PARTNERSHIP TO ENHANCE THE QUALITY OF LIFE OF PERSONS WITH DISABILITIES

WHO Proposal to AusAID

Disability inclusive development - implementing the evidence

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1. Executive Summary

Name and address of applicant Disability and Rehabilitation (DAR), Department of Violence and Injury Prevention and Disability, World Health Organization, Address:
Tel: +Fax: +
Email:

Name of Project: Disability inclusive development - implementing the evidence (DID)

Where will the initiative take place: Global, regional and country with a specific focus on the Asia and Pacific.

Proposed partnership: The project will work with a range of partners including : World Bank, Pacific Island Forum Secretariat and the Pacific Disability Forum, APCD Foundation, UNESCO, ILO, IDDC, Global and national DPOs, UNESCAP.

Project Summary: The **goal** of the project is to enhance the quality of life for persons with disabilities. The **objectives** are to:

- support greater policy dialogue and international cooperation on disability and development
- collaborate on actions at global, regional and national levels to improve the quality of life of persons with disabilities through existing regional and national structures
- strengthen WHO's capacity to support a twin track approach to disability specifically in Asia and Pacific

The **main activities** are awareness raising, improving access to scientific knowledge (through policy dialogue, development and dissemination of technical guidelines); and capacity building through technical and economic assistance. The **expected outcomes** are that decision makers and service providers have improved access to evidence based tools to inform disability related policy and programming in line with the CRPD; Community based rehabilitation (CBR) is implemented in line with the CBR Guidelines; Health and rehabilitation services (including assistive devices) are strengthened for persons with disabilities and their families; and disability data collection can be carried out using tools that will measure the impact of disability. The **main beneficiaries** of the project will be people with disabilities, their families, non government organizations specifically disabled people's organisations and Member States. There are no serious risks to the project.

Project cost: AUS 3,935,790 is the budget requested from AUSAID.

Project duration: January 2011 – June 2014

2. Analysis and Strategic Context

Estimates of the number of people with disabilities are variable based on the definitions and methods used. The most commonly quoted figure is 10%[1] of the world population, some 650 million people. It is estimated that as many as 80 per cent of persons with disabilities in the world live in developing countries. People with disabilities are at risk of inequities in health, lower education attainment, and higher rates of unemployment and underemployment. As a group, persons with disabilities are among the most vulnerable and least empowered in the developing world, and have been exposed to discrimination, poverty, exclusion and sometimes even overt hatred and violence. Women with disabilities experience double

1 This 10% estimate came in an unpublished WHO document No A29/INF.DOC/1 Geneva, 1976 citing a summary of results of different studies of disability undertaken in developed countries and of estimates of impairments prevalence in developing countries. This figure would have largely been based on impairment prevalence data which doesn't capture the full extent of disability (i.e. restrictions in participation). The world report will review the best available disability prevalence data.

discrimination - as women and as persons with disabilities, for example the World report identifies inequalities in accessing needed health care for both mainstream and specific services. Evidence of the multiple forms of discrimination facing women with disabilities are particularly evident in the Pacific region [2]. Other groups are also particularly marginalized, including persons with intellectual, mental, and multiple impairments, youth and those living in rural and remote areas [3]. This enormous population of potentially productive individuals faces serious threat to their full and equal enjoyment of all human rights and fundamental freedoms and respect for their inherent dignity.

Progress has been made at the policy level. Persons with disabilities have been intended agents and beneficiaries of development cooperation for the last four decades. The adoption of the World Programme of Action Concerning Disabled Persons in 1981 provided, for the first time, an international policy framework for disability-inclusive development. In 1993, the General Assembly adopted the Standard Rules on the Equalization of Opportunities for Persons with Disabilities, which reaffirmed the principles of inclusive policies, plans and activities in development cooperation and provided further guidance on disability-inclusive measures. In 2006, the UN General Assembly adopted the Convention on the Rights of Persons with Disabilities (CRPD), the first legally binding instrument that promotes both human rights of persons with disabilities and disability inclusive social development. The Convention recognizes the importance of international cooperation to support national implementation efforts, and outlines specific actions that could be taken by the international community such as:

- facilitating and supporting capacity-building;
- facilitating cooperation in research and access to scientific and technical knowledge;
- providing technical and economic assistance as appropriate;
- ensuring that international development programmes are inclusive of and accessible to persons with disabilities. For example while the Millennium Development Goals do not explicitly mention people with disabilities, the General Assembly concluded in its High Level Meeting on the MDGs in September 2010 that "policies and actions must also focus on persons with disabilities, so that they benefit from progress towards achieving the Millennium Development Goals" (A/RES/64/299, OP 28).

A gap exists between policy and practice at the level of countries and within international development. It is too soon to report the results of the CRPD on the lives of people with disabilities, however a global survey on the implementation of the UN Standard Rules in 2006 found that most of the 114 countries that responded to the survey have adopted policies. While progress has been made with regard to the recognition of the rights of persons with disabilities (South-North Center for Dialogue & Development[4]), in many cases programs and services were not implemented. For example of the 114 countries providing information:

- nearly 30 countries reported having taken no measures to enable children to receive education in integrated settings;
- 46 countries had no rehabilitation programmes;
- 65 countries had not put in place programmes to improve physical accessibility;
- awareness raising at the levels of the individual, institutions and society, remains an area with limited investment;
- about two thirds of countries had taken some measures to provide medical care, often in the absence of specific policies or legalisation.

Countries in the Asia and Pacific region show mixed progress with regard to policy and programme development on disability - many have rights based policies, yet few have specific

2 UNDP Pacific Centre, 2009, Pacific Sisters with Disabilities: at the Intersection of Discrimination

3 Pacific Islands Forum Secretariat (2009) Pacific Regional Strategy On Disability 2010-2015

4 South-North Centre for Dialogue and Development. *Global survey of government actions on the implementation of the standard rules of the equalization of opportunities for persons with disabilities*. Amman, Jordan, Office of the UN Special Rapporteur on Disabilities, 2006:141.

legislation[5]. Most governments are not making provision for inclusive mainstream services or disability specific services and where services exist, implementation is ad hoc, poorly coordinated and inadequately funded. Additional barriers to change include negative attitudes, inappropriate approaches, lack of capacity - infrastructure, human and financial - to implement inclusive policies and plans.

Despite developments, persons with disabilities continue to be kept on the margins of society in all parts of the world due in part to a lack of political will, poor access to scientific knowledge, a lack of technical and capacity building support, and economic assistance.

A twin track approach - which includes both disability-specific and mainstreamed interventions is required. While the importance of mainstreaming disability into overall development cooperation activities has been increasingly acknowledged, it has not yet taken place. Most agencies continue to implement disability-related activities, but disability issues and concerns are not mainstreamed in sector-wide approaches or given direct budget support. As a result, there is a lack of successful examples and knowledge about how to bring about disability inclusive policy and practice.

There is no global evidence base for action. Despite the universal relevance of disability and the magnitude of the issue, awareness of and scientific information on disability issues are lacking. There has been limited agreement on definitions and little internationally comparable information on the prevalence, distribution and trends of disability. The quality of research and data on the prevalence of disability and the issues affecting the lives of persons with disabilities has been identified as a specific problem in the Pacific region[6] .There are no existing tools that can measure the impact of disability on people's lives. Despite the policy and programme changes over the past two decades in the field of disability there is no global document that brings together the evidence to inform policy and practice. The World report on disability will fill this gap.

WHO's has been mandated, through the Resolution **(WHA58.23)** on "Disability, including prevention, management and rehabilitation", to provide support to Members **States in the following areas:**

- collecting more reliable data which is sex-disaggregated, and promoting studies of incidence and prevalence of disabilities as a basis for the formulation of strategies for prevention, treatment and rehabilitation;
- assessing potential use of available national and international resources for disability prevention, rehabilitation and care;
- strengthening health and rehabilitation programs - community-based and institutional rehabilitation;
- producing a world report on disability based on the best available scientific evidence;
- supporting policy development in accordance with the principles of the CRPD and training of human resources for health and rehabilitation;
- further strengthening collaborative work within the United Nations system and with Member States, academia, private sector, and nongovernmental organizations, including organizations of people with disabilities;
- promoting a clear understanding of the contributions that people with disabilities can make to society.

The staff available in WHO to respond to these demands is limited. There is one manager and three technical staff in Headquarters; 3 full time regional advisers on disability (Africa, Americas and South east Asia) and three part time regional advisers on disability (Europe, Eastern Mediterranean and Western Pacific).

5 Disability at a glance: a profile of 28 countries and areas in Asia and the Pacific. Bangkok, UNESCAP, 2006.

6 Pacific Islands Forum Secretariat (2009) Pacific Regional Strategy On Disability 2010-2015

3. Analysis and lesson learnt

Building on past successful experiences: The production and dissemination of world reports by WHO have proven to be a most valuable exercise. For example the *World report on road traffic injury prevention,* produced in partnership with the World Bank, has generated a large number of follow-up activities including increased political support, augmented advocacy and media attention, enabled countries to develop national plans of action, generated resolutions by other organizations, been the catalyst for numerous prevention programmes (Government and Non governmental) and new legislation, generated significantly more resources into the areas and ultimately contributed to saving and protecting human lives.

The *World report on disability*, being developed at the request of the World Health Assembly (Resolution 58.23) and in partnership with the World Bank, represents the first global document that compiles and analyses the way countries have developed policies and the responses to address the needs of people with disabilities. Although policy makers are the primary target audience, the Report is also intended for a broad multisectoral audience, including academics, disability and development actors, service providers, donors, media, people with disabilities and their families, and the broader community. The Report has chapters on disability data, health, rehabilitation, assistance and support, enabling environments, education and employment. Where sex and age disaggregated data are available, the report explores the specific impact on women and children. It will increase access to and promote the utilization of evidence-based research. The availability of this knowledge will play an important role in shaping policy and practice and enhancing the lives of people with disabilities. Through the Report we hope to:

1. demonstrate the gap between what exists and what is required - by summarizing and analysing existing information on the status of disability and the lives of disabled people;
2. contribute to reinforcing the paradigm shift towards human rights;
3. outline successful activities to remove barriers and promote participation by people with disabilities in their societies; and
4. provide governments and civil society with recommendations for actions in accordance with the CRPD at country, regional and global levels.

In short, to issue a *call to action* and offer a *path forward* based on evidence.

Key success factors in the Report's development: An underlying principal of this report is the building of partnerships for disability, rehabilitation and inclusion efforts. The report is being produced in cooperation with professional associations, non government organizations, organizations of persons with disabilities, experts and other UN agencies. The partners contribute enormous technical and political weight ensuring the best quality of information and the widest possible dissemination. Regional consultations on the preliminary draft of the World report, one of which was held in Manila, the Philippines for the South-east Asian and Western Pacific Regions, brought together a diverse group of experts including editors of the Report, chapter authors, academics, service providers, policymakers, government officials, NGO representatives, and disability advocates. The participants' feedback, cultural perspectives on the draft and the sources of regional information they provided, have helped to develop a final document that is relevant in diverse global contexts. People with disabilities have been involved in all phases of the report's development as advisors', editors, authors, reviewers. The World report forms part of the process of improving collaboration across sectors to bring about the necessary change in attitudes and approaches to persons with disabilities, and so ensure their full participation in every facet of life. See annexe 1 for a diagram representing this process.

WHO experience has shown that the launch of a World report (e.g. World report on road traffic injury, World report on violence and health) has been a catalyst for World Health Assembly resolutions which support actions arising from the recommendations of the Report.

Task Force on Disability: Following adoption of the UN Convention on the Rights of Persons with Disabilities, the WHO Director-General established a Task Force on Disability, bringing together representatives from regional offices and the different clusters within Headquarters. The Task Force is chaired by Dr Ala Alwan, ADG/NMH, and its secretariat is housed in the Disability and Rehabilitation team. The WHO Task Force on Disability works to ensure that WHO buildings, information products, employment opportunities and technical programmes are inclusive of and accessible to people with disabilities, in compliance with the Convention on the Rights of Persons with Disabilities. This initiative has been very successful in:

- *increasing awareness and visibility of disability* e.g. through internal seminars, intranet stories, quizzes, December 3rd celebrations;
- *building capacity within WHO* e.g. disability equality training has been provided for people who sit on interview panels; a WHO training module in accessible print has been delivered to 100 staff, mainly from Headquarters and is being translated and adapted and rolled out to regions; access training for all web developers and content producers targeting 196 members of staff in headquarters and regional offices has been developed and is scheduled to start in February 2011;
- *generating systemic change and making these changes visible* e.g. WHO vacancy notices now read "WHO is committed to workforce diversity"; a new WHO policy on employment and disability was adopted August 1 2010 and widely disseminated. An implementation strategy is under development with key stakeholders across the Organization. Access audits in Headquarters, EMRO, SEARO and WPRO have all resulted in access improvements in websites and physical infrastructure. A number of teams across WHO have taken up disability mainstreaming projects e.g. reproductive health, emergencies, physical activity etc.

Key success factors: Engagement at the highest level of the Organization and representation across the Organization. Quarterly video conferences have been held to share progress, exchange on lessons learnt and define priorities and next steps. A designated focal person with a disability with strong technical and communication skills provides support and regular follow up to Task Force members and "disability champions" in clusters and regional offices.

Technical Guidance. Accompanying the World Report, WHO has been developing a series of "*How to"* Guidelines which will assist governments to implement some of the recommendations in the Report. Examples include the following products.

1. The *Guidelines on the provision of manual wheelchairs in less resourced settings* developed in partnership with the US Agency for International Development, the International Society for Prosthetics and Orthotics and Disabled Peoples' International.

Key success factors. The Guidelines were developed in partnership with professionals, scientists, development agencies and NGOs, and in particular people with disabilities themselves and their organizations. These Guidelines respond to an important information gap. For the first time, guidelines were developed that address the design, production, supply and service delivery of manual wheelchairs, in particular for long-term wheelchair users in developing countries. The Guidelines are targeted at a range of audiences: for example policy makers, service providers, wheelchair users and donors. For example, they guide USAID funding and provision of wheelchairs. After the release of the Guidelines, USAID allocated USD 10 million to wheelchair services provision in developing countries for two consecutive years. This is an example of the role that WHO plays in providing technical guidance, which influences policies that can benefit people with disabilities worldwide. The Guidelines are also being used by individuals and groups with disabilities; for example, wheelchair users in Tanzania (Pan African Wheelchair Association) refused to accept the poor quality of wheelchairs being offered by an international agency as they didn't meet minimum standards as outlined in the Guidelines. As a result a major international donor has revised the wheelchairs that they now donate - which number half a million around the world.

2. *Community-based rehabilitation (CBR)*[7] *Guidelines* developed in partnership with the International Labour Organization; the United Nations Educational, Scientific and Cultural Organization; and the International Disability and Development Consortium – notably CBM, Handicap International, the Italian Association Amici di Raoul Follereau, Light for the World, the Norwegian Association of Disabled and Sightsavers. These Guidelines, launched on October 27 in Abuja Nigeria, illustrate how CBR can build on existing development initiatives to deliver a multisectoral approach to realize minimum living standards, access health care and improve educational opportunities and community participation by focusing on the capacity-building needs of persons with disabilities in their communities. In this way the Guidelines provide direction on how CBR can be used to implement the CRPD and contribute to achieving the MDG's.

Key success factors: It is too early to evaluate the impact of these Guidelines. However, the demand for them is very strong, due to a number of factors:

- CBR is currently implemented in over 96 countries around the world;
- There are no viable alternatives to CBR for providing concrete and sustainable benefits to persons with disabilities in communities in developing countries in line with the CRPD;
- There are networks of CBR practitioners in three regions : Africa, Asia and the Pacific, and Latin America and the Caribbean. Interest in a European network is growing. These networks provide a mechanism for CBR practitioners around the world to share knowledge and experience and to influence policy and practice within regions and at the level of communities. For example, in February 2009 the 1st Asia-Pacific CBR Congress was held in Bangkok. 630 participants attended from 53 countries in the region, including representatives from central and local governments, NGOs, disabled people's organizations, and regional and international organizations. This has spurred country action - India, despite having incorporated CBR as a strategy in its existing five-year plan, it has for the first time, developed a National CBR network with representation from across the country. 9 - 10 December 2010 the India CBR Network held its first meeting with over 400 participants from around the country including all major disabled people's organizations.
- Disability is a multisectoral issue and the partners in the Guidelines development reflect this. UN specialized agencies for health, education and livelihood, respectively WHO, UNESCO and ILO and the international Disability and development consortium (IDDC) have worked together to develop these Guidelines. More than 180 individuals and nearly 300 organizations, mostly from low-income countries around the world, have been involved in the development of the Guidelines.

Staffing: Designated disability focal persons are required to push the agenda at the different levels of the organization. The success of the Task Force activities is in part attributable to WHO having the right person, with the right knowledge and skills to provide support in a timely manner. At the level of the regions, a focal person on disability is required to move forward the disability and development agenda. Disability has commonly fallen to people in regions that have other technical responsibilities and whose core competencies are not necessarily disability related. The outcome is that these people manage requests from countries to the best of their ability, mobilizing headquarters staff or related networks when

[7] Community Based Rehabilitation (CBR), initiated in the mid 1980's, as a strategy designed to provide people with disabilities access to basic rehabilitation services in their own communities. CBR has evolved over the years so that is directly contributes to empowering persons with disabilities to access and benefit from education, employment, health and social services that enhance the survival and dignity of persons with disabilities, and improve their opportunities to make a living. CBR, is implemented through the combined efforts of people with disabilities, their families, organizations and communities, relevant government and non governmental health, education, vocational, social and other services. In 2004 a joint position paper developed by ILO, UNESCO and WHO on CBR[7], repositioned CBR as a strategy for rehabilitation, equalization of opportunities, poverty reduction and social inclusion of people with disabilities.

required but not being able to be proactive, develop a strategy for regional support or build capacity in the region.

Key success factors: In 2006 only one of the six WHO regions had a designated focal person on disability. In 2010 three regional offices have full time advisers on disability. For example the most recent region to recruit a full time disability adviser is the South East Asian Regional Office (SEARO). When the task force was initiated, the Regional Director in SEARO provided short term funding for a person to work on mainstreaming disability. The short term consultant increased awareness and visibility on disability and produce some very concrete results. This was important in engendering commitment to having a full time person in disability in the regional office. CBM agreed to fund the full time post which will facilitate fundraising for activities. Showing results will be the strategy for increasing donor interest in the region. Future funding for this position may include continued support from CBM, part funding by WHO as has been done in AFRO and AMRO, cross funding through different donors funds (as has been done in Headquarters). It is hoped that, with support from AusAID, the Western Pacific region can also benefit from the presence of a full time disability focal person.

Organization of people with disabilities (DPO's). WHO has official partnerships with a number of global organizations of people with disabilities including: Inclusion International, World Blind Union, World Federation of the Deaf, International Federation of the Hard of Hearing, Rehabilitation International (an organization of and for people with disabilities) and informal, yet long-term, collaboration with others including Disabled People's International and the Pacific Islands Disability Forum. WHO also participates in the Women with Disabilities Community of Practice. These relationship are very important to WHO. For example, all stakeholders, including DPOs, met to discuss priorities for implementing the CBR Guidelines in October 2010. DPO representatives will participate in the World report launch and associated technical meeting in June 2011, at which priorities for implementing the report recommendations at a global level will be agreed - see implementation plan for further details of DPO involvement at national level.

Key success factors: These organizations participate in WHO led activities and are involved in key strategic decision making. The Pacific Islands Forum, through the PFI coordinator Fred Miller - provided feedback to WHO on the concept note which served as the basis for this proposal. Further exchange by telephone enabled sharing of current and future activities and an initial discussion on roles and responsibilities. More broadly, DPO's and others have helped define our existing plan of action, provided guidance on WHO priorities after the adoption of the CRPD - including the Task Force - advised us on technical issues e.g. improving access to sign language users at our meetings and access to information products for people who are visually impaired and made concrete contributions to all of WHO's actions e.g. World Report on Disability, Guidelines development etc.

4. Rationale for AusAID Involvement

WHO and AusAID are committed to exert influence and demonstrate leadership in disability and development. The proposal presents an opportunity to further this objective by establishing a strategic multi-year partnership. The framework for this partnership has been developed in consultation with the WHO Western Pacific Regional Office, AusAID and the Pacific Islands Forum (PIF). The rationale for the partners is as follows:

Shared objectives. AusAID and WHO share a common commitment to improving the quality of lives of people with disabilities by promoting and improving access to the same opportunities for participation, contribution, decision making, and social and economic well-being as others. AusAID-WHO partnership framework 2009 - 2013, in support of a number of key areas in the Mid Term Strategic plan (MTSP) 2008 - 2013 and the outcomes of recent AusAID-WHO High Level Consultations (HLCs) in June 2010, indicated a strengthening of our joint work on disability. Mainstreaming disability has been the theme of the work of the Task Force on Disability, in accordance with the "Disability-inclusive development" emphasis of

AusAID. Consultations between WHO, AusAID and PIF identified strategic areas for collaboration.

Common guiding instruments, frameworks and approaches. AusAID and WHO realize that to make substantive changes in the lives of people with disabilities a twin track approach is required. WHO and AusAID, through *development for all*, are committed to and guided by the CRPD and regional frameworks and instruments, including the Biwako Millennium Framework (BMF) for Action: Towards an Inclusive Barrier-free and Rights-based society for Persons with Disabilities in Asia and the Pacific (2003–2012), the Biwako plus Five, and the Pacific regional strategy on Disability 2010 - 2015.

Maximize investment by building on current collaboration. WHO and AusAID, have previously collaborated on disability activities as outlined below and intend to strengthen this collaboration:

- developing the evidence-base for policy and practice: The *World report on disability*, as described above;
- capacity building: Development of a training package to support the implementation of the *Guidelines on the provision of wheelchairs in less resourced settings*;
- partnership development: support to the first Asia and Pacific congress on CBR and development of the regional CBR strategy.

Draw on each organizations strengths. Leveraging on the existing mandate, partnerships, experience and networks of each agency, WHO and AusAID, in collaboration with regional and national authorities, can increase policy level engagement by:

- establishing shared strategic development outcomes in support of international, regional and national efforts to progress CRPD implementation;
- influencing international policy dialogue, partnerships and cooperation that actively includes key regional stakeholders, such as the Pacific Island Forum Secretariat and Pacific Disability Forum, in policy level discussions and decisions;
- developing a robust evidence base of research and analysis on the links between disability and development, with a strong focus on the lived experience of persons with disability in the region, to inform policy and program decisions.

5. Program Description

A multi-year (four year) partnership between WHO and AusAID is proposed to contribute to strengthening global, regional and national level outcomes, with a key focus on developing partnerships, capacity and leadership in disability and development.

The **goal** of the project is to enhance the quality of life for persons with disabilities.

The objectives are to:

- support greater **policy dialogue and international cooperation** on disability and development:
- collaborate on **actions at global, regional and national levels** to improve the quality of life of persons with disabilities through existing regional and national structures;
- strengthen **WHO's capacity** to support a twin track approach to disability, specifically in Asia and Pacific.

6. Expected Outcomes

Outcome 1: Decision makers and service providers have improved access to evidence based tools to inform disability related policy and programming in line with the CRPD.

- Disseminate the World report on disability and related advocacy materials.
- Carry out policy dialogues "national launches" of the World report.
- Actively influence the media.

Result areas:

- National events for raising awareness and policy dialogue.
- A tool kit (fact sheets, posters, etc) for national level policy dialogue and programming.
- Media coverage of the World report

Outcome 2: Community-based rehabilitation (CBR) is implemented in line with the CBR Guidelines developed by WHO, ILO, UNESCO and IDDC.

- Translate and disseminate the CBR Guidelines.
- Conduct regional/country workshops to promote CBR and the CBR Guidelines.
- Support Member States to initiate CBR and/or strengthen existing CBR in line with the Guidelines.
- Support the development of regional networks of CBR practitioners for knowledge exchange
- Develop a Training of Trainers Package in line with the Guidelines.
- Support the development of tools for monitoring the effectiveness of CBR in countries.

Result areas:

- Guidelines on CBR - number of languages, formats. Numbers disseminated and downloaded from the website.
- CBR regional networks meeting reports.
- CBR global database of CBR implementing organizations.
- Guidance on monitoring CBR
- National CBR plans
- Pilot programs in countries.

Outcome 3: Health and rehabilitation services (including assistive devices) are strengthened for persons with disabilities and their families

- Support Member States to improve the accessibility of general health services (e.g. . reproductive health care services) to people with disabilities.
- Support Member States to promote access to rehabilitation services by strengthening specialized rehabilitation centres, linking these services with Community-based Rehabilitation (CBR).
- Develop guidelines to strengthen specialized rehabilitation services.
- Support Member States to develop national policies on rehabilitation, including assistive technology.
- Support Member States to train personnel at various levels in the field of health and rehabilitation with a focus on wheelchair services provision and prosthetics and orthotics.

Result areas:

- Guidelines on strengthening specialized rehabilitation services.

- Pilot programs in countries, for example projects on capacity building around women with disabilities in pregnancy and childbirth within mainstream maternity services will be conducted and evaluated in two countries in the Asia Pacific region
- Based on identified priorities through national planning meetings - policies, strategies, activities implemented to improve access to health services for persons with disabilities, for example putting in place regular health checks for vulnerable groups such as people with intellectual disabilities etc

Outcome 4: Disability data collection can be carried out using tools that will measure participation restrictions.

- Develop and test a standard instrument for disability surveys that will be able to assess the impact of disability on people's lives - disaggregated for example by sex, age.
- Support collection of country-level data on disability and implementation of the CRPD related to disability services including health, rehabilitation, assistive devices and technologies to enable participation [8].

Result areas:

- Standard instrument for disability surveys is available to measure impact of disability on people's lives [9].

Form(s) of Aid Proposed

WHO proposes a multi year (up to three years) AusAID **secondment** to WHO to strengthen alignment between WHO and AusAID commitments to CRPD implementation, with particular focus on Article 32 of the CRPD (international cooperation). Australia's unique networks and experience in the Pacific will ensure international, regional and national policy and program coherence between WHO and AusAID's work in the Pacific.

WHO proposes a four year **budget** available in annexe 3

7. Implementation Arrangements

Management and Governance Arrangements and Structure

The WHO Headquarters in Geneva will be responsible for the overall monitoring and reporting on the project, and the principle interlocutor between WHO and AusAID for this project. A planning, monitoring and evaluation (PME) system will be developed for this project to enable the follow-up of key project milestones. This PME system will be linked with the WHO results based management system and accountability framework (see below and in annexe 4). The presence of a WHO technical officer on disability in the WPRO office will enable joint planning, decentralized execution, monitoring and documentation as well as learning and sharing with local partners.

Representatives of AUSAID and WHO, at all levels of the organizations, will monitor the project. These may include the following:

8 Not budgeted for in this project. Application of the survey instrument would require additional resources and would be depending on country context.

9 This work will complement the work who has already done on World Health survey 9, WHO Quality of life(WHOQOL 9), World Health Organization Disability Assessment Schedule II (WHODAS II9) and the work of the Washington Group (see annexe 1). If surveys are funded and carried out during the cycle of this project it would be possible to assess change. As advised, this project doesn't include adequate resources for administering the tool across countries - additional resources would be required for that purpose.

- WHO HQ - Coordinator for Disability and Rehabilitation
- WHO HQ technical advisers as required (e.g. for CBR, assistive devices, mainstreaming)
- WHO WPRO regional adviser for mental health and injuries
- WHO WPRO disability technical officer- to be recruited under this project and financed by AusAID
- AUSAID secondee to WHO HQ
- A representative from AusAID
- A representative from PIF
- Country representative (WHO, AusAID) for priority countries - as required.
- Representative(s) from national DPOs - as required.

Other participants working directly or indirectly on the project may be invited at the discretion of WHO and AUSAID as appropriate.

The Representatives will meet (virtually or face to face) twice a year for:

- mutual information sharing and discussions on the project and situation analysis;
- participatory monitoring and assessment of project activities in regard to the objectives;
- appraisal of the means and resources provided to meet project objectives;
- decisions on future project orientations.

Annually, WHO and AUSAID and partners will:

- appraise the progress of the project (analysis of results planned and unplanned; gap analysis on activities and analysis of impact (i.e. projects influence on the environment) , hypothesis and context:
- develop an action plan for the next year, taking into consideration other AUSAID funded activities to avoid duplication and enhance collaboration.

WHO will be responsible for planning and facilitating these meetings in consultation with relevant parties (e.g. setting of objectives and agenda). The results of this meeting will feed into the annual WHO - AusAID high level strategic meeting. AusAID and WHO could convene more frequently if requested by one of the parties. Minutes of these meetings, together with agreed action points, will be disseminated among participants.

Implementation Plan. The implementation of the project will be managed at the level of the WHO country office for country level actions, at the level of WPRO for regional actions and at Headquarters for global actions. The process of policy dialogue will determine priorities at national level and this will generate buy-in for national level action. Representative organizations of people with disabilities at each level will be involved at all stages of the project's development - at the level of the "project committee", in the development of each core product/action and the development and monitoring of country pilot projects. A strategy for how to effectively involve people with disabilities will need to be agreed at the planning stage for each action. For example, in selecting countries and preparing for the national policy dialogues on the World report, initial discussions with PIF will be followed by specific consultation with DPOs in the selected countries.

Each level will be responsible for reporting on actions under their responsibility which will be consolidated by WHO Headquarters. This project fits within the overall programme, policy and monitoring structure of WHO. In this context, the project will be subject to all of WHO's operational procedures e.g. contracting, procuring, finance control, etc. WHO has internal operational oversight and audit procedures which obviate risks such as corruption and mismanagement.

Detailed activities are outlined in the budget for year one. The project committee mid and annual reviews will enable joint planning of future actions based on identified priorities.

Criteria for selecting pilot projects will be developed within the first six months of the project. They will need to take into consideration interest from the country, governance

arrangements[10], available infrastructure, human resource capacity, finances available, partner capacity (Government, NGO and DPO), and the ability for the project to leverage systemic change and increase regional capacity for action. Across the portfolio of activity, attention will be given to ensure gender equality, pro poor emphasis and cross disability involvement with a focus on underrepresented groups. Tools on how to assess the situation and the readiness of countries for policy change will be developed as part of the project. These tools will assist in providing a contextual analysis, building a baseline and identifying stakeholders, and will be employed with countries during national level policy dialogues on the World report.

Monitoring & Evaluation Plan. WHO has a results based management system and accountability framework which requires WHO to measure progress against objectives, expenditure and for informing the revision of policies and strategies. Further details in annex 4.

Mechanisms for monitoring are intrinsic to a number of the activities . For example

- *Outcome 1* - national policy dialogues will draw on situation analysis which will provide some contextual/ based line information, including gender issues and challenges based on available information. From this analysis progress can be measured, for example on pilot projects developed under *Outcome 3*. It is important to note that country initiatives will be defined based on national priorities. The mechanisms for monitoring each pilot action will be determined based on the action being implemented and the stakeholders involved.
- *Outcome 2* - the CBR guidelines promote monitoring and evaluation and provide guidance on developing a situation analysis and collecting base line information when initiating programs. This project will also develop more detailed guidance on monitoring CBR which will promote the need to collect disaggregated data- sex , age , socioeconomic status. Once completed, these guidelines will be used in pilot projects and learning shared through the CBR networks, through writing papers and giving presentations.
- *Outcome 4* will develop a tool that can be used by countries to evaluate progress in improving the wellbeing of its citizens with disabilities.

Cross-cutting issues

The strategy for **gender** analysis in the project will be consistent with the World Health Assembly Resolution *60.25 - Strategy for integrating gender analysis and actions into the work of WHO* http://apps.who.int/gb/ebwha/pdf_files/WHASSA_WHA60-Rec1/E/reso-60-en.pdf. WHO is developing a tool kit on gender analysis which will be available for use on this project.

Specific WHO-Actions to be taken include

- incorporating a gender analysis as part of the situation analysis which will inform policy dialogues and country projects - to inform activities regarding the differential impacts on women and men, girls and boys.
- Ensuring adequate involvement of women with disabilities in all actions e.g. meetings, seminars etc.
- Ensuring data collection and analysis is sex disaggregated
- Supporting countries to include a gender analysis when formulating actions plans based on the national policy dialogues e.g. in heath policies, programmes etc

Based on the pilot projects agreed with Member States, mechanisms will be put in place to ensure **child protection** and **environmental sustainability**.

10 Good governance has 8 major characteristics. It is participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive and follows the rule of law. It assures that corruption is minimized, the views of people with disabilities are taken into account and that their voices heard in decision-making. It is also responsive to the present and future needs of society.

What are the main risks that could affect the project's success?

There are **no major risks** to the project.

Implementation at country level: The WHO country offices have limited knowledge and capacity on disability. The focus to date has been on the prevention of disabilities and not inclusion of persons with disabilities. Medium risk. *Mitigation*: The Technical Officer in the regional office will work with WHO country offices to understand the importance of disability and engender support for action in line with regional and international frameworks. The technical officer will closely follow country activities drawing on the expertise of country and regional WHO personnel, providing support and building capacity where required over the duration of the project for the inclusion of people with disabilities, while ensuring that prevention actions continue and are respectful of people with disabilities.

Enabling country engagement and avoiding duplication of actions. It is important to ensure that actions align to the national systems and maximize the use of existing resources. *Mitigation*: The World report on disability is intended as part of a process that enhances collaboration and complementarity of actions across sectors to bring about the necessary change in attitudes and approaches to persons with disabilities and ensure their full participation in every facet of life. National level "policy dialogues/ launches" will be used to bring together all relevant stakeholders to review the national situation, identify priorities and plan for action drawing on the recommendations in the report. This consultative process will create a platform for exchange, enable actions to be based on nationally identified priorities aligned with existing initiatives and avoid duplication of efforts.

It is also important that for aid effectiveness that there is not duplication of AUSAID funded activities. *Mitigation*: AUSAID at all levels will be involved in the different levels of monitoring the project. Monitoring meetings will be used to discuss upcoming activities to avoid duplication of support and promote collaboration and complementarity.

Competing priorities: Humanitarian crises (natural disaster, disease outbreak etc) could influence priorities drawing away resources that are focused on this project. Medium risk, over the period of the project. *Mitigation*: dedicated human and financial resources to this project will enable a focus on the project objectives. Ensuring the rights of persons with disabilities are addressed in disasters is an important mainstreaming activities. This project will use these situations to ensure that the rights of people with disabilities are addressed in preparedness, response and recovery.

Paradigm shift: There has been an important shift in understanding of disability from an individualized, medical view to an emphasis on environmental factors that have a huge influence on the experience and extent of disability. This new way of viewing disability emphasizes human rights as the goal, and participation by people with disabilities as a core value. WHO, by the nature of its work on health is often associated with the more medical aspects of disability. Medium risk of occasional controversy over WHO's work, especially where there are fundamental conceptual differences - for example difference in understanding of the basis for mental health conditions. WHO's work will be guided by the CRPD and the available scientific evidence. *Mitigation*: regular dialogue between the DPOs and WHO is key to creating a space where concerns can be raised and solutions found. Relationships with DPOs representatives has been developing over the years and will continue to be a priority for the Organization.

Ensuring a multisectoral response. WHO's key interlocutors are the Ministries of Health. The rights of people with disabilities need to be addressed through a multisectoral approach and require all sectors to work together. Medium risk. *Mitigation*: As outlined in the section on Analysis and lesson learnt, WHO has developed all its key products, the *World report on disability*, the *CBR Guidelines* in partnership with other UN agencies that work in other development sectors and in consultation with a broad range of stakeholders. Implementation of these tools will be done in partnership with collaborators and regional and local actors from different sectors ensuring a multisectoral response to disability. Working with AusAID who has a multisectoral approach will help strengthen this approach.

Co-financing Additional resources will need to be mobilized to achieve many of the actions. Low-to-medium risk. *Mitigation*: WHO has continued to diversify its donor base over the past

three years and efforts to do so will continue to ensure that AusAID funding can assist in leveraging additional resources. Countries will also be encouraged to allocate resources towards the agreed activities. The AusAID secondee will also provide inputs into strategic and efficient options (for donors, and WHO) for resourcing global and regional activities.

Sustainability Issues

The project is oriented at building technical capacity through the development and dissemination of normative documents and support in their application.

Policy level- the situation analysis and readiness assessment will help determine policy changes.

Staffing*:* AusAID is requested to fund a disability technical officer in the Western Pacific Regional Office (WPRO) for the duration of the project and to second a senior staff member to WHO Headquarters for three years. WHO will endeavour to raise funds towards the salary costs of the regional technical officer in year four[11]. WHO will communicate with AusAID on successful mobilization of resources and will decrease salary contributions accordingly.

Country actions*:* see previous section on implementation plan. The choice of countries will take into consideration the potential for sustained change - for example, a country has demonstrated publicly its willingness to advance the rights of persons with disabilities e.g. has signed /ratified the CRPD and taken action towards implementation. Furthermore, technical choices at the centre of each action will take into account issues of technical sustainability, for example - the choice of assistive device technology in a country will take into consideration the needs of the users within the context and the ability of the supplier to sustain service provision. The senior level secondee will support WHO to foster multisectoral collaboration at the level of country support in Asia and the Pacific.

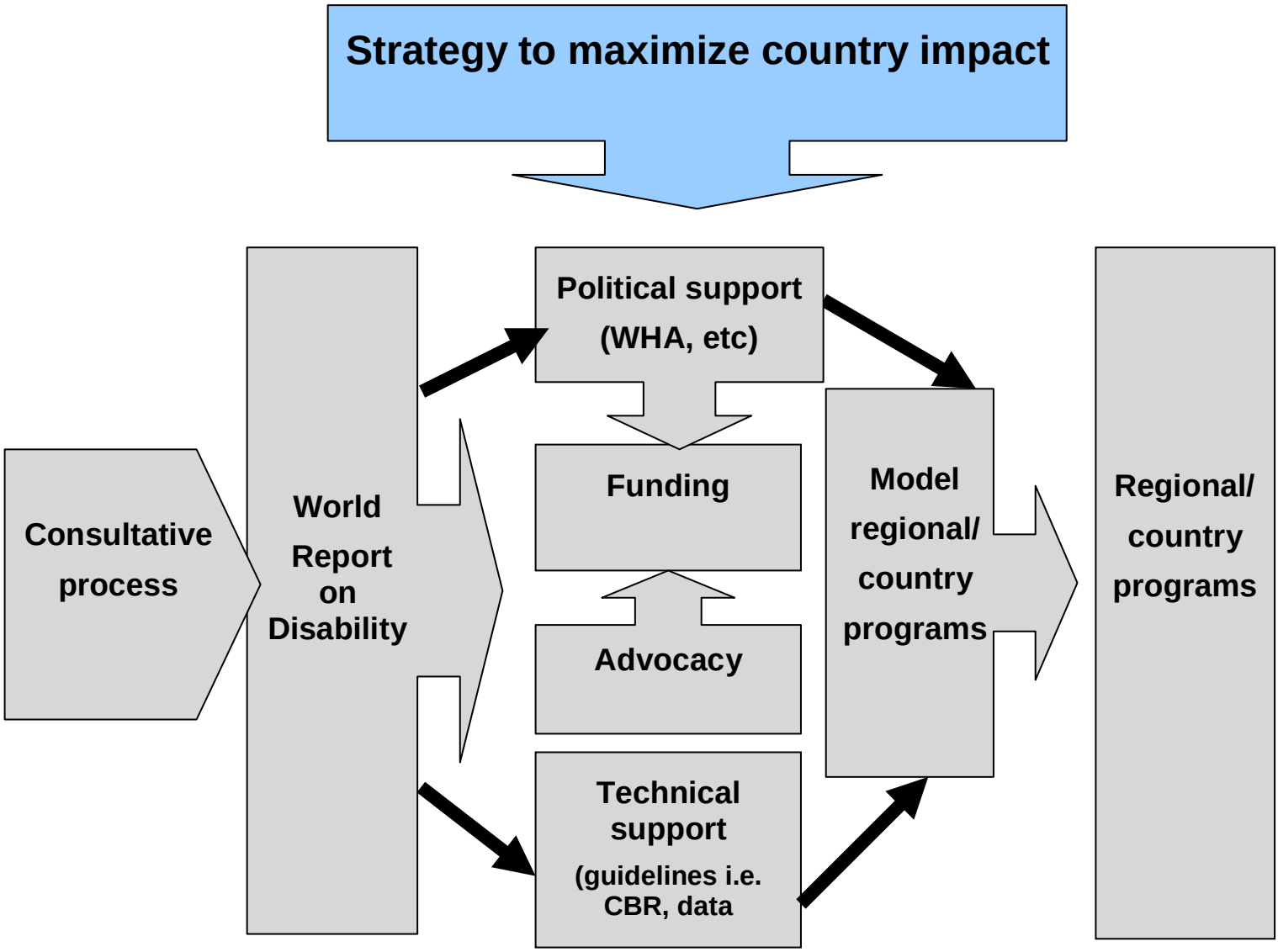
Networks: This project has as a cross-cutting objective relating to the development of networks at the level of the country, region and globally. These will support resource mobilization, sharing and exchange.

Financial: The team will work to diversify donor support for the proposed activities and draw on local resources for country level activities. However additional funding for activities will be required beyond the end of this project. The senior level secondee will support WHO to identify innovative strategies to diversify its donor base for inclusive development.

Overarching policy issues including gender, anticorruption, environment and child protection will be considered at the level of each action.

11 Across the Organization, the number of staff positions funded from regular budget contributions are very unlikely to increase.

1. Strategy to maximize Country impact using the world report and related guidelines



2. Program Management & Implementation Arrangements – Organization Chart and terms of reference for the WHO technical officer and the AUSAID secondment.

Please see attachments (4 in total)

WHO Headquarters

The AUSAID secondee will be placed in the Department on violence, injury prevention and Disability and in the unit on Disability and rehabilitation. Please see Organizational chart and Terms of reference

WHO Western Pacific Regional office

The Technical Officer on disability will be placed within the Department on *Building healthy communities and populations* and within the Unit on *Mental health and injury prevention*. Please see Organizational chart and Terms of reference

3. Detailed Budget / Cost Estimates (AUD)

Objective	Actions	Level of Activity (Global, Regional, Country)	July 2010 - June 2011	July 2011 - June 2012	July 2012 - June 2013	July 2013 - June 2014
All	Technical officer for WPRO (P4)	R	110,000	220,000	220,000	220,000
	Administrative assistant	R	9,000	18,000	18,000	18,000
Objective 1	Global and national level launches: Yr 1: Support disabled leaders and policy makers, from the Asia and the Pacific region to participate in the global launch. The aim is to sensitize them about the content of the report, and develop their capacity to organize a regional level event. Yr 2- 3 National level policy dialogues / planning meetings with seed money for country action	G	50,000	60,000	120,000	
	Develop a tool kit for national level policy dialogue and programming (including films, bags, posters, fact sheets, review and adaptation of support tools e.g. situation analysis etc)	C	10,000	25,000	50,000	
	Raise media awareness of the importance of disability at global, regional and national levels	G, R, C	35,000	25,000	15,000	15,000
	Carry out policy dialogues at global level on the world report e.g. Conference of States Parties (New York), Committee on the Rights of Persons with Disabilities (Geneva), Forum Disability Ministers (Fiji)	G, R		100,000	40,000	
Objective 2	Situational Analysis of Disability (Desk and Field Review) – Global and health policies, Resources, Stakeholders, Activities	R	40,000			
	Expert Consultation with five WHO CCs & other stakeholders/ experts to define scope, discuss regional priorities & how to scale up activities	R	25,000			
	Conduct regional/country workshops to promote CBR and the CBR Guidelines and support country action : Yr 1 Solomon Islands ; Yrs 2 - 4 two countries per year	C and R	25,000	50,000	75,000	100,000
	Support the development of regional networks of CBR practitioners for information and knowledge exchange ; Yr 2: Asia and Pacific congress in Manila ; Yr 3 CBR world congress in Bangalore India	G and R		50,000	80,000	50,000
	Development regional Training of Trainers Package in line with the Guidelines.	G	40,000	60,000	80,000	100,000
	Support the development of guidance and tools for monitoring the effectiveness of CBR in countries.	G, R, C		50,000	100,000	100,000
Objective 3	Develop guidelines on strengthening specialized rehabilitation services	G		80,000	80,000	120,000
	Support Member states to develop policies and through pilot projects improve access to health and rehabilitation services: YR 1 East Timor (wheelchairs) and Mongolia (policy); SEARO and WPRO (yrs 1 - 4) Reproductive health	R,C	60,000	120,000	180,000	280,000
Objective 4	Develop a standard instrument for disability surveys to measure impact of disability on people's lives - develop instrument , field test, focus groups, pilot test[1]	G, R, C		60,000	100,000	
		Sub total	404,000	918,000	1,158,000	1,003,000
		PSC	52,520	119,340	150,540	130,390
		Total	**456,520**	**1,037,340**	**1,308,540**	**1,133,390**
					Grand Total	**3,935,790**

Four countries have already been identified for 25 % of the budgeted support. Funding for additional countries will be decided following the national policy dialogues and will depend on the nature of the action and the local capacity.

∞ Application of the survey instrument would require additional resources and would be depending on country context. This has not been budgeted for in this project.

* Programme support costs include central services, for example human resource, internal oversight and organizational overheads, including running costs of the organization. They do not cover administrative support for technical activities. It is charged to all partners/ contributors to the Organization.

Please note: WHO will contribute to the costs (approximately 600 000 over the project period) of three staff, based in headquarters who will also work on this project. These include the Coordinator for disability and rehabilitation, two technical officers and one administrative assistant. It is anticipated that more time will be spent in year 1 and decreasing in years 2 - 4 with the arrival of the AUSAID secondee and the regional technical officer.

4. Monitoring and Evaluation Framework

At the *global level*: Monitoring and assessment of the Programme budget are Organization-wide processes conducted at the 12-month, mid-term period (Mid-term review) and upon completion of the biennium (Programme budget performance assessment) and are submitted to the governing bodies. The *Mid-term review* serves to track and appraise progress towards achievement of the expected results. It facilitates corrective action, and reprogramming and reallocation of resources during implementation. For each strategic objective, colour ratings are assigned (red, yellow or green) to indicate progress in achieving the expected results at the mid-term, and a narrative describes impediments, problems, risks and actions required to ensure that the expected results are achieved. The *end-of-biennium* Programme budget performance assessment is a comprehensive appraisal of the performance of each organizational level and of the Organization as a whole. It focuses on achievements as compared with planned results and on lessons learnt in order to inform planning for the next biennium. The assessment is a key input into subsequent programme budgets and possible revisions to the Medium-term Strategic Plan.