

Making disability inclusion a priority in the health sector: lessons from a political economy analysis in six countries

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Executive summary

Persons with disabilities continue to experience some of the largest and most persistent health inequities globally. Yet disability has only recently emerged as a recognised health systems issue within mainstream health policy and health sector reform. This paper examines how disability health equity has been advanced across six African countries, Côte d'Ivoire, Ethiopia, Kenya, Nigeria, Senegal and Tanzania, drawing on experiences associated with implementation of the WHO Disability Inclusion Guide for Action (GfA)² and similar or related policy processes.

Using political economy analysis, the paper explores the actors, institutions, ideas, coalitions and contextual factors that have enabled disability inclusion to gain traction within Ministries of Health and wider health sector reforms.

An important point to note is that progress has not occurred automatically. Rather, it has been driven by sustained advocacy and coalition-building efforts at national level, supported by a strengthening global normative framework and growing international attention to disability health equity. While implementation remains at an early stage, the experiences examined offer valuable insights into how disability inclusion can move from a marginal issue to a recognised health policy priority and, ultimately, towards the political commitment, institutional ownership and accountability mechanisms that make sustained implementation possible.

A central finding of this paper is that disability health equity gains traction when it is understood as a mainstream health systems and health equity issue rather than a specialist disability concern. Across the six countries, this shift in thinking has opened new opportunities to embed disability inclusion within wider health sector reforms, policies and planning processes. While important progress has been made in establishing political legitimacy and commitment, the critical challenge now is translating these gains into implementation, supported by effective accountability mechanisms and sustained investment.

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² World Health Organization (2023) **Health equity for persons with disabilities – Guide for action**. [hyperlink embedded in title]. Geneva: WHO. Available online.

Key findings

1. Global frameworks have created new opportunities for national action

New global commitments and normative guidance on disability inclusion, health equity and the right to health, including WHA Resolution 74.8³ and the 2022 WHO Global Report on Health Equity for Persons with Disabilities,⁴ have fundamentally changed the enabling environment for action at country level. Together with direct technical guidance and support from WHO, these developments have provided the legitimacy, evidence and shared policy framework through which governments, OPDs and development partners have been able to engage with disability inclusion as a mainstream health systems and health equity issue.

2. Building political attention for disability health equity requires sustained advocacy and engagement

The increasing visibility of disability inclusion within health sector policy processes has not occurred automatically. Across all six countries, progress has depended on sustained advocacy, relationship-building and engagement by Ministries of Health, WHO, Organisations of Persons with Disabilities (OPDs), civil society organisations and other partners. While countries followed different trajectories, the common challenge was establishing disability inclusion as a legitimate concern of Ministries of Health and wider health sector stakeholders and maintaining attention to the agenda over time.

3. The pace of progress should not be underestimated

Disability health equity remains a relatively new health policy agenda. Nevertheless, substantial progress has been achieved in a short period of time. In several countries, disability inclusion has moved from being largely absent from health sector discussions to being recognised within policies, action plans, technical working groups and broader reform processes. For a cross-cutting systems agenda, this political and institutional traction represents an important achievement and a necessary foundation for future implementation.

4. Leadership is most influential when it is institutionally positioned to shape wider reforms

The effectiveness of leadership depends not only on individual commitment but also on where responsibility was located within government. Countries where disability inclusion was supported by focal points with strong institutional authority and access to senior decision-makers were generally better able to connect the agenda with wider policy and planning processes. Formal mandates alone were rarely sufficient.

5. Coalition-building is both an outcome and a driver of change

A major finding from the six countries is that policy change depends on the ability of diverse actors to work together around a shared agenda. National dialogues and multistakeholder policy processes focused on disability health equity have been valuable not only for producing action plans, but also for building relationships, strengthening trust and developing

³ World Health Organization (2021). **World Health Assembly Resolution WHA74.8: The highest attainable standard of health for persons with disabilities** [hyperlink embedded in title; accessed 17/09/26]. Seventy-fourth World Health Assembly, 31 May 2021. Geneva: WHO. Available online.

⁴ World Health Organization (2022) **Global report on health equity for persons with disabilities**. [hyperlink embedded in title; accessed 17/09/26]. Geneva: WHO. Available online.

shared understanding between stakeholders, creating new coalitions capable of influencing policy and action over time. These advocacy coalitions do not emerge or sustain themselves automatically. Their effectiveness has depended on leadership, coordination and relatively modest but important financial and technical resources to convene stakeholders, maintain engagement and sustain momentum over time.

6. Meaningful OPD engagement strengthens policy influence and accountability, but OPDs are most effective when recognised as policy actors not just stakeholders

The cases examined demonstrate that OPDs are not simply participants in disability-inclusive health policy processes; they are central to their effectiveness. Their role is not limited to providing perspectives or validating decisions. OPDs contribute expertise, legitimacy, visibility and accountability that cannot be replicated by other actors. Where they are recognised as equal partners from the outset, policy dialogue is stronger, advocacy coalitions more resilient and policy agendas are more closely grounded in lived experience. These findings suggest that meaningful OPD engagement should be understood not only as a principle of good practice, but as a critical condition for effective and sustainable policy change.

7. The greatest influence is achieved when disability inclusion is linked to wider reform processes

The strongest examples of progress are where advocacy efforts have moved beyond disability-specific planning processes and to link into broader health sector strategies and reform agendas. Influencing national health strategies, planning processes, financing reforms, information systems and accountability frameworks will be essential for implementation, beyond the development of disability action plans themselves. The long-term value of these plans lies in their ability to influence the wider systems through which implementation, financing and accountability will be ultimately delivered.

8. Sustaining momentum through implementation will require a new phase of sustained advocacy

Across most countries, political prioritisation has advanced further than implementation. The challenge now is not simply to implement plans, but to sustain and strengthen the coalitions, leadership and advocacy efforts that helped create them. Progress will depend on maintaining political attention, strengthening accountability mechanisms, improving disability-related data, supporting ongoing OPD engagement, and ensuring disability inclusion remains visible within wider health sector reform processes over time.

Overall conclusion

The experiences examined in this paper suggest that disability health equity is beginning to establish itself as a legitimate component of mainstream health sector reform. Although the agenda is still at an early stage, growing emphasis on country ownership, health system strengthening and nationally led reform creates important opportunities for disability inclusion to become progressively embedded within health systems.

A central lesson is that advancing disability health equity is not primarily about creating new disability-specific programmes. It is about working to ensure that disability inclusion becomes an integral, cross-cutting priority in how health systems and services are planned, financed and delivered. Where strong leadership, effective coalitions, meaningful OPD engagement

and strategic engagement with wider reform processes come together, meaningful progress is possible, even in highly constrained political and financial environments.

Importantly, these achievements should be viewed as an important step in the pathway towards implementation, rather than the end point of the process. For a cross-cutting health systems agenda such as disability health equity, sustained implementation is unlikely to occur without first securing political legitimacy, institutional ownership, coalition support, accountability mechanisms and integration within mainstream health sector policies, planning and financing processes. The challenge now is to build on these foundations through sustained advocacy to ensure that growing political commitment is translated into action, accountability and measurable change over time.

1. Introduction

More than 1.3 billion people – around one in six of the global population – experience disability. Evidence shows that persons with disabilities consistently experience poorer health outcomes than the general population.

Yet, disability-related inequities have historically received limited attention in mainstream health policy and system strengthening efforts. This has contributed to a situation in which many of the barriers faced by persons with disabilities have remained unaddressed within health systems.

This has started to change in recent years and there has been a growing recognition that improving health equity requires a health systems approach, with disability inclusion integrated across governance, service delivery, workforce development, financing and information systems. Understanding how disability inclusion gains traction within health sector reforms, and the factors that enable or constrain progress, is therefore of growing importance.

This paper examines efforts to strengthen disability-inclusive health systems across six countries in sub-Saharan Africa: Côte d'Ivoire, Ethiopia, Kenya, Nigeria, Senegal and Tanzania. Drawing on Sightsavers' experience of supporting and engaging in these efforts, the analysis reflects organisational learning and insights generated through programme implementation, policy engagement and collaboration with partners. It explores how disability inclusion has gained traction within health policy and planning processes, particularly through application of the WHO Disability Inclusion Guide for Action (GfA).⁵

Using a political economy perspective, the analysis focuses on the actors, interests, incentives and institutional dynamics that shape reform processes. It highlights both common patterns and context-specific differences across countries, offering practical insights into how disability inclusion can move from commitment to a sustained health system priority. The analysis shows that progress is shaped not only by what needs to be done, but by who champions the agenda, how coalitions are built, how opportunities for change are identified, and the extent to which disability inclusion becomes embedded within existing health sector priorities and processes. The paper therefore aims to inform Sightsavers' and partners future

⁵ World Health Organization (2023) **Health equity for persons with disabilities – Guide for action**. [hyperlink embedded in title]. Geneva: World Health Organization. Available online.

engagement whilst contributing to wider discussions on advancing equitable and inclusive health systems and what may be required to sustain progress over time.

2. An evolving agenda on disability inclusion in health

Persons with disabilities encounter multiple and overlapping barriers in accessing care: health facilities that are physically inaccessible; information that is not available in accessible formats; health workers who lack the knowledge or confidence to provide appropriate care; and costs that are often higher relative to income. These challenges are compounded by wider structural and social factors, including poverty, discrimination and exclusion from education and employment.

The scale and consequences of these barriers are significant. Persons with disabilities have, on average, substantially poorer health outcomes than those without disabilities, including mortality rates that are 2.4 times higher and life expectancy that is 10 to 20 years shorter.⁶ They are also three times more likely to be denied healthcare, four times more likely to be treated badly when accessing services, and twice as likely to find health facilities or providers' skills inadequate to meet their needs.⁷ In addition, they are more likely to find healthcare unaffordable and face catastrophic health expenditure than other people.⁸

Taken together, these factors mean that persons with disabilities are systematically less able to benefit from health services, even where these services are formally available. This has important implications for broader health system performance, since disability-related health inequities are significantly influenced by the way health services are designed and delivered. Health systems that fail to include a significant proportion of the population cannot be considered equitable and are unlikely to deliver on commitments to Universal Health Coverage (UHC), quality of care or resilience, or the wider commitment to Leave No One Behind.

2.1 Disability health equity: key concepts and normative guidance

Disability inclusion within health systems is increasingly framed in terms of disability health equity. This reflects a shift from understanding disability primarily in terms of individual impairment, disability prevention or service need, towards recognising the systemic ways in which health systems enable or constrain equitable access and outcomes for persons with disabilities.

Disability health equity is concerned with ensuring that persons with disabilities can attain the highest possible standard of health on an equal basis with others. This requires tackling the unfair and avoidable barriers that contribute to poorer health outcomes for persons with disabilities. Many of these barriers are embedded within health systems themselves, including inaccessible facilities and information, inadequate workforce competencies,

⁶ The Missing Billion Initiative & Clinton Health Access Initiative (2022) **Reimagining Health Systems That Expect, Accept and Connect 1 Billion People with Disabilities** [hyperlink embedded in title], MBI & CHAI. Available online.

⁷ World Health Organization (2015) **WHO global disability action plan 2014-2021. Better health for all people with disability** [hyperlink embedded in title]. Available online.

⁸ Office of the High Commissioner for Human Rights (2020) **Policy Guidelines for Inclusive Sustainable Development Goals: Good Health and Well-Being** [hyperlink embedded in title]. Geneva: OHCHR. Available online.

discriminatory attitudes and practices, exclusion from health programmes and decision-making processes, and the failure to provide reasonable accommodations where required. Achieving disability health equity is therefore not simply a matter of providing additional services for a particular population group; it requires health systems to address the factors that systematically disadvantage persons with disabilities and to ensure that healthcare is accessible, acceptable, appropriate and of comparable quality for all.⁹

Advancing disability health equity therefore requires action across multiple dimensions of the health system. This includes:

- Ensuring access to the full continuum of promotive, preventive, curative, rehabilitative and palliative health services throughout the life course, including rehabilitation and assistive technology where needed, rather than prioritising only a limited set of specialised interventions;
- Addressing system-level barriers to access, quality of care and participation, rather than focusing only on individual-level constraints;
- Integrating disability considerations into mainstream health sector leadership, governance, financing, workforce development, service delivery, data and information systems, and monitoring and accountability processes.

Recent global policy developments have helped to elevate disability inclusion within the UHC and health systems strengthening agendas. In particular, World Health Assembly Resolution 74.8 on the highest attainable standard of health for persons with disabilities adopted in 2021 (WHA 74.8)¹⁰ and the WHO Global Report on Health Equity for Persons with Disabilities published in 2022 (WHO Global Report)¹¹ have strengthened the normative and policy foundations for advancing disability health equity and articulate a clear health systems framework and agenda for action at global, regional and national levels.

Importantly, these developments are firmly grounded in existing international commitments, particularly Article 25 of the UN Convention on the Rights of Persons with Disabilities (CRPD), which recognises the right of persons with disabilities to the highest attainable standard of health without discrimination on the basis of disability. They also align closely with the Sustainable Development Goals commitment to Leave No One Behind, positioning disability health equity not as a separate agenda but as an essential component of achieving equitable health outcomes and UHC for all.

This shift also reflects broader developments in global health, where equity is increasingly understood as central to system performance. Within this context, disability health equity can be seen as both a specific priority, given the scale of unmet need, and a test for realising wider commitments to equity and UHC.

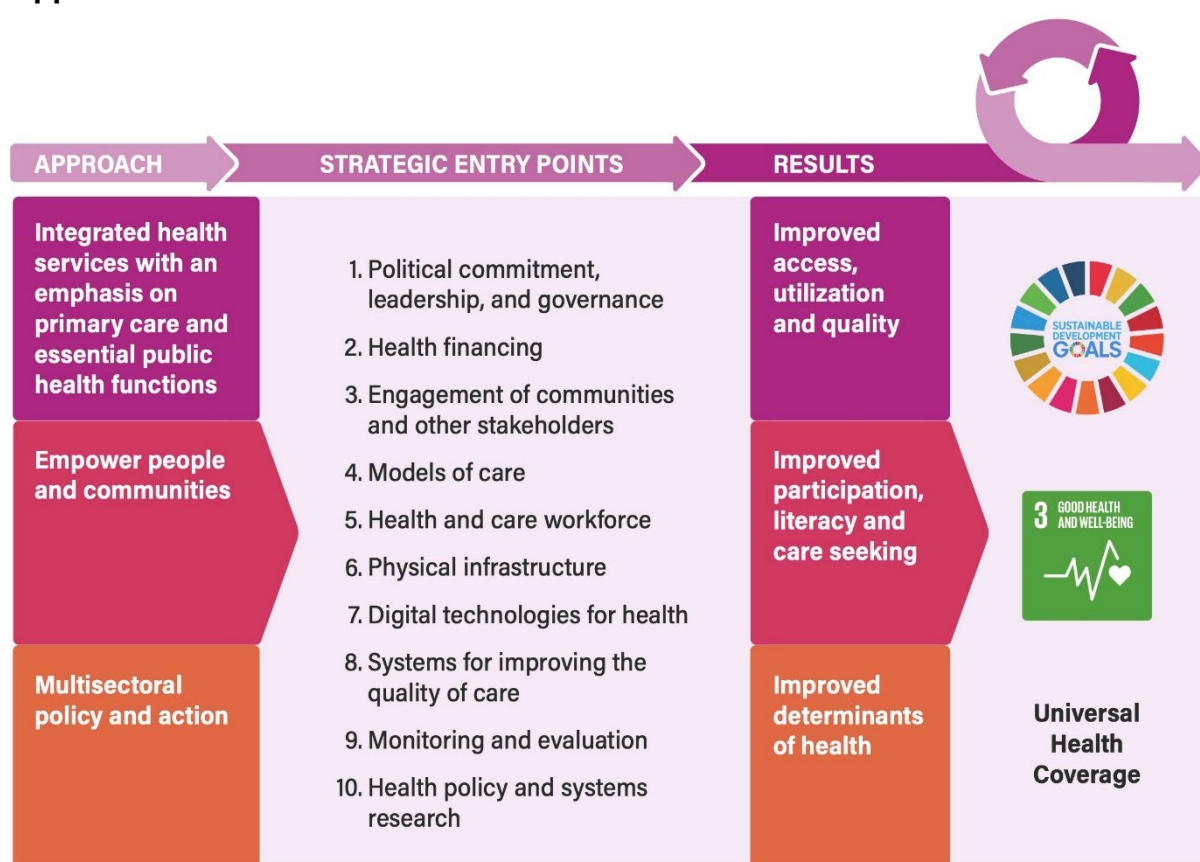
⁹ World Health Organization (2022) [Global report on health equity for persons with disabilities](#). [hyperlink embedded in title], op cit.

¹⁰ World Health Organization (2021) [World Health Assembly Resolution WHA74.8: The highest attainable standard of health for persons with disabilities](#) [hyperlink embedded in title; accessed 17/09/26]. Geneva: WHO. Available online.

¹¹ World Health Organization (2022) [Global report on health equity for persons with disabilities](#). [hyperlink embedded in title], op cit.

The WHO Global Report highlights the scale of inequities and identifies priority areas where change is needed. It emphasises that disability inclusion cannot be achieved through stand-alone initiatives, but requires an integrated approach aligned with broader system strengthening efforts and involving the active participation of persons with disabilities. A key insight from the WHO Global Report and related literature is that health inequities for persons with disabilities arise across multiple dimensions of the health system. This perspective broadens attention beyond a focus on preventing or treating specific impairments or health conditions to focus on addressing systemic barriers through system-level design and performance. Across ten strategic entry points based on the primary health care approach, key areas for action include prioritisation disability health equity in health sector leadership and governance, financing, service provision, quality of care, workforce competencies and training, physical infrastructure, and monitoring and evaluation.

Figure 1. Framework for health sector strengthening through the Primary Health Care Approach*



*Source: World Health Organization (2022) *Global Report on Health Equity for Persons with Disabilities*, Figure 6 (p.160), adapted from World Health Organization and United Nations Children's Fund (2020) *Operational Framework for Primary Health Care: Transforming Vision into Action*. Geneva: WHO.

To support countries with implementation of the Global Report recommendations countries, WHO published a Guide for Action on disability inclusion (GfA) in 2023, providing a suite of assessment and planning tools to support nationally led action planning, policy development and reform efforts.¹² Under the coordination of the Ministry of Health and with the engagement of a broad range of stakeholders including OPDs, the GfA provides a structured framework through which countries can assess the current state of disability inclusion within

¹² World Health Organization (2023) **Health equity for persons with disabilities – Guide for action** [hyperlink embedded in title], op cit.

their health systems, identify priorities for action across key health system domains through the development of a national action plan, and integrate these priorities into national health policies, strategies and plans. The GfA takes a whole-system approach, addressing all major aspects of health system functioning, including leadership and governance, financing, workforce development, service delivery, infrastructure, data systems and accountability mechanisms.

Importantly, the benefits of this approach extend beyond persons with disabilities themselves. Efforts to make health systems more accessible, responsive, people-centred and equitable often improve access and quality of care for many other groups who face barriers to healthcare, including older people, people with chronic health conditions, and those experiencing poverty or social exclusion. Disability is also distinctive in that it affects a large and growing proportion of the population and, directly or indirectly, touches the lives of most people at some point across the life course. From this perspective, disability health equity should not be understood as a niche or specialised agenda, but as an important test of whether health systems are capable of delivering on wider commitments to Universal Health Coverage, health equity and health for all.

The experiences examined in this paper suggest that, while implementation remains at an early stage, disability health equity is beginning to establish itself as a recognised and increasingly legitimate component of mainstream health sector reform. The challenge now is not only to build further political attention and commitment, but to translate these gains into sustained action, financing and accountability within health systems. At the same time, the growing focus on nationally led health system strengthening creates opportunities for advocates and reformers to influence multiple aspects of health sector development, opening pathways for disability inclusion to become progressively embedded within the way health systems are governed, financed and delivered.

2.2 Disability health equity as an emerging area of policy and practice

While disability has long been recognised within human rights and social inclusion agendas, disability health equity is a relatively recent area of focus within mainstream health policy and health systems strengthening. Much of the current agenda emerged in response to growing recognition of the significant health inequities experienced by persons with disabilities, with the COVID-19 pandemic acting as an important catalyst by exposing and exacerbating longstanding barriers to healthcare access and outcomes. Subsequent developments, including WHA 74.8, the WHO Global Report and the GfA, have helped establish a coherent global framework for advancing disability inclusion within health systems, but many countries are still at an early stage of engaging with disability health equity as a health systems issue. Compared with more established health equity agendas such as poverty and gender, disability inclusion has had relatively little time to become embedded within health sector institutions, accountability mechanisms, financing arrangements or routine planning processes. Many of the challenges identified in this paper should therefore be understood in the context of a relatively new agenda that is still in the process of gaining political attention, building coalitions and establishing institutional ownership.

This process has also unfolded during a particularly challenging period for global health. Many countries are facing growing fiscal pressures, declining levels of development assistance and increasing competition for limited health resources. These constraints are especially significant for disability health equity, which is an inherently cross-cutting agenda

that seeks to influence multiple dimensions of health system performance rather than a single disease programme, intervention or service area.

Yet these same pressures are also helping to reshape global health priorities in ways that could create important opportunities for disability inclusion due to a growing emphasis on country ownership, domestic resource mobilisation and nationally led health system reform. This shift is reflecting in emerging global health reform initiatives, including the Lusaka Agenda and Accra Reset, which both emphasise stronger national leadership and more sustainable, country-led and country-owned health systems.¹³ As an inherently cross-cutting agenda, every effort to strengthen health system governance, financing, workforce capacity, service delivery, data systems or accountability mechanisms has the potential to become an entry point for disability health equity as a priority. Progress is likely to be incremental and context-specific, achieved through sustained engagement with ongoing reform efforts rather than through a single policy decision or programme. But embedding disability inclusion within mainstream health sector priorities and institutions can be pursued through multiple pathways in this fast-evolving policy context.

Against this backdrop, the progress achieved over recent years should not be underestimated. The existence of a global normative framework, growing engagement by Ministries of Health, and increasing incorporation of disability inclusion into national health policies, strategies and reform processes represent significant advances compared with only a few years ago. Political prioritisation of health issues often unfolds over many years or even decades. Seen in this light, the progress made since the adoption of WHA 74.8 and publication of the WHO Global Report and GfA is particularly noteworthy. While implementation remains at an early stage, disability health equity is gaining recognition as a legitimate component of mainstream health sector reform and beginning to secure attention within national policy and planning processes. The challenge now is not only to build further political attention and commitment, but to translate these gains into sustained action, financing and accountability. Growing investment in nationally led health system strengthening creates new opportunities for disability inclusion to become embedded within the way health systems are governed, financed and delivered over time.

2.3 Sightsavers engagement with the WHO Guide for Action

Sightsavers is an international development organisation that works with governments, OPDs, civil society organisations and development partners to promote equitable access to health services and the inclusion of persons with disabilities. Over the past decade, disability-inclusive health has become an increasingly important area of Sightsavers' work, reflecting a recognition that the right to health is fundamental to achieving broader inclusion, participation and wellbeing for persons with disabilities.

A key focus has been to support governments and other health stakeholders to strengthen disability inclusion within national health policies, plans and systems. This has involved close collaboration with Ministries of Health, OPDs, the WHO and other partners to identify barriers to inclusion, strengthen stakeholder engagement, and support the development and implementation of more disability-inclusive approaches to health system strengthening.

¹³ See: The Lusaka Agenda: [The Future of Global Health Initiatives](#) (2023) [hyperlink embedded in title], available online & [The Accra Reset](#) (2026) [hyperlink embedded in title], available online.

As disability inclusion has gained greater prominence in the health sector in recent years, Sightsavers has worked with partners in several countries in the WHO African Region to strengthen disability inclusion within national health systems and reforms. This has included facilitating policy dialogue and collaboration between health sector actors and OPDs and contributing technical and operational support to country-led processes.

An important feature of this work has been Sightsavers' close collaboration with WHO at global, regional and country levels. WHO's normative mandate and convening role, including its responsibilities under WHA Resolution 74.8, have been critical in establishing disability inclusion as a health sector priority and providing frameworks to guide action by Member States. Within this context, NGOs such as Sightsavers can play a catalytic and complementary role by advocating for and supporting the uptake and application of WHO guidance, facilitating stakeholder engagement, generating momentum for action, and providing practical support to help country-led processes move forward.

The WHO's publication of the GfA in 2023 created an important new entry point for Sightsavers to promote this agenda and influence more structured, country-led processes to advance disability inclusion within national health systems. Since then, Sightsavers has supported GfA-related and similar policy processes in several countries, generating valuable learning on the opportunities, challenges and enabling factors associated with implementation.

This paper draws on experiences from six countries – Ethiopia, Tanzania, Côte d'Ivoire, Nigeria, Senegal and Kenya – to explore how political, institutional and stakeholder dynamics shape efforts to advance disability inclusion within health sector reforms, and the factors that can enable, constrain or sustain progress over time. Understanding these dynamics is not only important for explaining why progress varies across contexts, but also for informing more effective advocacy, partnership and policy engagement strategies to advance disability inclusion within health systems.

3. Analytical approach

Although there is now a clear global framework for advancing disability health equity, experience in applying this framework at country level remains relatively recent. Much of the existing literature on disability and health continues to focus on service delivery gaps, specific interventions or programmes, or descriptive accounts of barriers affecting persons with disabilities. There is comparatively limited analysis of how disability inclusion is practically advanced within health policy processes, such as how Ministries of Health engage with the agenda, how stakeholder coalitions form and operate around this issue, and how global guidance translates into national action.

This highlights an important gap in the evidence base. In recent years, substantial progress has been made in establishing a normative framework for action, strengthening the evidence base on disability-related health inequities, and developing technical guidance for governments and other stakeholders. However, experience increasingly suggests that technical guidance alone is insufficient to generate change. Translating the disability health equity agenda into practice, particularly at the level of national health systems, involves political decisions and dynamics that influence policy priorities, the allocation of attention and resources, the interpretation of normative guidance, and interaction among stakeholders with varying interests and capacities. These dynamics unfold within institutional settings that are

usually complex, fragmented and subject to competing pressures and priorities. Growing attention to implementation has therefore increased the need for a better understanding of the political and institutional dynamics that enable disability inclusion to gain traction within health sector reforms.

The experiences examined in this paper contribute to this emerging area of policy in practice. By analysing how disability health equity is being taken forward across six country contexts, the paper seeks to provide insight into the conditions under which the agenda gains political attention, the role of different actors and coalitions in promoting and sustaining change, and the factors that influence progress from policy commitment towards implementation. In doing so, it complements existing technical guidance by focusing not only on what should be done, but on how change is promoted, negotiated, supported and embedded within real-world health systems. This political economy perspective helps to explain not only why progress occurs, but also how and why it varies across contexts and what lessons may help strengthen future efforts to advance disability-inclusive health systems.

To explore these dynamics, the paper draws on two complementary analytical frameworks: a framework for analysing political prioritisation developed by Jeremy Shiffman and Stephanie Smith (2007),¹⁴ and the Advocacy Coalition Framework (ACF), a policy process framework that examines how coalitions of actors influence policy change over time.¹⁵

3.1 Shiffman and Smith framework: factors shaping political prioritisation

The first framework, developed by Shiffman and Smith, is concerned with understanding why some global health initiatives receive priority from international and national political leaders whereas others receive little attention. To analyse this question, the framework identifies four interrelated dimensions that shape whether an issue becomes a policy priority:

- Actor power: the strength, cohesion and influence of the individuals and organisations advocating for the issue;
- Ideas and framing: how the issue is understood, defined and communicated by different actors;
- Issue characteristics: the perceived severity, clarity and measurability of the problem;
- Political context: the institutional environment, policy windows and competing priorities.

Importantly, the framework highlights that political priority does not arise automatically from evidence or normative guidance supporting a particular issue or policy initiative. Even where the need for action is clear, progress depends on how issues are framed, who advocates for them, and how they align with broader political and policy agendas. This is particularly relevant to efforts to advance disability health equity. While recent years have seen

¹⁴ Shiffman, J. and Smith, S. (2007) 'Generation of political priority for global health initiatives: a framework and case study of maternal mortality', *The Lancet*, 370(9595), pp. 1370–1379. doi:10.1016/S0140-6736(07)61579-7.

¹⁵ See, for example, Chapter 10: 'The Advocacy Coalition Framework' in Cairney, P. (2019) *Understanding public policy: theories and issues*. 2nd edn. London: Red Globe Press.

important progress in strengthening the evidence base on disability-related health inequities and building a stronger normative consensus for action, these developments alone are unlikely to generate sustained political commitment. Progress will also depend on factors such as the influence and effectiveness of key actors, the strength of advocacy coalitions, and the extent to which the agenda aligns with wider political priorities and opportunities for reform.

3.2 Advocacy Coalition Framework

While the Shiffman and Smith framework helps to explain the determinants of political prioritisation, it is less focused on how policy processes unfold over time within specific health systems. To complement this perspective, this paper also draws on the Advocacy Coalition Framework (ACF). The ACF focuses on how groups of actors across government, civil society, international organisations and other stakeholders form coalitions around shared beliefs and work together (or in competition) over time within a particular policy domain. It places particular emphasis on the role of shared ideas and belief systems in shaping policy positions, the development of relationships and trust between actors, processes of learning and adaptation, and the influence of external events such as political transitions, legislative reforms, changes in financing environments or new global commitments.

This framework is particularly relevant to disability health equity because many of the key features associated with the agenda mirror the types of policy processes that the ACF seeks to explain. Disability inclusion in health is inherently cross-cutting and multi-actor; it does not sit neatly within a single programme area or institutional mandate. Advancing the agenda therefore requires coordination between a wide range of actors, including Ministries of Health, OPDs, WHO, development partners and others.

The agenda also often involves challenging existing ways of thinking, particularly where disability has traditionally been understood through a medical or service-specific lens. Shifting towards a systems-based understanding of disability health equity requires changes in how actors conceptualise the issue, which is a central concern of the ACF.

In addition, the processes examined in this paper, particularly those supported through the GfA, are explicitly designed to bring actors together, facilitate dialogue and build consensus around priorities. In this sense, they are not simply technical exercises, but processes of active coalition-building, negotiation and collective learning.

The processes across different countries have also been shaped by external developments, including new global commitments, domestic political changes, legislative reforms and shifts in the wider health financing environment, reflecting the ACF's emphasis on how changes in the broader policy context can create opportunities or constraints for coalition action and policy change.

3.3 Applying the analytical frameworks to the country case studies

Together, these two frameworks provide a useful lens for analysing the processes that shape efforts to advance disability health equity at country level. While the GfA primarily provides a technical framework and set of planning tools, experience of supporting its implementation has highlighted the importance of the political, institutional and stakeholder dynamics that influence whether and how it gains traction within national health systems. Implementing the GfA requires actors to build support for disability inclusion, shape policy

agendas, identify opportunities for reform, and navigate existing institutional arrangements and relationships. These are fundamentally political and institutional processes, rather than purely technical ones.

The Shiffman and Smith framework helps to explain how disability health equity enters and remains on the policy agenda. The ACF, in turn, helps to explain how different actors engage with the agenda over time and how their interactions influence policy processes and outcomes. Used together, the two frameworks provide complementary insights into both the factors that drive political prioritisation and the processes through which policy change occurs.

Our analysis is structured around the four dimensions identified by Shiffman and Smith: actor power, ideas and framing, issue characteristics and political context.

Within each of these areas, insights from the ACF are used to examine how coalitions of actors have formed and evolved, how relationships and shared understanding have developed, how policy brokerage has been exercised, and how these dynamics influence the trajectory of policy processes. Country examples are used throughout to illustrate how these factors interact in practice, and to highlight common patterns and important differences across contexts.

4. Overview of country-level entry points and engagement

Before turning to cross-cutting analysis, it is useful to situate each country case, as the dynamics discussed later are strongly shaped by context, sequencing and institutional histories. While the WHO GfA has been applied in a wider range of countries, this paper focuses on six countries in the Africa region where Sightsavers played a direct role in supporting the process; the analysis reflects learning from these experiences rather than from the full range of GfA implementation contexts.

4.1 Côte d'Ivoire

Among the countries where Sightsavers has been engaged, Côte d'Ivoire represents one of the most advanced and clearly sequenced examples of GfA implementation.

The process was initiated in April 2024, led by the Ministry of Health with technical support from WHO. Sightsavers played a significant role in introducing the GfA to the MoH and advocating for its uptake in Côte d'Ivoire, facilitating early engagement between WHO and the Ministry, and supporting multi-stakeholder coordination.

A critical enabling factor in this process has been the presence of a highly effective and committed focal point within the Ministry of Health, who has provided consistent leadership and coordination. This has been complemented by sustained and proactive engagement from the WHO country office, working closely with the Ministry, Sightsavers and other partners to maintain momentum and support technical processes over time.

A defining feature of this experience has also been the strong and sustained engagement of OPDs as equal partners throughout the process, an aspect of the process that was particularly prioritised by Sightsavers. As discussed further below in considering the significance of actor power and coalitions, OPD leadership has contributed substantially to the credibility, influence and impacts of the advocacy coalition in Cote d'Ivoire, including attention to disability inclusion in wider health policy discussions at national level.

The process has taken place alongside a parallel multi-stakeholder initiative focused on strengthening rehabilitation services, which has included significant overlap in membership with the disability inclusion Technical Working Group (TWG), as well as a shared focal point within the Ministry of Health. While this has created some opportunities for alignment and cross-learning, it has also introduced the potential for competition and duplication regarding mandates, priorities and future resourcing. For the Ministry, OPDs and other members of the TWG, the need to navigate the relationship between these processes to avoid confusion or competition for attention and resources emerged as an important factor affecting progress.

Overall, this case highlights the importance of structured processes and partner engagement, strong internal leadership within the Ministry, effective coordination across overlapping initiatives, sustained WHO support, and the centrality of OPD engagement and leadership as a practical driver of policy influence, accountability and sustainability.

4.2 Senegal

In Senegal, engagement on disability health equity has been closely linked to Sightsavers' engagement in the UK Government-funded WISH2 programme, as part of a consortium led by MSI Reproductive Choices, which supports inclusive sexual and reproductive health services across West Africa.

Following regional advocacy and learning exchange, Senegal initiated its GfA process in late 2025 with support from WHO and Sightsavers. With constrained resources to support the process within the WISH2 programme envelope, Sightsavers recommended a more condensed process and timeline, adapting the GfA approach to match available funding and operational realities. The country is currently in the assessment phase.

Building directly on experience from Côte d'Ivoire, Sightsavers adopted a deliberate strategy in Senegal to prioritise and support OPD engagement from the outset, recognising this as a critical factor for effective participation and policy influence.

Also based on learning from Côte d'Ivoire, Sightsavers has encouraged a deliberate strategy of linking the GfA process in Senegal with the development of the country's new National Strategy for Health System Transformation (Stratégie Nationale de transformation du système de sante (SNTSS) 2025-2034). This approach reflected growing recognition that the value of the GfA lies in both the development of a disability inclusion action plan and its ability to influence wider health sector reforms. By engaging with the national planning process from an early stage, the advocacy coalition has been able to identify opportunities to strengthen attention to disability inclusion within broader health system priorities and reforms.

4.3 Kenya

Kenya represents a different entry point, driven primarily by domestic legislative and policy developments rather than the GfA process itself.

A key foundation for current engagement is the Persons with Disabilities Act (2025), which establishes a statutory requirement for disability inclusion across sectors, including health. This legislation itself is the result of sustained advocacy and engagement by OPDs and wider civil society over a number of years, including Sightsavers and other partners. This earlier engagement has helped to establish both political commitment and a stronger enabling environment for disability inclusion within the health sector.

In response to the Act, the Ministry of Health has developed a Disability Mainstreaming Policy and Implementation Guidelines, led by its Disability Mainstreaming Unit (DMU). The DMU represents an important institutional development, signalling a shift towards system-wide mainstreaming of disability inclusion, rather than a narrower service-based approach.

Engagement by Sightsavers and International Disability and Development Consortium (IDDC) partners (including Humanity & Inclusion) is focused on supporting this Ministry-led process, rather than initiating a separate GfA process, including early engagement with decentralised health governance structures and plans to support continuing OPD-led engagement and social accountability mechanisms, particularly at county level.

In terms of resourcing, it is important to distinguish between government-led processes, which have driven the development of the policy and guidelines through the Ministry and DMU, and the more limited resources available to WHO, Sightsavers and civil society partners to support engagement and follow-up. In this context, partner support has relied on relatively modest, pooled contributions from IDDC members, resulting in a more targeted and facilitative approach focused on key moments in the policy cycle.

The Kenya case therefore illustrates how prior advocacy and legislative reform can create strong entry points, how institutional positioning within government matters (e.g. DMU status), and how and how civil society and development partners can complement government leadership through support for participation, accountability and implementation.

4.4 Tanzania

Tanzania was one of the early pilot countries for WHO's roll-out of the Disability Inclusion Guide for Action, and the process was therefore initially driven by WHO, working closely with the Ministry of Health and national stakeholders, including Humanity & Inclusion and the national OPD umbrella organisation, SHIVYAWATA. Tanzania benefited from relatively strong initial WHO resourcing as an early pilot country, enabling a comprehensive and structured process. The process has also been aligned with the Health Sector Strategic Plan (HSSP V), embedding disability inclusion within broader system priorities.

The process began in April 2023, when the Ministry of Health convened a national consultative meeting bringing together government, UN agencies, development partners and OPDs and agreeing to develop a national action plan. A Disability Inclusion GfA Technical Working Group was subsequently established to guide the process, followed by a national situation assessment and a series of technical consultations and workshops using the GfA action-planning tools. These activities culminated in the development and validation of the Health Equity Action Plan (2025-2030).

Sightsavers did not play an instrumental role in initiating this work. However, it became progressively more engaged as the process evolved, particularly as it moved from technical development towards formal adoption. This included supporting continued stakeholder engagement and coordination, helping to maintain momentum during slower phases of the process, and contributing to efforts to secure formal technical validation and endorsement.

This engagement has been particularly important in supporting the process through its later stages. The Action Plan has achieved validation from the Chief Medical Officer (CMO) in early 2026, and final ministerial endorsement in June 2026. Advocacy efforts will now seek to ensure that the Action Plan is clearly linked or incorporated into Tanzania's national health strategy and implementation processes.

This case illustrates that while early resourcing can support strong technical design, sustained partner engagement and advocacy is often critical in moving from plan development to formal policy adoption and integration.

4.5 Nigeria

Nigeria illustrates how processes can be initiated through targeted advocacy and agenda-setting by external actors but then shaped by more complex governance dynamics.

Sightsavers' initial engagement was through the UK-funded WISH1 programme, and subsequently through the Sightsavers-led and UK funded inclusive family planning (IFPLAN) project. These initiatives provided an entry point to engage with the Federal Ministry of Health (FMOH) and raise awareness of disability inclusion in health systems. Building on this, Sightsavers played an important role in introducing the WHO Global Report and the GfA, and, through sustained engagement, helped to generate interest within the Ministry.

However, translating this initial interest into a formal GfA process proved more complex than in some other countries. During the early stages, there were multiple stakeholders promoting different approaches to strengthening disability inclusion within the health sector. While this reflected growing momentum and interest around the agenda, it also meant that considerable time and effort were needed to establish a clear Ministry-led process that WHO could support through the GfA. Leadership within the Ministry has since been anchored within relevant technical departments responsible for health policy and planning at federal level, working in coordination with WHO, Sightsavers and a broader stakeholder group.

The national policy dialogue and subsequent assessment process culminated in the development of a draft National Action Plan by the end of 2025, providing a framework for advancing disability inclusion within the health sector. However, moving from action planning to formal endorsement required a further phase of engagement with state-level actors, reflecting Nigeria's federal governance structure and the importance of securing ownership beyond the federal level. At this stage, progress slowed significantly due to limited financial and human resources available to support continued coordination and consultation. Following the conclusion of the IFPLAN programme, Sightsavers' direct financial support came to an end, while broader resource constraints affecting WHO limited its ability to support subsequent stages of the process. As a result, FMOH, WHO and other partners needed to identify additional civil society partners and sources of funding to support state-level engagement and take the draft action plan through to formal endorsement.

This case therefore illustrates both the importance of early advocacy in generating interest in the disability health equity agenda and the challenges of sustaining momentum in a complex policy environment. While growing attention to disability inclusion created new opportunities, it also increased the risk of fragmentation. Significant effort was therefore required to coordinate actors, build alignment around a common process, and maintain a coherent approach under Ministry leadership. This has required WHO, Sightsavers and ministry stakeholders to play an important brokerage role, helping align different actors around a common process and reduce the risk of fragmentation within the emerging policy subsystem. The experience in Nigeria highlights the extent to which progress can depend on sustained coordination capacity and relatively modest but essential resources to support consultation, coalition-building and stakeholder engagement, particularly in a large and decentralised systems.

4.6 Ethiopia

Ethiopia entered the process with a strong policy emphasis on equity within the health sector and an existing commitment to disability inclusion reflected in national strategies and institutional arrangements.

The development of a disability health equity action plan was led by the Ministry of Health, supported technically by WHO and partners including Humanity & Inclusion. The process followed the structured phases of the Guide for Action, including situation assessment, stakeholder consultation, and drafting of a national plan.

Sightsavers did not play a direct in-country role in initiating this process as it does not have a country presence. Instead, support was provided through the global policy team, contributing to technical inputs and helping to align the process with the broader global disability health equity agenda.

A notable feature of the Ethiopia case is the evolving and somewhat complex policy landscape. Alongside the GfA-related process, the Ministry has continued to advance its own separate policy and planning processes. This highlights a potential tension within the GfA approach. In contexts where disability inclusion already has political recognition and established policy mechanisms, the value of creating a separate assessment and planning process may be less obvious. The challenge becomes not how to initiate action on disability inclusion, but how to ensure that the GfA complements, influences and strengthens existing national processes rather than operating in parallel to them. The Ethiopia experience therefore raises important questions about how global guidance can be adapted to support countries where the agenda is already established and government led.

5. Applying the analytical frameworks to examine how disability inclusion has been taken forward at country level

This section examines how disability inclusion has been taken forward across the six country contexts, structured around the four dimensions identified by Shiffman and Smith – actor power, ideas and framing, issue characteristics, and political context – and drawing on the Advocacy Coalition Framework (ACF) to understand how coalitions have emerged and evolved over time. While these dimensions are presented separately for clarity, the country cases demonstrate that they are deeply interconnected.

5.1 Actor power

5.1.1 Combining different sources of actor power

Across all six countries, the configuration and power of key actors driving the process have been among the most important determinants of how disability inclusion has advanced within health sector agendas.

A consistent finding across the case studies is that progress has rarely depended on a single organisation or individual. Rather, actor power has emerged through the interaction of different forms of authority, influence and expertise. WHO's normative authority and mandate under WHA 74.8 have been particularly important in establishing disability inclusion as a legitimate health sector issue and creating entry points for engagement with Ministries of Health. In many countries, WHO's involvement has lent political legitimacy and credibility to the agenda in ways that other actors would have struggled to achieve independently.

At the same time, progress has depended on partners bringing different but complementary forms of power, including advocacy capacity, technical expertise, country-level relationships, lived experience and operational support.

Particularly in the absence of significant donor financing, political legitimacy and the ability to influence decision-makers have often proved more important than financial resources alone. The agenda has generally advanced furthest where these different sources of influence have reinforced one another. Across the case studies, the power of the advocacy coalition was strongest where Ministries of Health, WHO, OPDs and civil society partners were able to combine their complementary assets in support of a shared agenda.

5.1.2 Leadership, institutional positioning and political sponsorship

The case studies suggest that actor power depends not only on who leads the process, but also on where leadership is located within government. The seniority, institutional positioning and convening authority of ministry focal points have emerged as some of the most important determinants of whether disability inclusion remains a technical initiative or becomes integrated into broader health sector priorities and reforms.

Côte d'Ivoire provides the clearest example of this dynamic. Leadership from a focal point positioned within the Minister's Cabinet has helped facilitate engagement across different parts of government, including ministries responsible for planning and finance, while also securing visibility for disability inclusion within wider health sector discussions. In this context, disability inclusion has been more easily linked to broader policy and planning processes and has achieved influence beyond the immediate GfA process.

Kenya presents a different configuration in which the agenda is rooted primarily in national legal and institutional mandate rather than broader health sector reform processes. Responsibility for advancing the agenda has largely been delegated to a relatively small technical unit within the Ministry of Health. While this unit has made important progress in developing disability mainstreaming policies and implementation guidelines, translating these commitments into broader health sector reform and implementation is likely to require stronger institutional ownership, political support and resourcing across the health system, including at county level.

Tanzania provides a further illustration of the importance of political sponsorship. Although substantial technical work had already been completed, progress towards formal adoption accelerated only once the agenda secured the attention and support of the Chief Medical Officer. This highlights how the influence of senior decision-makers can become particularly important as processes move from technical development towards formal endorsement and implementation.

Taken together, these experiences suggest that formal institutional responsibility is not sufficient on its own. Political sponsorship, convening authority and institutional location are important determinants of whether disability inclusion gains access to broader policy, planning and reform processes within health systems.

5.1.3 The role of OPDs

Across the country cases, the role of OPDs emerged as a particularly important dimension of actor power. While Ministries of Health and WHO possessed formal authority, OPDs brought a different but equally important source of influence through their experiential and

representative legitimacy and ability to articulate the real-life implications of disability exclusion within health systems.

The extent to which OPDs have been able to exercise this power has varied considerably across contexts. In Côte d'Ivoire, OPDs have played an unusually prominent role throughout the process, acting as equal partners in technical discussions, helping shape priorities and contributing directly to wider policy discussions, including integration of disability inclusion within the National Strategic Health Plan. A key enabling factor has been the willingness of the national OPD umbrella organisations to come together around disability health equity as a shared agenda. The GfA process provided an important platform for collaboration, leading to a formal agreement on joint advocacy between organisations that had not previously worked closely together, including more active engagement and recognition of the umbrella organisation representing women and girls with disabilities.

The effectiveness of this collaboration has been reinforced by the presence of highly respected and influential leaders within these organisations. With significant political, professional and advocacy experience, as well as strong networks and credibility with government and development partners, these leaders have played a pivotal role in advancing the agenda and securing engagement from senior health sector stakeholders in Côte d'Ivoire.

In Senegal, OPD engagement in the disability health equity agenda is at an earlier stage with a similar need for technical and financial support. Nevertheless, OPDs are clearly recognised by the ministry and other stakeholders as key actors in the process, which will help to maintain opportunities for continuing influence through work to develop and implement a national disability inclusion action plan and future engagement in wider health policy.

In Kenya the disability movement is well established and has played a central role in the political and legislative processes leading to adoption of the 2025 Persons with Disabilities Act. However, inconsistent opportunities for direct participation in the development of the MoH disability mainstreaming policy and guidelines has reduced the scope and potential for coalition-building among OPDs around this agenda. Going forward, creating entry points for OPD engagement and ownership of this agenda is likely to be a primary focus for the main NGO advocacy coalition partners pushing for implementation of the disability mainstreaming policy and guidelines, particularly at county level.

Across all six countries, relatively modest levels of financial and technical support were often essential to enable OPDs to attend meetings, participate in consultations, undertake joint planning activities and engage in advocacy processes. In many cases, this support was provided by Sightsavers or other development partners and proved critical in sustaining participation.

However, access to resources and opportunities for engagement did not in themselves guarantee OPD influence within health policy processes. This also depended on the extent to which OPDs were recognised by governments, development partners and other stakeholders as credible and legitimate actors within health policy processes, on the effectiveness and confidence of OPD leaders, and on the willingness to work collectively around shared priorities. As key actors within the advocacy coalition, OPDs' power rests not only on ensuring opportunities for participation, but also on the factors that enable them to be recognised and operate as influential partners in policy and decision-making processes.

5.2 Building and sustaining advocacy coalitions

The experiences across countries highlight that advocacy coalitions do not emerge automatically from the existence of a shared problem or policy objective. While the WHO Global Report and GfA provided a common framework for action, the coalitions that developed around disability health equity were largely constructed through processes of dialogue, relationship-building and collective learning. Across several countries, stakeholders that had previously had only limited interaction with one another came together through assessments, technical working groups and action-planning processes, gradually developing shared understandings of disability inclusion and its relevance to their own priorities and responsibilities. Coalition development also depended on opportunities for stakeholders to engage repeatedly, build trust and develop a shared understanding of the agenda. These interactions have contributed to the emergence of the shared belief that disability inclusion should be addressed as a cross-cutting health systems priority, providing a foundation for collective action and coalition cohesion over time.

Côte d'Ivoire provides the clearest example of this dynamic. The process has brought together actors from different parts of the Ministry of Health, other government institutions, OPDs, WHO and development partners who had not previously worked together around disability inclusion as a health systems issue. Importantly, the process itself helped generate a sense of shared purpose. Through joint assessment and planning, disability inclusion increasingly came to be understood as relevant to a wide range of policy and service areas such as planning, statistics, maternal and child health, service delivery and wider health sector reform. The involvement of representatives from different parts of the MoH and other ministries, agencies and health stakeholders has broadened the coalition beyond its original core members and helped create a stronger sense of collective ownership of the agenda.

Across the cases, progress has also depended heavily on a small number of focal points and champions located within government, WHO, Sightsavers and OPDs who not only sustained communication and relationships over time, but also acted as brokers between stakeholders who might not otherwise have worked together. Through convening, facilitation and relationship-building, these actors have helped bring ministries, OPDs, development partners and other stakeholders into a common policy process and maintain engagement through periods of uncertainty and delay. From an ACF perspective, this brokerage function is important in helping to manage institutional complexity, maintain coalition cohesion and reduce the risk of fragmentation. While much attention is often given to advocates and champions, the case studies suggest that policy brokers can play an equally important role in sustaining collective action around an emerging agenda by connecting actors with different mandates, interests and sources of influence. In several contexts, Ministry of Health focal points have played an especially important internal brokerage role, helping to connect disability inclusion processes with wider policy, planning and reform areas and agendas within their own ministries and across government.

A minimum level of financial and technical resourcing has also been necessary to convene stakeholders, facilitate engagement, develop policy products and maintain momentum over time. In several countries, Ministries of Health formally requested support for strengthening disability inclusion efforts from WHO, but themselves lacked the financial resources needed to fund the key activities involved in the agenda-setting phase. An underlying assumption of the GfA approach is that disability inclusion will ultimately be financed through mainstream health planning and budgeting processes once disability inclusion is established as a

recognised cross-cutting priority. However, before this transition can occur, coalition members often face resource gaps with persistent or recurrent uncertainty about how coalition activities will be funded.

In Tanzania, WHO was initially able to dedicate substantial resources and technical support as the country was prioritised as an early pilot for the GfA; however, as dedicated resources diminished, the advocacy coalition became more difficult to sustain, and progress increasingly depended on continued in-kind support from Sightsavers, particularly through the in-kind contribution of staff time to maintain engagement with the Chief Medical Officer and other key stakeholders.

In Nigeria, coalition activity has been disrupted numerous times by delays and interruptions in the programme-related external funding required to convene stakeholders and disseminate the national action plan beyond the federal level.

In Senegal, constraints on available funding compressed implementation timelines and limited opportunities for broader coalition-building and stakeholder engagement.

In Kenya, the pace of progress has been significantly constrained by limited human and financial resources among all advocacy coalition partners involved, including the MoH's own disability mainstreaming unit.

And, in Côte d'Ivoire, every step of the process has required core members of the advocacy coalition to find ad hoc contributions of funding for workshops and other activities, including unrestricted funds from Sightsavers.

At the same time, Sightsavers' experience shows that the resources required to sustain advocacy coalitions are often relatively modest when compared with the scale of the policy ambitions being pursued. Across countries, small amounts of catalytic funding were frequently sufficient to support key meetings, consultations, relationship-building, advocacy activities and technical coordination, provided participating organisations were willing to contribute their own time and expertise in kind. In the countries where the initial impetus for coalition formation came largely from WHO and Sightsavers, the advocacy coalitions would not have emerged without the complementary co-investment of technical and country-level staff from the MoH, OPDs and other organisations involved, many of whom have absorbed substantial responsibilities within existing roles.

Notably, efforts to strengthen OPD engagement were not driven solely by civil society partners. In Côte d'Ivoire, technical officials from the Ministry of Health and other government institutions, including the Ministry of Planning, participated directly in capacity-strengthening and advocacy planning activities with OPDs. Rather than viewing advocacy and participation as the responsibility of civil society alone, government actors recognised that stronger OPD engagement would enhance the quality, legitimacy and influence of the wider reform process. This investment in strengthening the participation of disability advocates has helped deepen relationships across stakeholders and suggests that actor power can be strengthened when government actors actively support, rather than simply accommodate, the participation of civil society stakeholders. These interactions were not merely procedural; they contributed to the development of shared understandings of disability inclusion and established working relationships; from an ACF perspective, this reflects the emergence of a policy subsystem in which actors begin to coalesce around shared beliefs and practices.

Across the cases, progress has also depended heavily on a small number of focal points and champions located within government, WHO, Sightsavers and OPDs sustaining communication and relationships. Where such coordination and communication mechanisms remained active despite financial, political and other setbacks and delays, coalitions have been better able to maintain momentum through periods of funding uncertainty and slow policy processes. In Côte d'Ivoire, for example, engagement resumed rapidly following a pause associated with the 2025 national elections, reflecting both strong Ministry leadership and the durability of the relationships that had been established through the process. This suggests that coalition strength is shaped not only by actor power per se, but also how that power is exercised by focal points and other key members of the core advocacy coalition to maintain relationships, sustain commitment and navigate periods of uncertainty over time.

5.3 Ideas and framing: positioning disability inclusion within health systems

The second dimension of the Shiffman and Smith framework – ideas and framing – has played a critical role in shaping how disability inclusion has been understood and prioritised across contexts.

In several countries, disability within the health sector was initially framed primarily in relation to rehabilitation or specialised services. This framing potentially limited the scope of engagement, as responsibility was seen to lie within specific units rather than across the system as a whole. While access to quality rehabilitation services and assistive technology remain central to the disability inclusion agenda in the health sector, progress in strengthening awareness and interest in disability health equity among mainstream health stakeholders has also called for disability inclusion to be framed as a cross-cutting issue linked to broader equity, right to health, UHC and system performance commitments and considerations. Carefully and deliberately framing the agenda in this way has facilitated enabled engagement and interest from a much wider range of health actors and has helped position disability inclusion within ongoing health system priorities rather than as a competing agenda.

This dynamic has been particularly evident in Côte d'Ivoire. Early discussions were more limited in scope, but through engagement led by WHO and partners disability inclusion was increasingly framed and understood in terms of system performance and access, and the broader Leave No One Behind agenda. Engagement from senior health stakeholders, including within WHO itself, became more substantive once the issue was positioned with mainstream health stakeholders in this way.

Tanzania and Nigeria also illustrate the importance of framing. In both contexts, sustained dialogue was required to move beyond a narrow understanding of disability as a clinical or rehabilitative issue. This process was gradual and depended in part on exposure to global frameworks and on engagement with OPDs, whose contributions helped to broaden understanding of the barriers faced by persons with disabilities across a broad range of health services and facilities.

Ethiopia provides a contrasting case where alignment between disability inclusion and broader health equity narratives existed from the outset. This reduced the need for extensive reframing and helped facilitate earlier integration into policy discussions.

Global frameworks have supported these shifts. The WHO Global Report and the GfA have provided a common language and conceptual structure, allowing actors to articulate

disability inclusion in ways that align with existing policy priorities. From an ACF perspective, these frameworks contribute to policy-oriented learning, enabling actors to gradually adjust their understanding of the issue.

5.4 Issue characteristics: data, evidence and the visibility of disability in health systems

The third dimension – issue characteristics – relates particularly to how clearly a problem can be defined and evidenced. Across the six countries, this has been a consistent area of weakness.

Disability inclusion suffers from low visibility within health system data. Disability identifiers are often missing or inconsistently applied within health information systems, prevalence estimates are contested, and there is limited routine data on access and outcomes. As a result, disability is often not visible in the datasets that inform planning and decision-making.

This has several implications. First, it makes it more difficult to demonstrate the scale of the problem in a way that resonates with decision-makers. Second, it limits the ability to compare disability inclusion with other health priorities, particularly in resource-constrained settings. Third, it constrains accountability, as it is difficult to track progress without clear indicators.

The GfA assessments have played an important role in partially addressing this gap. In each country, the assessment process has provided a structured way of examining how the health system performs across a range of dimensions related to inclusion. This has often been the first time that such a comprehensive analysis has been undertaken, and it has helped to generate a shared evidence base for discussion.

In Senegal, for example, the assessment produced quantified scores across multiple indicators, highlighting both areas of progress and significant gaps. Even where the data underpinning these scores were imperfect, the process itself created a focal point for discussion and prioritisation. Similarly, in Côte d'Ivoire and Tanzania, the assessments have helped to move discussions from general statements about inclusion towards more specific identification of system constraints.

At the same time, qualitative and experiential evidence, particularly from OPDs, has been critical in making the issue visible. In Nigeria, for example, testimonies from persons with disabilities were often more influential in illustrating barriers than statistical data, particularly in contexts where quantitative evidence was lacking or contested.

However, reliance on these types of qualitative data has limits. Without integration into routine data systems, disability inclusion risks remaining peripheral to core planning and budgeting processes. Strengthening data systems through the incorporation of disability identifiers and indicators will therefore be critical for moving beyond initial policy engagement to sustained institutionalisation.

5.5 Political context: institutions, policy windows and reform opportunities

The final dimension, political context, encompasses the institutional environment, governance structures and timing of policy processes. Across all six countries, these factors have significantly shaped both opportunities for engagement and constraints on progress.

Ethiopia entered the process with a strong policy emphasis on equity and an existing commitment to disability inclusion within the health sector. In this context, disability inclusion could be positioned as reinforcing existing priorities rather than competing with them. Actor power was therefore strengthened by an enabling institutional environment and broad policy alignment.

In Tanzania and, to a lesser extent in Cote d'Ivoire, wider political developments, particularly national elections in 2025, introduced uncertainty and delays and demonstrated how changes in political context can affect the ability of actors to exercise influence over time. As already noted, sustaining momentum in both countries required continued engagement from civil society advocacy coalition partners and effort to re-engage with senior MoH stakeholders and focal points following the elections.

Nigeria has illustrated a different challenge. While support for the agenda was successfully built within the Federal Ministry of Health, sustaining actor power has proved more difficult in a large and highly decentralised federal system. Maintaining momentum and translating national commitments into action requires engagement with a much wider range of institutions and stakeholders, including state-level actors with significant influence over implementation. This suggests that generating initial political attention is only one part of the challenge; actor power must also be capable of operating across multiple levels of governance and being sustained over time.

A further political context factor emerging consistently across the case studies is the importance of alignment with broader health sector reform processes. While the GfA and related national action plans have helped to generate attention, build coalitions and identify priorities, these processes are unlikely to achieve significant impact if they remain standalone initiatives. Across countries, progress has depended increasingly on the ability of advocacy coalitions to connect disability inclusion with wider policy, planning and reform processes that shape how health systems are governed, financed and delivered.

Côte d'Ivoire provides the clearest example of this dynamic. Coalition members recognised early that influencing the development of the new National Development Plan (PND) and the National Development Plan for Health (PNDS) would be essential if disability inclusion was to secure long-term political recognition and financing. This has become a central objective of OPD advocacy efforts and contributed to the incorporation of disability inclusion commitments within the national plan. Similar efforts have focused on engagement with wider systems reforms, including work with the national statistics agency on integration of disability-related data within health information systems. This experience illustrates how engagement with wider national planning processes can begin to influence mainstream health policy even before completion of a national disability inclusion action plan.

Comparable dynamics are evident elsewhere. In Senegal, the timing of the GfA process has created opportunities to engage directly with development of the National Strategy for Health System Transformation (SNTSS 2025-2034), achieving the integration of disability inclusion within the final strategy with recognition of vulnerability and disability within guiding equity principles and commitments to integrate disability considerations across sectoral policies. In Tanzania, attention is increasingly focused on ensuring that the newly endorsed action plan influences the emerging Health Transformation Plan and other major health policy and financing processes. In Nigeria, coalition members have similarly emphasised the

importance of ensuring that disability inclusion is reflected within broader planning and budgeting frameworks once the national action plan receives formal endorsement.

These experiences point to the importance of viewing disability inclusion action plans not as end points in themselves, but as instruments for influencing wider reform processes.

Ultimately, disability inclusion is unlikely to secure sustained financing, accountability or implementation unless it becomes integrated within mainstream health policies, strategies, plans, budgets and performance frameworks. From a political economy perspective, the most significant policy windows are therefore often those associated with broader health system reform rather than with disability-specific processes alone.

Across all contexts, the strongest examples of progress have combined effective leadership, favourable institutional positioning and supportive political conditions. Conversely, where one of these elements has been weaker, additional effort has been required to build, maintain and exercise influence. These dynamics illustrate how political context interacts with other dimensions. Even where actor power and framing are strong, unfavourable institutional conditions, timing or constrained resources can slow progress. Conversely, favourable policy windows can accelerate integration if actors are positioned to take advantage of them.

5.6 Transition points and the limits of current progress

A cross-cutting observation across all six countries is that political prioritisation has generally advanced further than implementation. Across contexts, significant progress has been made in raising the visibility of disability inclusion, securing engagement from Ministries of Health, establishing advocacy coalitions and developing policies, strategies and action plans. The next challenge is translating these gains into sustained implementation.

From a Shiffman and Smith perspective, this phase tests whether actor power has become sufficiently institutionalised, whether the issue is sufficiently visible to secure resources, and whether political context remains supportive. From an ACF perspective, it tests the resilience of coalitions and their ability to sustain engagement over time.

This transition is particularly challenging because implementation requires change across multiple parts of the health system. While advocacy coalitions have been effective in generating political attention and developing policy commitments, implementation depends on influencing a much broader range of actors. The challenge therefore shifts from securing commitment to embedding disability inclusion within the routine processes and institutional arrangements through which health systems function.

At the time of writing, in Côte d'Ivoire and Tanzania, national disability inclusion action plans have recently received formal endorsement following national elections in 2025. In both countries, the immediate challenge is no longer policy development but implementation. This includes ensuring that action plans influence wider planning, financing and accountability processes and that commitments are translated into changes in practice. In Kenya, the Disability Mainstreaming Policy and Implementation Guidelines have recently been launched, and attention is similarly shifting towards operationalisation, including engagement with national and county-level stakeholders.

A key challenge across all contexts is the absence of strong accountability mechanisms. While OPDs have increasingly participated in agenda-setting and policy development processes, their role in monitoring implementation remains less clearly defined and supported. Similarly, weaknesses in data systems and disability-related indicators limit the

ability to track progress and hold institutions accountable for commitments made. Without stronger systems for monitoring, reporting and accountability, there is a risk that disability inclusion will remain a stated policy priority without being consistently reflected in health sector decision-making or service delivery.

The transition to implementation should not be understood solely in terms of securing new funding. A central objective of the disability health equity agenda is to ensure that disability inclusion becomes integrated within mainstream health systems, policies, plans and budgets rather than being treated as a separate programme. Across a range of health system domains, important progress can potentially be achieved through changes to policy, planning, service delivery, workforce development, governance and monitoring systems within existing resource envelopes, provided disability inclusion is prioritised, supported by appropriate technical expertise and accompanied by effective accountability mechanisms. However, such changes are unlikely to occur automatically. Continued advocacy and engagement remain necessary to ensure that disability inclusion retains visibility alongside numerous competing health sector priorities.

At the same time, the findings suggest there are limits to what can be achieved through policy mainstreaming alone. While the current phase has focused primarily on establishing political commitment and policy frameworks, achieving substantial and measurable improvements in disability health equity will ultimately require greater investment. This includes both domestic resource allocation and increased attention from major health financing actors, including ministries of finance, bilateral and multilateral donors, development banks and global health initiatives. Advocacy coalitions therefore face a dual challenge: supporting integration of disability inclusion within existing health sector processes while simultaneously building the political commitment necessary to mobilise additional resources over time. This highlights that policy and implementation do not sit separately and instead interact in an ongoing and iterative manner, with experiences of implementation shaping future advocacy priorities, policy learning and reform efforts. OPDs can contribute across these interconnected domains, simultaneously advocating for policy change, influencing implementation practices and generating evidence from lived experience that then informs further policy development

This also points to the importance of sustaining advocacy beyond national policy processes alone. Country-level progress is likely to be strengthened where national advocacy efforts are reinforced by regional and global engagement that increases the visibility of disability health equity within wider health and development debates. The long-term theory of change underpinning many of these initiatives is therefore cyclical and mutually reinforcing: stronger coalition action contributes to greater political commitment; political commitment supports the institutionalisation of disability inclusion within health systems; institutionalisation helps generate stronger accountability, evidence and results; and these, in turn, strengthen the case for further political attention and investment. Whether advocacy coalitions can successfully navigate this transition from political prioritisation to implementation will be a critical determinant of the long-term impact of current disability health equity efforts.

6. Key lessons for advancing disability health equity

The experiences across the six countries suggest that disability health equity is beginning to gain traction as a mainstream health systems issue, but that progress depends on a distinct set of political, institutional and organisational dynamics. While contexts differ considerably,

several cross-cutting lessons emerge regarding how disability inclusion becomes prioritised within health systems and how momentum can be sustained over time.

6.1 Global legitimacy has created new opportunities for national action

The emergence of a strong global normative framework has fundamentally changed the context within which disability inclusion is discussed within health systems. The adoption of WHA 74.8, publication of the WHO Global Report and development of the GfA have provided a shared evidence base, policy framework and institutional mandate for action.

Across countries, WHO's involvement has played a particularly important role in establishing disability inclusion as a legitimate concern of Ministries of Health. Few of the national processes examined would have developed in the same way without WHO's normative authority and ability to engage directly with governments. At the same time, these global frameworks have provided civil society organisations, OPDs and other partners with a common language and reference point through which to promote change.

The experiences examined here reinforce the importance of viewing global guidance not simply as technical products, but as political resources that can be used to open policy space, build legitimacy and create opportunities for engagement at national level. Balancing a focus on national implementation with ensuring a sustained enabling framework at the global and regional level will need to remain a focus going forward.

6.2 Building political attention to disability health equity requires sustained advocacy and engagement

While recent global commitments and guidance have created a stronger enabling environment for action, the experiences examined across the six countries suggest that political attention to disability health equity does not emerge automatically. In every context, advancing disability inclusion has also required sustained advocacy, relationship-building and engagement by stakeholders championing the disability inclusion agenda, including OPDs and civil society organisations, WHO, Ministry focal points and other stakeholders.

This finding is particularly significant because disability health equity is fundamentally a systems reform agenda. Unlike a discrete service-delivery intervention, progress depends on influencing a wide range of stakeholders to recognise disability inclusion as a priority and to make changes to how health systems are governed, planned, financed, monitored and delivered. Considerable effort has often been needed to generate interest in the agenda, build shared understanding among stakeholders, establish institutional ownership, and identify opportunities to connect disability inclusion with wider health sector priorities and reforms.

The experiences examined in this paper therefore highlight the importance of understanding disability health equity as much as a political and institutional process as a technical or normative agenda. The challenge is not simply to define what should be done, but to understand and influence how positive change can be generated and sustained within complex health systems.

6.3 The pace of progress shouldn't be underestimated

A further key finding of this analysis is that the progress achieved in a relatively short period should not be underestimated. Political prioritisation of health issues often unfolds over many

years or even decades. By contrast, disability health equity has moved from being largely absent from mainstream health sector discussions to becoming an increasingly recognised component of health system reform within only a few years of the adoption of WHA 74.8, publication of the WHO Global Report and development of the GfA.

Many of the countries examined in this paper entered the process with little or no prior engagement with disability as a health systems issue and coalition members had often had very little interaction. Yet disability inclusion is now being incorporated into national policies, action plans, technical working groups and wider sector discussions. While implementation remains at an early stage, the extent to which Ministries of Health have engaged with the agenda represents a critical milestone, creating the political legitimacy, institutional ownership and policy entry points needed for sustained implementation going forward.

This finding is important because disability health equity remains a comparatively new policy agenda. Many of the challenges identified in this paper reflect the normal difficulties associated with building political attention, institutional ownership and implementation mechanisms around an emerging issue.

6.4 Institutional positioning shapes influence

The analysis demonstrates that leadership is one of the most important determinants of progress, but that leadership is not simply a matter of individual commitment, seniority of position, or technical expertise but is a combination of factors.

The countries that achieved the strongest progress were generally those where disability inclusion was supported by focal points or champions who possessed sufficient institutional authority and political standing to influence wider policy and planning processes but the location of responsibility within government also emerged as an important determinant of whether disability inclusion remained a technical initiative or became connected to broader health sector reforms.

This suggests that efforts to advance disability health equity should focus not only on establishing focal points or technical units, but also on ensuring that these actors have the authority, visibility and political support needed to engage wider parts of the health system. Leadership is most effective when it is institutionally positioned to influence decision-making beyond disability-specific processes. This will be particularly important as the agenda develops and the actors needed to sustain change across the system will continue to grow.

6.5 Coalition-building and policy brokerage are as important as technical outputs

One of the strongest findings emerging from the case studies is that coalition-building has been a central mechanism through which change has occurred. The GfA and similar processes have created opportunities for Ministries of Health, OPDs, WHO, civil society organisations and other stakeholders to engage with one another in ways that had not previously occurred. Through joint assessments, consultations and planning processes, stakeholders developed shared understandings of disability inclusion and stronger working relationships.

In several countries, this process itself has been as important as the technical outputs produced. Relationships, trust, collective learning and shared ownership have often proved just as significant as action plans and policy documents. This suggests that future efforts

should continue to invest in dialogue, convening and coalition-building as core elements of implementation rather than treating them as ancillary activities.

The findings also highlight the importance of brokerage and coordination functions within advocacy coalitions. Coalition members able to connect stakeholders, maintain relationships and navigate institutional complexity often play a critical role in sustaining momentum and preventing fragmentation as processes evolve. In the country experiences reviewed, these functions have frequently been performed by WHO country offices, Sightsavers staff and Ministry of Health focal points.

As disability health equity moves beyond agenda-setting towards implementation, active policy brokerage is likely to remain essential for maintaining coalition cohesion, navigating institutional complexity and sustaining progress over time. The case studies suggest that this requires more than technical coordination alone. It depends on leadership from strategically positioned actors, particularly senior Ministry of Health officials and focal points, who can convene diverse stakeholders, broker relationships across institutions and ensure that disability inclusion remains connected to wider health policy and reform processes.

Over time, strengthening brokerage functions within national health institutions may be critical to sustaining momentum, driving implementation and reducing reliance on external actors to maintain coalition effectiveness.

6.6 OPDs are key actors in policy change, not simply stakeholders

Across all countries, OPDs have played a central role in shaping advocacy efforts, influencing policy discussions and strengthening the legitimacy of disability health equity processes.

However, the experiences examined in this paper suggest that meaningful participation is neither automatic nor cost-free. Effective engagement depends on organisational capacity, leadership, relationships, opportunities for participation and access to resources. The strongest examples of OPD influence combined these elements and positioned OPDs as active policy actors rather than consultees. The financing of OPD engagement in these examples has largely been short term and from Sightsavers or other civil society organisations, raising questions about long-term sustainability.

The Côte d'Ivoire experience is particularly instructive. There, the process itself strengthened collaboration between umbrella organisations and helped create a more unified disability movement around a common health policy agenda. This highlights the importance of investing not only in individual organisations, but also in relationships and collective action across the disability movement.

Looking ahead, continued OPD engagement will be essential not only for policy development, but also for accountability. As implementation becomes more important, OPDs are likely to play a critical role in monitoring commitments, identifying gaps and maintaining political attention over time.

6.7 The value of disability inclusion action plans or policies lies in influencing broader health reforms

Taken together, the findings across the different countries suggest that disability health equity is most likely to advance when it becomes connected to wider health system reform processes rather than being pursued as a standalone agenda.

The strongest examples of progress have occurred where coalition members deliberately linked disability inclusion to broader policy and planning processes, including national health strategies, health information systems, financing reforms and sector-wide planning and budgeting mechanisms. In Côte d'Ivoire and Senegal, advocacy associated with the GfA process has contributed to the incorporation of disability inclusion within new national strategic health plans even before completion of a national disability health equity action plan, demonstrating how engagement with wider planning processes can create early opportunities for mainstreaming disability inclusion. In these contexts, disability inclusion became connected early on to the mainstream machinery of health sector decision-making rather than remaining confined to a standalone initiative.

This finding is particularly important given the cross-cutting nature of disability health equity. Because the agenda relates to how health systems are governed, financed, monitored and delivered, opportunities for change can emerge across multiple reform processes simultaneously. The challenge is therefore not simply to implement disability-specific plans, but to influence the wider reforms that shape how health systems function. The long-term value of disability inclusion action plans lies less in the production of standalone documents than in their ability to influence the wider systems through which implementation, financing and accountability are ultimately delivered.

6.8 The next challenge is implementation, accountability and financing – and sustaining advocacy

Across all six countries, the development of new policies, strategies and disability inclusion action plans represents an important achievement. These processes have helped establish political commitment, institutional ownership and clearer priorities for action, creating an essential foundation for implementation. However, experience to date suggests that implementation does not follow automatically from policy adoption. While disability inclusion has gained visibility within health sector policies, planning processes and reform agendas, translating these commitments into measurable improvements in health systems and health outcomes remains the central challenge.

Two interrelated obstacles appear particularly significant. First, financing remains a critical constraint. While mainstreaming disability inclusion within existing systems can achieve important progress, meaningful implementation will ultimately require both domestic resources and greater attention from major health financing actors, highlighting the continued importance of advocacy at both national and global levels. Second, weaknesses in data systems and indicators continue to limit the visibility of disability within health sector decision-making and performance monitoring. As a consequence, accountability mechanisms remain underdeveloped. While OPDs have increasingly participated in policy development processes, systems for monitoring implementation and holding institutions accountable are still emerging.

Overcoming these challenges will require sustained advocacy, continued coalition-building and ongoing engagement with wider health reform processes. The transition from political commitment to implementation should therefore be understood not as the end of advocacy,

but as a new phase requiring continued effort to ensure that disability inclusion remains visible, prioritised and acted upon within health systems over time.

The experiences examined in this paper also suggest that progress is most likely to occur through a gradual and mutually reinforcing cycle rather than through standalone programmes or one-off policy commitments or initiatives. The growing emphasis on country ownership, health system strengthening and nationally led reform creates significant opportunities for disability inclusion to become progressively embedded within how health systems are governed, financed and delivered, if the actors with interest in this agenda can take this opportunity. Broader health sector reforms will create opportunities to embed disability inclusion within mainstream systems and processes, and over time, implementation can generate evidence, accountability and results that can further strengthen political commitment and demand for investment.

7. Conclusion

Disability health equity remains a relatively new area of health policy and practice. Yet the experiences examined in this paper demonstrate that substantial progress can be achieved in a relatively short period through sustained advocacy, coalition-building and engagement, supported by global norms, national leadership and meaningful OPD participation.

The central finding is that disability inclusion gains traction not through standalone initiatives, but when it becomes connected to wider health system priorities, institutions and reform processes. Across the six countries, Ministries of Health, OPDs, WHO and other partners have begun to establish disability inclusion as a legitimate concern of mainstream health sector policy and planning. While implementation remains at an early stage, this represents a significant shift from only a few years ago.

The challenge now is to sustain this momentum and translate growing political commitment into implementation, accountability and financing. Achieving this will require continued advocacy and coalition-building, not less, as countries move from policy development towards implementation. Whether disability health equity ultimately becomes embedded within the way health systems are governed, financed and delivered will depend on the ability of advocacy coalitions to maintain influence, strengthen accountability and ensure that persons with disabilities remain at the centre of reform efforts.