The likely impacts and risks of COVID-19 for people with disabilities in humanitarian contexts, and mitigation measures.

By Naomi Clugston and Michelle Spearing, Disability Inclusion Helpdesk

People with disabilities in humanitarian contexts are particularly at risk during the pandemic. The Global Humanitarian Response Plan on COVID-19 identifies people with disabilities as the most affected population group. In 2011, the WHO estimated global prevalence of disability at 15% and rising. In humanitarian contexts prevalence is likely much higher. Even at 15%, there would be around 4.5 million people with disabilities in Yemen and more than 1.2 million people with disabilities in South Sudan. Globally, women are more likely to experience disability than men at 19% and 12% respectively, while disability prevalence is high among those 60 years old and over at 46%. Disability often intersects with other identify features such as age, ethnicity and gender to exacerbate vulnerability to violence and marginalisation.

There may be additional risk factors for contracting COVID-19 for some people with disabilities:

- **Public information on prevention and changes to humanitarian provision are often not provided in accessible formats or targeted to people with disabilities.** A COVID-19 needs assessment among refugees in Jordan found that 39% of people with disabilities lacked information about at least one of the following: how to stay healthy during the COVID-19 pandemic, COVID-19 symptoms, how and where to get a test, and government rules. People with intellectual disabilities may face difficulty understanding guidance and social distancing.
- **Water, sanitation and hygiene facilities are sometimes inaccessible to people with disabilities.** People with disabilities face particular barriers to accessing WASH facilities and these are exacerbated by COVID-19 restrictions. Given the role of hand-washing in preventing COVID-19 this increases risks of infection for people with disabilities. Consideration of disabilities must be built into COVID-19 WASH interventions.
- **Adherence to physical distancing measures may not be possible**, due to support needs or because of environmental conditions.
- **Reliance on tactile surfaces for communication and mobility and repetitive exposure due to operation of mobility devices also increases the risk of exposure to COVID-19 for people with certain disabilities, through environmental contamination.**

Some people with disabilities may be at greater risk of developing severe illness from COVID-19:

- **Some people with disabilities with underlying health conditions are at higher risk of developing severe illness from COVID-19.** Stigma and discrimination, inaccessible physical spaces and financial barriers can also prevent people with disabilities accessing healthcare. In some countries, discriminatory guidelines contravene the UN Convention on the Rights of Persons with Disabilities by denying people who cannot walk unaided or have intellectual disabilities access to lifesaving treatment if they are suspected of having COVID-19.

COVID-19 may have a negative impact on some people's mental health:

- **Rates of mental health conditions are already high in many humanitarian contexts and likely to be exacerbated by COVID-19.** For example, 20% of children living in Zaatari refugee camp in Jordan already experience intense anxiety on a daily basis, while 32.8% of people living in the Gaza Strip have severe depression and 42.6% meet the criteria for Post Traumatic Stress Disorder (PTSD). Research in high income settings suggest lockdown settings and their consequences has a significant negative impact on people's mental health. People experiencing these conditions often face barriers to participation in society and accessing health care, which can lead to the development of long-term psychosocial disabilities. A decade after the outbreak of SARS in China, many survivors continued to experience PTSD, depression and chronic fatigue.

People with disabilities may face more restrictions to accessing healthcare, social protection and education:

- **Pressure on healthcare systems is reducing access to healthcare.** Due to COVID-19 restrictions and the strain on humanitarian provision, 88% of surveyed refugees with disabilities in Jordan do not have access to hospitals or clinics for their regular checks or additional medical needs. As a result, 55% of people with disabilities' medical needs are not met.
- **People with disabilities may be excluded from humanitarian aid and social protection systems.** Historically,

humanitarian aid and social protection systems have excluded people with disabilities despite often being those at most need of financial support. Emerging evidence shows that people with disabilities are experiencing high rates of unemployment, extreme financial hardship, food insecurity, and exclusion from social protection during the pandemic. Refugees and displaced persons with disabilities are particularly vulnerable: a needs assessment of households that include persons with disabilities in Lebanon found that 69% of Lebanese households reported not being able to meet all their needs in April 2020, compared to 78% of Palestinian households, and 93% of Syrian households.

- **Children with disabilities may have greater difficulty accessing education during school closures.** In many humanitarian contexts, all children face significant barriers to accessing education. School closures during the COVID-19 are likely to further exclude children with disabilities, especially in contexts where remote learning programmes are inaccessible to children with disabilities.

People with disabilities in humanitarian contexts may be at higher risk of experiencing abuse and violence during COVID-19:

- **Intimate partner violence (IPV) is increasing globally due to lockdowns with specific risks to people with disabilities and reduced access to support.** Women with disabilities are 2-4 times more likely to experience IPV than women without disabilities. A survey of people with disabilities in Ethiopia found that 11.2% of respondents felt less safe and protected from violence and abuse since COVID-19; 41.6% of child respondents experienced fear/anxiety/feeling unsafe and able to express their feelings to caregivers; and 4.9% of child respondents experienced the same but were not able to express their feelings to caregivers.
- **People with disabilities are particularly vulnerable to violence and marginalisation in humanitarian settings including during the COVID-19 response**. People with disabilities may be explicitly targeted by armed actors, subject to sexual exploitation, abuse and harassment (SEAH) and neglected or deliberately marginalised in humanitarian responses, particularly in regions with increased military engagement in enforcement, aid distribution and healthcare provision and where there are high levels of stigma around disability.

How can programmes in humanitarian contexts mitigate these impacts and risks?

Refer to the Inter-Agency Standing Committee Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action and the Key Messages for applying the Guidelines to COVID-19 responses as well as related guidance. Key advice includes:

1. Promote meaningful participation

- Identify and monitor who may be more vulnerable to poor outcomes directly or indirectly from COVID-19: This shoud inform contact based approaches, and also help to identify those who are not being reached by interventions and appropriate mitigating actions.
- Meaningfully involve people with disabilities and organisations of persons with disabilities (OPDs) in the design and implementation of COVID-19 response and protection programmes to ensure they are accessible to and safe for people with disabilities. This should be seen as a routine aspect of delivering accountability to affected populations.
- Ensure consultations are ongoing and that they engage with local people with disabilities and local OPDs as leaders and decision-makers. This should be done within broader efforts at localisation during COVID-19 humanitarian response.
- Ensure COVID-19 programmes in humanitarian contexts collaborate on disability-inclusive responses through the cluster system, for example by conducting joint needs assessments or sharing data. Encourage better communication and coordination on disability across the cluster system and with the disability movement/sector (especially in relation to humanitarian, social protection and employment initiatives, as well as interaction between the health and social sectors).

2. Ensure that the needs of women and girls with disabilities are addressed in protection and VAWG prevention and response programming during COVID-19

- Prioritise the needs of women and girls with disabilities as VAWG prevention and response services are

adapted in response to COVID-19. Maintain life-saving GBV protection services and ensure accessibility for women and girls with disabilities, adapting and delivering accessible remote services where appropriate.

- Ensure that the needs of people with disabilities are addressed in SEAH protection and prevention programmes.

3. Remove barriers

- In accordance with the Core Humanitarian Standard and through application of Sphere standards, including the Humanitarian Inclusion Standards, take deliberate action to identify and remove barriers restricting participation of persons with disabilities in humanitarian responses to the COVID-19 pandemic.
  For example: Ensure WASH facilities in protection of civilian sites, internally displaced peoples' and refugee camps are accessible to people with disabilities and are kept clean. Work with local OPDs to ensure people with a range of disabilities are included in the design of facilities and distribution of hygiene products. Provide disability inclusion training to emergency responders to ensure they are aware of the risks associated with pre-existing conditions and barriers to accessing support that place some people with disabilities at greater risk of severe illness.
- Design all interventions (with appropriate budgets) to improve accessibility of the physical environment and to provide adjustments to accommodate individual requirements so that humanitarian assistance and protection are free of barriers to people with disabilities from the outset. This should include assessment of potential to manage physical distancing with solutions developed that enable adherence and do not further marginalise or negatively impact the individual.
  Ensure public health information campaigns utilise appropriate and accessible formats by consulting with OPDs that represent people with a range of disabilities about their preferences during the design and monitoring phases. Interaction and dialogue with people with disabilities should be maintained to avoid unintended consequence of behaviour change communications such as stigma and marginalisation.
- Conduct regular reviews of disease control measures including lockdown restrictions which include safeguarding assessments to ensure they do not inadvertently expose people with disabilities to additional harm, including an increased risk of violence and abuse.

4. Disaggregate data for monitoring inclusion:

- Coordinate with other actors to collect data on the environmental, structural attitudinal and institutional barriers facing people with disabilities – in all of their diversity – to COVID-19 response and recovery, disaggregated by age, gender and disability. This should inform programme design, monitoring and evaluation.
- Ensure that ongoing assessments of humanitarian needs and protection risks relating to COVID-19 incorporate the Washington Group Questions to enable disaggregation by disability status alongside sex and age.

WANT TO GET IN TOUCH WITH THE DISABILITY INCLUSION HELPDESK?
The Helpdesk is responding to a range of queries on disability inclusion, including those related to COVID-19. Send us an email and we can discuss your request further:
enquiries@disabilityinclusion.org.uk