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# Rehabilitation International News!

A GLOBAL ADVOCATE FOR REHABILITATION, INCLUSION AND HUMAN RIGHTS


## Editorial

**Dear Members of Rehabilitation International,**
**Friends and Partners of Rehabilitation International,**
**And All Interested Readers,**

Welcome to the February 2025 edition of the Rehabilitation International Newsletter!
In this issue, we bring you key highlights, including:

- **Advocating for Inclusion and Rights** – A look at strategic efforts to empower inclusion and promote disability rights.
- **Global Advocacy in Action** – Insights from the United Nations High-Level Meeting on Universal Health Coverage, showcasing impactful advocacy by RI
- **RI Regional** – A report **From Disability to Independent Life Project in Italy**, driving positive change.
- **Science Corner** – A deep dive into the article **Unheard and Unseen: The Diabetes Crisis Among the Deaf and Blind.**

We also continue to welcome your contributions—your insights and stories help strengthen our collective mission.
A heartfelt thank you to all our contributors for making this issue possible and to our readers for your ongoing support and engagement. Let's keep working together to advance Rehabilitation International's mission, fostering a more inclusive world with greater opportunities for all.

Warm regards,
Hannover, December 2024

**RI President & RI Media**

## In this RI News!

# Advocacy for People with Disabilities: Empowering Inclusion and Rights - 1


**Advocacy for people with disabilities is a powerful tool in ensuring equality, dignity, and opportunity. Whether through self-advocacy, individual support, or systemic efforts, every action contributes to a more inclusive society.**

Rehabilitation International is a global Advocate for Rehabilitation, Inclusion and Human Rights particularly for people with disability. It will need a concerted global effort and with well planned strategy. Although these 3 pillars in the implementation level all should be orchestrated together, this article will focus mostly on advocacy.

**Definition of Advocacy for People with Disabilities**

According to the United Nations (UN), the goal of advocacy is to create a specific change or action, rather than just convey information. Advocacy for people with disabilities refers to the efforts aimed at promoting and protecting the rights, dignity, and opportunities of individuals with disabilities. It involves influencing policies, removing barriers, ensuring equal access, and fostering societal acceptance. Advocacy can be conducted by individuals, organizations, or governments to improve the quality of life for people with disabilities and promote their full inclusion in society.

**Levels of Advocacy**

Advocacy for people with disabilities occurs at different levels, including:

1. Self-Advocacy – Individuals with disabilities speak up for themselves, assert their rights, and make personal decisions about their lives.
2. Individual Advocacy – Advocates or representatives (family members, friends, or professionals) support individuals in resolving issues related to education, employment, healthcare, and accessibility.
3. Systemic Advocacy – Organizations, policymakers, and activists work collectively to influence laws, policies, and societal structures to benefit all individuals with disabilities.

**Levels of Advocacy Based on Targets**

Advocacy efforts can also be categorized based on their primary targets:

1. *Community Advocacy* – Focuses on raising awareness and fostering inclusion at the local community level by engaging with schools, businesses, and public spaces.
2. *Institutional Advocacy* – Aims at improving policies and practices within organizations, such as workplaces, hospitals, and educational institutions.
3. *Governmental Advocacy* – Involves lobbying government officials, influencing legislation, and ensuring the enforcement of disability rights laws.
4. *International Advocacy* – Targets global institutions and policymakers to promote disability rights and inclusion at an international level, influencing treaties and global policie, including at UN level.

**Strategies for Advocacy**

Effective advocacy requires well-planned strategies, including:

- *Awareness Campaigns*: Educating the public and policymakers about disability rights and issues.

# Advocacy for People with Disabilities: Empowering Inclusion and Rights - 2

- *Collaboration and Networking*: Partnering with disability organizations, legal bodies, and government agencies.
- *Legislative Engagement*: Advocating for new laws and policies or improving existing ones.
- *Media and Digital Advocacy*: Using social media, blogs, and news outlets to amplify the message.
- *Education and Training*: Empowering individuals with disabilities to understand and exercise their rights.

**Advocacy Plan**

An advocacy plan provides a structured approach to achieving goals. A simple advocacy plan includes:

1. *Identifying the Issue*: Understanding the specific challenge faced by people with disabilities (e.g., lack of accessibility in public spaces).
2. *Setting Goals*: Defining clear objectives, such as implementing accessibility guidelines in buildings.
3. *Targeting Stakeholders*: Identifying key decision-makers, such as government officials, businesses, and communities.
4. *Developing a Message*: Crafting compelling narratives to raise awareness and gain support.
5. *Choosing Advocacy Methods*: Selecting appropriate strategies like petitions, protests, policy discussions, and/or media campaigns.
6. *Measuring Success:* Evaluating the impact through feedback, policy changes, or increased awareness.

**Taking Action**

Advocacy becomes effective when actions are taken to bring change. Some actions include:

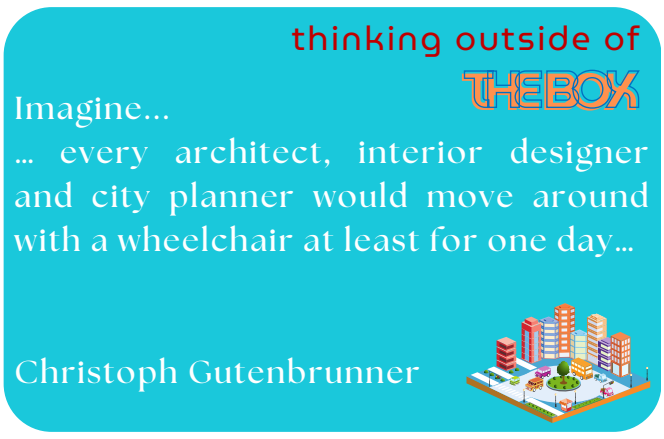
- Organizing awareness events and public forums.
- Engaging with lawmakers to introduce or amend disability laws.
- Conducting accessibility audits in workplaces and schools.
- Providing training on disability inclusion for employers and educators.
- Using storytelling and testimonials to highlight real-life experiences of people with disabilities.

**Conclusion**

Advocacy for people with disabilities is a powerful tool in ensuring equality, dignity, and opportunity. Whether through self-advocacy, individual support, or systemic efforts, every action contributes to a more inclusive society. By developing strategic plans, engaging stakeholders, and taking direct actions, advocacy efforts can lead to meaningful change and empower individuals with disabilities to live independent and fulfilling lives.

This article is based on report provided by:

**Dr. rer. biol. hum. Boya Nugraha, MS**
Consultant & Researcher in Rehabilitation within Health System



# Political Declaration of the High-level Meeting on Universal Health Coverage

## "Universal health coverage: moving together to build a healthier world" - Example for RI Advocacy - 1


**It is of major importance to advocate for inclusion of persons with disabilities to all health (and other) services and to make sure that rehabilitation is an integral part of all services. With regard to disability-inclusive services, it seems that there is a consensus to include this into international guiding documents.**

Background. In Summer 2023, the United Nations planned a political declaration on Universal Health Coverage (UHC). Organizations in consultative status with UN were invited to participate in a multi-stakeholder dialogue to discuss the contents of the declaration.

Intervention. The stakeholder dialogue was scheduled for May 8-9, 2023. According to UN, the hearing aims to "provide an opportunity for all relevant stakeholders to contribute to the ongoing preparatory process for the High-Level Meetings, with a focus on the current state of efforts and top needs to accelerate response. Participants will be encouraged to exchange views on key priorities for the High-Level Meeting, while underscoring experiences and best practices on the ground, highlighting the special challenges faced by civil society and other relevant stakeholders working in the field and the need for stronger accountability at all levels."

Rehabilitation international (RI) as an organization with UN consultative status with UN Economic and Social Council (ECOSOC) was represented by Prof Christoph Gutenbrunner, at that time RI-President elect.

RI delivered a statement entitled "Universal Health Coverage (UHC) must ensure unrestricted access to health services for Persons with Disabilities and include Rehabilitation and Assistive Technology":
"For the implementation of Universal Health Coverage and to make sure that persons with disabilities can profit from UHC services it is crucial to ensure and promote

- that persons with disability have unrestricted access to health services according to the principles of UHC; ·
- that barriers for access to health and rehabilitation services will be removed, including physical barriers, financial barriers, and barriers occurring from lack of awareness and expertise;
- ·that health professionals are appropriately trained in special needs of persons with disabilities including the principle of shared decision making;
- ·that high quality rehabilitation services and assistive technology is available for all persons in need, including persons with disabilities;

# Political Declaration of the High-level Meeting on Universal Health Coverage

## "Universal health coverage: moving together to build a healthier world" - Example for RI Advocacy - 2


- ·that rehabilitation services and assistive technology are appropriately equipped and financially resourced as well as designed to meet the special needs of persons with disabilities;
- ·rehabilitation services at primary care level and in the communities as well as the number of rehabilitation professionals and Community Based Rehabilitation (CBR) workers is expanded;
- ·research is performed on the implementation of rehabilitation and assistive technology in health systems, the access for persons with disabilities to health care, including rehabilitation and assistive technology, the needs and effects on rehabilitation interventions and assistive technology provision.

Furthermore, RI joined a statement, developed by six non-state actors with special focus on including rehabilitation in Universal Health Coverage.

In his oral statement Prof Gutenbrunner again highlighted the following main aspects:
a) Persons with disabilities must get full and unrestricted access to all health services, i.e. those that are included in Universal Health Coverage;
b) UHC must include rehabilitation services for all persons in need, including persons with disabilities and persons experiencing disabilities.

**Result**
The discussion during the multi-stakeholder Hearing included many aspects of access to health services, like aspects of gender, age, poverty and others. There were only very few statements mentioning access of persons with disabilities, however, the intervention of the RI representative was well received.

Even though it is not possible to demonstrate a clear intervention-effect relation we were happy to see that the final declaration includes the following paragraphs:

· "25. Implement most effective, high impact, quality-assured, people-centred, gender- and **disability-responsive**, and evidence-based interventions to meet the health needs of all throughout the life course, and in particular those who are vulnerable or in vulnerable situations, ensuring universal access to nationally determined sets of integrated quality health services at all levels of care for the prevention, diagnosis, treatment and care in a timely manner;"

· "37. Increase **access to health services for all persons with disabilities**, remove physical, attitudinal, social, structural, and financial barriers, provide quality standard of care and scale up efforts for their empowerment and inclusion, noting that persons with disabilities, representing 15% of the global population, continue to experience unmet health needs;"

# Political Declaration of the High-level Meeting on Universal Health Coverage

## "Universal health coverage: moving together to build a healthier world" - Example for RI Advocacy - 3

· "61. Develop, improve, and make available evidence-based training that is sensitive to different cultures and the specific needs of women, children **and persons with disabilities**, skills enhancement and education of health workers, including midwives and community health workers, as well as promote a continued education and life-long learning agenda and expand community-based health education and training in order to provide quality care for people throughout the life course"

· "67. Strengthen health information systems and collect quality, timely and reliable data, including vital statistics, disaggregated by income, sex, age, race, ethnicity, migratory status, **disability**, geographic location, and other characteristics relevant in national contexts as required to monitor progress and identify gaps in the universal and inclusive achievement of SDG3 and all other health-related Sustainable Development Goals (...)"

· "70. Ensure that **no one is left behind**, with an endeavour to reach the furthest behind first, founded on the dignity of the human person and reflecting the principles of equality and non-discrimination, as well as to empower those who are vulnerable or in vulnerable situations and address their physical and mental health needs which are reflected in the 2030 Agenda for Sustainable Development, including all children, youth, **persons with disabilities**, people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants"

On the other hand, rehabilitation only was mentioned twice , including it in UHC bit not giving it a special focus:
·"8. Recognize that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective and quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship".

30. Scale up efforts to promote healthy and active ageing, maintain and improve quality of life of older persons and to respond to the needs of the rapidly ageing population, especially the need for promotive, preventive, curative, rehabilitative and palliative care as well as specialized care and the sustainable provision of long-term care, taking into account national contexts and priorities".

**Conclusion**

It is of major importance to advocate for inclusion of persons with disabilities to all health (and other) services and to make sure that rehabilitation is an integral part of all services. With regard to disability-inclusive services, it seems that there is a consensus to include this into international guiding documents. On the other hand for full integration of rehabilitation into health system, more intensive advocacy seems to be needed.

This article is based on report provided by:

**Prof. Christoph Gutenbrunner MD, PhD**
RI President

# From Disability to the Independent Life Project and Inclusion : A very positive innovation in Italy - 1

With the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, January 2011) each acceding State has made a commitment to apply it in all its legislation, programs and policies. UNCRPD has opened a new legal, technical, cultural and political reference scenario. From that moment on, people with disabilities no longer have to ask for the recognition of their rights, but rather have to request their application and implementation. This is a profound cultural and political transformation: we have moved, in fact, from the recognition of needs to the recognition of human rights and fundamental freedoms. People with disabilities become an integral part of any human society, which must guarantee the enjoyment of the same rights as other citizens to support their "full and effective participation in society on an equal basis with others".

It is a cultural and technical revolution, which starts from the idea that disability is a social relationship, not a subjective condition of the person. People can move around in wheelchairs, orient themselves with a guide dog, communicate with sign language and not have disabilities, if the world with which they interact takes these characteristics into account. Therefore the objective of the treatments to which they are subjected is to guarantee the highest possible level of health, but in a context in which health is not the absence of diseases, but the well-being of the person. Therefore, rather than rebuilding a condition of presumed normality, people must be guaranteed the enjoyment of fundamental rights and freedoms, including those who move around in wheelchairs, find their way with a guide dog, and communicate with sign language.

It is rehabilitated if a lost functionality of the body is recovered, it is enabled when new skills are developed starting from the elements that allow a person to function in a certain way and on which adequate supports can be developed.

It has been understood that the rehabilitation outcome always requires, in order to be truly effective, a real connection with the person's individual, subjective, autonomous life and context of environmental and social relationships. All this, in a nutshell, has produced the definition within the WHO of a biopsycho-social model for rehabilitation.

The principle that people with disabilities are "part of human diversity and of humanity itself" is important. This ownership of belonging makes it clear that their conditions of functional limitations cannot be justifications for the denial of their rights and that the appropriate support interventions concern on the one hand contextual and social factors, but also personal factors which, if adequately treated, they can achieve results in terms of empowerment, enabling, resilience and therefore recovery of skills and abilities and therefore full citizenship.

The CRPD definition of people with disabilities highlights the interaction between the characteristics of people with functional limitations and the environmental and social context of life. The need to better define who the person is and describe their living conditions is evident. In this direction it is essential to design the person's functioning profile, which cannot be limited to his functional limitations and the performances linked to them, but must include other qualities and abilities, even potential ones, to operate on all qualities and skills. This evaluation must include the

# From Disability to the Independent Life Project and Inclusion : A very positive innovation in Italy - 2

strong participation of the person involved who must be able to direct the two processes for Orientals according to their own aspirations and life choices.

**A new perception of available aids**

The traditional distinction between prosthesis and orthosis, which focused on improving the body's functions for certain rehabilitation objectives, today must be completely reformulated on the basis of the new and in some ways extraordinary technological tools that allow participation and the development of skills and competences to be promoted. previously unthinkable. In particular, assistive devices produce a cultural dimension that is often defined as post-human, due to the new opportunities it offers. This applies to all people who use these devices today, even more so for people with disabilities.

The approach of the CRPD emphasizes that States "organize, strengthen and develop comprehensive services and programs for habilitation and rehabilitation, in particular in the fields of health, employment, education and social services". This means that the traditional welfare approach aimed at people with care and assistance disabilities, in a word of protection, must strongly address inclusion and full and effective participation, as emerged during the SAR-COV-2 pandemic.

**In Italy**

This approach has finally been adopted by the Italian Government to reform the entire Welfare system aimed at all people who for any reason find themselves in a condition of disability and need support (economic, health, employment, social...) from part of the State which in Italy operates through an organization called the National Institute for Social Security INPS.

All the legislation, the procedures for accessing these Welfare services, the needs and performance assessment methodologies were based on the ICF and WHO-DAS methodologies with Law 227 of 2021 and then implemented with Application Decree no. 62 of 2024. (A brief summary follows).

It is undoubtedly a profound innovation of which we are proud of national Welfare, which is simultaneously setting in motion an equally necessary innovation in the conception, management and valorisation of all rehabilitation cultural and scientific basis and clinical activities in the national health system.

**A brief Synthesis of Decree 62/2024**

“**Definition of the disability condition, of the basic assessment, of reasonable accommodation, of the multidimensional assessment for the development and implementation of the personalized and participatory individual life project**.”

Decree 62/2024, declining the indications of Law 227/2021, defines the purposes and principles of the action of state structures for the protection of the rights to inclusion and independent living for people with disabilities. It also defines in detail the methods, times and operational responsibilities for the full application of these innovative principles that reform welfare in Italy.

# From Disability to the Independent Life Project and Inclusion : A very positive innovation in Italy - 3

**Article. 2) Definitions** – Here is really easy to understand the deep changing aim.

1. For the purposes of this decree, the following apply definitions:

a) "***condition of disability***": a lasting impairment physical, mental, intellectual, neuro-developmental or sensory which, in interaction with barriers of different nature, can hinder flooding and effective participation in different life contexts on a basis of equality with others;

b) "***handicapped person and handicap***", wherever it occurs, is replaced by following: «***condition of disability***»:

c) ***ICF***: International classification of functioning, of disability and health - International Classification of Functioning Disability and Health (ICF), adopted by the Organization world health in accordance with articles 21, letter b), e 22 of the Protocol concerning the establishment of the Organization World Health Organization, signed in New York on 22 July 1946, rendered executive by legislative decree of the provisional Head of State 4 March 1947, n. 1068;

d) ***ICD***: International Classification of Diseases -International Classification of Diseases (ICD), adopted by the World Health Organization in accordance with Articles 21(b) and 22 of the Protocol concerning the constitution of the World Health Organization, New York July 22, 1946, made executive by legislative decree of the provisional Head of State 4 March 1947, n. 1068;

e) ***lasting impairment***: impairment resulting from any loss, limitation or anomaly of facilities or bodily functions, as classified by the ICF, which persists in time or for which regression or attenuation is only possible in the long run;

f) ***functioning profile***: description of the state of health of a person through the codification of functions and structures body, activities and participation according to the ICF taking into account the ICD, as a correlated developmental variable age, health condition, personal factors and context determinants, which can also include the profile of functioning for school purposes;

g) ***WHODAS***: WHO Disability Assessment Schedule, questionnaire assessment based on the ICF which measures the health and condition of disability;

h) ***supports***: services, interventions, performances and benefits identified at the conclusion of the assessment of the condition of disability and in the life project to improve abilities of the person and their inclusion, as well as to counteract the restriction in his social participation, graduated in «support» and «intensive support», based on frequency, duration and continuity of support;

i) ***intervention plan***: planning and control document coordination of individual supports relating to an area of intervention;

l) ***baseline assessment***: procedure aimed at ascertaining, through the use of the ICD and ICF classifications and their correlates technical operational evaluation tools, the condition of disability for the purposes of accessing support, mild or medium, or to intensive, high or very high support;

m) ***multidimensional evaluation***: procedure aimed at outline his profile with the person with a disability functioning within its life contexts, also respect to the obstacles and facilitators present in them, and to define, too based on his desires and expectations and preferences, he objectives to which the life project must be directed;

n) ***life project***: individual, personalized project and participated by the person with disabilities who, starting from his desires and his expectations and preferences, is directed to identify, in a unitary existential vision, the supports, formal and informal, to allow the person himself to improve the quality of one's life, to develop all of his potential, to be able to choose life contexts and participate in conditions of equal opportunity with respect to others;

# From Disability to the Independent Life Project and Inclusion : A very positive innovation in Italy - 4

o) ***quality of life domains***: relevant areas or dimensions in the life of a person with disabilities that can be assessed with appropriate indicators;

p) ***project budget***: set of human resources, professional, technological, instrumental and economic, public and private, which can also be activated within the local and regional communities system of informal supports, to be allocated to the life project.

**Art. 6)** and followings:

-Basic assessment (**Introductory medical certificate** involving WHO-DAS questionnaire and any other documentation , and ends within ninety days from receipt of the medical certificate) . The basic evaluation units are integrated with a healthcare professional on behalf of National Associations of persons suffering by different disability conditions in relation to the specific conditions of disability being assessed. During the baseline assessment, the affected person can seek assistance from trusted doctor or psychologist, without right to vote. The recognition of the condition of disability constitutes the result of the basic evaluation procedure, including:

a) the assessment and verification of the health condition of the person, described in the introductory medical certificate with the codes ICDs;

b) the evaluation of lasting and significant impairments state of health, functional, mental, intellectual or sensory, in accordance with the ICF indications and taking into account of the ICD;

c) the identification of functional and structural deficits that they hinder, in terms of health, the person's actions and that are relevant in terms of capacity according to the ICF;

d) the identification of the person's functioning profile, limited to the domains of mobility and autonomy in basic and instrumental activities for daily life activities, with need for continuous support;

e) the evaluation of the impact of functional impairments and structural in terms of capacity according to the ICF classification, in the domains relating to activity and participation, considering also the domains related to work and learning in the field of higher education;

f) the assessment of the level of support needs, light or medium, or intensive, high or very high support, related to the ICF domains on activity and participation.

g) the recognition of the condition of disability for minors includes, for the evaluation of relevant domains to learning, including scholastic learning.

Starting from 1 January 2025 in the basic evaluation it is used the - International Classification of Functioning, Disability and Health (ICF), approved by the 54th World Health Assembly May 22, 2001

**Art.10)** and followings:

The Certificate - The certificate that recognizes the condition of disability replaces for all purposes the related certifications. The transmission of the certificate in the interest of the person integrates the presentation of the request to purposes of obtaining social, socio-welfare benefits and social and health care.

# From Disability to the Independent Life Project and Inclusion : A very positive innovation in Italy - 5

Reasonable accommodation -. The person with a disability (or applicant /care giver) participate in the procedure relating to the identification of reasonable accommodation.

Reasonable accommodation must be necessary, adequate, relevant and appropriate to the extent of the protection to be granted and the context conditions in the specific case, as well as compatible with the resources actually available for the purpose.

Life Project . The life project is aimed at achieving the objectives of person with disabilities to improve personal and social conditions health in different areas of life, facilitating social inclusion and participation in different life contexts on a basis of equality with others. It identifies, in terms of quality, quantity and intensity, tools, resources, interventions, benefits, performance, services and reasonable accommodations, also aimed at to eliminate and prevent barriers and activate supports necessary for the inclusion and participation of the person himself in different areas of life, including scholastic ones, of higher education, housing, work and social issues. In the project of life are also included in the measures provided for in the legislation in force for overcoming conditions of poverty and marginalization and social exclusion, as well as any support that can be provided in favour of the family unit and of those who provide care and assistance to them. The person is the owner of the life project and of it requires activation, helps determine its contents, exercises the prerogatives aimed at making changes and additions, according to wishes, expectations and own choices. The life project must be sustainable over time that is guarantee continuity of tools, resources and interventions, benefits, performances, services and reasonable accommodations, always in compliance with self-determination of the beneficiary. The life plan tends to favour the freedom of the person with a disability to choose where to live and who to live with, identifying appropriate housing solutions and, where required, guaranteeing the right to home care and support social welfare, The State, the regions and local authorities, within the framework of related skills, guarantee the effectiveness and homogeneity of the life plan, regardless of age and conditions personal and social.

**Art.-21 ) and followings - Supports for the manifestations of will of the person**

Multidimensional evaluation process : The process of multidimensional evaluation, drafting andmonitoring of the life project conforms to the principle of self-determination and ensures the active participation of the person with disability to the entire evaluation process multidimensional, drafting and monitoring of the project life with the adoption of strategies and, within the limits of resources available, also through the use of tools, aimed at facilitate understanding of the phases of the procedure and how much proposed to support decision making and manifestation of desires, expectations and choices, even through the best possible interpretation of the same. The multidimensional evaluation procedure is carried out on basis of a multidisciplinary method and is based on the approach bio-psycho-social, taking into account the indications of the ICF and of the ICD. The process of multidimensional evaluation, drafting and monitoring of the life project conforms to the principle of self-determination and ensures the active participation of the person with disability to the entire evaluation process multidimensional, drafting and monitoring of the project life with the adoption of strategies, guaranteeing continuity, and portability of Life Project. The multidimensional evaluation unit develops the project life according to will of the person with a disability and with respect for his/her rights civil and social rights.

# From Disability to the Independent Life Project and Inclusion : A very positive innovation in Italy - 6

The multidimensional evaluation procedure is carried out on basis of a multidisciplinary method and is based on the approach bio-psycho-social, taking into account the indications of the ICF and of the ICD. Components of the multidimensional evaluation unit are:

- the person with disabilities
- the person exercising parental responsibility in the case of a minor, the guardian or support administrator, if equipped with powers
- a social worker, an educator or another social worker
- done or more healthcare professionals designated by the company health or by the health district with the task of guaranteeing social and health integration
- a representative of the educational institution in the cases of necessity
- where necessary, a representative of educational institution or the services for the employment of people with disabilities
- the general practitioner or paediatrician of free choice of the person
- a medical specialist or health services specialists or social and health care
- a representative of an association, foundation, agency or other body with specific expertise in the construction of life projects
- representatives of the public and private services where the person with disabilities also benefits from services or benefits informal

**Art.-31 ) Fund for the implementation of life projects**

For the implementation of the life projects they envisage the activation of non-refundable interventions, services and supports in the supply units of the reference territory, it is established in the forecast of the Ministry of Economy and Finance finances, for subsequent transfer to the autonomous budget of Presidency of the Council of Ministers, the Implementation Fund of life projects, hereinafter referred to as the «Fund». The equipment of the Fund is firstly determined at 25 million Euro per year starting from the year 2025.

This article is based on report provided by:

**Prof. Dr. Alessandro Giustini**

# Unheard and Unseen: The Diabetes Crisis Among Deaf and Blind - 1


A recent review published in Current Diabetes Reports highlights the significant healthcare disparities faced by individuals who are Deaf/Hard of Hearing (DHH) and Blind/Low Vision (BLV) when managing diabetes. The study uncovers alarming gaps in healthcare accessibility, clinician training, and diabetes technology adaptation for these populations.

With over 11 million DHH individuals and over 7 million BLV individuals in the U.S (1.08 million of those individuals are blind)., addressing these disparities is crucial. The study identifies systemic barriers contributing to higher diabetes prevalence and poorer management outcomes in these communities.

**Diabetes and the Deaf/Hard of Hearing Population**

Studies show that DHH individuals are 3.2 times more likely to be diagnosed with diabetes than their hearing counterparts. This increased risk is attributed to limited access to health information in American Sign Language (ASL), low health literacy, and inadequate medical communication.

| Factor | Impact on DHH Diabetes Patients |
|---|---|
| Limited ASL-based health education | Higher risk of undiagnosed diabetes |
| Low health literacy | Poor self-management and medication adherence |
| Inadequate clinician training | Miscommunication leading to improper treatment |
| Lack of accessible diabetes technology | Reduced ability to monitor glucose levels effectively |

Moreover, genetic conditions like Maternally Inherited Diabetes and Deafness (MIDD) further complicate care for some DHH individuals. Despite these challenges, the American Diabetes Association (ADA) does not routinely recommend hearing screenings for diabetes patients—a gap that must be addressed.

**Blind/Low Vision Populations and Diabetes**

The relationship between diabetes and vision loss is bidirectional—diabetes increases the risk of blindness, while BLV individuals are at greater risk for developing type 2 diabetes. Diabetes-related retinopathy remains the leading cause of blindness in the U.S., affecting 1 in 4 Americans aged 40 and older.

| Challenge | Impact on BLV Individuals |
|---|---|
| Inaccessible healthcare materials | Lack of diabetes education |
| Transportation barriers | Reduced clinic visits |
| Stereotypes about competency | Limited diabetes self-management support |
| Poorly designed diabetes technology | Difficulties using insulin pumps and CGMs |

Many BLV individuals report experiencing discrimination from healthcare providers, with some denied access to insulin pumps due to assumptions of incompetence. Such barriers highlight the need for greater disability awareness in clinical settings.

# Unheard and Unseen: The Diabetes Crisis Among Deaf and Blind - 2

**Healthcare Barriers and Systemic Inequities**

The study underscores how ableism and structural barriers hinder equitable diabetes care. These include:

- Communication failures: Only 50% of DHH patients receive ASL interpreters during medical visits.
- Lack of accessible health information: Major diabetes organizations do not provide ASL materials or Braille-based resources.
- Transportation difficulties: BLV individuals struggle with attending medical appointments due to poor transportation infrastructure.

These disparities contribute to higher hospitalization rates, diabetes-related complications, and mortality risks among DHH and BLV populations.

**Diabetes Technology and Accessibility**

Most diabetes management tools—such as continuous glucose monitors (CGMs) and insulin pumps—are not designed with accessibility in mind. This exclusion forces DHH and BLV patients to rely on external devices to make them usable, creating additional costs and frustrations.

**Solutions Needed:**

- More inclusive device design with built-in screen readers and Braille support.
- Expanded use of haptic and audio alerts to aid both DHH and BLV users.
- Better insurance coverage for assistive tools like vibration-based alarms.

**Best Practices for Clinicians**

Healthcare providers must enhance accessibility and communication strategies when treating DHH and BLV patients. Key recommendations include:

*For DHH Patients:*

- Always offer ASL interpreters (preferably in-person).
- Use written materials with simple language for additional support.
- Provide communication real-time transcription services (CART) for those who do not use ASL.

*For BLV Patients:*

- Introduce yourself verbally and offer visual descriptions.
- Ensure Braille or audio-based materials are available.
- Use clear, specific directions rather than gestures or vague language.

By implementing these patient-centered strategies, healthcare professionals can significantly improve diabetes outcomes in these marginalized communities.

**Conclusion**

The findings from this study expose deep-seated disparities in diabetes care for Deaf/Hard of Hearing and Blind/Low Vision individuals. Addressing these issues requires policy changes, clinician training, and accessible diabetes technology. Without immediate action, these populations will continue to face preventable health risks and poorer quality of life.

The healthcare system must prioritize inclusion, accessibility, and equitable treatment to ensure no individual is left behind in diabetes care.

**Reference**

Hughes, A.S., Mirus, K., Heydarian, N.M. et al. Diabetes Care Disparities in Deaf/Hard of Hearing and Blind/Low Vision Populations. Curr Diab Rep 25, 14 (2025).

This article was prepared by:

**Dr. rer. biol. hum. Boya Nugraha, MS**
Consultant & Researcher in Rehabilitation within Health System

# Virtual Event at the Commission on the Status of Woman

**Topic**: "Women with Disabilities Re-imagining the Future"
**Date**: March 19, 2025
**Time**: 8:30 AM EST (New York Time)
**Organizer**: RI Social Commission

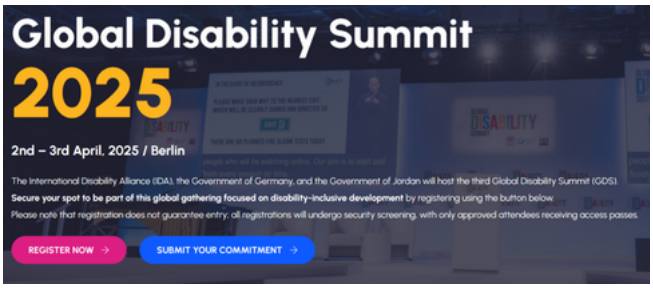
As the Beijing +30 process marks three decades since the Fourth World Conference on Women (1995), we reflect on the commitments made by States to ensure full equality and advancement for all women, including women with disabilities. Despite these commitments, barriers persist due to factors such as race, age, language, ethnicity, culture, religion, and indigenous status.

This event will amplify the voices of women with disabilities from the Global South, highlighting their inclusion—or lack thereof—by States as pledged in the Beijing Platform for Action (BPfA). It will also explore their advocacy strategies for driving meaningful progress toward equality and rights-based inclusion.
Join us in this critical conversation!

**For further information, please contact:**
smrcbbsr@gmail.com or ashahans10@gmail.com

## Global Disability Summit 2025

2nd – 3rd April, 2025 / Berlin




"The International Disability Alliance (IDA), the Government of Germany, and the Government of Jordan will host the third Global Disability Summit (GDS).

The Global Disability Summit aims to galvanize global efforts to realize disability inclusion around the world. It is a mechanism bringing together a wide variety of high-level stakeholders, engaging and discussing the progress in disability inclusion: governments, multilateral agencies, the private sector, academia and civil society organizations, organizations of persons with disabilities, and foundations."(*https://www.globaldisabilitysummit.org/*)

## Event Calendar

**RI Executive Committee Meeting** (on invitation)
31 March - 1 April 2025

**Global Disability Summit**
Berlin, Germany
2-3 April 2025

**COSP 18**
10-12 June 2025

# Call for contribution

A heartfelt thank you to all our contributors for your invaluable support, dedication, and engagement! Your efforts continue to inspire and drive our shared mission of creating a more inclusive world for everyone.

**We are excited to invite:**

- **Member Organizations**: Showcase your impactful programs, innovative projects, and success stories that advance rehabilitation and inclusion.
- **RI President & Vice Presidents**: Share your strategic insights, regional updates, and experiences from the frontlines of advocacy.
- **RI Commissions**: Contribute research findings, policy recommendations, or groundbreaking initiatives that shape the future of accessibility and empowerment.
- **RI Regions**: Highlight local achievements, unique cultural approaches to rehabilitation, and stories of resilience within your communities.

Whether it's a breakthrough initiative or an inspiring individual, we encourage you to share your activities, achievements, thoughts, or ideas with us. Your contributions provide valuable insights and help amplify the incredible work being carried out worldwide.

**Why Contribute?**

Your stories not only foster collaboration and learning but also inspire others within the Rehabilitation International community to take meaningful action. Together, we can create a powerful platform for change and advocacy.

**How to Submit?**

Please send your submissions to: **RI Media** (rimedia@riglobal.org)
We welcome articles, photos, videos, and any other materials that best showcase your work and its impact.

Let's continue to work together to shine a light on the exceptional efforts that make a difference in the lives of individuals and communities around the world.
We look forward to hearing from you soon!

**Don't forget to check and follow our social media:**

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**A GLOBAL ADVOCATE FOR REHABILITATION, INCLUSION AND HUMAN RIGHTS**

**SECRETARY GENERAL: MRS. TEUTA REXHEPI**
866 UNITED NATIONS PLAZA, OFFICE 422
NEW YORK, NY 10017, USA
PHONE: +1 (212) 420 – 1500
EMAIL: INFO@RIGLOBAL.ORG

www.riglobal.org