

CBM UK Discussion Paper

Achieving Health Equity through Climate Adaptation: A 3-country disability inclusion review



Photo: Woman receives primary eye care services delivered by trained health care professional at community level in Nepal. ©CBM Global

Introduction

The 2023 UN Intergovernmental Panel on Climate Change report underscored the profound disruptions climate change inflicts on health services. It highlighted the devastating impact of extreme weather events, the surge in climate-related food-borne and water-borne diseases, and the glaring weaknesses of health policies and systems to cope with these escalating health challenges. As health systems face mounting stress and increased demand, access barriers for those already experiencing health inequities, including people with disabilities, are likely to intensify.

States have a duty to take "all necessary measures to ensure the protection and safety of people with disabilities in situations of risk", Article 11 of the UN Convention on the Rights of Persons with Disabilities (CRPD). Alongside this, achieving universal health coverage is a target in the Sustainable Development Goals (SDGs). This right and achieving these targets are undermined by the impact of the climate crisis on health and health systems. Salas and Jha, (2019) argue for an integrated agenda and aligned solutions that recognise the interconnections between achieving universal health coverage and addressing climate change. Yet, few countries make provisions for people with disabilities – who continue to have poorer health outcomes and live with higher levels of poverty (WHO, 2022; WHO, 2012) – when setting policies to address, or planning to adapt to, the effects of climate change (McGill, DICARP and IDA, 2022, CBM Global, 2024¹).

The right to health is gaining traction in global climate negotiations, linked to the recent <u>UN declaration on the right to access a clean and healthy environment</u>, which affirms that environmental damage has negative implications, both direct and indirect, for the effective enjoyment of all human rights – including the right to health. However, much more needs to be done to bring in the perspectives of people with disabilities as well as their representative organisations, if we are not to miss a vital opportunity to achieve the right to health for all.

In this paper we examine how health systems might be adapted to promote health equity for people with disabilities in the face of climate change. To do this we use examples and draw lessons from three very different country contexts, Australia, Burkina Faso and Indonesia, using available literature and a small number of local stakeholder interviews with representatives of Organisations of People with disabilities (OPDs), healthcare providers including medics, and health sector policy makers.

We examine interconnectivities between health equity and health systems, particularly the disability dimensions, before looking at how health equity interacts with climate change. We then consider six key components of health systems, how each face climate related pressures, and how climate adaptations might be made in ways that are more disability inclusive. These are then collated into recommendations from reflections which draw on the perspectives, insights and lived experiences of local stakeholders in the three countries. The findings are indicative and are caveated² not least by the small sample size. That said, the paper signals clear legitimacy to the questions posed, and points to some high-level recommendations for realising climate resilient, adapted health systems that are more disability inclusive.

¹ See Annex for CBM Global (2024) analysis of disability inclusion in climate policies for the three focus countries in this paper: Australia, Burkina Faso and Indonesia.

² Sampling bias: Three countries selected were all countries where CBM Global works, and key informants were those that we have strong professional relationships with. Due to time constraints, wider perspectives were missed and we were reliant on people who were available to us. Language barriers: Interpreters were required for interviews in French (Burkina Faso) and Bahasa (Indonesia), which may have impacted information exchange and rapport between interviewer and interviewee.

Health systems and health equity

Social and economic determinants of health reflect wider inequities, such as low education rates and high levels of poverty. These create barriers to accessing health systems, and particularly impact people with disabilities. Inaccessible health facilities alongside inaccessible and unaffordable transportation impede access to services, by up to six and 15 times more for people with disabilities respectively, compared to people without disabilities (<u>World Health Organisation (WHO)</u>. Persistent health inequity means that, on average, people with disabilities have lower health status, higher mortality rates and more than double the risk of developing comorbid conditions (such as diabetes, stroke, depression, asthma, obesity or poor oral health) (ibid). Indeed, health inequities means "having the freedom to live a long and healthy life was not equally distributed" (Backholer et al., 2021:S7).

Key informants across the three countries all highlighted **inaccessible health services and infrastructure** as significant barriers, citing high costs for disability-specific services and physical inaccessibility of health facilities. In Indonesia, inaccessible health infrastructure, especially in remote areas, limits access to healthcare and medication. Indonesian communities are merging traditional medicinal practices with modern healthcare, particularly in rural areas where access to formal healthcare is limited (Sulistiadi, Wasir, Thalib, et al., 2024). In Australia, specialised health services needed by people with disabilities are often only available privately, making them unaffordable (Disability Advocacy Network Member, Australia).

Attitudes and behaviours of healthcare providers were also reported as barriers which negatively impact health-seeking behaviours among people with disabilities. An Australian occupational therapist noted that people with disabilities were often not adequately consulted on decisions affecting them. Their participation in service planning felt tokenistic, relying on the uncompensated time of resource-poor individuals or those needing fewer accommodations to participate. Attitudes of healthcare providers often mirror wider societal attitudes to disability. Informants cited the illegal practice of shackling people with psychosocial disabilities, preventing them from accessing necessary health services. This illustrated the importance of community awareness to addressing health inequity.

"[Shackling] is due to the lack of awareness and knowledge... [families of persons with disability] just don't know what to do." Doctor, Indonesia

The exclusion of people with disabilities from wider local planning processes and decisionmaking can impact health equity. For example, one respondent felt "not seen at all" due to their exclusion from policy conversations on social housing. Social housing in Australia was characterised by poor living conditions and inaccessibility, both key determinants of health for residents with disabilities (OPD representative, Australia). Exclusion from these related discussions has wider implications. Indeed, health systems must respond to and address the root causes of health risks (Watts et al., 2015), and this means centring wider social determinants of poor health.

WHO (2012) argued for better access to free and affordable healthcare at all levels of the healthcare system for people with disabilities, particularly at primary and community levels, including insurance coverage, trained healthcare workers, specialised care and measures to promote health seeking behaviours. Comprehensive, person-centred healthcare services are essential building blocks for achieving universal health coverage and resilient health systems. In the next section we examine how climate change has exacerbated these existing pressures on health services and health systems in our three focal countries.

Health under climate duress

Climate change poses significant threats to global health, exacerbating health inequities and disproportionately affecting climate-vulnerable populations, including people with disabilities. Its direct and indirect effects, such as frequent and intense heat waves, wildfires, higher temperatures, decreased food production, and increased spread of diseases, exacerbate existing health conditions, (Gaskin et al., 2017). Some groups are more affected by the health impacts of climate change with Gaskin et al. (2017: 802) highlighting that the most vulnerable populations are those with the weakest health protection systems and the least adaptive capacity. For example, Dasgupta and Robinson (2023) found that children's health is particularly susceptible to both long- and short-term exposure to high temperatures and droughts. According to the WHO (2022), people with disabilities are also particularly at risk, partly due to additional health complications related to their disability, such as increased risk for heat-related mortality and morbidity, but also due to heightened access barriers to basic water facilities, shelter, or healthcare. This underscores the importance of using an intersectional lens.

"In recent years, when considering persons with disabilities and how climate change affects them, we've noticed periods of extreme cold or extreme heat. These conditions have severely impacted the health of persons with disabilities, particularly those already in vulnerable situations." OPD Representative, Burkina Faso

Country specific contexts:

Indonesia, Burkina Faso, and Australia each have distinct environmental, socio-economic, and health system contexts, facing unique climatic and societal challenges that impact the health of their populations with disabilities.

Australia

Australia's unique geoclimatic features, such as being an island country, the driest inhabited land, and having a substantial coastal population, make it especially vulnerable to climate change and its health effects (Hanna and McIver, 2018; Blashki et al., 2007). Australia is predicted to experience extreme weather events, including heat waves, changes in rainfall, and worsening drying in certain parts, as evidenced by the increase in severe bushfires (Blashki et al., 2011).

In Australia, policy advisors, health professionals, and disability advocacy organisations have highlighted health risks related to heatwaves and bushfires. Conditions such as Multiple Sclerosis, Motor Neuron Disease, and schizophrenia medication affect the body's ability to regulate temperature, worsening the impacts of heatwaves for individuals with these disabilities (Policy Advisor, Australia; Community Health Worker, Australia). Health risks are also linked to increased smoke exposure from bushfires and higher humidity, which raises infection risks (Policy Advisor, Australia). Other health impacts include worsening hearing and deafness issues (ibid), increased respiratory illnesses (especially thunderstorm asthma) (Disability Service Provider and Advocacy and Strategy Advisor, Australia), and reduced food quality and production, exacerbating dental issues and raising other health and nutrition concerns (Dentist, Australia).

Indonesia

Situated within the volatile "ring of fire," Indonesia experiences significant seismic activity due to shifting tectonic plates. This predisposes it to frequent natural disasters, including volcanic eruptions, floods, and seismic events, fostering a culture of disaster preparedness among the population and policymakers (Aditya and Rastika, 2023). Indonesia faces several challenges in achieving disability-inclusive disaster risk management. These include gaps in policy and regulatory frameworks, a lack of disaggregated data, and inaccessible infrastructure such as evacuation routes and shelters. Additionally, there is often limited awareness of disability issues among disaster management personnel. However, frameworks, <u>training guidelines</u> and <u>initiatives</u> are being developed to address these challenges. These emphasise meaningful community engagement in

supporting community resilience and recognise the importance of including people with disabilities in all phases of disaster management.

Climate change-related health risks compound existing challenges faced by marginalised groups, such as people with disabilities (Smith et al., 2017). Sulistiadi, Wasir, Thalib, et al., (2024) reported that climate change led to high rates of diarrhoea, pneumonia, tuberculosis, and dengue, in Indonesia, particularly in Java, in 2021. New climate-related risks include constrained access to essential resources like food and clean water, alongside increased disaster-related risks such as drought and floods. Climate change is projected to significantly burden Indonesia's health system, due to climate-related diseases, with losses expected to reach 1.86% of national GDP, or approximately USD 21.6 billion from 2021 to 2050 (ibid, 2024). This undermines Indonesia's progress against the SDGs and towards universal health coverage, adding stress to its already constrained health system (ibid).

Burkina Faso

Located in the Sahel region, Burkina Faso is accustomed to low annual precipitation and varied temperature extremes. However, recent climate change has led to extreme heatwaves, droughts, and low/failed harvests, threatening subsistence agriculture and food security (Vinke et al., 2022). Projections indicate a Sahel regional annual temperature rise between 1.5° and a massive, and very dangerous, 4°C, by the 2050s compared to pre-industrial levels (World Bank, 2022). The consequences include heat-induced stress and mortality, with vulnerable, outdoor labourers, and poverty-affected populations impacted the most (ibid). Changes in rainfall patterns and drought-affected lands have caused floods, affecting an average of 248,000 people per year since 2000, damaging homes, roads, and other infrastructure (ibid). Drought impacted food insecurity affected over 20 million people in Burkina Faso between 2016 and 2020 (UK Centre for Ecology and Hydrology, 2021).

In Burkina Faso, 86% of people depend on subsistence farming (The Hunger Project, no date), and climate change is drastically reducing agricultural productivity. Sorgho et al. (2020) argue that for people with disabilities and their families, who are already marginalised, reduced agricultural yields increased food insecurity, and affected their ability to afford healthcare and other social services. Low harvests not only lead to an overall decline in health status and heightened malnutrition risk, but as an OPD representative observed, they also raise mental health risks:

"In this area, climate change has a huge impact, especially on the availability of food and in the harvest this year, the harvests are failing... So when the harvest is failing, it impacts their source of income because they have a lot of needs and it can cause a tendency for suicide." OPD Project Manager, Burkina Faso

Weak institutional systems and constrained financial resources limit effective planning and a health system's capacity to respond to climate-induced health risks (Sorgho et al., 2023). In Burkina Faso, for example, 444 health facilities had been impacted by instability by 2021, with 149 facilities completely closed, resulting in around 1.8 million people losing access to local healthcare (Makoni, 2022).

Cumulative effect:

Health systems and healthcare facilities are the first line of defence against climate-related shocks and stressors (WHO, 2021: 79). Yet, constrained health systems are ill-equipped to respond to climate change, frequently sidelining people with disabilities through, for example, disrupting local health services that people with disabilities disproportionately rely on. Health system adaptation should aim for greater climate resilience while being person-centred and disability inclusive. In the next section, we explore what inclusive health sector adaptation might look like, reflecting on the perspectives provided by our key informants in each country.

The nexus of health systems, climate adaptation and disability inclusion

People with disabilities comprise at least 15% of the world's population, yet their needs and interests are overwhelmingly absent in climate change discourse (Gaskin et al., 2017; Lindsay et al., 2022). In Australia, for example, frustrated OPD representatives noted that despite submitting their perspectives on climate change and its impacts on people with disabilities to the National Climate and Health Strategy consultation, they felt their views were absent from the final report, leaving them once again feeling "not seen at all" (OPD representative, and Disability Advocacy Network representative, Australia).

How climate change and extreme weather disproportionately affects people with pre-existing disabilities and chronic conditions are highlighted in Lindsay et al. (2022³). These include impacts on physical and mental health – including the risk of new injuries, worsening of existing conditions and higher mortality rates, and exacerbated mental health risks and conditions. Barriers in access to health and community services are also worsened, constraining people's access to medications, medical supplies and equipment, as well as impacting the provision of accessible transportation. Limited disability awareness and communication challenges affect service provision in community health centres and by first responders during extreme weather events. Impacts beyond the health sector included disrupted education and work, as well as the breakdown of important social supports and resources that help people cope and maintain resilience through crises.

This section takes a closer look at the specific climate-related stresses on health systems and explores these from a disability perspective, drawing on the insights from our key informants. We examine six core components of health systems, as identified in Debie et al. (2024): (1) service delivery, (2) health information systems, (3) health workforce, (4) health financing, (5) leadership/ governance, and (6) health infrastructure.

Each of these are examined in turn, considering the challenges to disability inclusive healthcare provision in the context of climate change. The respondents provide disability perspectives and experience of climate-vulnerability in both a high-income country context, where there is an established health system (Australia) and more resource-constrained health systems in middle- and low-income country contexts (Indonesia and Burkina Faso).

Service Delivery

Resilient health systems ensure the "provision of comprehensive and person-centred healthcare services with full accountability" (Debie et al, 2024). Such systems are responsive to diversity, a fundamental aspect of disability inclusion. Creating **person-centred** health services is critical for disability inclusion, as it allows for appropriate responses to individual needs, including communication styles and other access requirements. Services must be **comprehensive** because disabilities can intersect with various health conditions, both short- and long-term. Additionally, socio-economic determinants of health intersect with other characteristics, such as age and ethnicity. **Fully accountable services** must include accessible accountability measures to be inclusive of people with disabilities.

How far are health services meeting these requirements?

Respondents in all three focus countries identified some positive examples of inclusive services, such as the provision of assistive devices in Burkina Faso to enable access to health services. However, there were also significant challenges. In Australia, one respondent noted that **"the more complex the disability, the less patient-centred care the person receives" (Policy Advisor, Australia).** Another mentioned that **"persons with disabilities often feel fatigued from not being the standard or the model of a patient and the need to repeatedly communicate their needs to the care team" (Disability Service Provider, Australia).** Some respondents reported stark rights violations. In Indonesia, for example, there were **"instances where persons with**

A poster summary of Lindsay et al. (2022) scoping paper is available at this link: <u>Lindsay et al_Climate change</u> and disability poster_Oct 12 2022 (hollandbloorview.ca)

disabilities, especially children, are forced into rehabilitation centres or [are] institutionalised against their will, often due to societal stigma and lack of support systems." OPD representative, Indonesia

Addressing this requires comprehensive strategies that prioritise inclusion and equity, involving people with disabilities in decision-making about their own healthcare needs. In Indonesia, the government's Badan Penyelenggara Jaminan Sosial Kesehatan⁴ (BPJS Healthcare) programme, started in 2014, was a significant effort toward a comprehensive, healthcare system to ensure every Indonesian person had access to quality healthcare services. It focused on accessible healthcare services, expanding insurance coverage to reduce the financial burdens on people with disabilities, and implementing wider policies to promote inclusivity (Utami et al., 2023). The programme increased use of essential health services among people with disabilities, although challenges remained in ensuring comprehensive coverage and addressing disability-specific healthcare needs (ibid).

Health system adaptation to climate change relies on strengthening primary healthcare, especially for uniquely affected populations (Blashki et al., 2011). Primary healthcare can improve health across populations by targeting and tailoring provision to the structural causes of health inequities and building local resilience. Backholer et al. (2021) emphasise the need for comprehensive primary healthcare, early prevention and promotion to enhance healthcare access. One example provided by respondents was the need to prioritise comprehensive reproductive healthcare services tailored to the local needs of women with disabilities in the context of climate change (Doctor, Indonesia).

The intersectionality of disability with other characteristics reinforces the need for services to be person-centred. An Australian Occupational Therapist explained the need for adaptations that respond to Aboriginal and Torres Strait Islanders' perceived fear of hospitals. A community health centre worker articulated this in terms of 'cultural safety', emphasising the presence of Aboriginal staff, the use of Aboriginal names, cultural awareness training, community engagement in service design, and partnerships with Aboriginal organisations.

Improving stakeholder collaboration is essential to addressing this, involving representatives of people with disabilities and their intersecting marginalised identities. Health service delivery must adapt to and be flexible to the diverse needs of service users, which may involve different providers. For example, in Burkina Faso:

"What we've initiated is that at sites for internally displaced persons (IDPs), we have government health facilities that provide healthcare services. These are permanent structures. Additionally, we have support from NGOs, which usually employ mobile strategies to deliver services to IDPs." OPD Representative, Burkina Faso

Generally, our interviewees suggested limited examples of primary health services being prioritised in health system adaptation. They identified a stronger tendency towards prioritising crisis response planning for health services. An example from Indonesia was the development of disaster preparedness plans to ensure service delivery continuity during disasters. An informant explained that it was mandatory for all local agencies to draft and regularly update guidelines for their roles during disasters, which help maintain uninterrupted service delivery in emergencies. These guidelines also include provisions for healthcare services for people with disabilities during disasters (Doctor, Indonesia).

This Indonesian risk management requires establishing backup logistics for ensuring medicine supply in the event of a disaster, including village-level planning to meet 10% of medication needs in emergencies. Planning includes population mapping in villages, including people with disabilities, to ensure service delivery and supply distribution according to needs (Doctor, Indonesia). However, despite the significance of this approach, informants reported that these contingency plans are often not actually implemented in many health facilities (International agency representative, Indonesia).

Health workforce

To build a resilient health system, the workforce must be able to deliver "**responsive**, **fair** and **efficient** health services to achieve best health outcomes" (Debie et al., 2024, emphasis added). Investing in healthcare workers is crucial for health equity, especially amid climate change. This includes enhancing staff's disability awareness, inclusion skills, and knowledge of climate-related health risks, known as climate health education (Sorgho et al., 2021).

The WHO advocates for the deployment of Community Health Workers (CHWs) as a strategy to reach marginalised populations and reduce health inequities in low- and middle-income countries (Ahmed, Chase, et al., 2022). However, we must acknowledge the direct impacts of climate change on the health workforce. This can result in health staff being unwilling to take up or continue jobs in more climate-vulnerable locations, or even the death of workers due to disasters. A study from Australia found that in regions with underserved populations, the effects of climate change were prompting a third of healthcare workers to consider relocating (cited in Seervai, Gustafsson, & Abrams, 2022).

Beyond this, the equity impact of weak disability awareness among health staff is well documented and can create a significant barrier to accessing healthcare (Ssemata, Smythe, Sande, et al., 2024). In Australia, this lack of awareness of disability-related healthcare needs has been directly linked to why people with disabilities avoid hospitals (Policy Adviser, Australia). Distrust in healthcare providers, stemming from interpersonal racism towards First Nations peoples, further exacerbates this issue (community health centre worker; and disability service provider, Australia). It was reported that limited health seeking behaviours among Aboriginal and Torres Strait Islanders with disabilities reflects a "lack of trust, not a lack of need" (Occupational Therapist, Australia).

"There's a cultural distrust for people in power and people that are not their own" Disability Service Provider representative, Australia

Stigma significantly undermines the development of people-centred health services. Overcoming this requires greater mindfulness of historical context and the impacts of broken trust on health seeking behaviours. First Nations peoples prefer community-led health-care organisations, where providers are more likely to be culturally aware, especially in relation to mental health (Advocacy and Strategy Advisor, Australia). Applying Western concepts of disability can be inappropriate (Policy Advisor, Australia) and undermine access to health services for these communities (Disability Service Provider, Australia). In Indonesia, efforts are underway to draft curriculum and a training module for health providers to minimise stigma and improve inclusivity and equality in service provision (Ministry of Health official, Indonesia).

Health information systems

Resilient health systems rely on robust information systems that ensure "the **production**, **analysis**, **dissemination** and **use** of reliable information for policy decisions" (Debie et al., 2024, highlights added). Regular collection and use of quality data builds accountability and clarity within the system, thereby strengthening the health information system function. Effective health information systems are capable of processing and communicating information adequately, such as test results for pandemic responses. Conversely, poor data management, misinformation, or insufficient awareness, resources, and reporting, can weaken a health system's crisis adaptability. The lack of disability-disaggregated data often results in health policies and systems that fail to consider the needs of people with disabilities, especially in the context of climate change.

"A critical area of focus should be health information and data. The lack of disaggregated data on disabilities makes it difficult to address or even identify specific health needs related to climate impacts. This lack of visibility hampers our ability to formulate effective responses or prioritize interventions for those most at risk." OPD representative, Burkina Faso Effective collection, analysis, and dissemination of health information enhanced the inclusion of people with disabilities in health system crisis adaptation. For example, a respondent from Australia highlighted how the flexibility in the Ministry of Health's information sharing during the COVID-19 pandemic led to better outcomes for people with disabilities. Similarly, an interviewee from Indonesia noted that the availability of data on people with psychosocial disabilities informed policies for comprehensive mental healthcare at the primary level (Doctor, Indonesia).

However, most interviewees from the three focus countries identified critical issues in collecting and using disability-disaggregated data. An Indonesian OPD respondent reported severe difficulties due to societal stigma and varied definitions of disability. In Australia, the conceptualisation of disability among Aboriginal and Torres Strait Islanders highlighted the need for culturally relevant data collection frameworks to support inclusive and culturally appropriate healthcare provision.

When disability-disaggregated data is lacking, people with disabilities are likely to face increased health risks and access barriers to services during climate-related disasters. Effective data management is crucial for their inclusion in health system adaptations. For example, an Indonesian interviewee reflected that every individual health facility holds their own isolated data systems, resulting in scattered data, unusable for systems planning purposes, and hindering disability-inclusive climate responses.

Even with coordinated data collection efforts, the capacity to use this data and accountability mechanisms are key. In Australia, the poor effectiveness of the Vulnerable Persons Register resulted in the invisibility of people with disabilities during crises. Issues included significant gaps in registration, which left many climate-vulnerable people unregistered, and a heavy reliance on local services, which were difficult to maintain (Disability Advocacy Network member, Australia). This meant a lack of accountability for the provision of care, and the register ultimately not being used during disasters like floods (Community health centre worker; and Disability Service Provider, Australia). Even the name of the register posed problems, as it misrepresented people with disabilities as inherently vulnerable as opposed to being made vulnerable by the system (Disability Advocacy Network member, Australia).

Inclusive communication strategies are essential to ensure that information and policy decisions reach people with disabilities. Health information systems must prioritise using sign language, braille, and simple, jargon free words (OPD representative, Burkina Faso). An Indonesian respondent suggested using social media to disseminate health information, including videos with subtitles, sign language, and audiovisual description, though they noted this might not always reach all those in need (Ministry of Health Official, Indonesia). In the context of climate change, it is especially vital that health information systems produce, record, analyse and disseminate reliable disability disaggregated data to ensure inclusive health system adaptation and crisis response.

Health financing

Resilient health systems require "**adequate funds** for health to ensure people can use needed services and be **protected from financial catastrophes**" (Debie, et al. 2024, highlights added). Funding is the 'nuts and bolts' of the healthcare system, yet adequate funding to provide and protect health services remains a challenge in each of the three countries. Even in high-income Australia, lack of funding undermines holistic services provision; "it is a little bit hotchpotched at the moment, people are just plugging holes at this point" (Disability Service Provider, Australia).

It is not just the volume of finance that matters but also budget choices. Budgetary decisions impact the development and delivery of person-centred, comprehensive healthcare. In Australia, respondents noted a disproportionate allocation of funds into tertiary health (hospitals), over community health and primary care, despite the latter's role in prevention and early intervention (Community health centre worker, Australia). This disparity exacerbates systemic inequalities between public and private healthcare, in which healthcare centres serving poorer communities are more likely to be under-resourced, unable to meet individual health or access needs, have long waiting lists and significant service gaps (Occupational Therapist, Australia; Dentist, Australia). A community health centre worker attributed this disparity to politicians seeking "easy results".

Household finance cannot offset inequitable healthcare resourcing. The link between household poverty and healthcare access in Australia includes service affordability and private healthcare. For people with disabilities and chronic conditions, necessary services are often only available within the private system and are expensive. In Burkina Faso, respondents also highlighted how a poorly resourced healthcare system makes people with disabilities more vulnerable (OPD representative, Burkina Faso). An Indonesian doctor noted that individuals with psychosocial disabilities often rely on first-generation medications with higher "side-effect risks" because second-generation medications are costlier and less accessible to them. They also referenced the institutionalisation of family members with psychosocial disabilities as a coping mechanism, potentially exacerbated by health financing constraints.

Health social protections often do not cover certain conditions or medications, leading to neglect of these areas due to perceived expense. In Indonesia, the National Health Insurance does not sufficiently cover assistive devices (Ministry of Health official, Indonesia). However, people with disabilities can apply for financial aid for assistive devices and national health insurance payments. This is crucial as only 42% of people with disabilities have wages and salaries in Indonesia, compared to 80% of those without disabilities (AIHW, 2023). In Australia, disability-specific financial support (via the National Disability Insurance Scheme (NDIS)) reportedly reaches just 10% of people with disabilities (Disability Advocacy Network member, Australia).

Given the above, adapting health financing to climate change is essential for building resilient health systems. Two observations were noted: First, climate change is shifting health burdens, such as increasing non-communicable diseases, causing governments to divert funding from other health areas. Second, flexibility in climate finance is crucial, and needs to be included in Government policy. In Indonesia, for example, governors can declare a state of emergency, allowing everyone to access government-covered healthcare, regardless of their ID status, following a crisis, including those which are climate induced.

"National disaster means national government finances healthcare services, local disaster means local government finances healthcare services." Doctor, Indonesia

Leadership and governance

For health systems to be resilient, leadership and governance must ensure "strategic **policy frameworks** combined with effective **oversight**, **coalition**, appropriate **regulation**, system **design** and **accountability**" (Debbie et al., 2024 – highlights added). Multisectoral and collaborative approaches should consider environmental determinants of health and incorporate climate change into health policies and programmes (Mosadeghrad et al., 2023). This is crucial given the health inequalities faced by people with disabilities, who are particularly vulnerable to climate change (Lindsay et al., 2022).

Collaboration among health actors is essential for resilient health governance. A holistic, systemwide response to public health prevention and preparedness, including community engagement, helps reduce health inequities (Vardoulakis et al., 2022). However, interviewees noted that siloed government departments and responses hinder disability-inclusive action, with departments focused on disability inclusion often disconnected from those addressing climate change. This disconnect not only contradicts Article 33 of the CRPD (on government coordination) but also undermines the mainstreaming of disability inclusion in governments' climate response systems (Grant and Keogh, et al., 2023).

Including people with disabilities in National Adaptation Plans (NAPs) could help mitigate climate change impacts and protect health. However, climate policies and plans tend not to embed disability inclusion (refer to Annex for CBM Global's analysis of disability inclusion in climate policies in the three focus countries). At the local level, community adaptive capacity can be enhanced through including people with disabilities, particularly in climate disaster preparedness discussions (King and Gregg, 2022). Genuine co-design involving people with disabilities is crucial to overcome the lack of inclusive policy frameworks and stakeholder collaboration. Broadening

and strengthening health actor networks is one mechanism to help realise this. However, Australian respondents felt co-design processes were often tokenistic and lacked accountability (Policy Adviser; and Occupational Therapist, Australia).

The intersection of climate change, health and disability amplifies existing disparities and perpetuates systemic inequalities, including access to decision-making and resources (Pirmasari et al., 2023). First Nations peoples in Australia view health as connected to the land, with wellbeing integral to climate change response (Australian Department of Health and Aged Care, 2023). Their unique connection to Country means that when Country – lands, seas, and waterways – is healthy, then People will be healthy. Current climate change responses often fail to adequately incorporate First Nations cultural perspectives, (Australian Disability Service Provider, and Australian Policy Advisor).

One Australian respondent noted that health systems are reacting to and restructuring around climate-related changes as a 'new normal' rather than addressing the root causes of climate-related health inequalities. This potentially limits debate around what might be appropriate health adaptations and is associated with a narrow emphasis on secondary and tertiary care (Disability Service Provider, Australia). Another interviewee observed that funding prioritises hospital care rather than a preventative, holistic community healthcare, which could otherwise prevent hospital admission. Funding priorities were attributed to politicians seeking easy results rather than focusing on achieving longer term health equity and resilience (Community Health Centre worker, Australia).

Infrastructure

A robust infrastructure "allows products and diagnostics to travel through the healthcare system" thereby supporting all aspects of equitable patient care, from **procuring and providing essential medical products and technologies** to ensuring **quality, safety, efficacy,** and **cost-effective patient care** (Debie et al. 2024). A well-functioning infrastructure is essential for resilient health system and vital for disability-inclusive climate adaptation.

This can be achieved through close collaboration and integration of different networks and services. In Indonesia, for example, the Department of Social Welfare, the Department of Health, and the local Police Department work together to identify people with psychosocial disabilities and refer them to appropriate health services (Doctor, Indonesia). Awareness raising, identifying people with disabilities within communities, and building adequate medication reserves are also critical for a crisis-robust infrastructure (ibid).

However, other key informants in Australia and Indonesia described issues such as lack of collaboration, lost information, long or non-existent waiting lists, poor accessibility, growing privatisation of healthcare, and difficulties navigating the pharmacy system. These infrastructure issues exacerbate health inequalities for people with disabilities.

Respondents highlighted critical weaknesses in health infrastructure during the COVID-19 pandemic, including accessibility barriers, stigmatisation, and limited government support, which could predict inadequate responses to climate change emergencies (Disability Advocacy Network member, Australia; and OPD representatives, Indonesia). An OPD representative from Burkina Faso summarised this well –

"An insufficiently resourced infrastructure that fails to consider specific needs cannot provide equitable care for everyone." OPD representative, Burkina Faso

Information flow within the health infrastructure is also critical. Incomplete information from hospital admission through to discharge can lead to low-quality patient care (Disability Policy Adviser, Australia). Establishing a robust health information system that ensures responsible data management and feedback to patients and carers is essential (see section above).

Practical considerations for climate resilience in health infrastructure include physical accessibility. Adaptations like wheelchair tilts, ramps, signage, simple language information, and accessible transport to health centres must be available (community health centre worker, Australia; OPD representative, Burkina Faso; and OPD representative, Indonesia). Healthcare centres should be adapted and regularly assessed to serve as places of respite during climate-related emergencies, such as heatwaves (community health centre worker, Australia). Ensuring barrier-free access to care is crucial for meaningful inclusion of people with disabilities in climate adaptation measures.

Recommendations for climate-resilient, person-centred, inclusive health systems adaptations

This section compiles all the recommendations suggested by key informants in the three focus countries, reflecting their perspectives on and lived experiences of the six components of health systems discussed above.

Service delivery:

- **Prevention and early intervention:** Focus on primary healthcare to support resilience, to enable people to stay well, prevent worsening conditions and manage their symptoms at home. This responds better to changing health needs and reduces climate change impacts on health.
- **Community centred care:** Provide barrier-free healthcare tailored to individual needs, essential for building local climate-resilient health services.
- **Inclusive health services:** Embed principles of inclusion to prevent stigmatising or discriminatory attitudes and behaviours. Address racism, stigma and poor disability awareness, that undermine healthcare seeking behaviours including for intersecting identities, such as ethnicity. For First Nations people in Australia, for example, this includes cultural safety interventions (e.g. hiring Aboriginal staff, awareness training, engagement and partnership with representative groups).
- **Inclusive communication:** Improve health literacy in climate-affected areas through sign language, braille, simple language, and clear signage. Use social media accessibly with subtitles, sign language, and audio-visual descriptions.

Health workforce

- **Training and mentoring:** Build an inclusive attitude within all health staff to be trusted by people with disabilities. Training in inclusive health practices is essential to meet the needs of people with disabilities, including during climate-related events.
- **Zero tolerance for stigmatisation:** Ensure staff exhibit no stigmatising attitudes towards people with disabilities in all their diversity. This applies across different identities, including cultural and gender responsiveness.
- **Climate and disaster risk management:** Address and manage risks for staff and service provision, including climate health education.

Health information systems

- **Effective registration systems**: Create and support thorough registration systems with government budgets and stakeholder involvement to capture reliable health data that can support informed decisions for inclusive climate adaptation, preparedness and response.
- Accountability: Ensure established registers and data systems are robust and inform decision-making. Mechanisms must be in place to ensure that the captured data shapes government decisions.
- Inclusive health information and communications: Relay health information in accessible formats (e.g. sign language, braille, simple language) to enable barrier-free access for people with disabilities.

Health financing

• **Equitable healthcare:** Move away from a multi-tiered healthcare system based on income. Make healthcare free of cost at delivery and review rebate system, insurance or social protection systems to ensure they are financially accessible, and disability appropriate (e.g. cover assistive devices).

Leadership and governance

- **Cross-departmental collaboration:** Break down siloes between government departments to integrate disability inclusion across sectors, especially in climate change response and policy.
- **Co-design climate solutions:** Ensure genuine co-design of climate solutions with people with disabilities, including adequate accessibility, renumeration and accountability to avoid tokenism.
- **Investigate climate impacts:** Invest in research on the impacts of climate change on people with disabilities and prioritise findings in policy and investment, particularly into primary healthcare services.

Infrastructure

- Accessible infrastructure: Ensure transport to healthcare facilities, barrier-free buildings, and accessible information. Provide funding for accessible transport, e.g. in form of taxi vouchers, to remove financial barriers
- **Annual accessibility audits:** Conduct annual audits to keep accessibility adaptations up-to-date and effective.
- **Safe zones:** Fund the adaptation of public buildings and healthcare centres to serve as safe zones during climate emergencies.
- **Health passports:** Create health passports with accessibility information, medications and a list of carers/decisionmakers for people with learning disabilities to ensure continuation of quality, inclusive care including during climate-related emergencies.

Conclusions

This paper explored how health systems can be adapted to promote health equity for people with disabilities in the face of climate change. We highlighted the perspectives and experiences of people with disabilities on health systems strengthening and health equity, through a climate lens. This initial investigation is not exhaustive but reveals some opportunities and underscores critical issues that need to be addressed to leverage health rights within climate adaptions in the health sector. These adaptations aim to improve disability inclusion and work towards achieving universal health coverage and strengthened resilience.

Key points from our discussions include:

- **Consistent Exclusion Across Contexts**: Despite varying income levels and country contexts, the exclusion of people with disabilities from health services is a common issue.
- **Isolated Good Practices**: While there are pockets of good practice, there is a lack of coherence across health systems.
- **Component Analysis**: Breaking down health system components and looking at each systematically can reveal useful entry points for equitable adaptation. This approach, while acknowledging the interactions between components, helps in understanding how they can facilitate health equity in the context of climate change.

Our priority is to ensure equitable access for all, operating on the assumption that greater health equity leads to greater climate resilience for people with disabilities and in turn for the whole of society. This paper takes a first step in this direction, with further research needed to validate this assumption. Key areas for adapting health systems to be more disability-equitable and climate-resilient that have been identified include:

- 1. Data and Information: Central to a functioning health system, data and information are crucial for informed decision-making, monitoring health needs, and assessing service efficiency and effectiveness.
- 2. Reducing and Removing Barriers: This involves addressing health worker attitudes and behaviours, ensuring accessible communications, and improving infrastructure accessibility.
- **3.** Investing in Primary Healthcare: Focusing on primary healthcare can prevent hospital admissions, reduce costs and provide holistic, responsive and appropriate health services.
- **4. Meaningful Participation**: Ensuring that people with disabilities are actively involved in shaping health policies and programmes.

Underlying all these areas are budgetary considerations, which are essential to their effective implementation. This is about both decision-making and finance volumes. In under-resourced contexts, climate finance must be utilised to alleviate the burdens on health systems. Urgent action through international climate finance commitments is needed to tackle the climate crisis and prevent additional strains on vulnerable health systems. Recognising that people with disabilities are disproportionately impacted, climate finance must target adaptation and provide a health sector response that is disability-aware, and actively works to redress structural inequities, paving the way for universal health coverage and more resilient, healthy populations.

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Annex: Disability Inclusion in National Climate Action Plans

In 2024, CBM Global⁶ assessed Australia, Burkina Faso and Indonesia's national climate, humanitarian and Disaster Risk Reduction (DRR) plans to see the degree to which disability inclusion is integrated into the policies. The assessment applied 19 of the 40 targeted action points in the WHO Global report on health equity for people with disabilities as well as an additional five targeted action points (listed at the end of this Annex). The targeted action points were chosen based on relevance and operationalised into questions.



Country	Australia	Indonesia	Burkina Faso
Adaptation	Adaptation Communication; National Climate Resilience and Adaptation Strategy 2021-2025	National Adaptation Plan; Long-term Strategy for Low Carbon and Climate Resilience 2050	National Adaptation Plan; Adaptation Com- munication
Mitigation	Long-term Emissions Reduction Plan; Nationally Determined Contributions	Nationally Determined Contri- butions; Long-term Strategy for Low Carbon and Climate Resilience 2050	Nationally Determined Contributions
Disaster Risk Re- duction	National Disaster Risk Reduc- tion Framework; Humanitarian Programme	Government Regulation of the Republic of Indonesia Number 21 of 2008 Concerning Disaster Management	Decree No 2014- 466/PRES (De- cree)

WHO targeted action points:

- 1. Involving persons with disabilities in the creation of the climate plan.
- 2. Prioritising climate/ humanitarian/ DRR equity for people with disabilities.
- 3. Establishing a human rights-based approach to climate/ humanitarian action/ DRR.
- 4. Assuming a stewardship role for disability inclusion.
- 5. Making international cooperation more effective by increasing funding to address inequalities for people with disabilities.
- 6. Integrating disability inclusion in national climate/ humanitarian/ DRR strategy.
- 7. Setting actions that are specific to the climate/ humanitarian/ DRR sector in national disability strategies and plans.
- 8. Establishing a committee or a focal point in the respective Ministry for disability inclusion.
- 9. Integrating disability inclusion in the accountability mechanism of the climate/ humanitarian/ DRR sector.
- 10. Creating disability networks, partnerships, and alliances.
- 11. Social protection for people with disabilities.
- 12. Progressive universalism is a core principle and driver of climate financing, with persons with disabilities at the centre.
- 13. Making facilities and services accessible for people with disabilities.
- 14. Engaging with people with disabilities and their representative organisations.
- 15. Gender-sensitive actions that target people with disabilities.
- 16. Engaging people with disabilities in research and including them in the climate/ humanitarian/ DRR research workforce.
- 17. Requesting that providers in the private sector support the delivery of disability-inclusive services.
- 18. Creating a monitoring and evaluation plan for disability inclusion.
- 19. Integrating the specific needs and priorities of people with disabilities.
- 20. Language and communication access for people with disabilities.

Additional targeted action points:

- 21. Mental health of people with disabilities.
- 22. Mention of health.
- 23. Livelihood protection for people with disabilities.
- 24. Using local knowledge and expertise of people with disabilities.
- 25. Collecting, using and/or analysing data on people with disabilities.