Mainstreaming Disability Inclusion in JICA Projects

Sector-Specific Guidance Note

Health

Japan International Cooperation Agency (JICA)
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Sections 1,2,3 provide an overview for those seeking to understand the basics, while Section 4 offers specific steps for mainstreaming disability inclusion.

Main Target Areas Covered by this Guidance Note

In line with the Japan International Cooperation Agency (JICA) Global Agenda for Health, this Guidance Note focuses on the following areas.

1. Strengthening Health Service Delivery	• Strengthening the health system components of "Governance and leadership," "Human resources," "Facilities and medical equipment," "Financial and health facility management," and "Health information."
2. Strengthening of Capacity for Infectious Disease Control and Testing	• Construction/expansion/enhancement of infectious disease testing and research institutes, development of specialized human resources. • Strengthening early detection of infected individuals, contact tracing, etc.
3. Strengthening Quality Continuum of Care for Maternal, Newborn and Child Health including the effective use of Maternal and Child Health Handbooks	• Strengthening systems to provide quality services continuously. • Promoting the use of home-based records for maternal and child health, including maternal and child health handbooks.
4. Financial Protection in Health	• Development and improvement of health financing systems: policy and institutional advice, linkage with service provision, financial support.

For *shokuiku* (food and nutrition education) and school meals, please also refer to the Guidance Note for the Nutrition Sector. For social insurance schemes other than health financing (health insurance) —including pensions, employment insurance, and workers' accident compensation insurance—please also refer to the Guidance Note for the Social Protection Sector.

1. Basic Understanding of Persons with Disabilities and Health

This section explains the fundamental concepts essential for promoting disability inclusion in the health sector.

(1) Disability-Inclusive Health Systems

- Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD) stipulates that "States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability", which constitutes the fundamental principle of disability inclusion in health.
- Traditional health systems have been centered on a medical model that views persons with disabilities as "subjects of treatment or medical intervention." In contrast, the human rights model grounded in the CRPD positions persons with disabilities as subjects with rights-holders, requiring equal access to health services and participation in decision-making processes.
- A disability-inclusive health system is one in which persons with disabilities can receive health services of the same quality, scope, and standard as persons without disabilities, with reasonable accommodation is provided according to individual needs. In addition, mechanisms that enable persons with disabilities to participate in service design and policy decision-making are essential components.

(2) Universal Health Coverage (UHC) and Persons with Disabilities

- Universal health coverage (UHC) refers to "ensuring that all people receive adequate quality health services when they need them without suffering financial hardship." The term "all people" explicitly includes persons with disabilities.
- Persons with disabilities face specific challenges across all three dimensions of UHC: population coverage, service coverage, and direct costs [1]:
  - **Population coverage**: When disability-inclusive systems are insufficient, persons with disabilities risk being excluded, even if they are officially listed as target populations.
  - **Service coverage**: Persons with disabilities often have greater health needs and require specialized services such as rehabilitation. However, barriers such as limited accessibility and gaps in health workers' knowledge and skills can prevent them from receiving appropriate services.

  - **Direct costs**: Additional expenses, such as transportation and personal assistance, are not publicly covered alongside medical costs, increasing the financial burden on persons with disabilities and their families.

- Ensuring timely and appropriate access to quality health services for the world's 1.3 billion persons with disabilities is essential to achieving UHC.

(3) Achieving UHC and Disability-Inclusive Health Systems

- To make the concept of UHC a reality, inclusive mechanisms that ensure persons with disabilities are not excluded are essential.
- A disability-inclusive health system forms the foundation for achieving UHC. By addressing the needs of persons with disabilities, health services become more accessible, equitable, and of higher quality for everyone, thereby strengthening both the quality and equity of UHC.

2. Significance of Disability Inclusion in Health

(1) Contribution to the Achievement of the Sustainable Development Goals (SDGs)

- Disability inclusion in the health sector is essential for achieving the Sustainable Development Goals (SDGs). It directly contributes to Goal 3: "Ensure healthy lives and promote well-being for all at all ages", as well as to Goal 1 (poverty eradication), Goal 5 (gender equality), and Goal 10 (reducing inequalities).
- Specifically, Target 3.8 under Goal 3 (Health) highlights the importance of ensuring that all people—including persons with disabilities—have access to quality health services.

Target 3.8	Achieve universal health coverage (UHC), including financial risk protection, access to quality essential health services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

(2) Implementation of the Convention on the Rights of Persons with Disabilities (CRPD) [2]

- The Convention on the Rights of Persons with Disabilities (CRPD) underscores the crucial role of health systems and initiatives in enabling persons with disabilities to enjoy health throughout their lives and access quality health services.
- Article 25 (Health) specifies that States Parties have an obligation to ensure that persons with disabilities enjoy the highest attainable standard of health, without discrimination based on disability, encompassing a comprehensive concept of health.
- Additionally, Article 23 (Respect for Home and the Family) stipulates that persons with disabilities have rights to access information and education on reproduction and childbearing, and to receive appropriate assistance in child-rearing.
- The CRPD comprehensively guarantees the health-related rights of persons with disabilities, centered on the right to health under Article 25, and supported by interrelated provisions (including Articles 9, 12, 23, and 26). Accordingly, States Parties are required to undertake continuous, rights-based efforts to ensure both access to and quality of health for persons with disabilities.

(3) Contribution to JICA Global Agenda

- The JICA Global Agenda for Health aims to “achieve more resilient, equitable, and sustainable universal health coverage (UHC) by strengthening national health systems, including strengthening prevention, preparedness and response to public health crises during peacetime” [3].
- Ensuring access to health services for persons with disabilities is essential for building an equitable health system. By integrating a disability perspective across all four clusters of the JICA Global Agenda for Health, it can help achieve truly sustainable UHC that leaves no one behind.

(4) UN Political Declaration on UHC (UHC High-Level Meeting) (2019)

- The 2019 United Nations (UN) Political Declaration on UHC recognizes that persons with disabilities—who constitute 15% of the world's population—continue to have unmet health needs. It calls on countries to improve access to health services for persons with disabilities by removing physical, attitudinal, social, structural, and financial barriers, providing quality care standards, and promoting empowerment and inclusion. The declaration also emphasizes the development of disability-sensitive interventions and training that address the specific needs of persons with

disabilities, aiming to build an inclusive health system that leaves no one behind by 2030 [4].

(5) Adoption of Resolution EB148.R6 "The Highest Attainable Standard of Health for Persons with Disabilities" at the 74th World Health Assembly (2021)

- Resolution EB148.R6, “The Highest Attainable Standard of Health for Persons with Disabilities”, adopted at the 74th World Health Assembly, aims to address the significant barriers faced by persons with disabilities and promote a more inclusive health sector. The resolution focuses on three priority areas [5].
  - **Access to effective health services**: Remove physical, informational, and attitudinal barriers to ensure persons with disabilities can receive appropriate services.
  - **Protection during health crises**: Address the disproportionate impact of public health emergencies, such as the coronavirus disease 2019 (COVID-19), on persons with disabilities.
  - **Access to cross-sectoral public health interventions**: Develop interventions that are responsive to the needs of persons with disabilities.

3. Challenges in the Health Sector from a Disability Perspective

(1) Health Inequities Faced by Persons with Disabilities

- Persons with disabilities experience significant health inequities compared with persons without disabilities. These inequities are evident in the following three aspects [6]:
  - **Increased risk of premature death**: Persons with disabilities are at a higher risk of dying prematurely—up to 20 years earlier—than persons without disabilities.
  - **Higher incidence and severity of specific diseases**: Persons with disabilities are more vulnerable to mental health challenges and nutrition-related problems, such as malnutrition, and face a higher risk of serious maternal complications. In addition, health conditions that coexist with disabilities are often overlooked by health workers, which can lead to further deterioration of health.
  - **Deterioration of overall health status**: Barriers such as difficulties in accessing and using health services, economic constraints, and communication challenges interact to worsen the overall health status of persons with disabilities compared with persons without disabilities.
- A significant proportion of these disparities cannot be attributed to underlying health conditions or impairments. Rather, they arise from avoidable and unjust social and environmental factors. As such, they constitute "health inequities" that obstruct the realization of the right to the "highest attainable standard of health" as guaranteed under Article 25 of the CRPD [6].

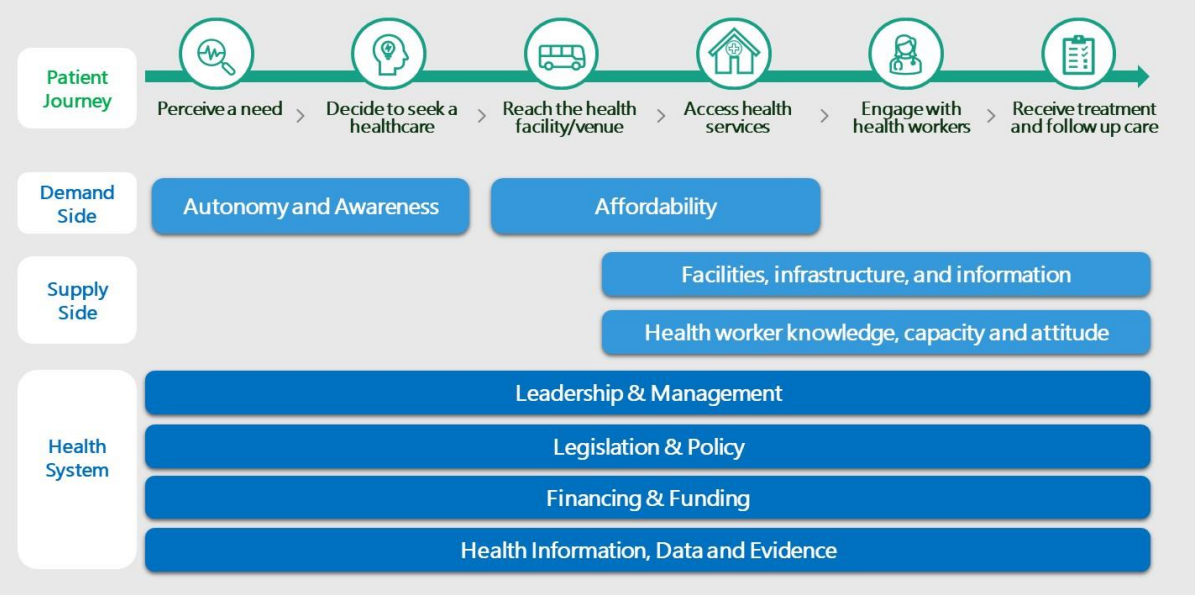
(2) Inequalities in the Use of Health Services

- In addition to health inequities, persons with disabilities face significant inequalities in health service utilization, limiting their ability to receive the health services they need. Key areas of inequality include [6]:
  - **Unmet health needs**: Many persons with disabilities experience unmet health needs due to high medical costs, lack of physical accessibility, limited knowledge among health workers, and discriminatory attitudes.
  - **Difficulty accessing specialized medical care**: Obtaining rehabilitation services, mental health care, and specialist referrals is often challenging.

- **Loss of preventive health opportunities**: Rates of preventive health service utilization, such as health examinations and vaccinations, are lower among persons with disabilities.

- When considering access to health services, the patient journey perspective is important. This perspective recognizes that access is not a single event but a continuum of stages that individuals must navigate, beginning with the recognition of a health need and extending through service utilization and follow-up care. As shown in the figure below, persons with disabilities encounter multiple barriers at each stage of this journey.

Figure: Barriers to Accessing Health Services

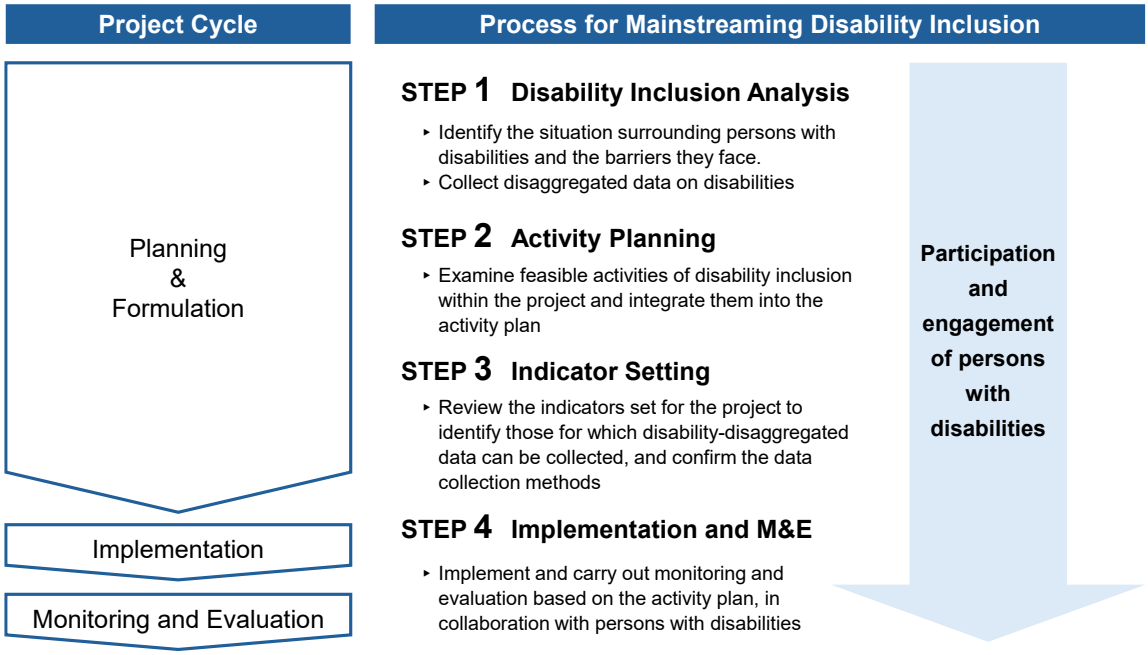


Source: Adopted from [7]

4. How to Mainstream Disability Inclusion in Projects: Steps for Implementation

- Mainstreaming disability inclusion in projects means incorporating and implementing a disability perspective at all stages of project planning, implementation, monitoring, and evaluation. This Guidance Note introduces methods for mainstreaming disability inclusion in the 4 STEPs as shown in the figure below.
- STEPs 1-3 correspond to the project formulation stage of the project cycle, and STEP 4 to the implementation and post-completion stage. While keeping all STEPs through project completion in mind, it is particularly important to work on disability inclusion at **the project formulation stage**.
- At the stage of obtaining the Official Request Letter from the partner government, it is important to consult with counterparts and the JICA local office to ensure that efforts for disability inclusion are included and that there is no risk of excluding persons with disabilities.

Figure: Process for Mainstreaming Disability Inclusion in Projects



- The table below shows when each STEP applies within the project cycles for technical cooperation, official development assistance (ODA) loans, and grant aid.

Scheme	Project Cycle	STEP
Technical Cooperation	At the time of preparing the Terms of Reference (TOR) for the data collection survey, and detailed or basic planning survey.	STEP 1（Analysis）
	At the time of drafting Main Point Discussed in the Record of Discussion (R/D) (activities related to disability inclusion), PDM, and Ex-ante Evaluation document.	STEP 2（Activity Planning） STEP 3（Indicator Setting）
	At the time of preparing the TOR of the project, implementing the project, and reviewing a monitoring sheet.	STEP 4（Implementation, Monitoring & Evaluation）
ODA Loans	At the time of preparing the TOR for the data collection survey and preparatory survey, and drafting Project Planning Document (1).	STEP 1（Analysis）
	At the time of preparing the Minutes of Discussion (M/D), Project Planning Document (2)/(3), appraisal document, and drafting Ex-ante Evaluation document.	STEP 2（Activity Planning） STEP 3（Indicator Setting）
	At the time of supervising the project and reviewing Project Status Report.	STEP 4（Implementation, Monitoring & Evaluation）
Grant Aid	At the time of preparing the TOR for the data collection survey and Preparatory Survey, and drafting Project Planning Document (1).	STEP 1（Analysis）
	At the time of preparing the Minutes of Discussion (M/D), Project Planning Document (2)/(3), appraisal document, and drafting Ex-ante Evaluation document.	STEP 2（Activity Planning） STEP 3（Indicator Setting）
	At the time of supervising the project and reviewing Project Status Report.	STEP 4（Implementation, Monitoring & Evaluation）

STEP 1 Disability Inclusion Analysis

- During project planning and formulation, conduct a disability inclusion analysis to assess the situation of persons with disabilities within the sector and identify the barriers they face. Additionally, collect disability-disaggregated data on the target groups.
- Use the disability inclusion analysis to ensure that the project design does not pose any risk of excluding persons with disabilities, or create disadvantages or negative impacts for them. Carefully review and confirm these aspects throughout the planning process.

> **JICA Country-Specific Disability-Related Information** (currently available in Japanese language only) contains disability-related information for each of the 55 countries where JICA implements projects. If information exists for the target country, it is recommended to check it first.
>
> As an English-language information source, the World Bank Group's Disability Data Hub provides country-specific data.

1) Reflect: The relationship between the project and disability

- Clearly define how disability intersects with the project. Identify the components of the project that have the strongest relevance to persons with disabilities.

2) Ask: Consult with persons with disabilities or their representative organizations to understand the barriers they encounter

- Engage and consult with persons with disabilities and/or their representative organizations about the kind of barriers that prevent access to and participation in health programs and services targeted by the project. Make sure to seek input from a wide range of individuals, including persons with diverse types of disabilities and women with disabilities.
- Then, request their participation in STEPs 2-4 described in the following sections. **It is crucial to involve persons with disabilities at all stages.**

CHECK

Including methods for engaging organizations of persons with disabilities, the **Guidance Note for Across All Thematic Areas** introduces the following under "Section 4: Specific Approaches for Mainstreaming Disability Inclusion."

- Methods for Engaging with Persons with Disabilities
- Forms of Participation of Persons with Disabilities
- General Accessibility Measures and Reasonable Accommodations
- Information and Communication Accessibility
- Inclusive Events (Meetings, Seminars, Training, etc.)

- Below are sample questions. Additionally, please refer to Appendix 1 for examples of barriers.

Barriers	Example Questions
Institutional Barriers	• What barriers exist in the current health system and health service delivery systems that prevent participation of persons with disabilities? (For example, national health policies or strategic plans do not explicitly mention access for persons with disabilities)
Physical Barriers	• What barriers prevent access to health facilities? • What physical barriers exist within the buildings of health facilities (hospitals, etc.)? (For example, no ramps installed or no wheelchair-accessible toilets installed.)
Communication Barriers	• What barriers exist when individuals cannot access necessary information about health services?
Attitudinal Barriers	• What attitudes and awareness of health service providers and stakeholders prevent program participation and service access?

3) Check: Collection of disability-disaggregated data[1]

Data	Information Sources
• Disability-disaggregated data of target groups in project target areas • Data on groups marginalized from health services and programs (women with disabilities, specific ethnicities, children with disabilities, etc.)	• Government statistics • Reports from ministries and agencies related to persons with disabilities, etc. • Interviews with persons with disabilities and their representative organizations

4) Explore：Situation of persons with disabilities within the sector

Key Information to Identify	Information Sources
• Existence of content addressing persons with disabilities or disability inclusion perspectives in health laws, policies, strategies, action plans, etc. • Existence of disability inclusion policies and strategies in the health sector	• Government documents
• Descriptions related to Article 25 in CRPD Concluding Observations	• CRPD Concluding Observations * On the search page of the CRPD (States Parties Reporting), specify the country and the type of document.
Stakeholders: Resources and Partners for Implementation • Ministries and departments responsible for persons with disabilities • Organizations of persons with disabilities • JICA's experience in disability and development (technical cooperation, JOCV, grassroots projects, etc.) • International and bilateral agencies with experience related to mainstreaming disability inclusion in the health sector	• JICA Country-Specific Disability-Related Information (currently available in Japanese only) • World Bank Group | Disability Data Hub >> Economies

[1] Data disaggregated by disability status and type of functional limitation, comparable to sex- and age-disaggregated data.

STEP 2 Activity Planning
(see Appendix 2 for Examples of Good Practice Examples)

- Based on the situation and barriers faced by persons with disabilities in the sector identified through the disability inclusion analysis in STEP 1, consider feasible activities within the project and incorporate them into the activity plan.
- Furthermore, when planning the overall project, ensure that the project's objectives and plans promote the inclusion and participation of persons with disabilities and do not promote their segregation or exclusion.

Examples of Activities to Promote Disability Inclusion

Note: Priority and feasible activities should be determined through consultation with stakeholders, including persons with disabilities and their representative organizations of persons with disabilities.

Barriers	Example Activities
Institutional Barriers	• Include the status, needs, and countermeasures for disability and persons with disabilities in national health policies and plans. • Allocate budgets for ensuring accessibility for persons with disabilities and additional costs required for applications and procedures. • Develop disability statistics disaggregated by age, gender, and socioeconomic indicators.
Physical Barriers	• Make health facilities barrier-free (including medical equipment such as weight and height scales) • Expand health services at community level (e.g., enabling home-based services for persons with severe disabilities who have difficulty going out, information provision at community level) • Expand online health services (accessible design according to disability type, support for caregivers/families regarding equipment use, etc.)
Communication Barriers	• Provide information in accessible formats (Braille, audio narration, videos with subtitles or sign language interpretation, easy-to-understand expressions using illustrations, etc.) • Provide information through diverse means (written materials, websites, radio, information provided through organizations of persons with disabilities, outreach by healthcare workers, etc.)
Attitudinal Barriers	• Implement training on human rights and disability for health program stakeholders, healthcare workers, etc. (rights of persons with disabilities, principles of inclusion, methods of non-discriminatory and accessible service provision, etc.)

Source: Developed based on [8] [9], etc.

STEP 3 Indicator Setting

- Among the indicators set for the project (indicators for project purpose and outputs), review which indicators can collect disability-disaggregated data and confirm the data collection methods.

Example:
If "facilities and equipment for appropriate health service provision are developed or improved" is set as a project output indicator,
Set "number of people who received health services at developed/improved facilities (disaggregated by presence of disability and disability type)" as disability-disaggregated data.

- Also, consider indicators to measure outputs (changes) expected from activities planned in STEP 2, and integrate them into existing indicators or add them. Below are examples of indicators incorporating a disability perspective.

Example Indicators
- Whether consultation with persons with disabilities was conducted during the development process of policy document (systems, strategies, guidelines, etc.); overview of consultation, if conducted - Existence or number of policy documents reflecting disability perspectives (e.g., ensuring accessibility for persons with disabilities, budget allocation for additional costs for access, etc.) - Number of human resources for health who have received training on human rights and disability - Number of countries that have newly introduced or updated their health information systems (of which the number of countries that have introduced systems to analyze access by persons with disabilities) - Number of trained personnel or countries in the use of health information data (of which the number of trained personnel or countries implementing data analysis on access by persons with disabilities)

STEP 4 Implementation and Monitoring and & Evaluation

- When implementing and monitoring activities, collaborate with persons with disabilities (and/or organizations of persons with disabilities) to confirm whether activity content is appropriate, and whether activities, deliverables, and services being implemented are accessible and user-friendly.
- Also, pay close attention to whether the promotion and implementation of project activities respect the diversity of persons with disabilities and are conducted in a manner that promotes their dignity, rights, and potential.
- During evaluation, assess the achievements of activities from a disability inclusion perspective, their implementation process, and outcomes. Below are sample questions designed from a disability inclusion perspective.

Guiding Questions from a Disability Inclusion Perspective

Six Evaluation Criteria	Sample Questions
Relevance	**Counterpart Country's Development Policies and Needs** • Do disability inclusion activities align with priority issues and contents stated in the counterpart country's disability policy or sector policy? **Appropriateness of Project Plan and Approaches** • Was mainstreaming of disability inclusion considered during project formulation? • Was information collected from persons with disabilities and organizations of persons with disabilities during project formulation? • Was participation of persons with disabilities promoted in the project implementation process? • Were methods employed to avoid excluding specific types of disabilities or specific groups of persons with disabilities (e.g., women with disabilities, ethnic minorities, or other minorities)?
Coherence	**Consistency with Japanese Government/JICA Development Cooperation Policies and Coordination with Other JICA Projects** • Were disability inclusion activities consistent with Japanese government and JICA policies? • Was coordination with other JICA projects undertaken to promote disability inclusion activities? **Coordination with International Frameworks** • Was the project consistent with the CRPD? • Did disability inclusion activities contribute to achieving global goals such as SDGs?

Six Evaluation Criteria	Sample Questions
Effectiveness	• To what extent were outcomes achieved for persons with disabilities through disability inclusion activities? • Did disability inclusion activities contribute to achieving project purpose and outputs?
Impact	• Can positive long-term or indirect effects be expected from disability inclusion activities? For example, fostering leadership of persons with disabilities, participation of persons with disabilities in decision-making processes, and institutional reforms. • Have any negative indirect effects emerged because disability inclusion activities were not implemented or because disability inclusion analysis was insufficient? For example, exacerbating discrimination or stigma against persons with disabilities.
Efficiency	• Were disability inclusion activities conducted within the planned budget and timeframe? • Was project efficiency being prioritized at the expense of excluding specific groups such as persons with disabilities?
Sustainability	• Will persons with disabilities and their representative organizations continue to be involved in the disability inclusion process? • Is continuation of outcomes achieved for persons with disabilities appropriately planned? • Will the services and systems established in the project continue to be expanded and maintained in a manner that ensures equality and participation of persons with disabilities?

Appendix 1: Barriers to Access and Participation for Persons with Disabilities in Health

Persons with disabilities face multiple barriers, including institutional, physical (environmental), communication, or attitudinal barriers such as negative attitudes, discrimination, and limited understanding. These barriers often interact and vary by context, creating complex challenges. As a result, addressing the needs of persons with disabilities requires multifaceted approaches that integrate multiple strategies, alongside responses tailored to individual needs.

Main Barriers Preventing Access to Health Services for Persons with Disabilities and Examples

Barriers	Examples
1. Demand Side (Service Users)	
Autonomy and Awareness	• Lack of information or delayed recognition regarding one's own health conditions and necessary services • Hesitation to go to health facilities due to past experiences (discriminatory treatment, refusal of services, etc.)
Affordability	• Out-of-pocket health expenses beyond medical costs, such as transportation fees, interpretation fees, and assistance fees incurred when using services
2. Supply Side (Service Providers)	
Knowledge, Capacity, and Attitude	• Insufficient content on disability in the training of health workers • Prejudice and discriminatory attitudes, invasion of privacy
Facilities, Infrastructure, and Information	• Insufficient physical accessibility of health facilities (buildings, rooms, equipment, toilets, etc.) • Limited information in formats accessible to different types of disabilities (Braille, sign language, etc.)
3. Health System	
Leadership and Management	• In many health ministries, there are no departments or staff responsible for disability inclusion, and there are few opportunities and mechanisms to incorporate the voices of persons with disabilities, resulting in the actual needs not being understood
Legislation and Policies	• While many countries have ratified the CRPD, the rights and obligations under Article 25 (Health) are not being fulfilled. There is insufficient "participation of persons with disabilities" in implementing legal regulations and policies to protect the right of persons with disabilities to receive health care and to realize health sector policies • Limited opportunities for persons with disabilities and organizations of persons with disabilities to participate in the formulation and evaluation processes of national health policies

Barriers	Examples
	and plans, and access to health care for persons with disabilities is not specifically mentioned
Financing and Funding	• Budgets allocated by health ministries are often insufficient to address barriers to health service access
Health Information, Data, and Evidence	• Limited data on disability, resulting in low priority • Insufficient evidence on effective interventions for disability-inclusive development

Within JICA's health sector initiatives under the four clusters of the Global Agenda, persons with disabilities are expected to encounter a wide range of barriers. These barriers vary by cluster and context, and examples anticipated under each cluster are outlined below.

(1) Strengthening Health Service Delivery Cluster

Barriers faced by persons with disabilities within the Strengthening Health Service Delivery Cluster exist systematically across all components of the health system. These barriers are interrelated, creating complex obstacles to accessing health services for persons with disabilities.

Examples of Barriers in the Strengthening Health Service Delivery Cluster

Health System	Examples
Governance and Leadership	• **Exclusion from policies and planning**: Health needs of persons with disabilities are not explicitly mentioned in national health policies and strategic plans • **Absence of specialized departments**: In many health ministries, there are no departments or staff responsible for disability • **Exclusion from decision-making processes**: Limited opportunities for persons with disabilities and organizations of persons with disabilities to participate in the formulation and evaluation of national health policies and plans
Human Resources	• **Insufficient disability understanding in basic education**: Insufficient content on disability in the basic education curriculum for health workers • **Lack of continuing education**: Few training opportunities on disability for current health workers • **Shortage of specialized human resources**: Absolute shortage of specialized human resources such as sign language interpreters and assistive technology specialists • **Attitudinal barriers**: Deep-rooted prejudice and discriminatory attitudes toward disability among health workers

Health System	Examples
Facilities and Medical Equipment	• **Lack of physical accessibility**: Problems with steps, space in building entrances, corridors, examination rooms, and toilets; lack of elevators, handrails, and facilities for persons with visual and hearing impairments; lack of height adjustment function for examination tables and medical equipment • **Inadequate information accessibility**: Insufficient information provision in accessible formats such as Braille, audio, sign language, easy-to-understand language and figures/pictures; inadequate accessibility of digital information • **Shortage of assistive devices and technology**: Shortage of transfer lifts, communication support equipment, etc.
Financial and Health Facility Management	• **Insufficient consideration for additional costs**: Insufficient consideration for additional costs (interpretation fees, transportation fees, assistance fees, etc.) necessary when persons with disabilities use health services • **Lack of inclusion in quality management**: Disability considerations and satisfaction are not included in health quality assessment indicators • **Unequal resource allocation**: Insufficient budget allocation to address the needs of persons with disabilities
Health Information	• **Lack of data collection:** Insufficient data collection and analysis regarding health status, health service utilization, and outcomes of persons with disabilities • **Inadequate classification and analysis:** Inability to conduct detailed analysis by disability type and severity • **Lack of evidence:** Limited research and evidence on effective intervention methods

Source: Developed based on [10], [6], [7], etc.

(2) Strengthening of Capacity for Infectious Disease Control and Testing Cluster

Barriers occur at every stage of the infectious disease surveillance loop, from detection to response evaluation. When the characteristics and needs of persons with disabilities are not adequately considered at each stage, their vulnerability during infectious disease outbreaks increases.

Examples of Barriers to the Strengthening of Capacity for Infectious Disease Control and Testing Cluster

Approach/ Surveillance Loop	Immediate Outcomes	Examples of Barriers
Detection	• Capacity to rapidly detect infectious disease outbreaks at the community and primary health care level is strengthened • Laboratories are equipped with testing capabilities • Systems of cooperation among laboratories have been established	• **Inadequate information accessibility**: Insufficient information provision through sign language interpretation, subtitles, easy-to-understand language, and digital divide-based information gaps • **Inadequate access to testing**: Physical accessibility problems at testing facilities, lack of reasonable accommodation in testing procedure
Reporting	• Systems are in place to ensure that infectious disease data and information are reported promptly and appropriately.	• **Exclusion from reporting systems**: Infection status of persons with disabilities is not appropriately reflected in reporting systems • **Inadequate data collection**: Detailed data such as infection rates, severity rates, and mortality rates by disability type are not collected • **Delayed information sharing**: Inadequate information sharing systems with disability support organizations and health facilities, or delayed timing of information sharing
Analysis and Interpretation	• Systems are developed to promptly and appropriately analyze and interpret infectious disease data and information, and capacity is strengthened	• **Inadequate data analysis**: Detailed data such as infection rates, severity rates, and mortality rates by disability type are not analyzed

Approach/ Surveillance Loop	Immediate Outcomes	Examples of Barriers
Response and Evaluation	• Response to serious infectious disease outbreaks, monitoring, and evaluation are conducted	• **Insufficient inclusion in response plans**: Special needs of persons with disabilities are not considered in infectious disease response plans • **Inadequate feedback mechanisms**: Lack of mechanisms to collect response evaluations and improvement proposals from persons with disabilities

Source: Developed based on [11], [6], [7], etc.

(3) Strengthening Quality Continuum of Care for Maternal, Newborn, and Child Health (MNCH) including the effective use of Maternal and Child Health Handbooks Cluster

In the MNCH cluster, persons with disabilities face diverse barriers. Across every stage of continuous care—from pregnancy to early childhood—it is essential to establish disability-inclusive support systems that address the service provision side, the beneficiary side, and multisectoral collaboration.

Examples of Barriers in the MNCH Cluster

Areas	Examples of Barriers
Service Provider Side	
Governance and Leadership	• **Exclusion of persons with disabilities from maternal and child health policies**: Special needs of mothers and children with disabilities are not considered in maternal and child health policies and strategies • **Inadequate planning for maternal and child health services**: Lack of specific plans and guidelines regarding pregnancy, childbirth, and childcare support for women with disabilities

Areas	Examples of Barriers
Human Resources	• **Insufficient understanding among maternal and child health workers**: Insufficient knowledge about disability in basic education and continuing education for midwives, obstetricians, pediatricians, and public health nurses • **Lack of communication support skills**: Insufficient opportunities to acquire sign language, visual communication, easy-to-understand explanation techniques, etc. • **Prejudice against mothers with disabilities**: Discriminatory attitudes and prejudice among health workers • **Shortage of specialized human resources**: Absolute shortage of health workers who can provide specialized support to pregnant women and mothers and children with disabilities
Facilities and Medical Equipment	• **Inadequate accessibility of obstetric and pediatric facilities**: Lack of height adjustment function for obstetric examination tables, difficulty accessing delivery rooms by wheelchair, inadequate newborn care equipment • **Insufficient accessibility of maternal and child health handbook and other information**: Undeveloped maternal and child health handbooks and guidance materials in Braille, audio, visual displays, and easy-to-understand language • **Inadequate mechanisms for independent record management in maternal and child health handbooks**: Inadequate mechanisms (e.g., audio input using apps, space for writing in Braille, binder format for record management) for persons with disabilities to write and manage records themselves • **Shortage of assistive devices and support equipment**: Shortage of breastfeeding support equipment, transfer equipment, and childcare assistive devices, for mothers with disabilities • **Inappropriate emergency response equipment**: Inadequately designed medical equipment that does not adequately consider persons with disabilities in emergency cesarean sections, neonatal resuscitation, etc.
Health Finance	• **Insufficient consideration for additional care costs:** Insufficient budgetary measures for additional medical expenses and support costs necessary for pregnancy, childbirth, and childcare of mothers with disabilities • **Inadequate budget for procuring support technology and equipment:** Inadequate budget allocation for procuring medical equipment and communication support equipment for persons with disabilities • **Underestimation of long-term continuous care costs:** Inadequate estimation of continuous medical and childcare costs for children with disabilities

Areas	Examples of Barriers
Health Information	• **-Lack of disability-specific maternal and child health data:** Undeveloped data collection and analysis systems by disability type and severity regarding pregnancy, childbirth, and childcare • **Inadequate maternal and child health handbook records:** Inappropriate recording items and formats for health information, developmental information, and support needs related to disabilities • **Weak evidence base:** Insufficient accumulation of research and evidence on effective support methods for mothers and children with disabilities
Service User Side	
Women, Families, and Community Participation	• **Restriction of self-determination rights of women with disabilities:** Excessive intervention by families and communities in decision-making regarding pregnancy, childbirth, and childcare of women with disabilities • **Social prejudice and discrimination:** Prejudice and discriminatory attitudes in communities such as "persons with disabilities should not have children" • **Insufficient family support capacity:** Insufficient knowledge and skills among families regarding appropriate support methods for mothers with disabilities and children with disabilities • **Inadequate peer support systems:** Undeveloped experience-sharing and mutual support networks among mothers with disabilities
Multisectoral	
Food, Gender, Water and Sanitation, Infrastructure, Digital Solutions, Education, etc.	• **Inappropriate nutrition support:** Insufficient nutrition guidance and support for pregnant women, mothers, and children considering disability characteristics • **Access barriers to transportation and mobility:** Inadequate transportation means and road infrastructure when mothers with disabilities access health facilities • **Insufficient linkage with educational institutions:** Undeveloped cooperation systems between health and education sectors in early detection and early intervention for children with disabilities, etc.

Source: Developed based on [12], [6], [7], etc.

(4) Financial Protection in Health Cluster

Problems related to disability in health financing systems occur at each stage of the three health financing functions—revenue raising, pooling, and purchasing. Despite having higher health needs than the general population, persons with disabilities face a high risk of catastrophic health expenditure and encounter complex barriers ranging from system design to day-to-day operation.

Examples of Barriers in the Financial Protection in Health Cluster

Health Financing Functions	Immediate Outcomes	Examples of Barriers
Revenue Raising	• A medium- to long-term plan for securing public health financing is developed. • Target populations for health financing systems (especially the poor and vulnerable) are identified. • Taxes and health insurance premiums are collected according to income and assets.	• **Exclusion from health financing plans**: Health needs and additional costs associated with persons with disabilities are not systematically incorporated into medium- to long-term health financing plans. • **Underestimation of disability-related health costs**: Additional health needs (rehabilitation, prostheses, etc.) of persons with disabilities are not appropriately estimated in health financing plans. • **Unfairness in tax and premium collection**: Uniform health insurance premium structure does not consider employment limitations due to disability, exemption systems are inadequately implemented.
Pooling	• Excessively fragmented health financial resource pools are consolidated.	• **Disparities due to system fragmentation**: Exclusion of many persons with disabilities from formal sector systems, low coverage rates in informal sectors. • **Undeveloped pools for persons with disabilities**: Absence of independent risk pools targeting persons with disabilities or resource reallocation mechanisms considering high health needs of persons with disabilities. • **Unfair resource reallocation**: Absence of resource allocation mechanisms considering the high health needs of persons with disabilities.

Health Financing Functions	Immediate Outcomes	Examples of Barriers
Purchasing	• Health services (benefit packages) are determined based on population needs and cost-effectiveness within budget. • Incentives are set for health facilities to provide quality services efficiently.	• **Inappropriate benefit packages**: Exclusion of essential services such as rehabilitation, assistive technology, and mental health services. • **Discrimination in health technology assessment**: Underestimation of quality of life (QOL) of persons with disabilities in cost-effectiveness analysis. • **Inappropriate reimbursement setting**: Appropriate reimbursement for additional time necessary for medical care for persons with disabilities (communication support, transfer assistance, etc.) is not set. • **Inadequate quality accreditation systems**: Accessibility and reasonable accommodation requirements are not included in health facility accreditation standards.

Source: Developed based on [13], [6], [7], etc.

Appendix 2: Examples of Good Practices in Mainstreaming Disability Inclusion in Health

(1) The World Bank: Consultation and Collaboration with Persons with Disabilities in the COVID-19 Emergency Response Project[2] (Philippines COVID-19 Emergency Response Project) (Philippines) [8]

During the COVID-19 pandemic, the World Bank's response in the Philippines emphasized the inclusion of persons with disabilities by actively seeking their input and consultation. Throughout the project cycle, persons with disabilities were recognized as a key stakeholder group, and systematic consultations with organizations of persons with disabilities were conducted.

This case highlights the critical importance of involving persons with disabilities in emergency response planning. It also demonstrates that short-term crisis response can catalyze long-term policy improvements, making it a good practice example of disability inclusion in the health sector.

- **Consultation and Collaboration with Persons with Disabilities in COVID-19 Response**
  - Positioned persons with disabilities as important stakeholders throughout the project.
  - Actively conducted consultations with organizations of persons with disabilities.
- **Specific Initiatives**
  - Through the Environmental and Social Management Framework, identified barriers to access to COVID-19-related information and barriers at hospitals for persons with disabilities.
  - Developed countermeasures such as additional training for health workers, clear indication of accessible service provision locations, and additional assessments for accessibility improvements.
  - Included disability indicators in the COVID-19 household survey to enable disaggregated data analysis.
- **Long-term Impact**
  - Through collaboration in this project, demonstrated the potential for inclusion in health projects beyond COVID-19 response.
  - The government's health facility assessment surveys for vulnerable groups now includes persons with disabilities.
  - An action plan for improving the health of persons with disabilities is scheduled to be formulated based on survey results.

[2] https://projects.worldbank.org/en/projects-operations/project-detail/P173877

(2) UNICEF: Survey on Disability-friendly Healthcare (DFHC) at Public Health Facilities through Identification of Barriers and Institutionalization of Training (Bangladesh) [14]

In 2019, the United Nations Children's Fund (UNICEF), in collaboration with the Government of Bangladesh's Non-communicable Diseases (NCDs) Control Programme and local non-governmental organizations (NGOs), conductive comprehensive research to identify barriers to disability-friendly healthcare (DFHC) services at public health facilities.

This case study represents a good practice example of how evidence-based barrier analysis can inform the development of training programs through collaboration with the government. By implementing these training programs at the government level, the initiative has helped institutionalize capacity-building efforts and promote sustainability through continuous improvement.

- **Implementation of Comprehensive Barrier Identification Survey**
  - Conducted DFHC evaluations in four areas—information, communication, infrastructure, and health worker capacity—at 150 public health facilities
  - Conducted consultations with a wide range of stakeholders including policymakers, administrators, health workers, NGOs, community leaders, persons with disabilities, and caregivers
- **Main Survey Results**
  - Almost all public health facilities were inadequate in DFHC in all four areas
  - Information and communication were mainly accessible only to caregivers
  - Infrastructure accessibility (entrances, toilets, etc.) averaged 20% (large hospitals 46%, primary care facilities 17.1%)
  - Most health workers were assessed as having inadequate capacity to provide DFHC
- **Recommendations from Stakeholders**
  - Persons with disabilities: Implementation of staff skill improvement training on information provision and communication
  - Community leaders, persons with disabilities, and caregivers: Installation of handrails, wheelchairs, and ramps
  - Health workers: Improvement of knowledge and awareness regarding DFHC
- **Institutionalization of Training through Collaboration with Government**
  - UNICEF and the government collaboratively developed training programs and materials for health workers
  - Conducted training for 434 health workers at 22 health facilities in 2021 (conducted in English and Bengali)
  - Published guidelines online, and the government conducted training for 360 newly hired doctors in 20 districts

- Conducted training for 65 health workers at four facilities in Cox's Bazar refugee camps in 2022
- Training continued to be implemented in 2023

(3) JICA: Project for the Improvement of Maternal and Child Health Services through Maternal and Child Health Handbooks (Technical Cooperation Project: 2017-2022) (Angola)

In the Project for the Improvement of Maternal and Child Health Services through Maternal and Child Health Handbooks in Angola, JICA developed and implemented a program to introduce maternal and child health handbooks in selected model provinces. The project established management systems and enhanced knowledge of maternal and child health among pregnant women and other community members. Based on these achievements, a national program was subsequently developed, along with a national deployment strategy for the handbook. Throughout the implementation of these activities, JICA paid particular attention to ensuring that services reached mothers and children with disabilities, actively promoting disability inclusion within the health sector. This case study illustrates a practical approach to achieving disability inclusion by integrating a disability perspective into existing project activities at a later stage.

■ **Raising Issues to Local Stakeholders and Understanding the Current Situation**

- Started with the question "Are mothers and children with disabilities visiting health facilities?" during regular online meetings during the COVID-19 pandemic
- Requested observation of the status of visits by persons with disabilities and responses by health workers during supervision facility visits

■ **Developing Common Understanding of Issues through Workshops**

- Organized current situation based on results of observations at health facilities in online workshops
- Common understanding of issues: "There are mothers and children with disabilities, but they are not connected to health services"; "We need to take some measures to ensure that mothers and children with disabilities are not left behind in services"
- Introduced examples of consideration for diverse needs through maternal and child health handbooks in Japan (Little Baby Handbook (handbook for low-birth-weight infants))
- Discussed and examined priority and feasibility of necessary initiatives in Angola

■ **Implementation of Specific Activities**

- Added content on disability to training materials for health workers (lecture slides) (March 2021)
- Conducted training for health workers using modified materials (April-May 2021)
- Added content on disability to training materials for community development workers (March 2021)
- Added content on disability to e-learning training materials (October 2021-February 2022)
- Included in national deployment strategy for maternal and child health handbooks (October 2021-March 2022)

■ **Achievements and Future Development**

- Disability understanding was promoted among project experts and local stakeholders
- The idea of "creating programs so that services reach persons with disabilities" was accepted by local stakeholders
- In the succeeding project[3], content on disability was incorporated into training materials (lecture slides), making field-level needs more visible
- In 2024, initiatives were launched to produce Braille maternal and child health handbooks, which were subsequently printed in 2025

Source: Developed based on [15], [16], etc.

[3] Project for Improving the Quality of Maternal Health Services at Primary Health Care Facilities (2023-2027)

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