Tip sheet – Including Persons with disabilities in your COVID-19 Health Response

This tip sheet provides an overview of the factors that may put persons with disabilities at heightened risk in the COVID-19 pandemic and response in humanitarian settings; and recommends actions to address these risks within your COVID health response. This note draws on actionable and evidenced recommendations from the IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action, health chapter applying these to the COVID-19 pandemic, the WHO guidance for Disability inclusion in COVID-19 response, SODEN Statement on how COVID-19 is affecting persons with disabilities in Somalia and the practical field experience of HI and collaborating partners in Somalia.

During the current phase of the COVID response the needs and rights of persons with disabilities, older persons and those with chronic illnesses need to be considered. This document shares practical tips on how to identify and reduce the risk faced by these groups by designing and delivering a more inclusive response in particular in poor displacement and urban settings.

WHY DOES DISABILITY INCLUSION MATTER IN COVID HEALTH RESPONSE?

Somalia has a weak health system and vulnerable populations have limited access to health care as diverse barriers are hindering access and protracted civil war, and droughts has aggravated the overall socio-economic and humanitarian situation (HRP Somalia, 2020[1]). As for January 2020 an estimated 5.2 million people are in critical need of humanitarian assistance and 2.4M in need of health services. Internally displaced persons (IDPs), including 15% of persons with disabilities; 2.7% of older person- as well as those living with chronic health conditions or residing in poor in urban areas are at heightened risks, and face additional risks in this COVID-19 crisis due to underlying health conditions; increased exposure to risk as they live in overcrowded sites and have limited access essential and specific health services, sanitation, income or food due to various access barriers. Risk factors include low economic status and financial access barriers, social stigma and discrimination, inaccessible health care facilities, inaccessible information about protective measurements, lack of outreach to the settlements and/or unavailability of protective masks for at risk groups and their support persons.

Persons with disabilities face increased risk of exposure due to insufficient access to protective measurement and assistive devices such as wheel chairs or crutches, while relying on other persons for move around or conduct self-care. Respecting physical distancing might be challenging when relying on a support person for daily activities. Social and community support systems that collapse can **disrupt care, access to services, protection and wellbeing**. Pre-existing **social stigma and discrimination or isolation increases** as misperception exist on for example persons with disabilities being more contaminated. Those can lead to additional protection risks (violence, abandonment, abuse) and anxiety and depression. **Additional environmental, attitudinal, institutional and communication barriers** to access handwashing stations, hygiene items like soap and detergence, practice protective measurement in constrained spaces like IDP sites are access testing and treatment facilities might be aggravated, in particular when response is not inclusive:

[1] https://reliefweb.int/report/somalia/somalia-humanitarian-response-plan-2020-january-2020

Barriers faced in accessing COVID prevention and response services

Physical barriers such as inaccessible, and hard to reach testing and treatment facilities (makeshift hospitals and triage centres), far away from IDP location, in addition to lack of RCCE outreach hamper those with difficulties to move around and see, such as persons using assistive devices and their caregivers to access health care. Lack of inaccessible isolation and/or quarantine centres without reasonable accommodation hampers access to health care, autonomy and protection. Inaccessible hand-washing stations in addition to challenges to conduct hygiene measurements, such as rubbing hands without support might lead to increased risks.

Stigma and discrimination & other attitudinal barriers in particular against persons with intellectual and psychosocial disabilities within family, community or services level might be increased and hamper access to health messages and services or led to de-prioritization or even denial of access. Misperceptions about underlying health problems contamination among persons with disabilities may induce violence, further isolation, and lower their access to health care services; health staff that is not sensitized might show discriminatory practices and conduct proper diagnoses, such as over shadowed diagnoses for those with more "visible" impairments (people who are blind, have a physical impairment).

Information and communication barriers might hamper equal access to public health and RCCE, such as lack of use of multiple and accessible formats (pictorial messages, plain language, use of braille, audio messages, sign language). Messages might not reach persons with difficulties reading, seeing, hearing or understanding as campaigns might not reach out pro-actively to persons with disabilities or are not supported by sign language, pictorial messages, and captioning; materials are not sufficiently diverse, depicting persons with diverse types disabilities/abilities, their needs and capacities; Health staff may not be skilled on inclusive communication and know how to accommodate critical consultations such as organizing sign language interpretation.

Institutional Barriers lead to discriminatory practices**.** Health staff is not trained on inclusive health provision leading to challenges in identification, provision of accessible and understandable health information or proper health practices for persons with disabilities and support persons. Access to health for persons with disabilities is not monitored as health information and monitoring systems are not collecting disaggregated data by disability or do not monitor particular health risk they face; lack of budget for accessible messages, personal assistance, accessibility of isolation and quarantine centres, health centres, additional protection masks for support persons leads to further risks and discrimination. Health policies and standards might be insufficiently inclusive, such as lack of priority lanes, adapted testing; informed consent for persons with disabilities). Organizations of persons with disabilities are insufficiently consulted by health workers.

RECOMMENDATIONS FOR PROGRAMMERS TO ADDRESS IDENTIFIED RISKS: NEEDS ASSESSMENT, ANALYSES AND PLANNING

- **Collect data on persons with disabilities and access barriers** in COVID-19 assessment (disaggregate health data by disability; assess access barriers and risks and accessibility for service locations such as isolation and treatment centers). Ensure that organizations of persons with disabilities, persons with disabilities and their families are actively involved in those.
- **Disaggregate data on COVID-19 information systems by gender, age and disability**, by using the Washington Group short set of questions, translated into Somali[2]. Use online training for enumerators in English available or deliver training with existing training pack.

[2] Contact HI to share Somali version.

- In the absence of time, consult individuals with disabilities and/or organizations with expertise on disability inclusion.[3]
- **In any mapping on health response actors collect information on disability inclusiveness of provided services,** including organizations of persons with disabilities and local disability specific actors, able to share their expertise, engage in community mobilization and do specific outreach to persons with and without disabilities at risk of not accessing services and/or information[4].
- **Ask community leaders to suggest persons with different difficulties** (hearing, seeing, moving, intellectual, psychosocial disabilities and/or communication) to engage them and/or their organizations in planning risk communication, community engagement and consultation processes, see footnotes 2 & 3 for contact details should you lack those.

Design and implementation of Risk communication & Community engagement (RCCE) and Health structures dedicated to COVID-19 response

- **Appoint a focal point on disability/inclusion** to provide leadership for inclusive programming for at risk groups
- **Assess and adapt COVID-19 standards and protocols**, such those for isolation, quarantine in consultation with persons with disabilities, support persons and/or organizations with expertise[5]. This to ensure continuity of care, protection, maximum autonomy, and modifications of specific food, assistance, medication.
- **Assess and adapt RCCE and messages** whenever possible in meaningful consultation with persons with disabilities to ensure accessibility: Provide Easy Read formats and use pictograms, engage organization representing persons with intellectual disabilities. Ensure use of Sign Language in TV and Social media spots; Use Braille, captioning and alternative communication [6] format whenever appropriate, engage organization representing people with visual impairments other visual impairments. Depict persons with disabilities in a positive manner and engage persons with disabilities in the campaigns.[7] **Share in your campaign information on additional risks** faced by persons with disabilities, due to the barriers and/or their health conditions they may face, as appropriate, see the annexed pictograms developed by WHO.
- **Facilitate rapid online sensitization sessions** for frontline health workers on: Inclusive communication, accessibility of interventions, how to ensure protective environment during consultations, potential health and social consequences on persons with disabilities.
- **Provide resources to adapt** makeshifts hospitals, isolation centers and quarantine to be accessible to persons with disabilities and their care-givers; to ensure critical health referrals or to install protective measurements for persons with disabilities (purchase additional protective gear; sanitizer to clean assistive devices, transportation costs for access to health services). At minimum, strive to ensure that at least 15% of facilities are fully accessible.

[3] See a first list of contacts at the end of the document.
[4] See a first list of contacts at the end of the document.
[5] See a first list of contacts at the end of the document.
[6] Augmentative and alternative communication, are various methods of communication that can help people who are unable to use verbal speech to communicate.
[7] See a first list of contacts at the end of the document.

Monitoring and evaluation

- **Ensure health data is disaggregated** by gender, age and disability using the Washington group;
- **Ensure persons with disability[8] are involved in cluster mechanisms, monitoring** and evaluation activities. Ensure barriers to accessing preventive messages, treatment and screening facilities are identified in participatory manner and services are adapted to address barriers and risks.
- **Appoint a focal point on disability/inclusion** similar to gender focal points to ensure situation of persons with disabilities is discussed in coordination meetings
- **Disaggregate program health indicators** to monitor access, health risks and mortality of persons with disabilities, such as the number of persons with disabilities reached in RCCE, access testing and/or treatment.
- **Ensure your accountability &feedback mechanisms in response to CONVID-19** are accessible to diverse group of persons with disabilities, use different formats and channels.

RECOMMENDATIONS FOR FRONTLINE STAFF, INCLUDING HEALTH AND HYGIENE PROMOTORS, AND HEALTH WORKERS AND TESTING AND TREATMENT FACILITIES

- Ensure health outcomes for persons with disabilities are responsive, fair and efficient **by identifying persons with disabilities that might be isolated, left out in need of preventive and curative services**: Reaching out to them through door to door campaigns when feasible; Collaborate with networks of persons with disabilities[9] to ensure health information reaching them; Consider reaching out to mental health hospitals, care institutions, day-care centers, prisons and/or those persons with psychosocial disabilities living on the street.
- **Register disability as characteristic like gender and/or age in COVID-19 monitoring systems** and records by using the Washington group set of questions. Document additional support needs or any suspected protection risks and ensure referral is done.
- **Offer distance diagnosis of COVID-19 and/or COVID-19 hotlines** in accessible manner:
    - Consider telephone consultation, text messaging and video conferencing for the delivery of health care for people with disability.
    - Provide additional targeted information on COVID-19, highlighting disability specific information relevant to people with disability and their support networks, accessible health services; and
    - Locations where hygiene items (soap, detergence) and/or sterilizing equipment can be accessed when their supplies are low, or
    - In situations where they may be required to self-isolate.
- **Ensure MHPSS via phone, social media and/or other means is accessible** and adapted to men, women, boys and girls with disabilities.
- **Ensure reasonable accommodation**[10] such as
    - **F**or critical consultations, offer payment for sign language interpretation,
    - Transportation costs for support persons,

[8] See contact details of organizations of persons with disabilities at the end of the document.
[9] See initial list with contact details at end of Document.
[10] Reasonable Accommodation is an individual measure that benefits a specific person – but may also bring wider benefits. For instance, a path that is made accessible for one person can subsequently be used by many. The same may be true of changing the procedure for obtaining cash transfers, reorganizing food distribution methods, or reorganizing work to meet the needs of a colleague with a disability. IASC Guideline on Disability Inclusion 2019, see for examples, Annex 1: Providing reason-able accommodations, page 189 of the Guideline.

    - Ensure support persons are available when person with disabilities require this during quarantine or when in isolation,
    - Ensure protective gear is provided to care givers/ support person and persons with disability,
    - Provide pick-up and delivery of medical and hygiene supplies, or other.
- **Allow one family member or care-giver appointed by person with disability** to join sensitization events, consultations, and/or treatment. Ensure caregivers have access and increase to personal protective equipment including masks, soap, gloves and hand sanitizers.
- **Ensure COVID-19 related health facilities are close by and can be accessed** by persons with disability, use universal design principles[11]when designing and building makeshift hospitals.
- **Monitor and address barriers** that hinder access and autonomy for persons with disabilities: Ensure the accessibility of hand sanitization stations, clear obstacles, ensure consultations in downstairs areas, ensure walking distances are reasonable and resting spots are available and regularly cleaned. Provide wheelchairs, walkers inside hospital to facilitate transportation and clean those regularly.
- **Ensure attitudinal barriers and protection risks such as sigma, misperceptions and denial of access to health services reported by persons with disabilities in Somalia are identified in risk assessments and not perpetuated RCCE and treatment choices**, for instance engage person affected by stigma in the RCCE teams and messaging and ensure protection actors reach out equally to persons with disabilities at risk of neglect, isolation and/or abuse.

[11] Universal Design is an approach that advocates that "the design of products, environments, programs and services [should] be usable by all people, to the greatest extent possible, without the need for adaptation. The principles of universal design facilitate accessibility, including for persons with disabilities. IASC Guideline Disability Inclusion 2019.

For more…

…Information, feedback and/or recommendation on Inclusion &/or Connecting with organizations below contact Humanity & Inclusion (HI): Inclusion Technical Advisor: Paul Mugambi, p.mugambi@hi.org, shamgpaul@gmail.com and Inclusion Officer: Mohamed Haji, m.haji@hi.org
Contacts of Organizations of Persons with disabilities and disability specific organizations, a list under development (12/04/2020):

Organization Name	Email Address
Somali Union for the Blind	somaliunionfortheblind@gmail.com
Somali National Disability Council	ndc.somalia@gmail.com
Somali Women Disability	uwd01@hotmail.com
Disability Aid Foundation	awad@daf.so
Somali Association Female with Disability	safdi.somalia@gmail.com
National Disability Cluster	somali.disability.cluster@gmail.com
Raho Somalia	rahosom@gmail.com
Somali Association for the Deaf	sonad.deaf@gmail.com
Somali National Association of the Deaf	sonaddeaf@gmail.com
Sanca Centre	sancacenter@gmail.com
Institute for Education of Disabled People in Somalia	iedsom.mog@gmail.com
Somali Disability Journalists Association	shaaciye011@gmail.com
Somali Disability & Empowerment Organization (SODEN)	info@somalidisability.org
Albasiir School for the Blind	ismailahmedali26@gmail.com
Iftin Foundation	abdiwali@iftinfoundation.org

Annex 1: WHO key messages on Disability Pictograms

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german humanitarian assistance

#COVID19 and disability

People with disability are at a greater risk of contracting coronavirus because of:

Physical barriers to access hygiene facilities

Need to touch things

Difficulty in enacting social distancing

Difficulty accessing information

World Health Organization

#coronavirus

#COVID19 and disability

People with disability may have risks of developing more severe cases of coronavirus because COVID-19 exacerbates existing health conditions, particularly related to:

Respiratory functions

Diabetes

Heart disease

Immune system

World Health Organization

#coronavirus

#COVID19 and disability

Health workers should:

Ensure COVID-19 health care is accessible, affordable and inclusive

Deliver telehealth for people with disability

World Health Organization

#coronavirus

#COVID19 and disability

Governments should:

Ensure public health information and communication is accessible

Undertake targeted measures for people with disability

World Health Organization

#coronavirus

Additional Information to share during RCCE targeting persons with disabilities: