform health and disability laws, policies, strategies and plans for consistency with the UNCRPD.

Targets and action areas

<table>
<thead>
<tr>
<th>Target 1.1. By 2030, ensure that health care services are accessible</th>
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<tbody>
<tr>
<td>• Develop leadership and governance for disability-inclusive health</td>
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<tr>
<td>• Remove barriers to service delivery (including impediments to physical access, information and communication, and coordination) across all health care programmes, including those on sexual and reproductive health, mental health, health promotion and other population-based public health initiatives</td>
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<tr>
<td>• Include training on disability-inclusive health care in health care educational curriculums</td>
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<th>Target 1.2. By 2030, ensure that the right of persons with disabilities to health care is fully protected</th>
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<tr>
<td>• Develop and/or reform health and disability laws, policies, strategies and plans for consistency with the principles of the UNCRPD</td>
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<th>Target 1.3. By 2030, ensure that all persons with disabilities are fully covered by health insurance</th>
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<tr>
<td>• Introduce or review legislation ensuring that persons with disabilities, in all contexts, are fully covered by health insurance or appropriate social protection mechanisms</td>
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<tr>
<th>Target 1.4. By 2030, ensure that all persons with disabilities have access to the full range of appropriate rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation</th>
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<tr>
<td>• Provide leadership and governance for developing and strengthening policies, strategies and plans on habilitation, rehabilitation, assistive technology, support and assistance services, community-based rehabilitation, and related strategies</td>
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<tr>
<td>• Provide adequate financial resources to ensure the provision of appropriate habilitation and rehabilitation services, as well as assistive technologies</td>
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<tr>
<td>• Develop and maintain a sustainable workforce for rehabilitation and habilitation as part of a broader health strategy</td>
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<tr>
<td>• Expand and strengthen rehabilitation and habilitation services, ensuring (a) integration across the continuum of care, covering primary (including community), secondary and tertiary levels of the health care system, and (b) equitable access, including timely early intervention services for children with disabilities</td>
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<tr>
<td>• Make available appropriate assistive technologies that are safe, good quality and affordable</td>
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<tr>
<td>• Engage, support and build the capacity of persons with disabilities and their family members and/or informal carers to support independent living and full inclusion in the community</td>
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<th>Target 1.5. By 2030, eliminate direct and indirect costs that negatively affect access to health care</th>
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<tr>
<td>• Remove barriers to financing and affordability through options and measures to ensure that persons with disabilities can afford and receive the health care they need without impoverishing and catastrophic expenditures</td>
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Objective 2. Promote the health and well-being of persons with disabilities

28. Ensuring good health and well-being throughout the life course is essential for sustainable development and the building of prosperous societies. Studies have shown that wider health determinants – among others, poverty, inequality, life-course events, the built environment and public policies – shape not only people’s health but also their ability and resilience in facing health problems and seeking and accessing appropriate health care services. Well-being is generally associated with good health and the availability of and access to basic resources, and it is dependent on economic, social, gender, political,
behavioural and environmental determinants. Good community support networks (including family members, next of kin and/or carers) are also essential, as they provide support for persons with disabilities across the life course.

29. Evidence has shown that persons with disabilities are disadvantaged in accessing and using health care services and public health interventions and are at higher risk of poor health outcomes, such as obesity, hypertension, fall-related injuries, and mood disorders, including depression. The COVID-19 pandemic has exacerbated such inequities, with persons with disabilities experiencing a higher risk of morbidity and mortality, as well as a higher risk of poor mental health status.

30. It is therefore essential to ensure that all interventions aimed at promoting health and well-being are disability inclusive in order to address inequities in health outcomes and improve quality of life for persons with disabilities. At the individual level, public health programmes need to address risk factors for health – such as tobacco use, substance misuse and abuse, and unhealthy eating habits – and promote health literacy and healthy behaviour, including physical activity and preventive health examinations, as well as access to personal hygiene and devices to support it. At a community and societal level, interventions need to address economic, social, political and environmental factors that can have a direct impact on all aspects of life, including health and well-being. A Health-in-all-policies approach is needed. To realize this, intersectoral and multisectoral action – involving different disciplines and sectors, such as public health, housing, childcare, education, infrastructure and transport, as well as partners operating at multiple levels, including state, local and community levels – is needed to achieve health equity, foster social justice and promote the health and well-being of persons with disabilities.

31. Strategic priorities:
(a) Adopt an intersectoral and multisectoral approach to health that addresses social determinants of health, and promote healthy living and disability-inclusive living environments.
(b) Introduce and promote programmes, initiatives and health care services – including preventive health examinations, sexual and reproductive care, and mental health services – that promote the health and well-being of persons with disabilities.
(c) Address the health needs of persons with disabilities, across the life course and in all contexts, resulting from segregation and institutionalization, from neglect and abuse, and from violence, including physical, psychological and sexual violence.

Targets and action areas

<table>
<thead>
<tr>
<th>Target 2.1. By 2030, ensure that persons with disabilities have access to preventive health examinations</th>
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<tr>
<td>• Introduce evidence-based screening programmes and services that are disability inclusive</td>
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<tr>
<td>• Provide disability-inclusive health care training and specialized training for health professionals</td>
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<th>Target 2.2. By 2030, ensure that persons with disabilities have access to sexual and reproductive health care services, including family planning, information and education</th>
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<tr>
<td>• Introduce, strengthen and promote sexual and reproductive health care services, including health education, for persons with disabilities</td>
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<th>Target 2.3. By 2030, substantially strengthen intersectoral action for health</th>
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<tr>
<td>• Introduce, strengthen and promote intersectoral approaches to health</td>
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<th>Target 2.4. By 2030, reduce risks and threats to the health and well-being of persons with disabilities and offer protection from neglect, abuse and/or violence</th>
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<tr>
<td>• Introduce, develop and promote disability-inclusive well-being activities related to physical and mental health</td>
</tr>
<tr>
<td>• Introduce and/or strengthen relevant legislation and programmes aimed at protecting persons with disabilities against neglect, abuse and/or violence</td>
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3 For the complete list, please refer to the background document https://apps.who.int/iris/handle/10665/362016.
Objective 3. Ensure that all health policies and programming, as well as resilience-building and recovery plans during public health emergencies, are disability inclusive

32. The term “health emergencies” refers to a wide range of events, including pandemics, conflicts, and economic or other types of crises, such as climate change, that can pose a significant risk to people’s health. Health emergencies have a significant impact on persons with disabilities. Persons with disabilities often experience structural disadvantage and are thus more vulnerable than persons without disabilities to the effects of such emergencies. Vulnerability is not an inherent characteristic of people but rather, according to the Hyogo Framework for Action 2005–2015, can be defined as “the conditions determined by physical, social, economic and environmental factors or processes, which increase the susceptibility of a community to the impact of hazards”. Individuals experience health emergencies in different ways, depending on their specific vantage point and the resources they have access to within a larger social and cultural context.

33. Health emergencies exacerbate existing health inequities experienced by persons with disabilities and create new ones. Persons with disabilities can be particularly exposed to the risks of health emergencies, and to measures taken to address them, as observed during the COVID-19 pandemic. Health emergencies, such as pandemics, can have an impact on health workforce issues, on the accessibility of health-related information and health promotion programmes, on access to health services and interventions, and on the coordination of health care across sectors. Interrupted access to health care and to social support, as well as lack of emergency deinstitutionalization or accessible evacuation, shelters and communication during health emergencies can have a negative impact on the health and well-being of persons with disabilities. The UNCRPD needs to be upheld during health emergencies and to be seen as an integral element of the health emergency response. Disability-inclusive emergency response is closely linked to the strengthening of health systems.

34. Strategic priorities:
   (a) Strengthen health systems so that they are resilient to health emergencies.
   (b) Ensure that risk, disaster and emergency management fully addresses the needs of persons with disabilities so that they are fully protected during health emergencies.
   (c) Address the conditions, including those related to information, communication, segregation, physical environment and economic factors, that make persons with disabilities more vulnerable to the effects of health emergencies.

Targets and action areas

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<tr>
<th>Target 3.1. By 2030, strengthen or develop leadership and governance for disability-inclusive health emergency response</th>
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<tr>
<td>• Ensure appropriate leadership for disability-inclusive health emergency response, with active involvement of persons with disabilities and their organizations</td>
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<tr>
<th>Target 3.2. By 2030, ensure that all health emergency policies, initiatives, strategies and programmes are disability inclusive</th>
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<tbody>
<tr>
<td>• Ensure the development of appropriate disability-inclusive health emergency response</td>
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<tr>
<td>• Ensure active involvement of persons with disabilities and their organizations in all phases of health emergency risk management</td>
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Objective 4. Build an evidence base on disability and health

35. Data collection contributes to national, regional and global development efforts and poverty alleviation, as it provides the basis for decision-making and policy implementation. The availability of reliable data is crucial for monitoring progress, evaluating measures and promoting disability inclusion.

\[^{4}For the complete list, please refer to the background document https://apps.who.int/iris/handle/10665/362016.\]
Evidence-based disability research is also essential for strengthening health systems to include and address the needs of persons with disabilities.

36. However, international and national data-collection systems often do not collect data on disability, a fact that has become even more evident during the COVID-19 pandemic. Also, where available, disability-disaggregated data are not usually internationally comparable, as indicators may use the term “disability” in a variety of ways, leading to problems of data consistency and cross-country comparisons. Research in key priority areas, such as unmet needs for health care services, barriers to service delivery and level of health outcomes, including in rehabilitation, is further hindered by either a complete lack of data or a lack of good-quality and accessible data. As a result, disability research is relatively scarce, with great variability among Member States.

37. To ensure that persons with disabilities in the Region are not left behind, it is important to ensure the availability of accurate, relevant and internationally comparable disability-disaggregated data on health, produced through a variety of research designs and with an emphasis on participatory methods. Evidence-based disability research in key health priority areas can serve as the basis for eliminating disability discrimination, promoting disability inclusiveness in health care and health care systems, and adopting equitable and effective health policies across the Region.

38. Strategic priorities:
   (a) Ensure the collection of reliable disability-disaggregated data within national health information systems.
   (b) Ensure that data in censuses, population surveys and national health surveys are disaggregated by disability in order to be able to obtain reliable information on the socioeconomic status and health of persons with disabilities.
   (c) Support research that seeks to address and eliminate disability discrimination and empower persons with disabilities.
   (d) Support disability research by increasing funding, adopting a multidisciplinary approach and actively involving persons with disabilities and their organizations.

Targets and action areas

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<tr>
<th>Target 4.1. By 2030, ensure the collection of relevant, standardized and internationally comparable data on disability</th>
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<tr>
<td>• Ensure the availability and use of robust data-collection tools on disability</td>
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<tr>
<th>Target 4.2. By 2030, strengthen disability research</th>
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<tr>
<td>• Support, strengthen and promote disability research</td>
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Implementation and governance

39. Effective implementation at the national level will require strong political commitment to work towards a disability-inclusive health sector, including resource allocation, funding mechanisms, inclusion of persons with disabilities in all processes and the elaboration of detailed and measurable actions at all levels, from policy to service delivery, in order to reach national and regional targets.

40. Implementation of the framework will also require solid partnerships between organizations of persons with disabilities, Member States, WHO/Europe, academia, and national and international organizations, including the European Disability Forum, at the subregional and national level.

41. Effective implementation of the framework will be through national disability inclusion action plans, with clear strategies and mechanisms to accomplish national and regional targets. National action plans,

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For the complete list, please refer to the background document https://apps.who.int/iris/handle/10665/362016.
which will include clearly defined priority actions, timelines and resources, will be elaborated with the support of national, regional and international stakeholders, assisted by WHO/Europe.

42. WHO/Europe will support Member States in the development and implementation of national action plans that will promote disability-inclusive health policies (or in their further development, for Member States that have already established relevant action plans), with the aim of combating exclusion, promoting the rights of persons with disabilities, building resilient health systems and, ultimately, building healthier populations in the Region.

43. For the successful delivery of the framework, Member States will need to:
   (a) recognize the health inequities experienced by persons with disabilities;
   (b) include persons with disabilities and their organizations in all processes and decision-making; and
   (c) act, in partnership with persons with disabilities and their organizations, to implement the actions in this framework (see Fig. 2).

44. Actions are broadly divided into core strategic-level actions and operational-level actions, informed by a primary health approach. Core strategic-level actions refer to high-level actions and include governance, leadership, funding and community engagement. Operational-level actions refer to on-the-ground actions that support the strategic actions and include health care practices, training and accommodations. As Member States demonstrate great variability in terms of their health care systems, policy frameworks and health sector infrastructure (including governance and leadership, and operational-level infrastructure), the exact prioritization of the actions in this framework needs to be decided by each Member State, in consultation with persons with disabilities and their representative organizations. Organizations of persons with disabilities will play a key role in the implementation of targets and indicators and in the achievement of the goals of the framework, as they will work closely with Member States to protect the rights of persons with disabilities and to promote their inclusion and empowerment.

45. It is recommended that core strategic-level actions are implemented first to establish a robust policy framework, appropriate governance and leadership infrastructure and the availability of funding mechanisms. The elaboration of these actions, in close partnership with persons with disabilities and their representative organizations, will also lead to capacity-building in preparation for the operational-level actions. The complete set of actions can be found in the background document.

46. The implementation of the framework will be overseen by the WHO Regional Committee for Europe through consultations with an ad hoc high-level advisory group of independent experts from various domains, which will (a) advise Member States on implementation and offer technical assistance on the establishment of their own monitoring and evaluation framework at national and subnational levels; (b) advocate for political commitment and allocation of adequate financial resources to strengthen and sustain disability-inclusive health care across Member States; and (c) report to the WHO Regional Director for Europe at regular intervals regarding progress towards meeting the targets at the regional and subregional levels.
**Monitoring and evaluation framework**

47. Targets and indicators of success will act as measures of progress and drivers for policy action. The indicators are part of established international data collection, where possible, to reduce reporting burden. The targets and the indicators are aligned primarily with or developed through the following:

(a) The EPW Measurement Framework, from which relevant indicators have been adapted to address disability specifically. This ensures alignment with programmatic work by WHO/Europe, not only helping to mainstream disability inclusion in health care, but also raising awareness of the needs of a substantial part of the population of the Region.

(b) The WHO Global report on health equity for persons with disabilities (as decided by resolution WHA74.8 on the highest attainable standard of health for persons with disabilities, to be launched in December 2022), from which targets and indicators relevant to the European Region have been selected, and the WHO Global Disability Action Plan 2014–2021, which has been used to identify targets and indicators that are still relevant. This ensures that previous work is used and built on, where relevant.

(c) The elaboration of indicators relevant to the Region and to disability from appropriate Sustainable Development Goals (SDGs) (specifically SDG 3, SDG 5, SDG 16 and SDG 17), the WHO Global Reference List of 100 Core Health Indicators (2018), the UNCRPD, and the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025, to ensure the framework can directly contribute to the 2030 Agenda for Sustainable Development.

(d) The elaboration of new targets and indicators not included in the documents mentioned in (a), (b) and (c) above, or for which adequate data may not currently exist but which are nonetheless important. These targets and indicators need to be part of the agenda for WHO/Europe and Member States in the Region in order to be developed further in time for the midterm evaluation and to ensure that any existing data gaps are bridged.

48. Evaluation will require robust disability-disaggregated data. WHO/Europe will offer technical support at the national level and at the subregional level in liaison with the Central Asian Republics Information Network and the European Health Information Initiative. WHO/Europe will also support Member States’ national statistical offices in developing or strengthening their data-collection mechanisms to include disability. The full monitoring and evaluation framework can be found in the background document.

49. Member States will prepare a midterm (2026) and a final (2030) monitoring report. WHO/Europe will prepare a midterm report (including a mapping exercise and relevant case studies) to be submitted to the 76th session of the Regional Committee (2026), with a final report planned for submission at the 80th session (2030).