World Health Organization

European Region

Good practices on disability-inclusive health

The WHO European framework to achieve the highest attainable standard of health for people with disabilities

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Abstract
This good practices document showcases a diverse set of disability-inclusive health initiatives implemented across the WHO European Region, mapping real examples against the objectives of the *WHO European framework for action to achieve the highest attainable standard of health for persons with disabilities 2022–2030*. The case studies include systems reforms, service coordination platforms, workforce training, digital accessibility solutions, and inclusive governance models co-produced with organizations of people with disabilities. Collectively, they demonstrate that sustainable progress in disability-inclusive health is achieved through co-design with people with disabilities and their representative organizations and through integration with financing, service standards and accountability structures. Effective practices prioritize proactive outreach to reduce stigma, interministerial and intersectoral collaboration to prevent fragmentation, and capacity-building of health workers on inclusion. Cross-cutting policy directions emphasize the importance of shared governance roles with people with disabilities, systematic disability-disaggregated data collection, nationwide accessible communication formats, and sustained public health financing for universal design and workforce development. These case studies illustrate how the commitment of Member States towards advancing health equity for people with disabilities is producing tangible impact across the Region. This document is intended as a practical resource for Member States in the Region to help them adapt, replicate and scale disability-inclusive approaches.

Keywords
PERSONS WITH DISABILITIES, HEALTH SERVICES ACCESSIBILITY, HEALTH SERVICES FOR PERSONS WITH DISABILITIES

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Executive summary

This document presents a diverse set of disability-inclusive health practices implemented across the WHO European Region. While the initiatives vary in scale and geography – from local health services to national health legislative reforms – they share several strategic principles, based on the *WHO European framework to achieve the highest attainable standard of health for people with disabilities 2022–2030*. Across contexts, progress is greatest where disability-inclusive health considerations are treated as a systems obligation rather than a temporary project. Effective approaches are rights based and coproduced with organizations of people with disabilities, sustained through dedicated financing and integrated across health, social protection, education and community services. A key observation across the case studies is that to be durable accessibility and inclusion need to be embedded into core governance, financing and workforce systems. Reforms that rely solely on awareness raising or infrastructure upgrades, without strengthening data, accountability or service standards, do not lead to sustained change. In contrast, investment in structural reforms, including workforce capacity-building, strengthened care pathways and planning that is conducted in cooperation with organizations for people with disabilities, can lead to sustained and impactful improvements.

To achieve disability-inclusive health systems, the following recommendations are provided for consideration by Member States.

1. **Embed disability inclusion into mainstream health systems and health financing frameworks.** Inclusive health service delivery should be mandated through provider contracting, national benefit packages and disability-inclusive compliance standards. Embedding disability inclusion into financing ensures it is sustained over time rather than dependent on short-term projects.
2. **Institutionalize shared governance with organizations of people with disabilities.** These organizations should have formal roles in decision-making structures, monitoring processes and evaluation mechanisms. This shifts participation from consultation to codesign.
3. **Invest in disability competencies of the health and care workforce and inclusive professional standards.** Disability inclusion should be integrated into education curricula, licensing requirements and continuing professional development for the health and care workforce.
4. **Strengthen disability-disaggregated data systems across health and social sectors.** Routine, comparable data are essential for identifying inequities, allocating resources effectively and measuring progress. Data systems need to include service utilization indicators and links to social and demographic datasets, with clear disability disaggregation methods using a standard functional approach.
5. **Coordinate policies between health and other sectors.** Policies must be planned and delivered holistically and with coordination between various ministries to avoid fragmentation.
6. **Ensure continuity and resilience of disability-inclusive services in emergencies and recovery planning.** Health emergencies, including those produce by pandemics, conflict or displacement, exacerbate risk of exclusion. It is necessary to embed disability inclusion into emergency preparedness, continuity-of-care systems and reconstruction policies.
7. **Ensure all health programmes have dedicated funding streams for disability inclusion as a standard practice.** Sustainable resourcing is essential for system-wide adoption. Budget lines should be transparent and reviewed with input from organizations of people with disabilities.

The case studies described are drawn from across the WHO European Region and are grouped to show good practice in four areas of objectives:

- **objective 1**: equitable access to health
- **objective 2**: health promotion
- **objective 3**: disability-inclusive response to health emergencies
- **objective 4**: building an evidence base on disability and health.

Further information on the case studies or about the technical work on disability inclusion more broadly can be obtained from eurofpwds@who.int.

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Introduction

The *WHO European framework for action to achieve the highest attainable standard of health for people with disabilities 2022–2030*[1] is closely linked to the *Global report on health equity for persons with disabilities*[2] and envisions that, by 2030, people with disabilities will be fully included and considered in all health care planning, delivery and leadership across the WHO European Region. This inclusion aims towards a disability-inclusive health sector and the promotion of the health and well-being of all people in order to achieve the highest attainable standard of health for people with disabilities of all ages and across all contexts in the Region. This document showcases good practice examples for each of the four objectives of the Framework, focusing on universal health coverage, health promotion, protection during health emergencies and data mechanisms. It aims to facilitate the sharing of good practices and learning concerning disability inclusion in health across Member States and demonstrate the diversity of current practices across the Region, ranging from local initiatives to national or regional projects, through individual case studies. It can be treated as a dynamic document, where new case studies can be added as they become available. These case studies will also inform the monitoring and evaluation process of the Framework, complementing the established seven indicators and aggregated data with local examples. The seven indicators are presented in Table 1, with the case studies mapped against each.

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[1] The WHO European framework for action to achieve the highest attainable standard of health for persons with disabilities 2022–2030. Copenhagen: WHO Regional Office for Europe; 2022 (https://iris.who.int/handle/10665/364994, accessed 25 November 2025). Licence: CC BY-NC-SA 3.0 IGO.

[2] Global report on health equity for persons with disabilities. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/364834, accessed 25 November 2025). Licence: CC BY-NC-SA 3.0 IGO.

Table 1. The seven indicators for achieving disability-inclusive health systems and the case studies that illustrate them

Indicator	Case study
1. The Member State has implemented disability inclusion measures in national health programmes and strategies (Y/N)	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9, 1.10, 1.11, 1.12, 1.13, 2.1, 2.3, 2.4, 2.7
2. Disability disaggregated private household out-of-pocket payments on health as a percentage of total health expenditure	1.1, 1.10, 1.13
3. Use of any means of contraception or sexually transmitted disease prevention among people with disabilities aged 15 and over (%)	2.5
4. People with disabilities (per 100 000 population) reaching the recommended levels of physical activity, age-standardized	1.3, 2.6, 2.7
5. Noncommunicable disease mortality rate (per 100 000 population), age-standardized and disaggregated by disability	To be collected in the future
6. Existence of strategies to maintain essential health services for people with disabilities during health emergencies (Y/N)	1.11, 3.1, 3.2, 3.3, 3.4
7. Use of a valid, reliable monitoring tool providing internationally comparable data on the health and social situation of people with disabilities (Y/N)	4.1, 4.2, 4.3, 4.4

N: no; Y: yes.

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Objective 1. Equitable access to health care

Case study 1.1 Azerbaijan
Sign language interpretation with health workers

Azerbaijan's Sign Language Interpretation Service (SLIS)[3] was developed by the State Medical-Social Expertise and Rehabilitation Agency to support independent access to health and social services, and other public services, and enhance social inclusion and well-being for people with hearing and speech impairments. SLIS provides real-time, remote sign language interpretation through digital platforms, ensuring that individuals can communicate directly service providers without relying on family members or third parties.

Key project activities

- A real-time video-based sign language interpretation system operates through a unified phone number via video calls (Zoom, WhatsApp, Telegram) or real-time online chat.
- Deployment of trained sign language interpreters to mediate communication between people with hearing or speech impairments and health and care workers.
- Awareness and outreach to inform people with hearing or speech impairments and public service institutions about how SLIS works and how to access it.
- Regular training for sign language interpreters in medical terminology, service ethics, confidentiality standards and disability-inclusive communication practices.

Impact

> *"I used to go with my mother and interpret, but now she goes to the hospital without me."* **User of SLIS**

Since its launch, SLIS has significantly improved access to health care services for people with hearing and speech impairments. More than 130 individuals used the service within the first 3 months, with a majority of calls related to medical consultations, hospital visits, examinations and medication instructions. The service has reduced miscommunication risks during clinical consultations, strengthened patient autonomy and ensured informed medical decision-making.

Challenges and mitigation strategies

- Challenges included limited awareness among public institutions, connectivity issues and the need for capacity-building for interpreters. Mitigation measures include ongoing outreach campaigns, strengthened partnerships with hospitals and public agencies and investing in interpreter recruitment and digital infrastructure upgrades.

Policy recommendations

- Roll out SLIS across all public sector institutions, including hospitals and emergency response networks.
- Develop national certification and continuous professional education pathways for sign language interpreters and practice placements within health care settings.
- Strengthen multiagency coordination to ensure seamless referrals and system-wide use.
- Expand service coverage hours and explore 24/7 support for emergency medical needs.
- Promote public awareness campaigns (e.g. in television/radio) to increase visibility and mainstream accessible communication practices such as SLIS.

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[3] Ölkəmizdə ilk dəfə olaraq görüntülü ünsiyyətə əsaslanan onlayn surdotərcümə xidməti istifadəyə verildi [For the first time in our country, an online sign language interpretation service based on video communication has been launched] [news release]. State Medical-Social Expertise and Rehabilitation Agency; 29 July 2025 (https://dtsera.gov.az/media/press-reliz/olkemizde-ilk-defe-olaraq-goruntulu-unsiyyete-esaslanan-onlayn-surdotercume-xidmeti-istifadeye-verildi, accessed 25 November 2025) (in Azerbaijani).

Case study 1.2 Bosnia and Herzegovina

Strengthening early identification in primary health care

A multisectoral early intervention system was established to support early identification and timely coordinated support for children with developmental disabilities and their families. The programme improves cooperation across health, social protection and education to ensure children are supported in their natural environments with equal access to inclusive education.

Key project activities

- Integration of early intervention services within primary health care.
- Creation of an intersectoral early intervention pathway for children aged 0–6 years, with clear referral and follow-up procedures.
- Provision of appropriate health workforce across preschool, primary and secondary schools to strengthen in-school service provision.
- Cooperation with international and nongovernmental organizations to support implementation and capacity-building.

Impact

Early intervention services have been established within the Sarajevo Health Centre with intersectoral pathways in place. The number of assistants in preschools and primary schools, who also assist with health care initiatives and activities, has increased. This has strengthened the foundations of inclusive education, improved the functional abilities of children and enhanced the coordination of services available to families across Sarajevo canton.

Challenges and mitigation strategies

- Initial gaps included the absence of a unified registry of children with disabilities needing services, fragmented early-intervention pathways, variable school readiness and limited workforce capacity.
- Mitigation measures include formal interdepartmental cooperation, expansion of the assistant workforce, deployment of mobile expert teams and progressive alignment of school programmes with individual needs.

Policy recommendations

- Adopt a canton-wide data system to register referrals, monitor progress and support joint planning.
- Consolidate intersectoral governance (i.e. including health, social, education) with defined roles and shared protocols for early identification and follow-up.
- Ensure sustainable funding for multidisciplinary teams across preschool and school levels.
- Strengthen transition planning from adolescence to adulthood to avoid service drop off.

Case study 1.3 France

Promoting inclusive parasport for health promotion

The French Parasport Health Institute (Institut Parasport Santé; IPS)[4] aims to promote health, autonomy, participation and access to sport for people with physical, sensory and cognitive disabilities. It provides assessments, training and individualized support to enable safe and adapted participation in physical activity and to develop professionals' capacity in parasport and rehabilitation.

Key project activities

- Clinical assessment of motor, physiological and cognitive capacities of people with disabilities.
- Provision of guidance for people with disabilities to select and practise an adapted sport and support their performance, thus contributing to preventive health strategies.
- Outreach team for home-based support and coordination with community services.
- Training and professional development for approximately 250 health, rehabilitation and sports professionals per year.
- Development of novel assistive technologies, adaptive equipment and digital training tools.
- Engagement with national partners in health, research, parasport federations and community organizations, thus mobilizing sizable resources to support parasports infrastructure and state funding.

Impact

The IPS is expected to support approximately 5000 people with disabilities per year, through a total of 16 000 consultations annually. It strengthens pathways to inclusive physical activity, increases access to adapted training environments and builds national expertise in parasport medicine and rehabilitation. The initiative advances France's commitment to health promotion, participation and disability inclusion and aims to become France's first sports-based preventive medicine centre for people with disabilities.

Challenges and mitigation strategies

- Developing new assistive technologies and integrated support models requires sustained coordination between clinical, engineering, academic and community partners. To address this, IPS has established collaborative research networks, start-up incubation spaces and regional partnerships to support innovation, knowledge exchange and sustainable programme development.

Policy recommendations

- Strengthen public funding for community-based parasport and health promotion.
- Invest in training pathways to build shared expertise for health and sport professionals.
- Expand access to adapted equipment, assistive technologies and inclusive facilities.
- Support national and international replication of parasport health institutes.
- Promote public awareness to reduce stigma and increase participation in parasport.

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[4] Institut Parasport Santé [Parasport Health Institute] [website]. Institut Parasport Santé; 2025 (https://ips-fondation.org, accessed 25 November 2025) (in French).

Case study 1.4 Ireland
Health passport for adults with intellectual disabilities

The Health Passport[5] developed by the Irish Health Service Executive ensures that adults with intellectual disabilities can communicate their health, communication and support needs clearly in all health care encounters, thereby improving patient safety, dignity, shared decision-making and equitable access. By providing a standardized, easy-to-use paper passport and a free national mobile application (app), the initiative promotes person-centred care and continuity across all levels of the health and education sectors.

Key project activities

- Input from people with intellectual disabilities, families, clinicians and advocacy organizations to codesign the Health Passport content and layout.
- Phased national roll out: 2017 (pilot paper version), 2019 (dissemination across the Executive), 2021 (Passport identity app launch), 2025 (updates to broaden applicability).
- Structured sections covering identity, communication preferences, reasonable adjustments, diagnoses, medications/allergies and decision-making supports.
- Use of Passport embedded in hospital admission packs, preoperative checks and general practitioner reviews to ensure it is routinely requested and read at the point of care.
- Training and job aids for frontline staff, families and carers on how to complete, update and present the Passport, aiming to include it in quality assurance and safeguarding programmes.

Impact

Improved clinical handover quality and fewer communication-related errors have been reported alongside improvements in preventive health practices (e.g. allergies, communication tips, behavioural triggers). Service users describe feeling heard and understood, and families report reduced stress during emergencies because key information is immediately available. Staff confidence in making reasonable accommodations has increased, contributing to safer, more individualized care and better outcomes.

Challenges and mitigation strategies

- Uneven uptake between services and regions, addressed by appointing local clinical champions, incorporating Passport checks into admission workflows and adding prompts in electronic systems.
- Keeping content current, mitigated by linking updates to annual care plans, medication reviews and automated reminders within the app.
- Digital literacy and device access barriers, mitigated by maintaining a high-quality paper version and offering carer support to populate and present the passport.

Policy recommendations

- Mandate health providers use and request the Health Passport as part of routine documentation and health service delivery for adults with intellectual disabilities (and others who may benefit) and ensure sustainable funding sources.
- Embed disability-inclusive communication and reasonable-accommodation training in health and care worker training and in annual refresher curricula for all staff.

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[5] Health Passport (HSE) [website]. Health Service Executive; 2025 (https://www.hse.ie/eng/services/list/4/disability/disability-quality-improvement/health-passport-intellectual-disabilities, accessed 25 November 2025).

Case study 1.5 Ireland

Intersectoral children's disability network teams

Children's disability network teams (CDNTs)[6] deliver equitable, needs-based access to multidisciplinary disability services for children and young people aged 0–18 years, irrespective of diagnosis or location. The programme restructures provision around CDNTs to prioritize early intervention, family-centred planning, participation in home, school and community settings and smooth transitions across the life course.

Key project activities

- Establishment of CDNTs that integrate physiotherapy, occupational therapy, speech and language therapy, psychology, social work and nursing into coordinated teams.
- Standardized referral and triage pathways so that access is based on complexity of need rather than diagnostic label, with clear thresholds for early intervention.
- Family-centred practice to co-produce goals in individualized family service/support plans, and coaching models that embed strategies in daily routines at home and school.
- Delivery of supports across schools, homes and community settings.
- Cross-sectoral collaboration between education, health and social care.
- Continuous professional development and shared learning across disciplines to strengthen inclusive communication and improve outcomes for the child.

Impact

Where CDNTs are fully implemented, families report more coherent pathways and earlier access to targeted supports. Children benefit from coordinated interventions that improve participation at home and school and reduce secondary complications, supporting smoother life stages transitions. The CDNT model has strengthened collaboration between services and supports a more transparent, needs-based allocation of resources.

Challenges and mitigation strategies

- Recruitment and retention pressures across core disciplines increased waiting times, mitigated via targeted hiring campaigns, graduate pipelines to CDNTs and flexible roles to improve retention.
- Variation in capacity and fidelity across regions, mitigated by national service guidance, performance dashboards and resource re-allocation to areas of greatest need.
- Historic fragmentation between sectors, mitigated by formal interagency governance, shared protocols and joint training for school and health staff.

Policy recommendations

- Expand funded training and supervised practice placements to grow the multidisciplinary and multisectoral workforce and reduce vacancy rates in CDNTs.
- Scale evidence-based early-intervention models and embed outcome measurement to track participation, family-reported outcomes and equity of access to CDNTs.
- Strengthen integrated planning with health/education/social care and invest in transition supports for those moving across schooling stages and to adult pathways.

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[6] Policy framework for service delivery of children's disability network teams. Dublin: Children's Disability Network Team; 2022 (https://www.cho7cdnt.ie/assets/files/pdf/policy-framework-for-children-s-disability-network-teams.pdf?utm_source=chatgpt.com, accessed 25 November 2025).

Case study 1.6 Ireland
National Clinical Programme for People with Disability

The National Clinical Programme for People with Disability (NCPPD)[7] was established to transform how disability services are designed, led and governed across Ireland. Guided by the United Nations Convention on the Rights of Persons with Disabilities (CRPD), it promotes inclusive, competency-based leadership and participatory governance involving professionals, civil society organizations and people with lived experience in leadership positions. The NCPPD aims to strengthen equitable access, interdisciplinary collaboration and person-centred service delivery across the health and social care system.

Key project activities

- Competency-based leadership roles at national level that are open to all professional backgrounds, rather than exclusively to medical practitioners.
- Establishment of disability advisory groups to replace traditional clinical advisory groups, chaired by a person with lived experience of disability.
- Development of life-course committees and cross-departmental coordination.
- Ongoing co-production of priorities, service design and review processes with people with disabilities and advocacy organizations.

Impact

The NCPPD has institutionalized inclusive leadership and participatory governance within disability services. Competency-based appointments at national and team level have broadened leadership beyond traditional professional hierarchies. The disability advisory group structure has strengthened shared decision-making, improved communication across professional and lived-experience perspectives and influenced system reform beyond specialist disability services. Independent review of the national model for children's disability network teams is ongoing and capacity-building supports for team leaders continue to be developed.

Challenges and mitigation strategies

- Resistance to shifting away from traditional hierarchical governance and medically led leadership models mitigated by advocacy for legislative reform and alignment with contemporary rights-based approaches to disability to guide decision-making and defend equity-focused reforms.
- Workforce shortages across health and social care, limiting full implementation, addressed by development of workforce optimization strategies and leadership support programmes at national and team levels.

Policy recommendations

- Ensure meaningful representation of people with lived experience in all levels of governance, oversight and service planning.
- Review and modernize legislative frameworks to align disability services with CRPD principles and person-centred practice.
- Prioritize workforce development and support measures to ensure sustainability and quality of interdisciplinary disability services.

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[7] National clinical programme for people with disability governance structure and function. Dublin: Health Service Executive; 2020 (https://www.hse.ie/eng/about/who/cspd/ncps/disability/programme-governance/clinical-programme-for-disability-governance-structure-and-function.pdf, accessed 25 November 2025).

Case study 1.7 Ireland

Improving autism assessment and intervention pathways

This protocol establishes a tiered, needs-focused and person-centred approach to autism assessment. It aligns the intensity of assessment with the clarity and complexity of presentation, promotes strengths-based formulation and identifies individualized service and support needs across the life course.

Key project activities

- Development of a tiered assessment protocol, offering different levels of complexity to meet the diverse needs of autistic people.
- Seven iterative revisions of the assessment protocol were informed by piloting, stakeholder consultation and independent evaluation.
- Implementation across primary care, disability and mental health services, allowing clinician choice of tier band tools, based on need.
- Identification of strengths and needed supports in every assessment.
- Provision for interdisciplinary collaboration, including psychologists, occupational therapists and speech and language therapists.

Impact

Independent evaluation demonstrated that the tiered model improves efficiency of diagnosis and support, maintains assessment quality and supports meaningful identification of service needs. Service users reported positive experiences of the strengths-based approach. Health and care workers reported increased confidence with experience, supported by peer learning and clinical leadership.

> *"I think the priority in all of this seemed to be the child and I think that's how it absolutely should be."* **Parent**

Challenges and mitigation strategies

- Limited community team resources and high caseloads, addressed through development of in-reach support teams.
- Initial clinician discomfort with varying assessment intensity, mitigated through peer support, training and leadership guidance.
- Professional body concerns and differing interpretations of evidence, addressed through structured consultation and protocol revisions.
- System fragmentation across disability, mental health and primary care services, mitigated through integrated reporting pathways.

Policy recommendations

- Establish a single point of access to direct referrals to the appropriate assessment tier.
- Ensure autism-awareness and reasonable accommodation training for all health and social care staff.
- Promote protocols that recognize co-occurring neurodiversity and mental health needs, rather than single-condition frameworks.
- Support continuity of services across life stages by reducing siloed transitions.

Case study 1.8 Ireland
Disability awareness training by autistic people

This programme aims to improve the understanding of and communication with autistic people among staff in health and social care services, ensuring more equitable access, reduced stigma and improved service experiences. The training is codesigned and codelivered by autistic people, positioning autistic lived experience as a central source of expertise, while promoting a neuro-affirmative and rights-based approach.

Key project activities

- Codesign of three online introductory modules with autistic people, clinicians, administrators, families and service users.
- Delivery of neuro-affirmative content emphasizing communication, sensory needs, predictability, acceptance and empathy.
- Inclusion of lived-experience trainers, including autistic health and care workers.
- Integration of training into national online learning platform, with more than 3300 staff completing modules.
- Planned expansion into additional modules to widen representation and deepen practice application.

Impact

> *"I found this to be an excellent training programme! The use of real-life people and their own examples of scenarios was hugely beneficial, as opposed to having actors or people speaking on their behalf. I also believe that having examples of people with autism working in health care to be a great addition, as this reduces the stigma that may be attached to autism. I also felt the pace of the training was just right and it has a lot of information without being information overloaded."* **Participant**

Feedback from over 3300 participants indicated strong relevance, high satisfaction and improved confidence in communicating with autistic people. Participants reported gaining practical skills applicable across clinical and administrative roles. The programme also highlighted autism as a dimension of staff identity, normalizing neurodiversity within the health workforce and supporting a more inclusive organizational culture.

Challenges and mitigation strategies

- Prioritizing essential content within limited training time was challenging, addressed through iterative codesign and structured simplification.
- Representing the broad diversity of autistic experiences was difficult, mitigated by committing to phased development of additional modules.
- Participants varied in baseline knowledge and expectations; the modular design allowed flexibility and accessibility across staff groups.

Policy recommendations

- Embed codesign methodologies in all disability-related training and service development.
- Ensure ongoing delivery and expansion of neuro-affirmative training for all clinical and non-clinical staff.
- Recognize and support neurodiversity within the health workforce by promoting reasonable accommodations and inclusive organizational practices.

Case study 1.9 Portugal
Family-centred early intervention system

The National System of Early Childhood Intervention (SNIPI)[8] guarantees timely, family-centred support for children aged 0–6 years with developmental delays or at risk, through coordinated intersectoral action across the relevant ministries. SNIPI identifies needs early, strengthens caregiver capacity and delivers intervention to promote participation and well-being.

Key project activities

- Operation of intersectoral early intervention teams to bring together health, education and social-solidarity professionals.
- Co-creation of individualized family support plans and provision of coaching to embed strategies in daily routines.
- Use of the International Classification of Functioning, Disability and Health for Children and Youth as a shared framework for assessment and goal-setting across sectors.
- Referrals embedded within primary care and preschool systems to ensure systematic early identification.
- Use of a national legal mandate (Decreto-Lei No. 281/2009)[9] and multi-ministerial governance for sustainability.

Impact

Early interventions took place predominantly in educational settings (45%), followed by mixed settings (36%), home (14%) and other contexts (5%). In 2023, 8209 children transitioned from the programme: 54% of those involved (4439) successfully transitioned to formal schooling, showing significant progress in their development; 12% of children no longer needed intervention, reflecting improvements that allowed their support to be discontinued; while only 19.7% required additional or different interventions. This indicated that most children benefited from the initial approach, and that system monitoring ensured ongoing support when needed. SNIPI has strengthened community inclusion and increased family empowerment through coordinated, intersectoral and transdisciplinary support.

Challenges and mitigation strategies

- Early implementation faced siloed practices, uneven geographical coverage and complex multi-ministerial budgeting. The SNIPI addressed these through the creation of local intervention teams nationwide, joint training and shared protocols, standardized referral pathways integrated within the National Health Service and a formal national coordination structure.

Policy recommendations

- Maintain the national legal mandate and interministerial governance, with dedicated joint budgeting.
- Ensure intersectoral collaboration across health and social care and education.
- Acknowledge families as the unit of intervention to maximize impact and long-term outcomes.
- Strengthen workforce development on transdisciplinary, family-centred practices and coaching.
- Consolidate standardized referral and eligibility pathways integrated with universal child health and preschool systems.

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[8] Sistema Nacional de Intervenção Precoce na Infância [National System of Early Childhood Intervention] [website]. Sistema Nacional de Intervenção Precoce na Infância; 2025 (https://snipi.gov.pt/familias#no-back, accessed 25 November 2025) (in Portuguese).

[9] Decreto-Lei No. 281/2009, de 6 de outubro [Decree-Law No. 281/2009, of 6 October]. Lisbon: Portuguese Ministry of Health; 2009 (https://diariodarepublica.pt/dr/detalhe/decreto-lei/281-2009-491397, accessed 25 November 2025) (in Portuguese).

Case study 1.10 Spain

Universal access to public health care services

This programme seeks to ensure that people with disabilities in Andalusia, Spain, can access public health care services on an equal basis with others by removing architectural, communication, informational and procedural barriers across the health system. Grounded in the principles of the United Nations Convention on the Rights of Persons with Disabilities and developed through co-creation with civil society, professional bodies and public institutions, the programme forms part of the III Comprehensive Action Plan for People with Disabilities (2021–2026) and promotes accessibility, universal design, informed consent, improved care pathways and disability-inclusive emergency preparedness.

Key project activities

- Co-creation of the project with disabled people, families, associations, experts, unions and local entities.
- Integration of universal design and accessibility criteria into health facility quality assessments and improvement plans, including architectural adaptations and equipment upgrades.
- Establishment of communication support protocols and disability-inclusive professional training on accessible communication and safe mobilization practices.
- Introduction of technological and digital solutions to enhance accessibility and continuity of care.

Impact

The programme strengthens the structural capacity of the Andalusian health care system to deliver disability-inclusive services. A 24/7 helpline supports people with disabilities and their families in navigating care and accessing entitlements, including a dedicated line for people with hearing disabilities. Funding streams have been established to modernize services, adopt new technologies and improve independent living supports. While some implementation delays have been reported, the programme has contributed to increased accessibility awareness, expanded disability-inclusive planning and recognition of accessibility as a core quality standard in public health service delivery.

Challenges and mitigation strategies

- There are gaps in disability-disaggregated data and incomplete integration of health and social service systems. This will be mitigated by development of monitoring frameworks tied to annual reporting cycles and a commitment to integrated data systems disaggregated by disability type and support needs.
- Persistent accessibility barriers occur in some health care facilities and there is inconsistent support during climate-related emergencies. These are addressed by ongoing evaluation of accessibility gaps and targeted operational improvements linked to regional emergency preparedness plans.

Policy recommendations

- Establish mandatory universal design standards across all public health care facilities, with regular audits to ensure compliance.
- Integrate disability-disaggregated data collection into regional health information systems to monitor access barriers, service outcomes and health inequities and use these data to guide dedicated resources to disability within health systems.
- Institutionalize continuous training for all health care workers on disability inclusion, accessible communication and disability-responsive emergency procedures, making it a requirement for professional certification and facility accreditation.
- Create a permanent disability advisory mechanism within the health sector, ensuring people with disabilities and their representative organizations codesign, monitor and evaluate health policies, emergency plans and service reforms.

Case study 1.11 Ukraine

The national strategy for a barrier-free environment

The aim of the National Strategy for a Barrier-free Environment[10] is to ensure universal, equitable and dignified access to health services for all people in Ukraine, with a specific focus on people with disabilities, by making accessibility a prerequisite for licensing and state financing, thus embedding barrier-free principles across infrastructure, information and digital systems. The strategy mandates that health care facilities are universally accessible, transforming health care access from an aspiration into a guaranteed right.

Key project activities

- State health financing linked to accessibility initiatives so that facilities must meet barrier-free standards to receive contracts under the Medical Guarantee Programme.
- Application of comprehensive universal design standards (e.g. for ramps, elevators or restrooms), accessible information formats and inclusive e-services and portals.
- Workforce capacity increased based on programmes such as WHO's Mental Health Gap Action Programme (mhGAP) for primary care and integration of rights-based approaches in medical curricula.
- Universal design in capital projects was ensured using an operational manual that requires universal design in all renovations and new builds.

Impact

Accessibility has shifted from a voluntary add-on to a system norm. As of early 2025 more than 3000 facilities – including over 1700 primary care clinics and at least 450 general hospitals – comply with barrier-free requirements tied to contracts from the National Health Service of Ukraine. Mental health capacity expanded markedly: over 114 000 primary care specialists completed mhGAP training, with more than 20 000 doctors actively providing care. Reconstruction efforts and digital upgrades are embedding inclusive design to improve quality, safety and continuity of care.

Challenges and mitigation strategies

- Legacy infrastructure and uneven standards are challenging and are being addressed by mandating formal accessibility certification for licensed practices and updating equipment lists (including accessible gynaecological chairs) to enforce compliant procurement.
- Communication barriers for people with hearing or speech impairments are mitigated by accessible contact options (SMS/email).
- Fragmented data and variable service quality are being addressed through a rehabilitation module based on the International Classification of Functioning, Disability and Health to standardize documentation and enable monitoring.
- The wartime surge in rehabilitation and mental health needs is being mitigated via training and deployment of multidisciplinary rehabilitation teams and plans for 200 integrated mental health centres (23 operational).

Policy recommendations

- Make accessibility a non-negotiable precondition for public financing and contracting across all health services to accelerate compliance and sustain inclusion.
- Use emergency recovery as a lever for system reform, embedding disability inclusion in reconstruction policies and multi-year investments.
- Institutionalize routine facility monitoring with disability-disaggregated indicators to track facility-level compliance and outcomes.

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[10] Реалізація Національної стратегії зі створення безбар'єрного простору в Україні на період до 2030 року [Implementation of the national strategy for creating a barrier-free environment in Ukraine for the period until 2030]. Kyiv: Government of Ukraine; 2020 (https://nssu.gov.ua/bezbariernist, accessed 25 November 2025) (in Ukrainian).

Case study 1.12 United Kingdom

Training health workers on needs of adults with intellectual disabilities

This programme aims to enhance the knowledge, clinical skills and confidence of health and care workers to provide high-quality, person-centred medical care for adults with intellectual disabilities. It supports the development of specialist expertise and strengthens local health service delivery to ensure equitable access to health care on an equal basis with others for people with intellectual disabilities.

Key project activities

- Postgraduate certificate delivered jointly by the Royal College of Physicians and Edge Hill University.
- Two academic modules combine clinical practice, person-centred care, preventive health, rehabilitation and end-of-life considerations.
- Hybrid delivery model uses in-person teaching, online sessions and workplace-based practice.
- Involvement of experts by experience, including individuals with lived experience of intellectual disabilities.
- Students develop and implement a service improvement project addressing local service needs.

Impact

Participants report improved confidence and competence in assessing and caring for adults with intellectual disabilities. The programme strengthens disability-inclusive practice in clinical settings, supports more personalized and responsive care and encourages the translation of learning into workplace change. Graduates contribute to improved workplace culture, peer education and service development.

Challenges and mitigation strategies

- Time constraints due to participants' clinical workloads are mitigated by flexible hybrid learning schedules.
- Need for local supervision and organizational support for applied learning is addressed through early identification of supervisors through internal networks and education leads.
- Limited familiarity among some staff with student shadowing or disability-inclusive practice is mitigated through gradual introduction to clinical environments, supported reflection and structured mentoring.

Policy recommendations

- Make disability-inclusive health care training mandatory across undergraduate and postgraduate programmes.
- Embed person-centred and competence-based learning on disability within national clinical education standards.
- Promote the involvement of people with lived experience in curriculum design, delivery and evaluation.
- Expand access to funded training opportunities to build equitable workforce capacity across regions.

Case study 1.13 European Union

The European Disability Card

The European Disability Card (EDC)[11] aims to ensure equal access to services for people with disabilities when travelling or living within European Union (EU) Member States. It provides standardized proof of disability status, facilitating recognition of rights and access to benefits across borders and leading to better access to health services.

Key project activities

- Development of a standardized physical and digital disability card recognized across participating EU Member States.
- Coordination between the European Commission, national authorities and the European Disability Forum.
- Awareness campaigns to inform people with disabilities and service providers of the Card.
- Training and guidance for public services, including not just the health system but also cultural institutions and transport providers, to recognize and apply accommodation practices.
- Legal framework enabled national issuance of the EDC and mutual recognition of status.

Impact

The EDC enhances mobility, autonomy and participation by removing administrative barriers previously faced when proving disability status abroad. Particularly in health care, it has enhanced access to services across the EU. The EDC strengthens access to health and raises awareness among service providers, promoting consistent and respectful accommodation practices. While not a replacement for health insurance, it provides a standardized, EU-wide proof of disability. This directly reduces barriers to care by streamlining administrative processes for both patients and providers, thus building a more accessible and integrated social environment.

> *“I used to go with my mother and interpret [for her], but now she goes to the hospital without me.”* **Family member**

Challenges and mitigation strategies

- Differences in disability assessment criteria across Member States require clear guidance to ensure mutual recognition without harmonizing national support systems.
- Awareness and uptake challenges among both users and service providers are being addressed by ongoing communication and training initiatives to support consistent implementation.

Policy recommendations

- Scale recognition of the EDC to all EU Member States and expand its scope of benefits.
- Integrate card recognition into standard service provider training and accessibility protocols.
- Link the EDC to emergency preparedness to ensure inclusive health emergency support and continuity of health services for people with disabilities, no matter where in the EU.
- Fund and promote the development of training toolkits for service providers to build institutional capacity.

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[11] Disability cards to help Europeans with disabilities fully enjoy their right to free movement [website]. European Commission; 2025 (https://eures.europa.eu/disability-cards-help-europeans-disabilities-fully-enjoy-their-right-free-movement-2025-04-04_en, accessed 25 November 2025).

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Objective 2.
Health promotion

Case study 2.1 Bulgaria

Digital health monitoring for older people and people with disabilities

Bulgaria's Digital Assistant Programme aims to enhance safety, independence and preventive health monitoring for a broad group of people, including people with disabilities and older adults. It is municipally led and publicly financed at local level, combining wearable monitoring, a family-facing application (app) and a 24/7 support centre embedded within the municipal social care system. The programme strengthens the capacity of local services to ensure timely support at home, reduce unattended critical incidents and alleviate family anxiety.

Key project activities

- Distribution of smart bracelets that record pulse, blood pressure and temperature with automatic uploads every 4 hours and on-demand readings.
- Fall detection via gyroscope plus location data to assist people who may get lost (e.g. due to dementia); one-touch emergency connection with operators.
- The mobile app can be used for families/caregivers to visualize trends, receive alerts (such as inactivity for more than 12 hours) and coordinate support.
- A 24/7 support centre for technical help, well-being check-in and emergency escalation.
- Close coordination with Burgas municipal social services ensures that users can also be linked to home care, community nursing, psychosocial support and in-person visits.
- Local authorities ensure outreach to isolated households, prioritization of vulnerable individuals and continuity of the service beyond initial enrolment.

Impact

The involvement of the municipality as the lead implementer is central to the programme's success, ensuring inclusivity, continuity and public accountability. Municipal engagement ensures coordination with local health and social care structures, building sustainable support networks. In Burgas, local public funding and staffing support have enabled more than 100 people to be equipped with bracelets, contributing to faster assistance and improved day-to-day reassurance. Across Bulgaria, approximately 400 users have benefited. The model demonstrates how publicly coordinated community support can deliver early response interventions.

Challenges and mitigation strategies

- Device adherence can lapse; this is mitigated by app notifications, operator reminders and clear charging guidance.
- Connectivity and hardware reliability challenges are addressed by monitoring for lost signals and with rapid technical follow-up or device replacement.

Policy recommendations

- Recognize telecare and remotely supported living services as part of national and municipal social care frameworks, enabling stable public funding.
- Integrate general practitioners and community nurses for clinical follow-up and clear escalation pathways.
- Expand municipal partnerships and subsidy schemes so low-income and rural households can access devices, including targeted outreach to isolated older adults and caregivers.
- Pilot hospital-to-home discharge coordination led jointly by municipal services and local health facilities, reducing readmissions and supporting safe recovery at home.

Case study 2.2 Greece
Promoting independent living

The Greek Movement for Change[12] organization aims to enhance autonomy, well-being and full participation in community life for people with disabilities. It promotes access to health care through fostering connections between people with disabilities and health services. It also empowers people with disabilities through structured learning, peer interaction and individualized support plans.

Key project activities

- People with disabilities and their caregivers empowered by supporting access to health care facilities.
- Provision of training for supported and independent living, including budgeting, cooking, self-care and community mobility, which are all health-promoting activities.
- Partnerships with universities and cultural organizations to promote support for the project.
- Individual and family counselling to strengthen support networks and ensure continuity of care.

Impact

Participants have increased access to health care and increased self-confidence, communication ability and independence in daily life, ultimately contributing to health promotion. Families report reduced caregiver strain and improved relationships. The programme has contributed to reducing stigma and expanding understanding of disability inclusion in the broader community and enhancing disability inclusion in health care, while also paving pathways to employment and supported independent living.

Challenges and mitigation strategies

- Sustaining the programme requires stable funding, trained staff and consistent community collaboration. This is being addressed through partnerships with academic institutions, volunteers and municipal agencies to support programme continuity and capacity-building.
- Provision of sufficient resources and supported living placements is challenging and is being addressed by efforts to secure long-term resources and expand the number of available placements.

Policy recommendations

- Increase public funding to scale community-based inclusion programmes contributing to health promotion for people with disabilities and their caregivers.
- Expand supported and independent living services nationwide.
- Integrate community-based peer learning models into social and health policy frameworks.
- Strengthen collaboration between service providers, universities and municipalities.
- Promote public campaigns to reduce stigma and increase inclusion in community spaces.

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[12] Society for the Friends of the Disabled: Movement for Change [website]. Movement for Change; 2025 (https://drasigiatokatiallo.gr, accessed 25 November 2025) (in Greek).

Case study 2.3 Ireland

Breast cancer awareness for people with intellectual disabilities

Ireland's Breast Health and Education Awareness Programme[13] was jointly developed by Breast Cancer Ireland and Special Olympics Ireland to deliver accessible education in community club settings with the aim of improving breast cancer awareness, self-examination skills and timely support for people with intellectual and developmental disabilities.

Key project activities

- Club-based workshops for Special Olympics athletes, families and community members.
- Hands-on practice using tactile breast models to recognize concerning changes.
- Distribution of easy-read booklets that reinforce key messages after the workshop.
- Use of a mobile app with reminders and short videos to support regular self-checks.
- Peer demonstration by athletes and delivery by trained facilitators from Breast Cancer Ireland and Special Olympics Ireland.

Impact

- Since 2023 more than 133 athletes have participated in workshops, with plans to reach at least 100 additional participants through expansion to new clubs. Participants report increased confidence to self-check and several individuals identified lumps and sought medical assessment, demonstrating direct health impact. The programme has raised awareness among families and club communities, strengthening supportive networks around people with intellectual and developmental disabilities and promoting breast health for women who are more at risk of being missed in screening programmes.

Challenges and mitigation strategies

- Scaling delivery of education programmes to additional regions requires facilitator capacity, materials and travel resources.
- Future funding for expansion is required and this is being addressed by partnership-based delivery, peer educators and the use of digital tools to help to maintain quality and extend reach while funding is mobilized.

Policy recommendations

- Embed accessible, easy-read health education (in general as well as for breast health) within national public health strategies.
- Fund a phased national roll-out through community clubs such as the Special Olympics, with monitoring of uptake and preventive health outcomes.
- Codesign materials with people with intellectual and developmental disabilities and their organizations and standardize the use of tactile models and visual tools.
- Train peer educators and facilitators to sustain local delivery and reduce stigma.
- Integrate referral pathways to primary care for timely assessment and follow-up from community clubs.

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[13] Special Olympics Ireland and Breast Cancer Ireland join forces to launch inclusive breast health education programme [news release]. Special Olympics Ireland; 30 August 2023 (https://www.specialolympics.ie/news/health-news/special-olympics-ireland-and-breast-cancer-ireland-join-forces-to-launch-inclusive, accessed 25 November 2025).

Case study 2.4 Ireland

Time to Move on from Congregated Settings initiative for deinstitutionalization

Ireland's Time to Move on from Congregated Settings[14] initiative is a strategy for community inclusion that aims to support adults with disabilities to transition from institutional settings into community-based living arrangements. The goal is to promote autonomy, dignity, inclusion and improved health and well-being through person-centred support and to ensure access to mainstream health services.

Key project activities

- Implementation of a national policy to close institutional residential services and develop small, community-based structures.
- Individualized transition planning based on personal goals, support needs and preferred living arrangements.
- Collaboration across health, housing and social care sectors to ensure coordinated service delivery.
- Staff training to shift from institutional models to person-centred, rights-based practices.
- Provision of integrated community supports to promote daily living, participation and access to health care.

Impact

The initiative has resulted in a reduced number of people living in congregated settings. Over the course of 14 years (2009 to 2023), a 63% reduction occurred in the number of people in congregated settings, going from over 4000 residents to approximately 1500 in 2023. Individuals who transitioned to community living report improved quality of life, increased social participation, greater privacy and strengthened mental health and well-being. The approach has also enhanced access to primary health care and strengthened rights-based, person-centred service cultures across providers.

Challenges and mitigation strategies

- Limited supply of accessible and affordable community housing was addressed through partnerships with housing authorities and approved housing bodies.
- Staffing shortages and the need for cultural change is mitigated through workforce planning, training and mentoring.
- Higher per-person costs of community-based services compared with institutional provision required advocacy for sustained multiannual funding.

Policy recommendations

- Ensure sustained, multiannual funding to support individualized community-based services by producing evidence that can show the health benefits for deinstitutionalized adults and that this may not only save funds over the life course but also improve quality of life.
- Expand workforce training in person-centred and rights-based practice to support cultural transformation.
- Embed structured collaboration across health, housing and social services to support transitions to community settings.
- Strengthen monitoring and evaluation of quality-of-life outcomes to guide continuous improvement.[15]

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[14] Time to move on from congregated settings. Dublin: Working Group on Congregated Settings, Health Service Executive; 2011 (https://www.hse.ie/eng/services/list/4/disability/congregatedsettings/time-to-move-on-from-congregated-settings-–-a-strategy-for-community-inclusion.pdf, accessed 25 November 2025).

[15] McCarron M, Lombard-Vance R, Murphy E, O'Donovan MA, Webb N, Sheaf G et al. Quality of life outcomes and costs associated with moving from congregated settings to community living arrangements for people with intellectual disability: an evidence review. Dublin: Health Research Board; 2018 (https://www.hrb.ie/wp-content/uploads/2024/06/Quality-of-life__outcomes_and_costs_living_arrangements_for_people_with_an_intellectual_disability_2018.pdf, accessed 25 November 2025).

Case study 2.5 Israel
Inclusive Sexual Health Services for People with Disabilities

Israel’s inclusive Sexual Health Services for People with Disabilities programme[16] aims to promote autonomy, dignity and safety among individuals with intellectual, developmental and neurocognitive disabilities. It provides rights-based therapeutic, educational and preventive services that support healthy relationships, personal security and inclusion in different aspects of human life, with a focus on sexual education. The project is fully funded by the Ministry of Social Affairs and Social Services and reflects Israel’s national commitment to inclusive health and sexual care.

Key project activities

- Six national centres managed by three service providers have operated since 2000 and offer this programme.
- Around 1500 individuals supported annually through therapy (20 000 therapy hours annually), workshops and family support.
- Professional training in inclusive sexual health support for over 200 professionals including psychologists, social workers and educators.
- A total of 154 workshops and interventions across 730 community and residential settings.

Impact

> *“This service gave my daughter the tools to understand her boundaries and feel safe in her community.”* **Parent of participant**

The programme has strengthened well-being, self-esteem, sexual education and social participation for thousands of people with disabilities. Therapeutic interventions have reduced the risk of sexual abuse and improved families’ capacity to support relatives with disabilities. Through its combination of therapy, prevention and sexual education, the service has helped to foster respect for the rights, sexuality and autonomy of people with disabilities, while building a national professional network for inclusive sexual-social care.

Challenges and mitigation strategies

- Persistent social and cultural taboos surrounding the sexuality of people with disabilities continues to limit access to services and dialogue; this is mitigated by developing tailored and culturally adapted resources for diverse communities and enhancing professional capacity-building.
- Geographical disparities in service coverage is addressed by the introduction of mobile and digital outreach initiatives.

Policy recommendations

- Integrate inclusive sexual health support services into national disability and health strategies.
- Ensure sustainable government funding and expand access across all regions.
- Embed sexual education and safety frameworks for people with disabilities into schools, community settings and residential care settings.
- Increase professional training on inclusive sexual health and relationships and professional responsibility to address this area with clients with disabilities.
- Strengthen programme partnerships with families, nongovernmental organizations and community leaders.

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[16] תויולבגומ םע םישנאל םילילכמ תינימ תואירב יתוריש [Inclusive sexual health services for people with disabilities]. Jerusalem: Ministry of Welfare and Social Security; 2025 (https://www.gov.il/he/pages/people-with-disabilities-independent-living-life-skills-sexual-social-programs?chapterIndex=1, accessed 25 November 2025) (in Hebrew).

Case study 2.6 Poland

Health screening and health education for athletes with disabilities

The Healthy Athletes[17] programme in Poland aims to improve the health, well-being and participation of people with intellectual and developmental disabilities by providing accessible health screenings, preventive education and follow-up support. The initiative addresses persistent health inequalities by ensuring individuals receive appropriate and quality care during Special Olympics sports events and beyond, enabling them to participate safely and confidently.
It is important to note that many people with intellectual disabilities are excluded from eye examinations and access to assistive technology (e.g. prescription spectacles), have untreated dental issues, have lower bone density and have difficulty with strength and flexibility.

Key project activities

- Provision of free health screenings across multiple disciplines.
- Health workers trained to provide care to people with disabilities during sports participation.
- Referral pathways established for athletes requiring additional assessment or treatment.
- Health education sessions for athletes, families and coaches focus on unique health needs of athletes with disabilities.
- Collection of anonymized data to monitor unique health trends of people with disabilities and support advocacy for accessible health services.

Impact

The programme has led to earlier identification of health conditions, increased confidence and participation among athletes and greater awareness of the need for disability-inclusive health practices among health care workers. The initiative has strengthened partnerships between sport organizations, health care providers and community services, contributing to more inclusive health systems and improved overall well-being for people with intellectual and developmental disabilities. Additionally, the majority of trainees (72%) strongly agreed that they are confident in their ability to provide health services to people with intellectual disability and 74% of trainees strongly agreed that they are confident in their ability to match their communication style to the literacy level of different patients.

Challenges and mitigation strategies

- Compared with the national need, there is still limited availability of trained health care professionals familiar with disability-inclusive practices.
- Need for ongoing funding to support screenings and equipment given the clear impact of this programme to catch health issues early not only for the person and for the health system; once screened, there is variation in access to follow-up services depending on regional health care capacity.

Policy recommendations

- Integrate disability-inclusive screening practices into mainstream primary care services.
- Allocate sustained public funding to ensure continuity of the programme.
- Expand professional training on disability inclusion within medical and allied health education curricula.
- Strengthen referral and follow-up pathways to ensure continuity of care after screening.

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[17] Healthy athletes [website]. Special Olympics; 2025 (https://www.specialolympics.org/what-we-do/inclusive-health/healthy-athletes, accessed 25 November 2025).

Case study 2.7 Turkmenistan

Promoting inclusive health through sports

The Central Club of Physical Culture and Sports for People with Disabilities[18] in Turkmenistan was established to promote an inclusive society in which people with disabilities can improve their health, build confidence and integrate socially through adaptive sports. Its mission is to create opportunities for empowerment, self-development and participation, supported by collaboration between the State, local communities and international partners.

Key project activities

- Rehabilitation and adapted sports through 42 sports groups nationwide to reach a diverse range of people with disabilities, including those with sensory impairments, physical impairments and intellectual impairments.
- Regular medical supervision, sports medicine and injury prevention support to optimize training and safeguard health.
- Training of 120+ former athletes with disabilities to be “adaptive sports instructors”.
- Legal literacy seminars on disability rights.
- International cooperation for exchanges and development.

Impact

With a clear focus on health promotion, the Club has achieved demonstrable results in health, social inclusion and empowerment for over 1600 people with disabilities, from 13 to 70 years of age. Participants show improved in physical functioning, greater psychological well-being and enhanced self-confidence. The programme has increased social inclusion (mitigating mental health difficulties and isolation), allowing participants to engage in community and international events and to take on leadership roles within their local branches. Legal literacy seminars have increased awareness of rights guaranteed under the Convention on the Rights of Persons with Disabilities. Overall, the programme serves as a national model of inclusive health promotion and social participation and contributes to the development of a more inclusive and healthier society.

Challenges and mitigation strategies

- Limited accessibility across the country has been mitigated through decentralizing activities into regional branches.
- Diverse disability needs are challenging and are being addressed through tailoring programme planning to address the range of needs.
- Persistent social stigma is being addressed by training coaches with lived experiences of disability to promote trust and motivation in participants.

Policy recommendations

- Study the socioeconomic gains of inclusive sports for health (e.g. reduced hospital admissions, reduced isolation) and share such results with governments to help to increase funding for such programmes, contributing towards preventive health.
- Integrate adaptive sports into national health promotion policy frameworks, supported by the section on people with disabilities in the WHO guidelines on physical activity and sedentary behaviour.
- Promote awareness campaigns and public engagement to enhance participation of people with and without disabilities in supporting inclusive community sports as the benefit goes beyond people with disabilities to societies at large.
- Strengthen cross-sector partnerships (including between the State and international partners) for sustainability.

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[18] Центральный физкультурно-спортивный клуб инвалидов Туркменистана [Central Club of Physical Culture and Sports for People with Disabilities] [news release]. Ashgabat Innovative; 28 February 2012 https://ashgabat.in/2021/02/28/centralnyj-fizkulturno-sportivnyj-klub-invalidov-turkmenistana, accessed 25 November 2025) (in Russian).

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Objective 3. Disability-inclusive response to health emergencies

Case study 3.1 Iceland

Disability-inclusive emergency response

An initiative was put in place to ensure that emergency response and recovery efforts during the seismic activity and displacements caused by earthquakes in the Reykjavik Peninsula area of Grindavík could adequately address the needs of people with disabilities.[19] It sought to minimize the disproportionate disruption to essential services (e.g. personal care staff, loss of assistive devices, inaccessible shelters) experienced by people with disabilities, with the aim of preserving health and well-being and promoting coordinated humanitarian responses across national and local authorities.

Key project activities

- Coordination among Civil Protection, Ministry of Justice, Red Cross and local municipalities guided emergency actions and immediate identification of people with disabilities.
- Provision of accessible temporary housing, evacuation of users with their critical assistive devices, continuity of care and financial support to displaced individuals.
- Development of clear and accessible information channels, including helplines and dedicated online platforms.
- Establishment of psychosocial support networks focused on trauma, stress and resilience.
- Inclusion of disability advocates in planning discussions to ensure practical accommodation measures.
- Structured after-action learning to inform future emergencies and improve preparedness models nationally.

Impact

The initiative improved the continuity of care and safety for individuals with disabilities during repeated evacuations. Collaboration between sectors strengthened the capacity of emergency services to recognize and respond to diverse support needs. Community-based organizations played a pivotal role in emotional support and social connection, helping to prevent isolation during prolonged displacement. The experience now informs national emergency planning and contributes to evolving best practices in inclusive disaster response.

Challenges and mitigation strategies

- Repeated displacement created service coordination challenges and strain on families. Local authorities addressed these issues by strengthening communication systems, expanding flexible support options and ensuring that disability-related needs were incorporated into shelter planning. Partnerships with organizations representing people with disabilities helped to build trust and improve responsiveness.

Policy recommendations

- Compulsory representation of people with disabilities in all emergency decision-making and planning bodies.
- Ensure accessible communication formats are available before and during evacuation, including plain language and sign language interpretation.
- Expand psychosocial support systems for displaced residents with disabilities who have been unable to return to homes.
- Develop dedicated emergency response training on disability inclusion.

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[19] Félagslegar áskoranir vegna yfirstandandi jarðhræringa á Reykjanesskaga og samfélagleg áhrif þeirra [Social challenges due to the ongoing earthquakes on the Reykjavík Peninsula and their social impact]. Reykjavík: Institute of Social Sciences, University of Iceland; 2024 (https://www.althingi.is/altext/pdf/155/fylgiskjol/s0331-f_III.pdf, accessed 25 November 2025) (in Icelandic).

Case study 3.2 Israel

Inclusive emergency preparedness using the national assistance database

Formation of a national assistance database[20] aims to ensure that people with disabilities receive timely, coordinated and appropriate assistance during health emergencies, including natural disasters, conflict situations or public health crises. Once it is operational, in April 2026, the database will enable authorities to identify individuals who may require support before, during and after emergencies, helping to ensure continuity of care, preserving autonomy and preventing harm. By integrating disability considerations into national emergency planning, the programme strengthens overall resilience during health emergencies.

Key project activities

- A centralized, national digital database of individuals with varying support needs and disabilities.
- Personal, medical, communication and support/care needs collected.
- Two-tier system for continuous assistance or only situational support.
- Data-sharing between national ministries and local authorities.
- Individuals can verify their entries in the database and request removal.
- Guidelines for first responders and emergency teams on providing inclusive care.

Impact

The initiative will strengthen preparedness and improve health emergency responsiveness for people with disabilities, particularly for those relying on electricity-dependent medical devices, mobility assistance or continuous support. Local authorities report greater confidence in planning evacuation routes and shelter access, and continuity of medical support. Public trust improved by emphasizing informed participation and respectful data protection.

> *"The database constitutes a vital infrastructure for providing aid to persons with disabilities during an emergency."* **Representative of an organization for people with disabilities**

Challenges and mitigation strategies

- Managing sensitive personal data across multiple institutions requires coordinated governance and strong privacy safeguards.
- Initial public hesitation regarding registration was addressed through transparency measures and collaboration with disability advocacy organizations.
- Technical challenges related to real-time data updating are being managed through phased system upgrades and ongoing user training for municipal staff.

Policy recommendations

- Ensure data protection protocols and continuous oversight mechanisms for inclusive databases for emergency planning.
- Expand training for health emergency and municipal personnel on disability-inclusive response strategies and how to understand and use data points in the database.
- Increase public communication campaigns to support informed participation and trust to share expected needs during a health emergency.
- Integrate disability-responsive planning into all national emergency preparedness frameworks.

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[20] מאגר מידע לסיוע לאנשים עם מוגבלות בחירום [Database for assisting people with disabilities in emergencies]. Jerusalem: Ministry of Welfare and Social Security; 2025 (https://www.gov.il/he/pages/molsa-information-database-in-emergencies, accessed 25 November 2025) (in Hebrew).

Case study 3.3 Netherlands (Kingdom of the)

Involving people with disabilities in decision-making during the coronavirus pandemic

This initiative focused on ensuring disability-inclusive decision-making in health care home services during the coronavirus disease (COVID-19) pandemic. It aimed to prevent blanket suspensions of services by involving people with disabilities, their caregivers and health and care workers. A bottom-up approach was introduced to replace earlier top-down health emergency management models, protecting continuity of care and preserving autonomy and informed consent for people with disabilities.

Key project activities

- Reassessment of individual care needs using a standardized "traffic light" tool to categorize which services could be safely continued (green), modified (yellow) or postponed (red).
- Structured discussions between district nurses, people with disabilities and informal caregivers to determine needs and preferences.
- Shift from centralized, top-down managerial decisions to collaborative, bottom-up decision-making structures involving frontline professionals and people with disabilities.
- Introduction of weekly support telephone calls to individuals whose services were paused in order to maintain safety, emotional well-being and continuity of contact.

Impact

This approach resulted in improved decision-making that was more person centred. People with disabilities reported feeling informed and actively involved in decisions regarding changes to their care. Home health care professionals gained greater autonomy and responsibility in care planning. The shift to collaborative decision-making helped to reduce unnecessary cancellations of services, safeguarded continuity of essential care and contributed to more resilient and responsive health system practices during public health emergencies and better health outcomes for people with disabilities.

Challenges and mitigation strategies

- Limited communication between decision-makers and home health care staff under remote working conditions was mitigated by creating structured communication channels and involving frontline teams in operational decision-making.
- Initial blanket reductions in home health care services due to uncertainty and risk prioritization were addressed by adopting individualized assessments and person-centred decision tools.
- Avoidance of health care services by people with disabilities due to infection fears was mitigated by offering alternative tele-health and remote contact support where appropriate.

Policy recommendations

- Adopt person-centred reassessment tools to guide care modifications during health emergencies.
- Ensure the participation of people with disabilities and frontline providers in emergency health decision-making structures to ensure consent and agreement and, therefore, improved outcomes.
- Safeguard continuity of essential home health care services and prohibit blanket suspensions based solely on emergency conditions.
- Normalize, value and institutionalize bottom-up communication pathways within health emergency preparedness planning as taking more time at the beginning may save much more time in the long term as it builds trust in health system by users with disabilities, who are more likely to accept actions by health systems when involved.

Case study 3.4 Spain

Strengthening disability inclusion in emergency response

The Spanish Plan of Measures against Social and Personal Vulnerability[21] strengthens the capacity of emergency response systems to ensure that people with disabilities receive protection, support and dignified assistance during health emergencies. Through specialized training delivered by the Spanish National School of Civil Protection, the programme promotes disability-inclusive response protocols, accessible communication and person-centred emergency planning.

Key project activities

- Development of training curricula focused on disability inclusion in emergency response.
- Delivery of three structured courses for civil protection staff and volunteers, combining theory and practical simulation exercises.
- Promotion of inclusive communication approaches and respectful interaction with people with disabilities.
- Initiatives to strengthen skills in identifying disability-related needs and adapting emergency protocols accordingly.

Impact

Since 2019 the training programme has increased awareness and strengthened the capacity of 171 front-line responders to provide equitable support during emergency situations. Evaluations showed high participant satisfaction and demonstrated improvements in knowledge, communication practices and practical response skills. The programme has also led to strengthened engagement and representation of people with disabilities in emergency response planning and coordination mechanisms.

Challenges and mitigation strategies

- Limited availability of systematic data and evaluation of long-term outcomes.
- Need for sustained integration of disability perspectives into broader emergency coordination structures.
- Variation in staff familiarity with disability-inclusive principles.

Policy recommendations

- Ensure the engagement and representation of people with disabilities and their organizations in emergency planning, coordination and response.
- Mandate disability-inclusive training for all first-line emergency personnel to strengthen preparedness and equitable response.
- Embed inclusive communication standards and universal accessibility principles in all emergency response protocols.

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[21] Protección Civil impulsa la formación de equipos y gestores de emergencias en la atención integral a las personas con discapacidad [Civil protection promotes the training of emergency teams and managers in the comprehensive care of people with disabilities] [news release]. Ministry of the Interior; 10 October 2019 (https://www.proteccioncivil.es/-/protección-civil-impulsa-la-formación-de-equipos-y-gestores-de-emergencias-en-la-atención-integral-a-las-personas-con-discapacidad?p_l_back_url=%2Fbuscador%3Fq%3Dcursos%2Ben%2Bdiscapacidad&p_l_back_url_title=Buscador, accessed 25 November 2025) (in Spanish).

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Objective 4. Building an evidence base on disability and health

Case study 4.1 Georgia
The cost of raising a child with disabilities

A study on the cost of raising a child with disabilities in Georgia[22] was implemented collaboratively by the United Nations Children's Fund and the Government of Georgia and aimed to generate evidence to support the transformation of the national disability support system. Specifically, it sought to identify the additional goods and services required for children with disabilities to participate equally in society, including with health services, and to understand the related financial burden on families. The findings inform efforts to move towards a needs-based support model, promoting children's health, inclusion and well-being.

Key project activities

- An expert panel identified required goods and services and estimated associated costs across groups of children with different support needs.
- Validation workshops with parents, service providers and civil society organizations to confirm needs, costs and coverage under State programmes.
- Eight functional support profiles created to reflect varied needs among children with disabilities.
- Findings integrated into national policy dialogue to inform ongoing reform of disability assessment and social protection systems.

Impact

The study provided the first systematic national evidence on the additional costs of raising a child with disabilities in Georgia. By demonstrating the magnitude and diversity of needs, it highlighted that many families were unable to afford essential services, including health care. This has strengthened the Government's commitment to shifting from a uniform benefit model to an individualized support system aligned with functional needs. The findings are now informing revisions to disability assessment procedures and improvements to social protection measures to reduce financial barriers and promote the health and well-being of children with disabilities.

Challenges and mitigation strategies

- Families face a significant financial burden due to limited Government coverage for key health costs. Advocacy should prioritize expanding state support.
- Regional disparities and administrative fragmentation create unequal access to health services, as benefit procedures are complicated and transportation is insufficient. Effective policy reform must address these gaps by decentralizing service planning, improving transportation and streamlining assessment and procurement pathways for beneficiaries.

Policy recommendations

- Invest in health financing studies to understand catastrophic health costs and needs of children and adults with disabilities and how these need to inform policy-making.
- Expand government financing to substantially reduce the portion of health costs, including for rehabilitation, paid out of pocket by families.
- Implement a needs-based benefits system tailored to each child's support needs.
- Broaden state coverage to include essential health items such as medications and assistive devices.
- Regularly review and adjust disability health benefits to reflect actual expenditures and changing needs over time.

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[22] The cost of raising a child with disabilities in Georgia. New York: United Nations Children's Fund; 2022 (https://www.unicef.org/georgia/reports/cost-raising-child-disabilities-georgia, accessed 25 November 2025) (in English and Georgian). Licence: CC BY-4.0.

Case study 4.2 Georgia
Model Disability Survey

The aim of the Model Disability Survey in Georgia[23] was to generate nationally representative, internationally comparable evidence on disability and functioning, disability-inclusive health and social policies aligned with the Convention on the Rights of Persons with Disabilities and the Sustainable Development Goals.

Key project activities

- A population-based survey across 3303 households (median household size: 3), covering 2298 adults and 705 children.
- Operationalization of the International Classification of Functioning, Disability and Health framework to assess health conditions, functioning, participation, environmental barriers/facilitators, assistive products and service needs.
- Multilingual implementation (Azeribaijani, Armenian, Georgian and Russian) with trained interviewers, computer-assisted tools and rights-based/ethical protocols.
- Inclusion of detailed questions on health status, chronic conditions, medication use and unmet needs for health care and assistive products.

Impact

The Model Disability Survey produced the first comprehensive, nationally representative disability dataset for Georgia, strengthening policy design and monitoring. About two thirds of adult respondents were women and more than 70% were 45 years of age or older; 46% experienced moderate disability and 13% severe disability. Close to 20% reported severe difficulties in their daily life, with moderate and severe difficulties more frequent among women. Only a third reported having the assistive products they needed. The findings underline a high burden of chronic noncommunicable conditions among adults. They also highlight gendered and age-related inequities in health, with women and older adults experiencing higher levels of disability, reinforcing the need for targeted health interventions.

Challenges and mitigation strategies

- Representative coverage across languages and regions was challenging and was mitigated by multilingual tools, piloting and interviewer training to ensure cultural and linguistic equivalence.
- Initial hesitancy regarding data use was mitigated by community engagement, clear communication and sensitivity training to build trust.
- Complex datasets made policy integration challenging and this was addressed using WHO technical support for analysis and inter-agency policy dialogues to translate evidence into action.
- The breadth of health-related variables (chronic conditions, functioning, environmental barriers and service use) required strengthened analytical capacity within health and social ministries to interpret results for planning.

Policy recommendations

- Institutionalize periodic disability data collection within national statistics for trend monitoring and planning.
- Use the Survey findings to strengthen integrated noncommunicable disease prevention, rehabilitation and community-based care pathways for people with disabilities.
- Increase access to essential medicines and assistive products through expanded financing, simplified procedures and clear information on entitlements.
- Advance universal design to remove environmental barriers across physical, social and digital domains through coordinated, cross-sectoral policy.

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[23] Model disability survey: results for Georgia 2022. Copenhagen: WHO Regional Office for Europe; 2023 (https://iris.who.int/handle/10665/373589, accessed 25 November 2025). Licence: CC BY-NC-SA 3.0 IGO.

Case study 4.3 United Kingdom

Training on end-of-life care together with researchers with intellectual disabilities

The Kingston University Intellectual Disability (KIND) in London[24] promotes inclusive health research and equal participation of people with intellectual disabilities as researchers. KIND focused on improving palliative and end-of-life care through co-produced research, training and resources that empower people with intellectual disabilities to shape health policies and practices affecting them.

Key project activities

- Development of the Victoria and Stuart toolkit[25] to support conversations about dying.
- Inclusive employment of six researchers with intellectual disabilities since 2021.
- Co-production of studies on death, dying, bereavement and health equity.
- Two research training courses delivered for 18 students with intellectual disabilities – 13 gained paid research roles.

Impact

The KIND Research Group has transformed inclusive health research by co-creating with people with intellectual disabilities at every stage of the working process. Its resources are widely used in the United Kingdom and internationally, with translations and national policy uptake. The Victoria and Stuart Toolkit has become a benchmark for inclusive end-of-life planning and communication; it is adopted by National Health Service trusts, service providers and training programmes in the United Kingdom. The employment model demonstrates how universities can successfully include people with intellectual disabilities as equal research partners.

> *"This toolkit has changed the way I will discuss death and dying with the people we support. I feel it would benefit anyone and everyone."* **Health worker**

Challenges and mitigation strategies

- Inclusive research is challenging to achieve and requires sustained time, resources and institutional flexibility. University systems had to be adapted to support accessible recruitment and training.
- Discussing death and dying can be emotionally demanding, but creative and supportive strategies – such as using music, props and humour – have helped to build resilience and trust among all team members.

Policy recommendations

- Embed disability-inclusive research principles into health and academic funding frameworks to ensure people with disabilities are empowered to fully participate.
- Adopt the Victoria and Stuart Toolkit and similar co-produced resources in national care standards.
- Promote replication of the KIND model in universities and health institutions worldwide and explore transferability in other health care contexts.
- Recognize people with intellectual disabilities as experts with lived experience to contribute to policy development.

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[24] The KIND Research Group (intellectual disability research) [website]. Kingston University London; 2025 (https://www.kingston.ac.uk/research/HSSCE/the-kind-research-group-intellectual-disability-research, accessed 25 November 2025).

[25] The Victoria & Stuart project [website]. Kingston University London; 2025 (https://www.victoriaandstuart.com/end-of-life-care-planning-toolkit, accessed 25 November 2025).

Case study 4.4 European Union
Disability-disaggregated large-scale SHARE survey

The Survey of Health, Ageing Retirement in Europe (SHARE)[26] aims to strengthen the evidence base on disability and health by providing a harmonized, longitudinal and population-based dataset covering individuals aged 50 years and older across 28 European countries and Israel. SHARE allows for disability disaggregation, cross-country comparison and analysis of long-term trends in health, functional status, socioeconomic conditions and access to care. As a research infrastructure, SHARE supports policy formulation through data-driven insights into disability inclusion and health system performance.

Key project activities

- Structured, harmonized cohort interviews every 2 years since 2004 with adults aged 50 years and older.
- Data collection on physical and mental health, functional ability, social participation, employment, pensions and living conditions.
- Variables enabled identification of people with disabilities through both administrative disability status and functional limitations.
- Cross-country comparable questionnaire maintained, translated and culturally validated.
- Open, free data access for qualified researchers affiliated with academic, government or international institutions.
- Collaboration with global studies for international comparison.

Impact

SHARE has strengthened the availability of high-quality data on disability and ageing across Europe, supporting academic research and evidence-informed policy-making. By enabling disability-disaggregated analysis within large representative samples, the study has contributed to improved understanding of health inequalities, care needs, social participation patterns and the impact of social protection systems on people with disabilities. The SHARE data also show that households with adult members with disabilities experience significant extra costs due to needs for specialized goods and services, including for health, transport and home adaptations. The dataset has supported comparative research and informed public health planning, pension policy and long-term care strategies. SHARE findings highlight the importance of health policies that promote early frailty screening and interventions to promote independence and improve mental health among older adults in Europe.

Challenges and mitigation strategies

- Data access requires institutional affiliation and statistical capacity, which has been addressed through open training materials and documentation.
- The cohort begins at age 50 years, which limits insights on younger people with disabilities; this is mitigated by alignment with complementary national datasets.

Policy recommendations

- Ensure sustained funding for longitudinal research data collection that is disability disaggregated and can expose gaps in disability health equity.
- Use SHARE data to inform disability-inclusive health and social protection reforms.
- Encourage cross-sector analysis combining SHARE with national administrative datasets and health equity experts.

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[26] Welcome to SHARE [website]. Share; 2025 (https://share-eric.eu, accessed 25 November 2025).

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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