

Disability Inclusion Helpdesk Query No: 35

Query title	The impacts of COVID-19 on people with disabilities: a rapid review
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Query	What is the evidence of how the coronavirus (COVID-19) pandemic might impact on people with disabilities and pre-existing health conditions? Please draw on any emerging global evidence from the current outbreak in coronavirus, as well as other similar epidemics? (e.g. Ebola) Please ensure to cover both primary and secondary impacts.
Enquirer	DFID Disability Inclusion Team

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Box 1: defining disability

Persons with disabilities are:

'...those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.'
 (Article 1, UN Convention on the Rights of Persons with Disabilities)

1. Overview

The Coronavirus (COVID-19) pandemic is a global public health emergency, with more than 1.2 million confirmed cases and nearly 70,000 deaths as of 5 April 2020.¹ There is currently very limited data and evidence on the impacts of COVID-19 on people with disabilities and pre-existing health conditions, with no disability-disaggregated data on mortality rates available in the public sphere. However, reports from the media, disability advocates and disabled peoples' organisations (DPOs) point to several emerging impacts, including primary and secondary impacts.² Most of the available data is from high-income countries (HICs) though reports from low- and middle-income countries (LMICs) are likely to emerge over the coming weeks.

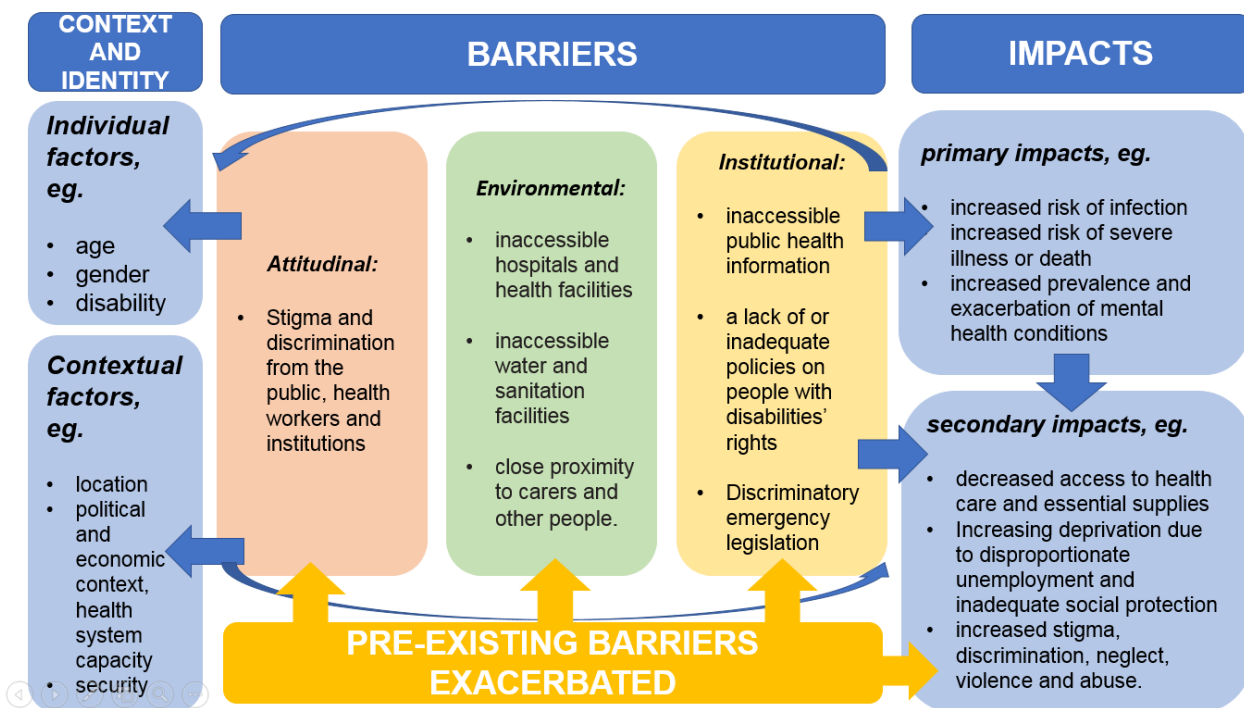
¹ The outbreak was declared a Public Health Emergency of International Concern on 30 January 2020. See <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen>

² For the purpose of this query, primary impacts have been defined impacts directly from the COVID-19 virus itself, while secondary impacts are the broader repercussions of the *response* to the COVID-19 pandemic.

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People with disabilities may be at greater risk of contracting COVID-19 for several reasons. Public health information on prevention measures is often not being provided in accessible formats (Strother, 2020; McQuigge, 2020; Barlozzari, 2020; von Hammerstein, 2020; Qualitative, 2020; Nkhoma, 2020; AlterPresse, 2020; Ansah, 2020; Beijing Daily Client, 2020; Ogwu, 2020); water, sanitation and hygiene facilities are inaccessible to some people with disabilities (WHO, 2020; UNDESA, 2019; expert contribution from Disability Rights Fund); social distancing and self-isolation measures are unfeasible for some people who depend on carers to provide for their essential needs (OHCHR, 2020a; ITV, 2020; Bernhard, 2020); and people with disabilities in residential institutions and some humanitarian contexts often live in close proximity to large numbers of people, sometimes in unsanitary conditions, and they rely on carers or officials to prevent and respond to outbreaks (Minkowitz, 2020; UNOCHA, 2020).

Diagram 1: Disability and COVID-19 conceptual framework



People with disabilities and those with underlying health conditions are more likely to develop serious illness from COVID-19, and early reports suggest that they may be more likely to die. WHO notes that COVID-19 can exacerbate underlying health conditions such as respiratory or immune response conditions, which can result in more severe illness or death (WHO, 2020b). This is supported by data from China and Italy that suggests that patients with underlying health conditions and risk factors, including, but not limited to, diabetes mellitus, hypertension, chronic obstructive pulmonary diseases, coronary artery disease, cerebrovascular disease, chronic renal disease, and smoking, might be at higher risk for severe disease or death from COVID-19 (Guan et al. 2020; COVID-19 Surveillance Group, 2020). Older people³ are also at higher risk of developing serious illness or dying from COVID-19 (WHO, 2020), and World Health Survey data shows that across 43 LMICs one third of people aged 50 or older have a disability, which suggests potentially compounded risk (Hosseinpoor et al. 2016).

In addition to the increased risk due to underlying health conditions, other attitudinal, environmental and institutional barriers increase the risk for people with disabilities developing severe illness or dying from COVID-19. These include physically inaccessible healthcare facilities, lack of capacity amongst health

³ WHO's publicly available information does not define at what age people are more at risk, and different governments have provided different information on the age groups most at risk based on specific contexts.

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workers to treat people with disabilities, and stigma and discrimination against people with disabilities in the health sector (WHO, 2020a; WHO, 2011; Kuper and Heydt, 2019). Many countries have recently introduced guidelines and practices that may lead to discrimination by permitting de-prioritisation of treatment for people with disabilities when health systems have reached capacity (Viega, 2020; Cinone, 2020; SIAARTI, 2020; NICE, 2020a; NICE, 2020b). This would put people with disabilities at greater risk of severe illness and death, and contravene the UN Convention for the Rights of Persons with Disabilities (UNCRPD), which states that people with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability, and that people with disabilities have an inherent right to life on an equal basis with others. It would also contravene the World Medical Association's statement on medical ethics in the event of disasters (WMA, 2017).

COVID-19 may increase the prevalence of mental health conditions and exacerbate pre-existing mental health conditions and psychosocial disabilities. While there is very limited research available on mental health impacts to date, media reports and governments are increasingly highlighting the potential mental health impacts of COVID-19 as a result of fear and anxiety over contracting COVID-19, economic and financial pressures, potentially long periods of social isolation, and family pressures and conflict (Williams and Saxena, 2020; Kirton, 2020; Yuhong et al. 2020; Guan et al. 2020; Long and Fowers, 2020; Australian Department of Health, 2020; National Health Commission of the People's Republic of China and Ministry of Civil Affairs of the People's Republic of China, 2020; Zhou et al., 2020).⁴

Some of the emerging secondary impacts on people with disabilities include: decreased access to healthcare, food and medications, due to increased pressure on healthcare systems, markets and supply chains, made worse by the reality of pre-existing accessibility challenges (WHO, 2011; Kuper and Heydt, 2019; Henriques-Gomes, 2020c; Ryan and Marsh, 2020; Lee and Westcott, 2020; Yang et al., 2020); increased and disproportionate impacts on livelihoods as a result of containment measures that restrict movement, as in low and middle income countries people with disabilities are more likely to be in informal work or self-employed, with less access to labour protections (IDA, 2020; Nebehay and Mutikani, 2020; UNDESA, 2019); limited access to or inadequate social protection, as many social protection schemes are already inaccessible or inadequate for people with disabilities and increased pressure on these schemes may intensify exclusion (Henriques-Gomes, 2020b; Allam, 2020; Kidd et al., 2019 ; Al-Issa, 2020); and increased stigma, discrimination, neglect, violence and abuse, for example by being devalued in public messaging about COVID-19 (Ryan, 2020; Kukla, 2020; Arielle, 2020; Moore, 2020; Ekstrand, 2020), being falsely associated with COVID-19 infection (Chacha, 2020), being left behind by carers and communities who are quarantined or fearful of infection (BBC News, 2020; IDA, 2020; expert contribution from Disability Rights Fund), or being abused by family members, carers or community members in close confinement (IDA, 2020; Dunkle et al. 2018; Fraser, 2020).

It is important to highlight the interaction between impairments and barriers at different levels which may result in disproportionate impacts for people with disabilities. This relationship is outlined in diagram 1 above and shows that these impacts are likely as a result of the interaction between individual factors (eg. age, gender, disability), contextual factors (eg. political, economic and security context) and attitudinal, environmental and institutional barriers. Available reports from the media and governments on the impacts of COVID-19 tend to frame people with disabilities as being more "vulnerable" to COVID-19 based on their underlying medical conditions, rather than explaining the contextual factors and attitudinal, environmental and institutional barriers that lead to unique impacts on people with disabilities.

Impacts on people with disabilities in LMICs will be better understood in the coming weeks and



⁴ Please note the distinction between feelings of fear, anxiety and depression, mental health conditions and psychosocial disabilities. Feelings of fear, anxiety and depression are normal responses to difficult situations, and are distinct from mental health conditions which may either have a short-term or mild to moderate impact on day to day functioning. Psychosocial disabilities are defined in the UNCRPD long-term mental impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

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months through DPO reports and research if data is disaggregated. Speculative reports suggest the situation will be worse for people with disabilities in some LMICs where health systems have fewer resources (Whiting and Handley, 2020). People with disabilities already face a multitude of barriers to access to healthcare, jobs and social protection, as well as stigma and discrimination, many of which are likely to worsen during and in the aftermath of this crisis (WHO, 2011; Kuper and Heydt, 2019; UNDESA, 2019; Kidd et al., 2019 ; Dunkle et al. 2018). Where some of these impacts have begun to be addressed by governments this has been in response to advocacy from people with disabilities and DPOs, which points to the need for early and close coordination with and leadership of people with disabilities and their representative DPOs in the COVID-19 pandemic response. For example across Europe and the UK, various governments have responded to advocacy by DPOs who are leading on the protection of the rights of people with disabilities in the COVID-19 response, making changes to their responses upon the advice of these DPOs (European Disability Forum, 2020). According to the Disability Rights Fund (2020), as of 2016, only 2 percent of bilateral and multilateral human rights and international development funding went to people with disabilities and their representative organisations, therefore there may be a risk that DPOs are not prioritised in the COVID-19 response in LMICs.




Publicly available literature sharing lessons from past epidemics on disability inclusion is limited.⁵

The available data and evidence suggest that past epidemics may have led to increases in disability prevalence and have had significant mental health impacts, and there is guidance available on mental health provision in public health emergencies in LMICs available from the experience of Ebola in Sierra Leone (Jagadesh et al., 2018; Xu et al., 2019; Hawryluck et al., 2004; WHO, 2014). Available lessons show that information on disease prevention and response has not always been accessible and that people with disabilities may face worsening deprivation, including through impacts on livelihoods and limited access to social protection schemes (Government of Sierra Leone, 2015; Plan International, 2015; Oxfam, 2015;). Impacts may continue after emergencies are over, for example additional efforts may need to be made to ensure children with disabilities go back to school (Government of Sierra Leone, 2015; Plan International, 2015). It is likely that more lessons will be disseminated in the coming weeks as the international community continues to draw comparisons between COVID-19 and other epidemics, particularly Ebola in West Africa.

Lessons from other similar epidemics	
 General	<ul style="list-style-type: none"> Disability inclusion appears not to have been prioritised by mainstream actors in the response to previous epidemics. Lessons on disability inclusion come from two areas: firstly, DPOs and disability-focused NGOs working in West Africa at the time of Ebola which adapted programmes to respond to the outbreak, although lessons in the public sphere are still limited; and learning around the provision of mental health and psychosocial support (MHPSS) around which the WHO was instrumental, convening partners and developing strategy and guidance. Epidemics have seen increases in disability prevalence and mental health conditions, including for survivors of disease and through the psychological impacts of exposure to disease. Anecdotal evidence has pointed to the increased risk of contracting the disease at the centre of previous outbreaks, including brief references online to lack of WASH facilities and lack of accessible public health messaging. Interruptions in the provision of routine healthcare, including vaccinations and screening, may lead to an increase in disability prevalence. Epidemics may lead to increasing social isolation of people with disabilities. Lesson learning which integrates a focus on gender and disability, acknowledging the intersectional nature of risk and exclusion, is very limited.
 Healthcare and public health messaging	<ul style="list-style-type: none"> Public health campaigns have not always been accessible and inclusive for people with disabilities, meaning people with disabilities can lack the knowledge of how to protect themselves and others.

⁵ It is worth highlighting that many sites hosting information about disability and Ebola had since taken the information down.

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	<ul style="list-style-type: none"> • There appear to be opportunities to “build back better” particularly in relation to mental healthcare provision by decentralising services and training non-specialist providers.
 Livelihoods, employment and social protection	<ul style="list-style-type: none"> • The social impacts of epidemics, including for people with disabilities who may face additional barriers, have sometimes been overlooked in other health crises. • Similar recent epidemics have seen worsening deprivation for people with disabilities due to the disproportionate economic impacts and failure to provide inclusive social protection. Anecdotal evidence suggests this led to increased food insecurity. • Including people with disabilities in livelihoods and employment opportunities has been encouraged in recovery plans in response to epidemics.
 Education for children with disabilities	<ul style="list-style-type: none"> • Education interventions should ensure home-based learning programmes are accessible for children with disabilities during epidemics where schools are closed. • Additional effort is required to support children with disabilities back into education after school closures end.
 Stigma and discrimination	<ul style="list-style-type: none"> • People with disabilities and survivors of epidemics often face stigma and discrimination, including from family members, in schools and communities, negatively affecting mental health and wellbeing as well as access to basic services. • Medical guidelines that may discriminate against people with disabilities in accessing treatment have been evident in other similar epidemics. • Stigma is a barrier to effective outbreak control as it is associated with challenges adopting healthy behaviours and increasing transmission.

Recommendations for a disability-inclusive COVID-19 response include:⁶

The findings of this rapid evidence review point to a number of implications for a disability-inclusive response to COVID-19. People with disabilities are disproportionately impacted by COVID-19 not only because it can exacerbate underlying medical conditions, but because of attitudinal, environmental and institutional barriers to their participation in and benefit from the pandemic response. Key recommendations include the following:

- 1) Deliver a twin-track approach: ensuring people with disabilities are included in all response communications and activities, and developing interventions that address the specific needs and impacts on people with disabilities.
- 2) Engage people with disabilities or their representative organisations (DPOs) and disability-focused organisations in ensuring DFID’s COVID-19 response is inclusive.
- 3) Provide information on COVID-19 prevention and government response measures in accessible formats.
- 4) Identify and remove barriers to prevention measures for COVID-19. For example, implementing disability and gender-sensitive WASH prevention interventions, providing additional support to carers of people with disabilities and institutions to provide protection from outbreaks.
- 5) Identify and remove barriers to safe access to treatment for COVID-19. For example, ensure medical protocols do not discriminate on the basis of disability; ensure purpose-built and adapted hospitals, testing and quarantine facilities are accessible, including signage and information, physical premises and healthcare worker awareness and attitudes.
- 6) Identify and remove access barriers to social support, essential healthcare, food, education and social protection schemes. For example, ensuring food aid is distributed from accessible locations or delivered to people’s homes, delivering home learning programmes using accessible media, consider paying benefits upfront and using remote means to make assessments, and ensuring

⁶ Please note the Disability Inclusion Helpdesk is currently developing a DFID guidance note on ensuring a disability-inclusive response to COVID-19.

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people with disabilities and their support workers in homes and communities have access to training, testing and the necessary protective equipment.

- 7) Provide funding for and partner with DPOs and disability-focused organisations to build capacity on disability inclusion.
Consider the intersections between age, gender and disability and other factors which may mean some people with disabilities are less likely to be included.
- 8) Collect disability-disaggregated data and gather lessons learned on what works in disability inclusion in COVID-19 response, including on stigma and discrimination against people with disabilities.
- 9) Start thinking about how to ensure an inclusive recovery, particularly through engaging people with disabilities and DPOs and planning for a twin-track approach.

2. Methodology and availability of data and evidence

The methodology for this query is described below.

Search strategy: Studies were identified through searches using Google and relevant electronic databases (Science Direct, and Google Scholar). Due to the rapid and recent nature of the evidence, evidence was also identified on Google News and social media. Key search terms included: coronavirus, corona, COVID-19, Ebola, SARS, H1N1, Zika, disease, virus, outbreak, pandemic, epidemic AND disability, disabled, impairment, psychosocial, mental health, pre-existing health condition, underlying health condition. DFID Disability Inclusive Development Programme consortium partners⁷ and relevant experts were contacted for evidence recommendations (see Section 6 for experts who responded).⁸

Criteria for inclusion: To be eligible for inclusion in this rapid mapping, evidence had to fulfil the following criteria:

- **Focus:** Evidence on the impact of the COVID-19 virus pandemic and other similar epidemics on people with disabilities.
- **Time period:** January 2000 – March 2020.
- **Language:** English, Italian and Spanish, with targeted searches in Mandarin and Farsi using Google Translate.
- **Publication status:** publicly available – in all cases published online.
- **Geographical focus:** Global, with a focus on low and middle-income countries (LMICs). Targeted searches on countries with the highest number of cases⁹ as of mid-March 2020 (USA, China, Italy, Iran, Spain, South Korea).

Summary of evidence: Due to the very recent nature of the outbreak, evidence on the impact of COVID-19 remains at an early stage and there is no disability-disaggregated data on mortality and morbidity rates. Evidence is also significantly fragmented with most sources coming from news reports and websites of disability rights advocates and disabled people's organisations (DPOs) and is mostly from the countries most affected to date. In particular, DPOs in the UK, Spain and Italy who have highlighted concerns around healthcare, social care, food security, housing and social protection. Impacts in LMICs are likely to emerge in the coming weeks. This paper also identified research from other similar epidemics – primarily Ebola

⁷ The Disability Inclusion Helpdesk is funded under the DID programme. The DID consortium partners are ADD International, BBC Media Action, BRAC, Institute of Development Studies (IDS), International Disability Alliance (IDA), Humanity & Inclusion, Leonard Cheshire Disability, Light for the World, Sense, Sightsavers and Social Development Direct.

⁸ The query involved six days of researcher time.

⁹ Based on Worldometer's daily ranking of countries: <https://www.worldometers.info/coronavirus/>

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(West Africa), Zika (in the Americas), and SARS (China and globally). No lessons learned on disability were found in the context of Ebola (DRC or Uganda) or Cholera (Yemen or Haiti). This evidence includes peer-reviewed journals and reports by INGOs and UN agencies.

Evidence gaps: this review identified the following areas where there is limited evidence as of 1st April 2020:

- Evidence on the impacts of COVID-19 on people with disabilities in LMICs is extremely limited, though there are speculative reports from media and aid agencies.
- Evidence on the mental health impacts of COVID-19, with only a few studies emerging from China and some media reports.
- Evidence on the impact of school closures on people with disabilities, however this may become available as more countries close schools due to the pandemic.
- Data and evidence on the impact on and engagement of people with disabilities in other epidemics, including Ebola, SARS and Zika. There is some research on the mental health impacts of outbreaks, particularly SARS, and some accompanying guidelines, particularly for Ebola, but in general there is a severe lack of data and evidence on disability inclusion in the response to similar recent epidemics.
- Lessons learned on disability inclusion from similar recent epidemics.
- Data, evidence and lessons which takes an intersectional approach, for example which address the impacts for women and girls with disabilities.

3. Lessons learned from similar epidemics

There is a limited number of applicable lessons from similar epidemics in LMICs and some from high income countries. However, it should be noted that whilst there is some evidence on the impact of epidemics on disability prevalence and a handful of resources on providing mental health and psychosocial support (MHPSS), data and evidence on disability inclusion in the response to similar epidemics is extremely limited. The available literature points to some emphasis on mental health and psychosocial support, acknowledging the significant negative impacts on mental health and wellbeing caused by previous epidemics, for example in Sierra Leone and West Africa during and after Ebola and emphasis on research with survivors and healthcare providers involved in the response to SARS in China and globally in 2003.

This section draws heavily on lessons learned from the Ebola outbreak in West Africa in 2014-2016, and touches on lessons from the Zika outbreak in 2015-2016 and the SARS pandemic in the early 2000s.¹⁰ It also touches briefly on SARS, MERS and H1N1 (swine flu). Due to time constraints and size of the literature, this report does not include the lessons from the HIV/AIDS epidemic.



General lessons on disability inclusion are:

- **Disability inclusion appears not to have been prioritised in the response to similar epidemics, particularly by governments and mainstream NGOs**, including during the Ebola outbreak in Sierra Leone 2014-16 (IDS, 2014). For example, the Educational Centre for the Blind and Visually Impaired (ECBVI) in Sierra Leone accused the National Ebola Response Centre of neglecting people with visual impairments and ActionAid stated that people with disabilities and their families had not been included in planning meetings (Adeola, undated). Lessons on disability inclusion in previous epidemics are therefore limited; this may be due to the underinvestment in disability inclusive development in the past. However, in the case of Brazil, learning suggests that

¹⁰ No lessons on disability inclusion were identified in the available literature on responses to Ebola in DRC or Uganda, or the Cholera epidemics in Haiti or Yemen.

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children born with disabilities as a result of the Zika virus were included in discourse around people with disabilities more broadly in Brazil raised awareness of disability in general, including those affected by Zika (Scott et al., 2019).

- **Several NGO, media and DPO reports have made brief references to the increased risk that people with disabilities have faced, particularly in the Ebola crisis.** The data and evidence is limited with few statistics and evaluations available. For example, inaccessible public health messaging and living conditions for people with disabilities, including that they were more likely to live in informal settlements, in dilapidated buildings and remote communities.¹¹ This review found only one minor references to the barriers associated with lack of WASH facilities or inaccessible WASH facilities for people with disabilities.¹²
- **Other epidemics have seen increases in disability prevalence.** A 2018 study with Ebola survivors in Freetown, Sierra Leone, found that Ebola is likely to increase disability prevalence, with 80% of Ebola survivors reporting difficulties using the Washington Group Extended Set.¹³ Survivors were found to be more likely than their close contacts who had not suffered from the disease, to report difficulties with vision, mobility and cognition, as well as higher levels of anxiety and depression (Jagadesh et al., 2018). A recent systematic review of 15 studies with data from 1775 Ebola survivors in West Africa, DRC and Uganda, highlights a significantly higher prevalence of hearing loss amongst survivors of Ebola than those who had not contracted the disease (Xu et al., 2019).
- **The mental health impacts of similar epidemics have also been documented and guidelines on providing mental health and psychosocial support have been developed.** These include impacts on those exposed directly or indirectly to disease as well as negative psychological consequences for healthcare workers involved in the response. For people with disabilities, the negative impacts of increasing social isolation have been highlighted (Adeola, undated). For example, an online survey of 129 people in SARS quarantine in Toronto, Canada found that 29% respondents displayed symptoms of PTSD and 31% symptoms of depression. Prevalence of PTSD increased the longer quarantine lasted, and exposure (either directly or through an acquaintance) was also associated with negative mental health impacts (Hawryluck et al., 2004). A 2009 survey with 549 employees in a hospital in Beijing found that employees who had been exposed to SARS and either been quarantined, worked with SARS patients or had friends or family members who had been infected were between two and three times more likely to experience serious PTSD symptoms than those who had not been exposed (Wu et al., 2009). Available guidelines include the WHO's practical guidance on providing psychological first aid (PFA) in the context of Ebola. These include guidance on addressing the specific challenges faced by Ebola survivors, how to address misinformation, how to support people to address barriers related to stigma and how those providing PFA can practise self-care (WHO, 2014). Interventions to address the mental health impacts of Ebola in West Africa include the Enabling Access to Mental Health in Sierra Leone (EAMH) programme which provided psychosocial support to survivors, preventative mental health support to children and families, as well as decentralising mental health services.¹⁴
- **Disability prevalence may also increase as an indirect result of epidemics due to interruptions in the provision of routine healthcare, for example screening and vaccinations.** A study in Guinea (Camara et al., 2017) found that the Ebola outbreak halted screenings for *Trypanosoma brucei gambiense*, an infection spread by the tsetse fly and leading to "sleeping sickness" which can lead to disability. A Sightsavers evaluation found that 32 million eye health

¹¹ <https://www.politicosi.com/articles/ngo-calls-disabled-protection>

¹² <https://www.globalgiving.org/projects/ebola-healthcare-crisis-epidemic-in-sierra-leone/updates/?subid=54986>

¹³¹³ <http://www.washingtongroup-disability.com/washington-group-question-sets/extended-set-of-disability-questions/>

¹⁴ <https://www.mhinnovation.net/innovations/facilitating-mhpss-ebola-virus-disease-crisis>

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treatments were missed due to the Ebola crisis (Platt et al., 2015). A 2015 theoretical study examining Ebola in Sierra Leone points to the possibility that disability prevalence may have increased as a result of routine infant vaccinations being halted and routine medical care for the general population disintegrating (Berghs, 2015).

- **Increasing social isolation of people with disabilities** (Adeola, undated). For example, in Sierra Leone people who relied on assistance of others for their mobility, especially those who required assistive devices but did not have them, were reluctant to ask for support due to fear of contracting Ebola. In addition, carers were reluctant to support people with disabilities due to the same fear.¹⁵
- **Coordination between the health and social sectors to support children with disabilities**, including funding for social support, is important. In the case of Brazil's response to Zika, coordination was informal at first before formal mechanisms were introduced (Venancio de Siqueira et al., undated).
- **It appears that women and people with disabilities are usually treated as separate groups in the response to pandemics**, as learning on the impact of epidemics for women and girls with disabilities is very limited in the available literature. An intersectional approach may consider, for example, the likely disproportionate amount of unpaid care and increased risk of violence on women and girls with disabilities.



Healthcare and public health messaging

- **Public health campaigns have not always been accessible and inclusive for people with disabilities, meaning people with disabilities can lack the knowledge of how to protect themselves and others** (Adeola, undated). Inaccessibility includes inaccessible formats, relevance of messaging and geographical and social isolation of people with disabilities (Adeola, 2015). For example, learning from Humanity & Inclusion's (HI) work in Sierra Leone during the Ebola crisis found that national prevention messages distributed in pamphlets and via radio were not always accessible. Messaging also failed to address the challenges some people with disabilities may face in following government guidelines such as not touching others if they relied significantly on carers. Anecdotal evidence suggests that members of the blind community died before messaging could be made accessible to them. In response, HI worked with local DPOs to develop appropriate messages and disseminate these through community-based rehabilitation volunteers (CBRV), including delivering audio and Braille prevention guidelines to people with visual impairments.¹⁶
- **There appear to be opportunities to "build back better" particularly in relation to mental healthcare provision.** For example, in 2015 the Government of Liberia and WHO hosted a regional meeting to discuss how mental healthcare could be strengthened in response to Ebola.¹⁷ For example, prior to the Ebola epidemic there was one psychiatric hospital in Sierra Leone. During the epidemic, the Enabling Access to Mental Health in Sierra Leone (EAMH) programme, funded by the EU and led by CBM, strengthened and decentralised mental health services. The programme combined advocacy, capacity building and awareness raising and introduced District Mental Health Units with trained professionals to provide mental healthcare to those affected by the outbreak.¹⁸

¹⁵ <https://childrenincrisis.wordpress.com/2014/10/13/joseph-kamara-sierra-leone-another-setback-for-people-with-disability/>

¹⁶ <https://humanity-inclusion.org.uk/en/news/saving-lives-through-ebola-awareness>

¹⁷ <https://www.cbm.org/news/blog/blogs/blogs-2015/building-back-better-from-west-africas-ebola-outbreak/> - this rapid review could not locate a report from this meeting.

¹⁸ https://www.mhinnovation.net/innovations/facilitating-mhps-ebola-virus-disease-crisis?qt-content_innovation=1#qt-content_innovation

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Livelihoods, employment and social protection

- **Other epidemics have seen worsening deprivation, including food insecurity¹⁹, for people with disabilities due to the disproportionate economic impacts they face and failure to provide inclusive social protection** (Government of Sierra Leone, 2015; Plan International, 2015; Adeola, undated)²⁰. In Sierra Leone, rising food prices led to increasing food security for people with disabilities.²¹ Research in Liberia found 72% respondents believed that Ebola had created more hardship and greater burdens for people with disabilities, elderly people and those living with HIV (Oxfam, 2015). For example, HI worked in Sierra Leone to ensure people with disabilities had access to humanitarian relief during the Ebola crisis after finding people with disabilities and their families struggling to buy food or essential non-food items such as soap.²²
- **Inclusive social protection schemes can support people with disabilities in times of crisis and help break the cycle of poverty and exclusion** (Villwock Bachtold, 2019; Fundação Oswaldo Cruz, 2019). A recent study in Vietnam found that people with disabilities are less likely to access employment-based social insurance schemes due to a number of barriers, suggesting that such schemes introduced in times of crisis may not have been accessible (Banks et al., 2019). The links between poverty, inequality and disability potentially leading to disproportionate impacts on people with disabilities and their families, should be considered and addressed, with governments and international actors putting inclusive social protection and insurance schemes in place (WHO, 2011).
- **Attention to livelihoods and employment opportunities for people with disabilities should be an important part of epidemic recovery plans.** For example, the National Ebola Recovery Strategy for Sierra Leone 2015-2017 includes livelihoods support and employment creation for people with disabilities (Government of Sierra Leone, 2015). Livelihoods initiatives were part of the MHPSS response to Ebola in Sierra Leone, according to the WHO (2015).



Education for children with disabilities

- **Ensuring home-based learning programmes are accessible for children with disabilities during epidemics where schools are closed.** In Sierra Leone, HI distributed radios to children with disabilities and their families to ensure children could access radio-based education programmes for children. HI reported that families enrolled in the Plan-led DFID-funded Girls Education Challenge (GEC) project (of which HI was a partner) tended to be very poor and so did not have access to a radio.²³
- **Additional effort is required to support children with disabilities back into education after school closures end.** Children with disabilities already faced a number of barriers to education in LMICs and these have been exacerbated in previous epidemics. The National Ebola Recovery Strategy for Sierra Leone 2015-2017 includes targeted support for children with disabilities to access school (Government of Sierra Leone, 2015). According to HI, parents of children with disabilities were reluctant to send them back to school after the state of emergency was lifted, undoing significant progress to overcome negative attitudes to education for children with disabilities. In response, HI launched a back to school campaign including distributing in-kind

¹⁹ <https://www.channel4.com/news/ebola-sierra-leone-disabled-elderly-vulnerable-lockdown>

²⁰ <https://childrenincrisis.wordpress.com/2014/10/13/joseph-kamara-sierra-leone-another-setback-for-people-with-disability/>

²¹ <https://www.channel4.com/news/ebola-sierra-leone-disabled-elderly-vulnerable-lockdown>

²² https://www.hi-us.org/helping_people_with_disabilities_cope_with_ebola

²³ https://www.hi-us.org/protecting_children_with_disabilities_during_the_ebola_crisis

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resources such as notebooks and pencils. The Ebola crisis resulted in increases in sexual violence and exploitation of girls in Sierra Leone, and several of HI's cohort of girls with disabilities did not return to school having become pregnant during the emergency.²⁴ Consultation for Plan International's DFID-funded Girls Education Challenge (GEC) project found these were exacerbated, with respondents reporting children with disabilities were more likely to face social isolation than their peers during the Ebola crisis. The project made changes to school infrastructure, provided bursaries, held remedial classes outside of school and provided protection and psychosocial support (Plan International, 2015).



Addressing stigma and discrimination²⁵

- People with disabilities and survivors of epidemics often face stigma and discrimination, including from family members, in schools and communities, negatively affecting mental health and wellbeing as well as access to basic services.** Learning from the Ebola crisis in Sierra Leone points to Ebola survivors and people with disabilities, healthcare providers support workers facing stigma in the aftermath of the epidemic which negatively affects mental health and wellbeing (WHO, 2014; WHO, 2015; SDDirect, undated).²⁶ According to contextual analysis for DFID Sierra Leone's SABI, a citizen-led accountability programme, this may be further reinforced as people did not often disclose mental health conditions relating to the impact of the civil war due to prevailing stigma (SDDirect, undated). US Centers for Disease Control and Prevention (CDC) guidance to schools in the US during the Ebola outbreak noted that students should not be sent home by teachers unless instructed to by health officials in an effort to prevent discriminatory treatment of students and others on the basis of assumptions and stereotypes relating to race, nationality or disability. Discrimination on the grounds of disability preventing children from accessing education, including through harassment, had been reported in a number of communities (US Department for Education, 2014). Evidence from other outbreaks has shown that stigma and discriminatory attitudes are prevalent. A population-based survey in Hong Kong found that 17% of people surveyed said they avoided people who had recovered from SARS and 36% expressed job-related discriminatory attitudes (Lau et al., 2006).
- Medical guidelines that may discriminate against people with disabilities in accessing treatment have been evident in other similar epidemics.** A 2015 paper on response to public health emergencies noted the lack of government guidelines in how to allocate scarce resources in the event of a severe pandemic, however protocols had been developed by other organisations which raised significant rights-related concerns particularly for people with disabilities (Hanschke et al., 2015). The desk review analysed and compared approaches taken in response to public health emergencies in several countries including Brazil, Mexico, Singapore, South Africa, Cambodia and the UK. It found that several protocols included guidelines excluding all people with disabilities from receiving any care during these emergencies, whether their disability affected the likelihood of a positive outcome in treatment. Other guidelines suggest some people with disabilities should be refused care because of perceptions around lengthy and burdensome use of resources, poor quality of life or a 'limited long-term prognosis' (ibid, p.261). The study highlights that these protocols could lead to subjective decisions made on the basis of attitudes towards disability. Limited training and lack of disability awareness amongst health workers was recently highlighted in a flagship report on health and disability, which may make this more likely (Kuper & Heydt, 2019). The study advocates for reflection on the tension between rights and limited resources from a legal and ethical standpoint, involving people with disabilities, and decision making on how this tension

²⁴ <https://www.hi-us.org/protecting-children-with-disabilities-during-the-ebola-crisis>

²⁵ It is important to note that addressing response to COVID-19 could draw lessons from the disability sector and associated literature in addressing disability stigma and discrimination.

²⁶ <https://www.cbm.org/news/blog/blogs/blogs-2015/building-back-better-from-west-africas-ebola-outbreak/>

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is to be addressed in preparation for subsequent epidemics when time will be limited to do this in a meaningful way (ibid).

- **Stigma is a barrier to effective outbreak control as it is associated with challenges adopting healthy behaviours and increasing transmission.** Targeted interventions are therefore needed to address stigma. According to a 2019 literature review, findings from other epidemics including the HIV/AIDS pandemic, point to a need to (taken from Fischer et al., 2019):
 - anticipate and monitor stigma
 - assess the general public's knowledge and understanding of the disease
 - work with community groups and leaders
 - implement public awareness campaigns
 - provide skill-building, training and education programmes
 - evaluate stigma reduction initiatives

4. Primary impacts of COVID-19 on people with disabilities

3.1 People with disabilities may be at greater risk of contracting COVID-19 due to attitudinal, environmental and institutional barriers that form part of the COVID-19 response

The World Health Organisation (WHO, 2020) and disability advocates noted below suggest that people with disabilities may be at greater risk of contracting COVID-19 due to several barriers. Many of these barriers are not new but are likely to be exacerbated during the pandemic. Data and evidence show, for example, that prior to COVID-19: people with disabilities in LMICs had less access to information, lack of accessible WASH facilities, inaccessible healthcare facilities, limited health worker capacity and high costs of access to these services (UNDESA, 2019; WHO, 2011; Kuper & Heydt, 2019). Importantly, people with disabilities in LMICs may face intensified barriers due to a higher rate of institutionalisation (UNDESA, 2019), and further barriers in humanitarian settings, including poor processes for identification by humanitarian agencies (UNDESA, 2018).

Barriers to accessing public health information about preventative measures: News reports and reports from DPOs highlight that official public health information on COVID-19 has at times not been provided in accessible formats for people with disabilities, including in South Korea (Strother, 2020), Canada (McQuigge, 2020), Italy (Barlozzari, 2020), Germany (von Hammerstein, 2020), Nigeria (Qualitative, 2020), Malawi (Nkhoma, 2020), Haiti (AlterPresse, 2020), Indonesia (Ansah, 2020), and China (Beijing Daily Client, 2020). Inaccessible communications may increasingly emerge as a barrier in some LMICs where there may be less resources available to provide accessible information, as has been noted in Nigeria (Ogwu, 2020). Many countries have since made information accessible as a result of advocacy by DPOs. For example, as a result of advocacy by German Disability Council, the German Government has introduced a fax, email and phone relay service for deaf persons, easy to read communications, subtitled videos and videos in sign language, and information handouts in braille (European Disability Forum, 2020).²⁷

Barriers to implementing basic hygiene measures, following social distancing or self-isolation measures: A recent disability briefing from the WHO (2020) notes that people with disabilities may have difficulties implementing basic hygiene measures during the pandemic due to physical barriers, for example sinks that are physically inaccessible. In addition, stigma and discrimination from others when using household or public facilities, for example due to misconceptions that people with disabilities could contaminate water sources or latrines (UNDESA, 2019). Inaccessible WASH facilities in LMICs has also been highlighted by DPOs since the start of the pandemic (expert contribution from Disability Rights Fund). Reports from prior to the pandemic note that women and girls with disabilities more often report anxieties about their privacy, safety and security, and incidents of physical and sexual harassment and assault while accessing sanitation facilities (Caruso et al. 2017; Stevenson et al. 2016; Caruso et al. 2018; Sommer et

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al. 2015). These barriers are likely to be more severe in humanitarian settings and informal settlements. In addition, women and girls with disabilities experience challenges with menstrual hygiene management including particularly due to stigma (House et al. 2012), and women and girls often take responsibility for assisting with sanitation and hygiene for people who are sick, older people and people with disabilities (Enfield, 2018). Disability rights advocates have reported that some people with disabilities who require support from a carer to meet their essential needs such as washing and feeding may not be able to maintain distance from their carers (OHCHR, 2020a; ITV, 2020; Bernhard, 2020). WHO (2020) has noted that for some people with disabilities it is necessary to touch surrounding objects (for example hand rails) to obtain information from the environment or for physical support, which puts them at risk of contracting COVID-19.

Barriers to preventing the spread of COVID-19 in residential institutions:

Press reports have shown that people with disabilities who live in care centres, nursing homes, group homes, psychiatric facilities and prisons are at particularly high risk of contracting COVID-19. A recent article highlighted that this is likely due to the close proximity to large numbers of people, as well as overcrowding and lack of cleanliness, dependency on carers and staff who may not have adequate resources or training to prevent outbreaks, or who may be increasingly absent due to sickness and social distancing or self-isolation measures. In addition, there is often a high risk of abuse (Human Rights Watch, 2020; Minkowitz, 2020). Guidance for residential institutions is emerging, including from the UK,²⁸ and no-visitor policies were implemented in several contexts before lockdown rules came into effect.²⁹ The UN Special Rapporteur on the rights of persons with disabilities has highlighted that states have a heightened responsibility to people with disabilities in institutions, psychiatric facilities and prisons who are at higher risk (OHCHR, 2020a).

Box 2: Who is most at risk?

The following groups of people with disabilities have been highlighted as particularly at risk:

- Older people (WHO, 2020; Public Health England, 2020)
- People in institutional care (OHCHR, 2020a)
- Refugees and displaced people with disabilities, particularly in camp settings (UNOCHA, 2020)
- prisoners and detainees (OHCHR, 2020a)

Although disaggregated data demonstrating the probable disproportionate impact on people with disabilities in residential institutions does not exist, several media reports have emerged highlighting residential institutions as possible hotspots for the virus. The situation may be more challenging in LMICs where institutionalisation, particularly for mental health, and for women and children, is common (Kothari, 2005; WHO, 2011).

- **South Korea:** 100 patients in a psychiatric ward contracted COVID-19 (seven of whom died) (Kim, 2020; South China Morning Post, 2020).
- **Spain:** at least three provinces (Canary Islands: LaVoz, 2020; Granada: Cappa, 2020; Salamanca: Salamancartvaldia, 2020) have highlighted outbreaks in residential facilities for people with disabilities, and DPOs have called for these people and their carers to be prioritised for protective equipment and testing (EuropaPress, 2020).
- **Italy:** 20 people with disabilities tested positive for COVID-19 in a residential home in Sicily (Il Fatto Quotidiano, 2020).
- **Indonesia:** a network of Indonesian disabled communities have been advocating for protection of thousands of people with intellectual and psychosocial disabilities living in orphanages and care homes in confined and unsanitary spaces (Tribune News, 2020).

²⁸ Public Health England, 2020: <https://www.gov.uk/government/publications/covid-19-residential-care-supported-living-and-home-care-guidance/covid-19-guidance-on-residential-care-provision>

²⁹ Care Quality Commission, UK: <https://www.cqc.org.uk/guidance-providers/adult-social-care/information-adult-social-care-services-during-coronavirus-outbreak>

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People with disabilities in humanitarian contexts may experience barriers to preventing the spread of COVID-19 in settings where the transmission risk is high. Prior to the pandemic the UN noted that people with disabilities in humanitarian contexts are often under-identified because the disability identification process is often based on self-identification or the perception of the person who is registering the IDP or refugee, and in some settings individuals are reluctant to identify their disability to avoid stigma (UNDESA, 2018). The UN COVID-19 Global Humanitarian Response Plan highlights that for people living in informal settlements, IDP and refugee camps, social distancing may not be possible, and they may be in crowded and unsanitary settings that lack adequate health, water and sanitation facilities and that are often already less accessible to people with disabilities (UNOCHA, 2020). People in these contexts may be denied or unwilling to access healthcare or there may not be adequate coverage where they live, and movement restrictions due to COVID-19 may worsen these existing challenges for people with disabilities (UNOCHA, 2020).

3.2 Higher risk of serious illness due to COVID-19 for people with some underlying health conditions and disabilities, and early reports suggest that they may be more likely to die from COVID-19 (Ebhart et al, 2020; ISS, 2020).

The WHO advises that both people with disabilities and those with underlying health conditions are more likely to suffer serious adverse health consequences. People with underlying conditions such as cardiovascular disease, diabetes, chronic respiratory disease, compromised immune system function, and cancer are more likely to develop serious illness because their existing health conditions may be exacerbated (WHO, 2020b). WHO also notes that people with disabilities may be more likely to develop serious illness from COVID-19 as they may be disproportionately impacted by outbreak because of serious disruptions to the services they rely on (WHO, 2020b). Prior to the pandemic many people with disabilities in LMICs already experienced barriers to healthcare that may now be exacerbated, including barriers such as health facilities being physically inaccessible, high costs of care and transport, limited funding for reasonable accommodations in hospitals, lack of capacity amongst healthcare workers, and stigma and discrimination against people with disabilities in the health sector (WHO, 2011; Kuper and Heydt, 2019).

This rapid query did not find any reliable disability-disaggregated data on mortality rates and morbidity rates from COVID-19, however the following emerging evidence points to significantly greater risk to those with underlying health conditions:

- **China:** the Chinese Centre for Disease Prevention and Control published data showing the majority of deaths in China have been of people with underlying health conditions (Cuffe, 2020).
- **UK:** the UK government's social distancing measures have highlighted particular risks of severe illness from COVID-19 for people with a range of underlying health conditions as well as people with intellectual disabilities (it is not clear why this group of people with disabilities have been specifically mentioned) (Public Health England, 2020).
- **Italy:** A report from Italy's national health authority from 17 March 2020 found that more than 99% of a sample of Italy's COVID-19 fatalities were people who had pre-existing health conditions, including 75% who had high blood pressure, 35% who had diabetes, and 33% who had heart disease (Ebhart et al., 2020).

Medical protocols and guidance have emerged in multiple countries that may lead to discrimination against people with disabilities and their access to treatment for COVID-19. This may contribute to increased mortality rates for people with disabilities and underlying health conditions given pressure on health services. The guidelines below may contravene the UNCRPD which affirms that people with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability and an inherent right to life on an equal basis with others (Article 10, UNDESA, 2020), and that State Parties must put measures in place to ensure the protection and safety of persons with disabilities in situations of risk and humanitarian emergencies (Article 11, UNDESA, 2020). In the context of COVID-19, UN experts have stated "Everyone, without exception, has the right to life-saving

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interventions and this responsibility lies with the government. The scarcity of resources or the use of public or private insurance schemes should never be a justification to discriminate against certain groups of patients” (OHCHR, 2020b).

Examples of medical protocols and guidance that may lead to discrimination against people with disabilities include the following. It should be noted that in several cases guidelines have since been updated or removed from websites:

- Guidelines suggesting people who cannot walk unaided or who have intellectual disabilities will not be taken to hospital even if they have suspected COVID-19 (Madrid, Spain: Viega, 2020).
- Protocols that suggest people with severe intellectual disabilities and diseases such as motor neurone disease should not be prioritised for ventilator support (USA: Alabama³⁰).
- Age limits for access to intensive care units (Italy: SIAARTI, 2020).
- Reports of care homes in the UK applying “do not attempt resuscitation” notices in care plans without proper consultation with people in the homes or their families, which has since addressed by the Care Quality Commission (Booth, 2020; Disability Rights UK, 2020b).
- Triage guidelines with exclusion criteria based on certain types of disability, though these have since been updated to clarify that people with stable long-term disabilities, intellectual disabilities or autism should not be deprioritised (UK: NICE, 2020a; NICE, 2020b).

As the virus spreads around the world, the impact is expected to be worse in regions with weaker health systems, particularly in Sub-Saharan Africa, where countries like Mali, Liberia, Central African Republic and Burkina Faso only have a few ventilators for millions of people and there is shortage of trained health personnel to use them (Associated Press, 2020).

3.3 COVID-19 may increase the prevalence of mental health conditions and worsen pre-existing psychosocial disabilities.

To date, comprehensive data on the mental health impacts of COVID-19 is not available, and there is no evidence to suggest mental health impacts could develop into disabilities. However, news reports have pointed to potential mental health impacts that may emerge. A recent blog from the former Director of the WHO’s Department of Mental Health and Substance Abuse highlights people’s experiences of fear, stress, anxiety, and depression, including through exposure to COVID-19 or as a result of social distancing measures; economic and financial stress; pressure from working without the support of childcare; family conflict and violence; and healthcare workers’ long working hours and hazardous exposure to COVID-19 (Williams and Saxena, 2020). Limited evidence on the mental health impacts includes:

- **China:** A survey of 5,000 Chinese citizens by the Chinese Psychology Society found 21.5% displayed obvious symptoms of posttraumatic stress disorder (PTSD; Kirton, 2020). A survey of 4357 health care workers (1026 males and 3331 females) in China found that 39.1% health care workers had experienced psychological distress during the epidemic response (Yuhong et al., 2020). China has published several guidelines for emergency psychological crisis interventions as of January³¹ having learned from the response to the SARS in 2003,

³⁰ Please note it appears as though these criteria have been removed from the website. The story appeared in the Sun: <https://www.thesun.co.uk/news/11272880/people-with-down-syndrome-autism-and-cerebral-palsy-could-be-left-to-die-from-coronavirus-under-new-guidance/>

³¹ Including the notification of principles for emergency psychological crisis intervention for the COVID-19 epidemic on January 26; the notice of psychological assistance hotlines for the epidemic on February 2; and guidelines for psychological assistance hotlines during the COVID-19 epidemic on February 7 ([National Health Commission of China, 2020](#))

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after which post-traumatic stress disorders, depression and chronic fatigue still existed widely amongst survivors a decade after the initial outbreak (Guan et al., 2020).

- **USA:** A recent survey found 62% respondents were worried that they or someone in their family will get sick; 51% that their retirement or college savings will be impacted; and 36% that they will not be able to afford testing or treatment for coronavirus if they need it (Hamel et al., 2020). Among working people, 53% were worried they will lose income due to a workplace closure or reduced hours; and 41% were worried they will put themselves at risk of coronavirus exposure because they can't afford to stay home from work (Hamel et al., 2020). The survey was conducted two weeks before it was reported that 3.3 million people had filed claims for unemployment due to COVID-19 (Long and Fowers, 2020).
- **China and Australia:** Governments in Australia and China have highlighted the psychological side effects of COVID-19 and are providing remote psychological services to citizens (Australian Department of Health, 2020; National Health Commission of the People's Republic of China and Ministry of Civil Affairs of the People's Republic of China, 2020). China is providing targeted psychological services to COVID-19 patients and their close contacts, people who are suspected of having contracted COVID-19, people with disabilities, healthcare workers and the public via telephone and social media platforms (Zhou et al., 2020).

COVID-19 may have specific mental health impacts on people with disabilities. In the USA, family members of people with disabilities have reported that people with intellectual, developmental or psychological disabilities may experience heightened anxiety and stress if they are isolated or their routines change due to COVID-19 social distancing measures (Torres, 2020). In response to advocacy by DPOs, the Spanish Health Ministry has given permission to autistic people to spend more time outdoors during COVID-19 lockdown (Confederación Autismo España, 2020). Research from prior to the COVID-19 pandemic also suggests people with pre-existing mental health conditions are particularly affected during emergencies because they are likely to experience more distress as a result of a crisis, exacerbating existing conditions and potentially causing new conditions to develop; the existing infrastructure for mental health care often breaks down in a crisis, for example, supply chains for psychotropic medications may be interrupted, mental health workers and other caregivers may be unavailable, and psychiatric facilities may be damaged; and stigma and discrimination can be barriers to accessing humanitarian assistance; and finally, people with psychosocial disabilities are already at higher risk of experiencing violence and abuse (Ryan et al., 2020).

An increase in the prevalence of mental health conditions is likely to have broader impacts on human rights and economic development in LMICs. People with mental health conditions already experience social exclusion, social and economic deprivation, poor health, injuries, and unequal access to health, education, income, housing and social support (Ryan et al., 2020). Before the COVID-19 pandemic, the World Economic Forum estimated that mental health conditions would cost the global economy 16 trillion US Dollars (USD) in lost economic output by 2030, USD 7 trillion of which was attributed to LMICs (Ryan et al., 2019). Given the scale of the impacts of COVID-19, the social and economic costs of mental health conditions could be expected to increase significantly without intervention.

5. Secondary impacts of COVID-19 on people with disabilities

4.1 Reduced access to essential and routine health services.

The COVID-19 pandemic is pushing healthcare systems beyond their capacity to receive and treat patients. This has led to concerns that healthcare and medications may become increasingly inaccessible for people with disabilities with pre-existing conditions, and result in disproportionate health impacts on people with disabilities. These challenges are in addition to existing barriers that many people with disabilities experience when accessing healthcare, which may be exacerbated by the pandemic. Pre-existing barriers to healthcare for people with disabilities include health facilities being physically

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inaccessible, high costs of care and transport³², limited funding for reasonable accommodations, lack of capacity amongst healthcare workers and stigma and discrimination against people with disabilities in the health sector (WHO, 2011; Kuper and Heydt, 2019). Examples of decreased access to healthcare for people with disabilities since the COVID-19 outbreak began are:

- **Australia:** a survey of families with children with disabilities found that 34% had had their disability support services cancelled, and 15% were unable to buy the medication they needed (Henriques-Gomes, 2020c).
- **India:** women with disabilities have reported that health facilities have been difficult to access while lockdown measures have been in place because women with disabilities have not been able to go to police stations to request passes to leave their homes, and in some cases women with disabilities have been denied medical aid (IDA, 2020a).
- **UK:** a press report suggests that people with disabilities have struggled to access vital medical supplies during the pandemic due to stockpiling of goods (Ryan and Marsh, 2020).
- **China:** a news report noted that people with HIV have struggled to access vital medications, and many people are reluctant to contact local officials to get their medicine delivered because they are concerned about revealing their HIV status and the associated stigma and discrimination (Lee and Westcott, 2020). Another report suggests that mass quarantines and restrictions to public transport have created a barrier to people with psychiatric disorders who visit psychiatric outpatients' clinics to obtain medications (Yang et al., 2020).

This rapid query did not find any reliable evidence to suggest that the overall prevalence of disabilities may increase as a result of COVID-19, however as access to healthcare services rapidly decreases research on this may emerge.

4.2 Economic impacts on people with disabilities and their families

Research shows that there is a significant correlation between disability and poverty in LMICs, with disability reinforcing poverty, and poverty leading to disability (Banks et al., 2017) and emerging reports suggest that COVID-19 may have disproportionate impacts on the livelihoods of people with disabilities.

Increased and disproportionate unemployment of people with disabilities: there is currently very limited publicly available data on the impact of COVID-19 on people with disabilities' employment. However, it has been reported that tens of millions of people around the world have become unemployed due to measures to contain COVID-19, and rates of unemployment are expected to increase (Nebhay and Mutikani, 2020). In India, women with disabilities in informal work, some of whom are single or women who have been abandoned by their husbands or families, have reported that since the lockdown they have lost their wages, they have no income to purchase food, and those who do not have a bank account or who live in remote areas with empty ATMs will not be able to access government payments (IDA, 2020a). Unemployment is likely to disproportionately impact people with disabilities because in most countries, people with disabilities are more likely to be employed in the informal sector and to be self-employed and therefore have limited labour protections (UNDESA, 2019). Prior to the COVID-19 pandemic there were already significantly lower rates of employment amongst people with disabilities around the world (UNDESA, 2019).

Exacerbated barriers to social protection: In Australia the media reported that people with disabilities, including indigenous people living in remote areas (Allam, 2020), have still been required to attend face-to-face assessments to access social protection during the pandemic, despite advice to otherwise practice social distancing (Henriques-Gomes, 2020b). Reviews and reassessments for disability benefits have since been suspended in the UK (UK Department of Work and Pensions, 2020). Pre-COVID-19 evidence

³² The World Report on Disability (WHO, 2011), for example, found that half of people with disabilities cannot afford healthcare, and they are 50% more likely to experience catastrophic health expenditure.

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highlights that people with disabilities already face significant barriers to accessing social protection in many LMICs, including those associated with travel, and social protection schemes are often vastly inadequate to meet people with disabilities' needs (Kidd et al., 2019). Many advocates and DPOs have called for an increase to social protection payments for people with disabilities during the pandemic due to the higher costs they may face (for example, Al-Issa, 2020, and Disability Rights UK, 2020), and the International Labour Organisation (ILO) has called for governments to make rapid progress toward collectively financed, comprehensive, and universal social-protection systems during the pandemic response (ILO, 2020). Governments have recently announced changes to schemes to ensure support for people with disabilities, including in Brazil³³ where virtual assessments will be made, and Mexico,³⁴ where benefits for children with disabilities will be paid upfront for up to four months.

Decreased access to food and essential supplies: Media and DPO reports in the UK (Ryan and Marsh, 2020; Disability Rights UK, 2020c), Italy (Tralli, 2020) and Australia (Henriques-Gomes, 2020) have noted that people with disabilities have not been able to order food to be delivered to their homes due to stockpiling and increased demand on supermarkets. Stockpiling and pressure on supply chains may have more dramatic impacts in LMICs. Women with disabilities in India have reported that they have not been able to go to markets and online order forms have not been in accessible formats (IDA, 2020a); and DPOs in LMICs are beginning to report lack of access to markets and stores for food and sanitary supplies due to increasing prices and health and security risks (expert contribution from Disability Rights Fund). Pre-pandemic research shows that people with disabilities in some LMICs are more likely to live in food insecure households (Brucker et al., 2014; Mitra, 2018), and since the outbreak the UN Special Rapporteur on the rights of persons with disabilities has urged that “access to additional financial aid is ... vital to reduce the risk of people with disabilities and their families falling into greater vulnerability or poverty. ... Many people with disabilities depend on services that have been suspended and may not have enough money to stockpile food and medicine or afford the extra cost of home deliveries” (Al-Issa, 2020).

Housing for people with disabilities in LMICs may also become insecure. Women with disabilities in India have reported that they have been evicted from housing and shelters during lockdown measures, leaving them outside and vulnerable to exploitation and abuse (IDA, 2020a). In Indonesia it was reported that blind university students were expelled from their dormitory during lockdown measures in Bandung City, leaving them living on the sidewalks and demanding their rights to shelter (Tribune News, 2020). In the UK, Disability Rights UK have highlighted the eviction of a disabled boy and his family from charitable accommodation due to fears of spreading infection (Disability Rights UK, 2020d).

4.4 Increased risk of stigma, discrimination, neglect, violence and abuse.

People with disabilities across the world experience diverse forms of stigma and discrimination from the public that may be amplified during the COVID-19 pandemic. In Kenya, media has reported that people with albinism are experiencing increased discrimination and abuse during the pandemic and falsely associating people with albinism with COVID-19 (Chacha, 2020). Research from prior to the pandemic shows that in LMICs some of the drivers of disability stigma include a lack of understanding of the causes of disabilities; cultural and religious beliefs that blame disability on misdeeds of ancestors, family members or supernatural forces; misconceptions about the abilities of people with disabilities; and discriminatory policies and legislation (Rohwerder, 2018) Attitudes towards people with disabilities vary significantly by impairment type and local context, but reports suggest that people with intellectual disabilities, severe mental health conditions, albinism and sensory disabilities are often more stigmatised than people with other disabilities, and women and girls with disabilities are doubly disadvantaged due to the additional stigma of gender (Rohwerder, 2018).

³³<https://www.folhape.com.br/economia/economia/coronavirus/2020/03/26/NWS,134981,10,1669,ECONOMIA,2373-BOLSONARO-INCLUI-PERICIA-MEDICA-INSS-ENTRE-ATIVIDADES-ESSENCIAIS.aspx>

³⁴<https://politica.expansion.mx/presidencia/2020/03/25/amlo-adelanta-apoyos-para-menores-con-discapacidad-ante-coronavirus>

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Examples of stigma, discrimination, neglect, violence and abuse in the context of COVID-19 include:

Devaluing of people with disabilities through public messaging about COVID-19: Many disability advocates have highlighted that public messaging about COVID-19 has devalued people with disabilities by framing the issue as presenting a serious risk “only” for people with chronic illnesses and older people, exacerbating the social exclusion that many people with disabilities already experience (Ryan, 2020; Kukla, 2020; Arielle, 2020; Moore, 2020; Ekstrand, 2020).

Increased social isolation and neglect of people with disabilities, particularly children: media reports that in China a 16 year old boy with cerebral palsy died when his father who normally cared for him was placed in mandatory quarantine, and other family members and the state did not provide adequate care (BBC News, 2020). This may have a more dramatic impact on people with disabilities in LMICs, where care is most often provided by family members and where there are limited state disability care or child protection systems (UNDESA, 2019). A group of women with disabilities in India have highlighted that personal assistants for women with disabilities have left and are not being allowed to return due to social distancing measures, leaving women with disabilities dependent on neighbours and family members (IDA, 2020a). Similarly, DPO reports are emerging in LMICs of people with disabilities losing the support of carers and family members who are unwilling to be in close contact due to COVID-19. In addition, people with disabilities may be experiencing increased social isolation due to social distancing measures and a lack of access to the internet and usual methods of communications due to office closures, as many people do not have access to the internet at home (expert contribution from Disability Rights Fund).

Recent news and articles have pointed to possible increases in violence, abuse and discrimination against people with disabilities. These include increased discrimination and abuse against people with psychosocial disabilities:

- **UK:** Human Rights Watch has raised concerns about emergency changes to the Mental Health Capacity Act that would lower the threshold for detention on mental health grounds by requiring only one doctor’s recommendation for detention rather than two – a threshold of two doctors was a safeguard against the abuse of power (Human Rights Watch, 2020).
- **Italy:** disability advocates have reported an upsurge in compulsory psychiatric treatment (Minkowitz, 2020).
- **France:** disability advocates have reported that people with a psychosocial who are infected with COVID-19 have been turned away from mainstream hospitals and treated instead in psychiatric institutions and mobile hospitals that lack the infrastructure to treat COVID-19 (Mikowitz, 2020).
- **Rwanda:** it has been reported that people with psychosocial disabilities who live on the streets and do not have access to food and water have been beaten by whips by security personnel while going to search for food and water during COVID-19 restrictions on movement (Minkowitz, 2020).

There is limited data and evidence on increases in intimate partner violence or violence perpetrated by carers. In India, women with disabilities have reported an increase in violence by partners and personal attendants as household stress has increased, there has been no form of community protection for women with disabilities, and women with disabilities have not reported violence because they fear abandonment by their families (IDA, 2020a). In China, police reports of domestic violence have tripled during the epidemic, and similar concerns about domestic violence have been raised in Italy and by domestic violence organisations that suggest increased household tension and domestic violence may be due to forced coexistence, economic stress, and fears about the virus (Fraser, 2020). Violence against people with disabilities is common, including by family members and primary carers, therefore people with disabilities may be at risk of violence during the COVID-19 response (Fraser et al., 2019). Recent data showing women and girls with disabilities are at higher risk of intimate partner violence (IPV) indicates that women and girls may be more likely to experience this during COVID-19 (Dunkle et al., 2018; Fraser, 2020).

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4.5 Other possible secondary impacts

There is currently no data and evidence on the impacts of school closures on children with disabilities. Sightsavers (expert contribution) suggests that in addition to disrupting education, school closures may also affect access to food programmes, social support, personal assistance or medical care, often accessed through schools. Children are at increased risk of child protection issues without the protective and social environment of a school and linked services. There are increased risks for children with disabilities, if they are unable to access such services, and they are likely to be more at risk of contracting COVID-19 and yet have less access to prevention and treatment. Given gaps between children with disabilities and children without disabilities have been growing (Male and Wodon, 2017) there is a risk that school closures for COVID-19 could exacerbate existing inequalities, therefore the need for accessible education when education is provided in alternative formats should be considered.

In addition, there is no data and evidence on the gendered impacts on people with disabilities, for example relating to unpaid care which is often done by women. In LMICs research shows that carers of people with disabilities are most often female family members (UNDESA, 2019). In the same way, carers (and particularly women) may also be at increased risk of contracting COVID-19 from the people they care for.

6. Conclusion

The findings of this rapid evidence review point to a number of implications for a disability-inclusive response to COVID-19. People with disabilities are disproportionately impacted by COVID-19 not only because it can exacerbate underlying medical conditions, but because of attitudinal, environmental and institutional barriers to their participation in and benefit from the pandemic response. Key recommendations include the following:

- 10) Deliver a twin-track approach:** ensuring people with disabilities are included in all response communications and activities, and developing interventions that address the specific needs and impacts on people with disabilities.
- 11) Engage people with disabilities or their representative organisations (DPOs) and disability-focused organisations in ensuring DFID's COVID-19 response is inclusive.** For example, in planning, identifying people with disabilities, sensitizing healthcare and other service providers and government departments, conducting situational analysis, messaging to the public, advocacy, monitoring and lesson learning.
- 12) Provide information on COVID-19 prevention and government response measures in accessible formats.** For example, by encouraging governments to provide sign language interpretation and real-time captioning at press conferences and public service announcements, and working with DPOs and disability-focused organisations to provide this information if governments fail to do so, and where government guidelines might be less visible. Use channels accessed by persons with disabilities including those in poor and remote areas.
- 13) Identify and remove barriers to prevention measures for COVID-19.** For example, implementing disability and gender-sensitive WASH prevention interventions, providing additional support to carers of people with disabilities and institutions to provide protection from outbreaks.
- 14) Identify and remove barriers to safe access to treatment for COVID-19.** For example, ensure medical protocols do not discriminate on the basis of disability; ensure purpose-built and adapted hospitals, testing and quarantine facilities are accessible, including signage and information, physical premises and healthcare worker awareness and attitudes. Pay attention to the additional barriers at-risk groups face, such as people with disabilities in institutional settings or those who rely heavily on carers. Work to encourage priority testing and personal protective equipment for these groups in addition to healthcare workers.

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- 15) Identify and remove access barriers to social support, essential healthcare, food, education and social protection schemes.** For example:
- a. Ensure persons with disabilities have adequate and continuous access to medicines, healthcare, personal assistance and/or rehabilitation, and housing;
 - b. Establish support mechanisms including accessible hotlines and virtual peer support groups to facilitate support during social distancing, isolation and quarantine;
 - c. Consider accessibility when developing remote learning arrangements for children during school closures, for example radio programmes, training teachers to deliver remote support and drawing on expertise of special education teachers;³⁵
 - d. Help governments to strengthen social protection systems, to ensure any benefits continue to be paid and/or are increased to meet daily living requirements/ match extra costs because of the pandemic (e.g. to hire additional personal assistance); ensure schemes are provided through accessible modalities (eg. women with disabilities may be less likely to hold bank accounts), include people with disabilities in job retention schemes;
 - e. Ensure steps are taken to ensure persons with disabilities benefit from programmes and initiatives designed to mitigate food insecurity.
- 16) Provide funding for and partner with DPOs and disability-focused organisations to build capacity on disability inclusion.** For example, through:
- a. Delivering disability awareness training for mainstream actors and healthcare workers.
 - b. Sensitise governments on how COVID-19 and national preparedness plans may disproportionately impact persons with disabilities.
 - c. Support DPOs and disability-focused organisations to influence national preparedness plans and government policy and to play an active role in the pandemic response.
- 17) Consider the intersections between age, gender and disability and other factors which may mean some people with disabilities are less likely to be included.**
- 18) Collect disability-disaggregated data and gather lessons learned on what works in disability inclusion in COVID-19 response.**
- a. Collect COVID-19 morbidity and mortality rates disaggregated by disability using the Washington Group Questions, in addition to age and sex disaggregation.
 - b. Gather lessons learned to strengthen programmes and partner capacity, including by capturing and sharing regularly disability-targeted and/ or inclusive COVID-19 responses.
 - c. Expand the evidence base on how the pandemic and the response impacts persons with disabilities, including through capturing data on the barriers and enablers for persons with disabilities.
- 19) Start thinking about how to ensure an inclusive recovery, particularly through engaging people with disabilities and DPOs and planning for a twin-track approach.** For example, by ensuring inclusive social protection, livelihoods and education programmes.

³⁵ In some contexts, supporting parents to home-school children will be challenging due to low literacy levels amongst adults. In these cases raising awareness of COVID-19 amongst parents and the importance of education to encourage them to send children back to school during recovery phase may be useful.

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Helpdesk services are provided by a consortium of leading organisations and individual experts on disability, including Social Development Direct, Sightsavers, Leonard Cheshire Disability, ADD International, Light for the World, Humanity & Inclusion, BRAC, BBC Media Action, Sense and the Institute of Development Studies (IDS). Expert advice may be sought from this Group, as well as from the wider academic and practitioner community, and those able to provide input within the short time-frame are acknowledged. Any views or opinions expressed do not necessarily reflect those of DFID, the Disability Inclusion Helpdesk or any of the contributing organisations/experts.

For any further request or enquiry, contact enquiries@disabilityinclusion.org.uk

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