 

**The Socioeconomic Impact of COVID19 on Persons with Disabilities**

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The socioeconomic impact of COVID19 on persons with disabilities

# Purpose of this report

COVID19 has had a devastating impact on all communities globally. However, its impact has not been equal, and persons with disabilities have been amongst the worst affected. Prior to the pandemic, persons with disabilities experienced widespread discrimination and exclusion. COVID19 has exacerbated existing inequalities resulting in persons with disabilities dying at higher rates, being pushed further into poverty and excluded from pandemic response measures.[[1]](#footnote-1)

With UNPRPD support, the OHCHR commissioned eight case studies into the socioeconomic impact of COVID19 on persons with disabilities in a diverse range of States. This report is a summary of the findings of those case studies (which can be found in annex to this report), as well as other notable reports on the disability specific impact of COVID19. Guidance based on the UN Convention on the Rights of Persons with disabilities (CRPD) on key common themes identified across the case studies is offered to support field presences and organisations of persons with disabilities (OPDs) in their advocacy to States and donors on ensuring inclusive COVID19 response and recovery efforts.

# Equal access to health care

Persons with disabilities are experiencing higher COVID19 infection and mortality rates.[[2]](#footnote-2) States are obligated to provide health care, including COVID19 prevention and treatment, to persons with disabilities without discrimination (Articles 5 and 25, CRPD). Yet many persons with disabilities have been denied their right to COVID19 health care, resulting in poor health outcomes and disproportionately higher mortality rates.[[3]](#footnote-3)

Our case studies identified numerous barriers to accessing health care that persons with disabilities have experienced during the pandemic including inaccessible information, transport and health care facilities, lack of trained staff, extra costs, lack of support services or rules that prevent those seeking health care to be accompanied by a personal assistant or a family member. The closure of borders and interruptions in supply chains has also had a detrimental effect on access to regular medications.

Discriminatory medical protocols have resulted in persons with disabilities infected with COVID19 being denied lifesaving treatment.[[4]](#footnote-4) For example, clinical frailty scales that inform triage policy (designed to assist healthcare professionals in prioritising access to Intensive Care Units and ventilator support) have been found to classify those that cannot do everyday tasks like cooking and dressing independently as ‘frail’. This would capture and deny life-saving treatment to many persons with intellectual impairments and long-term stable conditions such as cerebral palsy. Persons with disabilities have also had blanket ‘Do Not Attempt Resuscitation’ (DNAR) notices imposed on them without their consent.[[5]](#footnote-5) These discriminatory medical protocols are the result of ableist assumptions about the overall health of persons with disabilities and negative assumptions about their quality of life.

**Vaccine programs**

Evidence suggests that persons with disabilities are at significantly increased risk to COVID19 infection and poor health outcomes. Many persons with disabilities experience higher levels of exposure to infection because they live in institutionalised settings and/or through their close contact with human supports including personal assistants. There is an increased risk of death and poor health outcomes because some have underlying health conditions that make them more vulnerable to the virus and owing to the numerous barriers that persons with disabilities experience to accessing health care (see above).[[6]](#footnote-6) All these social determinants of health should be factored in prioritization exercises, including in vaccination program planning.

## What States should be doing

Immediately

1. In vaccination rollouts, prioritize persons with disabilities with relevant underlying health conditions on an equal basis with others. [[7]](#footnote-7)
2. In developing national vaccine roadmaps and deciding upon priority groups, factor in social and environmental determinants of health, including barriers to accessing healthcare (such as inaccessible prevention and healthcare information, transport and healthcare facilities, discriminatory triage policies, as well as dependency on human support and institutionalisation) that may disproportionately expose persons with disabilities to COVID19 infection and poor health outcomes.
3. Provide free COVID19 testing in the community that is accessible to all persons with disabilities. Test results should be provided with necessary support to persons with intellectual disabilities that may need assistance in understanding the results and their consequences.
4. Ensure that COVID19 targeted health services and facilities, including testing, treatment and quarantine facilities are accessible.
5. Ensure that persons with disabilities have continued access to their regular health care at all times to prevent health decline and death.
6. All feasible measures should be taken, including preparedness planning, to ensure that future border closures and movement restrictions do not further disrupt access to medical supplies.
7. Repeal discriminatory policies and protocols that deny access to treatment on the basis of disability, level of support need and/or quality of life assessments.

Recovering better**[[8]](#footnote-8)**

* Challenge and remove ableist assumptions that create barriers for persons with disabilities in accessing health care. To help achieve this awareness raising campaigns and training programs for health care professionals on the rights and the diversity of persons with disabilities should be provided.
* OPDs should be meaningfully consulted in the development and monitoring of public health legislation, guidelines and protocols.
* Independent and effective monitoring, facilitated by disability-disaggregated data, of implementation of public health guidelines and protocols should be strengthened to ensure early identification of adverse negative impacts and timely remedial action.
* In the implementation of the SDGs, States should review their national health-care systems framework with the aim of achieving universal health coverage including disability-specific services, financial risk protection, access to quality essential health care services and affordable medicines, including vaccinations.[[9]](#footnote-9)

# Social protection

COVID19 has highlighted and added to the risk of economic vulnerability of persons with disabilities, who are less likely than others to be employed and are overrepresented in the informal sector where they do not have access to employment-based social security and labour rights. Owing to a lack of access to social security, persons with disabilities working in the informal sector report continuing to work despite lockdowns, thereby exposing themselves to COVID19 infection.[[10]](#footnote-10)

At the same time that income levels have decreased, many persons with disabilities have experienced an increase in their expenses as the costs of regular medications, food and safe transport (for example taking a taxi instead of a bus) have increased.[[11]](#footnote-11) A number of States including Ecuador, Argentina and South Africa have provided cash transfers, tax cuts and other emergency support to help mitigate these additional costs.

Some States have automatically extended formal disability certificates, which are a prerequisite to access disability specific social protections. This good practice has allowed for continued access to essential support and prevented exposure to COVID19 infection during reapplication processes. However, owing to significant administrative barriers, lack of information and support in the application process, as well as restrictive qualification criteria, many persons with disabilities do not have a disability card.[[12]](#footnote-12) Those that do not have been excluded from receiving COVID19 emergency support.

## What States should be doing

Immediately[[13]](#footnote-13)

1. Automatically extend disability related social protections and any formal certification(s) that are a prerequisite to access social protections.
2. Provide financial support to persons with disabilities in the informal sector.
3. Increase existing social protections to cover disability-related extra costs, including for human support, transportation, and essential medicines.

Recovering better

1. All available resources should be used to secure access to social protections that ensure an adequate standard of living in accordance with Article 28 of the CRPD.[[14]](#footnote-14) As well as disability specific benefits, all mainstream social protection benefits should be accessible and inclusive.
2. Efforts should be made to increase access to disability cards, including simplification of assessment procedures, application processes and additional support for applicants.
3. In accordance with the Sustainable Development Goals (SDGs), Goals 1 and 8 in particular, all economic recovery programs should be disability-inclusive in a manner that reflects the CRPD and sustainable.[[15]](#footnote-15) Budget allocation should be based on non-discrimination and respect the rights of persons with disabilities. Budgets that provide for essential support to persons with disabilities, including medical costs and assistive devices, should be ring-fenced and not subject to austerity measures.
4. States should not implement austerity measures that disproportionally impact persons with disabilities, leaving persons with disabilities further behind within economic recovery planning.
5. Targeted measures should be taken to ensure that persons with disabilities are not left behind in the economic recovery, including adopting budgetary policies that respond to the additional costs that persons with disabilities experience. Particular attention should be paid to ensuring that women and girls with disabilities are included in economic policy and targeted measures are taken to reduce the inequalities that they continue to experience.[[16]](#footnote-16) Education and retraining programs, including IT training, should be developed to allow persons with disabilities to increase their skill set and opportunities to access employment.[[17]](#footnote-17)

# Data collection and disaggregation

Collection of disability disaggregated data is essential to design and monitor policy that gives effect to the rights of persons with disabilities, including within pandemic response, and is a requirement of States parties to the CRPD under its article 31. Data collection and disaggregation is essential to leave no one behind, and to ensure an intersectional approach that targets the realities of those experiencing enhanced exclusions such as women and girls and underrepresented populations among persons with disabilities, such as persons with intellectual and psychosocial disabilities.[[18]](#footnote-18)

States that have collected and published disability-disaggregated data have been best placed to identify health and social protection gaps and take remedial action.[[19]](#footnote-19) In contrast, States that have developed emergency response measures based on out-dated and under-inclusive data have further excluded some persons with disabilities from essential socioeconomic support, such as cash transfers and food packages.

## What States should be doing

Immediately

* Collect, keep and publish COVID19 infection and mortality rates disaggregated by disability, age and gender. Data collection should include all persons with disabilities including those in institutionalised settings. In data collection, internationally comparable and tested methodologies (such as the Washington Group question sets) should be used.[[20]](#footnote-20)

Recovering better

1. States need to implement data systems at census and survey levels that include identification modules to disaggregate by disability, including in situations of humanitarian emergencies.[[21]](#footnote-21)
2. Data collection and administration protocols should ensure confidentiality and privacy in accordance with article 22 of the CRPD.

# Participation

Globally, persons with disabilities and their representative organisations have not been meaningfully consulted in the development of COVID19 response measures. This has resulted in policy being developed and implemented that is under-inclusive or harmful to persons with disabilities. Where they are able to operate safely and independently, [[22]](#footnote-22) OPDs can support States to prevent harm and remove harmful policies. OPDs have worked with governments to address access to life-saving COVID19 treatments and inaccessible COVID19 prevention information.[[23]](#footnote-23) Accessible information and disability-disaggregated data are essential tools to allow for OPDs and persons with disabilities to support States in inclusive policy development.

## What States should be doing [[24]](#footnote-24)

Immediately

* Ensure that persons with disabilities and OPDs are meaningfully and consistently consulted in the development, implementation and monitoring of all aspects of COVID19 response and recovery planning and policy.[[25]](#footnote-25)

Recovering better

1. Implement formal mechanisms for the meaningful consultation of persons with disabilities and OPDs in all legislative and policy development, including COVID19 recovery planning.
2. Remove administrative barriers and legal requirements that prevent OPDs from meaningfully and independently participating in policy development.
3. Ensure the accessibility of information, the physical environment and communication links for persons with physical, sensory, psychosocial and intellectual impairments, so that all who wish to participate can do so.[[26]](#footnote-26)

# Access to COVID19 information

Persons with disabilities have been excluded from equal access to essential COVID19 public health information, including prevention guidance, and information on response measures and services. Barriers to accessing information include failure to provide information in accessible formats including sign interpretation, captioning, audio, and easy-to-read, among others. The digital divide, which persons with disabilities are disproportionately negatively impacted by, has been a further barrier to accessing information. Persons with disabilities are thus not informed of essential prevention measures, lockdown rules, when and how to access testing and treatment, the results and follow-up instructions once tested, as well as the availability of emergency assistance services such as food parcels and cash transfers. In some instances lack of access to accurate COVID19 information has allowed incorrect and harmful misinformation to spread. By way of example, in the DRC, the false rumour circulated that persons with albinism are particularly likely to spread COVID19, resulting in persons with albinism being driven out of their homes.[[27]](#footnote-27)

## What States should be doing

Immediately

* Provide all COVID19 public health and response service information in a range of accessible modes, means and formats including, sign interpretation, easy-to-read, captioning, and screen reader accessible (for online information).

Recovering better[[28]](#footnote-28)

1. Provide all public information in a range of accessible modes, means and formats.
2. In the dissemination of information, take targeted action to reach persons with disabilities and their networks, including those living in remote areas.
3. Promote support to persons with disabilities, including personal assistance, to ensure their access to information and take regulatory measures to ensure new information and communications technologies meet accessibility standards.

# Impact of COVID19 on persons with disabilities living in institutionalised settings

Persons with disabilities living in institutionalised settings (such as psychiatric institutions, care homes, orphanages and nursing homes) have experienced significantly higher infection and mortality rates than those living in the community.[[29]](#footnote-29) In Scotland 47% of all COVID19 deaths were in institutionalised settings,[[30]](#footnote-30) and in Canada four in every five COVID19 deaths were in long-term care homes.[[31]](#footnote-31) Contributing to increased risks of infection have been the inadequate provision of Personal Protective Equipment (PPE), overcrowding and difficulty in adhering to social distancing measures between staff and residents, and in some instances the discharge of COVID19 infectious patients from hospitals back into institutionalised settings.[[32]](#footnote-32)

Residents in institutions have also been exposed to abuse and neglect, isolation and a general decline in their physical and mental health.[[33]](#footnote-33) Many institutions were, or continue to be, sealed off to the outside world. In some, residents have been sedated and forced into de facto solitary confinement.[[34]](#footnote-34) Insufficient working telephones, assistive devices, Internet access and lack of support have meant that many people living in institutionalised settings are denied communication with the outside world. The suspension of visitation rights, including for welfare monitoring, and inadequate access to communication with the outside world, means that any harm and abuse suffered by residents is likely to remain undetected.

## What States should be doing

Immediately

1. Provide sufficient PPE and promote preventative measures within institutionalised settings including reducing overcrowding.
2. Implement emergency deinstitutionalization measures with appropriate community-based support, to reduce infection rates and reduce the risk of other harms to residents and staff.
3. Ensure that confidential and safe reporting mechanisms are available at all times for residents and/or staff to report abuse, violence or exploitation.
4. Ensure that independent monitoring of all institutionalised settings continues, including by national human rights institutions, for early detection of neglect, abuse, violence or exploitation.
5. In the event of lockdowns, ensure that residents have the necessary equipment and support to continue to communicate with friends and family outside the institution whenever they so wish, including through the provision of mobile phones, in a manner that respects their right to privacy.
6. Implement exceptions to total bans on movements to and from institutions.
7. Provide free, frequent and rapid testing to all residents, visitors and staff.
8. Collect, keep and regularly publish data on COVID19 infection and mortality rates within institutionalised settings.

Recovering better[[35]](#footnote-35)

* Develop and implement community-based support for persons with disabilities in their houses and in their communities.
* Establish a programme to progressively eliminate institutionalisation as an alternative to community-based support.

# Inclusion in international response aid

International donor agencies and States have been quick to provide aid to developing countries to support their COVID19 responses. By the end of September 2020 the World Bank, for example, had committed $43 billion in aid packages for COVID19 response.[[36]](#footnote-36) Aid has been used to fund activities on COVID19 prevention such as awareness raising campaigns and the provision of PPE and medical supplies, support services for survivors of gender based violence and remote-learning education programs for students. However, evidence shows that persons with disabilities are not expressly included within all COVID19 foreign aid programmes and are, therefore, excluded from this support.[[37]](#footnote-37)

Equal access to humanitarian assistance is not only a requirement under the CRPD (Articles 32, 11 and 5) but also essential to achieve the 2030 Agenda for Sustainable Development and its commitment to leaving no one behind. Guidance to donors on disability-inclusion monitoring of aid is offered in the OHCHR’s ‘Monitoring the inclusion of persons with disabilities in COVID-19 response and recovery funding for mainstream programs’.[[38]](#footnote-38)

## Recommendations to donors[[39]](#footnote-39)

* When providing aid for COVID19 response and recovery, ensure that programs are developed to ensure equal access of persons with disabilities to the support provided.
* Noting that persons with disabilities are disproportionately impacted by the COVID19 crisis, as well as ensuring that mainstream programs are inclusive, fund disability targeted programs that seek to remedy this impact.
* Ensure that aid is not used in manner that contributes to a violation(s) of the rights of persons with disabilities.
* Develop and implement a disability inclusion policy that sets out how donor's aid programmes will mainstream disability inclusion.
* Through the use of indicators, disability markers and disability-disaggregated data, monitor aid programs to ensure access barriers that persons with disabilities are experiencing are identified and remedied.

### Annex I. United Kingdom

As part of a multi-agency UNPRPD project, the OHCHR commissioned an independent consultant to undertake a study into the impact on persons with disabilities of triage policy in the United Kingdom (UK) during the COVID19 pandemic between January and November 2020. The case study is the result of desk research as well as interviews with stakeholders, including organisations of persons with disabilities (OPDs). All information contained is correct as of February 2021.

During 2020 the UK registered one of the highest COVID19 mortality rates worldwide. Persons with disabilities in England accounted for six in ten (59.5%) of all COVID19 related deaths from the start of the pandemic until November 2020.[[40]](#footnote-40) Persons with learning disabilities had a 3.7 times higher risk of death than other people.[[41]](#footnote-41) One reason for this increased risk is living conditions within institutionalised settings where preventative measures such as social distancing could not be implemented. Furthermore, during the first wave of the pandemic it was widely reported that persons with disabilities were being returned from hospital to residential care with COVID19.[[42]](#footnote-42)

Attitudinally, environmental and institutional barriers that exist across the UK have compounded the higher risk of death for persons with disabilities through discriminatory medical protocols including the use of ‘Do Not Attempt Resuscitation’ (DNAR) Notices as well as triage guidelines that effectively exclude persons with disabilities from critical care.[[43]](#footnote-43)

# Good Practice

## Disaggregated data collection and publication

The UK collects and publishes data on COVID19 infection and mortality rates disaggregated by disability, age and sex. Data collection is essential to design and monitor policy that gives effect to the rights of persons with disabilities and is a requirement of States Parties to the Convention on the Rights of Persons with Disabilities (Article 31).

## Remedial action

In response to concerns raised by health care professions, patients and OPD’s that the NICE guidance and Clinical Frailty Scale was negatively impacting on persons with disabilities access to healthcare, remedial action was taken to prevent further harm. NICE issued amended guidance and NHS England released a statement clarifying the position that treatment decisions must be made on an individual basis.

## Independent oversight and investigation

Following reports of blanket DNAR notices, the Care Quality Commission (CQC), an independent regulator of health care in the UK, has opened an investigation into the use of DNAR notices. The CQCs report will be published in Spring 2021.

# UK Triage guidelines and related medical protocols

## Clinical Frailty Scale

To help prevent UK hospitals from being overwhelmed, on 20 March 2020 the UK’s National Institute for Health and Care Excellence (NICE) published new guidance on the treatment of patients in critical care requesting health professionals to grade all adult patients using a Clinical Frailty Scale (CFS) on admission to hospital irrespective of COVID19 status.[[44]](#footnote-44) The guidance based decisions concerning admission to critical care on the ‘likelihood that the person will recover to an outcome that is acceptable to them and within a period of time consistent with the diagnosis’.[[45]](#footnote-45) Under the NICE Guidelines persons graded five (‘mildly frail’) or less on the CFS are assumed likely to benefit from critical care; for persons graded above five there is uncertainty regarding the likely benefit of critical care and advice is needed to make a decision regarding treatment.[[46]](#footnote-46) The grading in the NICE guidelines means that those who can not do everyday tasks like cooking, managing money and personal care independently are considered frail, and as a result might not receive intensive care treatment and/ or may be the focus of discussions around DNAR Notices.

The CFS does not distinguish between those who can’t do everyday tasks because they are nearing the end of their lives and those who require personal assistance because of their impairment, but are healthy.[[47]](#footnote-47) A representative of one OPD stated: “We know that someone might need a lot of support, but they might have a fantastic quality of life, [the CFS] was basically making a very discriminatory judgement on the quality of people’s lives”.

NICE amended the guidance on 31 March 2020, following the concerns raised by OPDs. The amended guidance emphasised that the CFS scale is intended to be part of a holistic assessment and that health professionals must be aware of the limitations of the CFS. The revised guidelines explicitly stated that the CFS should not be used for people with stable, long-term disabilities, learning disabilities or autism.[[48]](#footnote-48) NHS England also wrote to health providers highlighting the changes to the guidance[[49]](#footnote-49).

In April 2020, NHS England also published a reference guide on patient management that identified four groups of patients that should not ‘ordinarily be conveyed to hospital unless authorised’ including ‘patients who could be cared for in a community setting’. This guidance was perceived by some senior NHS staff to place obstacles to emergency medical treatment in front of persons with disabilities.[[50]](#footnote-50) In August 2020, the Care Quality Commission (CQC) released a statement emphasising the importance for persons with disabilities and older people to access hospital care and treatment for COVID19 and other conditions when needed, to try to counter the perception hospitalisation was discouraged or not permitted.[[51]](#footnote-51)

## Do Not Attempt Resuscitation (DNAR) Notices

Under NHS England’s reference guide on patient management, patients with DNAR Notices in place would not ‘ordinarily be conveyed to hospital’. Reports emerged in April 2020 of large numbers of letters being sent by general practitioners to care homes that suggested patients were unlikely to be admitted to hospital because of the NICE guidance on the treatment of patients in critical care and the NHS England reference guide on patient management, and requesting DNAR forms to be signed. In response, NHS England released a statement telling all NHS trusts, GPs and Clinical Commissioning Groups (CCGs) that any decisions regarding the treatment of COVID19 for persons with learning disabilities and/ or autism should be made on an individual basis. On 7 April 2020, NHS England further emphasised the need to not send out blanket DNAR Notices and the advice was further emphasised by the UK’s Secretary of State for Health during a daily briefing.[[52]](#footnote-52)

## Impact on Persons with Disabilities

NHS England have denied claims that persons with disabilities have been denied critical care during the COVID19 pandemic and emphasised in a public statement that the CFS amounted only to clinical guidance and not policy[[53]](#footnote-53). It is important to also note that some guidance released by NICE and NHS England was quickly revised or withdrawn following criticism, including by OPDs.

However, the NICE and NHS England guidance has negatively impacted persons with disabilities. OPDs suggest that the NICE guidelines around the use of the CFS set a tone regarding access to treatment for persons with disabilities that became hard to withdraw. Many hospitals reported scoring patients using the CFS, to prevent a shortage of ICU beds. As a result, numerous patients with disabilities were not admitted to hospital for treatment.[[54]](#footnote-54)

One NHS Trust is reported to have asked clinicians and GPs to use the CFS to identify people who might stay at home should they become seriously ill from COVID19 rather than be admitted to hospital.[[55]](#footnote-55) A representative of one OPD underscored the negative message that use of the CFS gave: “If you have an on-going health condition, we do not want to see you in hospital. That was shocking and frightening”.

Turning Point, an organisation that provides supported living and residential care for persons with learning disabilities reported receiving a high number of DNAR notices from doctors without consultation with the person concerned and/or family members.[[56]](#footnote-56) Care home managers reported to Amnesty International cases of local GPs or CCGs requesting them to insert DNAR forms into the files of residents as a blanket approach.[[57]](#footnote-57) These reports have prompted an investigation by the CQC into the blanket use of DNAR Notices. Initial findings from the CQC have confirmed DNAR notices have been wrongly allocated to some care home residents and that some DNAR notices wrongly applied may still be in place.[[58]](#footnote-58)

## Case study: A male with tetraplegia following a spinal cord injury

“In the last 30 years prior to the pandemic, I have not been asked about having a DNAR Notice. In the eight months since the start of the pandemic, I have been asked twice. Each time was prior to an operative procedure, unrelated to COVID. Each time the conversation went something like this:

Nurse: “I'm sorry to have to ask this, but do you wish to be resuscitated?”

Me: Yes, of course (a very clip response!)

“I was very prepared for the question because I had seen the media reports about the increase in DNAR Notices. I felt irritated, but I managed to largely ignore what was behind it. Disabled people's rights have been stripped away very quickly without any understanding of the impact this may have or the damage it has caused. Rights that many have fought for over 50 years, stripped away within weeks”

## Case study: Persons with learning disabilities’ restricted access to hospitals

Mencap is a UK charity for persons with learning disabilities. Mencap reported receiving a series of letters and phone calls was a blanket letter being sent to every person who is in receipt of care, regardless of their age, health or disability [status]. Then a GP called us to ask what the people we support could and couldn’t do, like whether they can use stairs. Some of them are wheelchair users so of course they can’t use stairs but that doesn’t mean that they aren’t fit and healthy. It really felt as though they had been written off before they were even assessed for how they might benefit from medical intervention. It was clear that assumptions were made about the people we support because they need care, and that somewhere it has been decided that their lives are not worth trying to save. But people with a learning disability deserve to get treatment like anyone else – their lives are just as valuable as the next person’s”.

Mencap reported that the GP surgery subsequently apologised and that the issues were resolved; the people Mencap report remain safe and well. However, Mencap expressed deep concern that this ever happened in the first place and that it points to health inequalities people in the UK with a learning disability have faced throughout the pandemic.[[59]](#footnote-59)

# Lesson learnt

The UK’s experience between January and November 2020 of medical protocols introduced to help allocate health resources and to prioritise hospital treatment and care provide valuable lessons for further pandemic responses:

* The UK’s experience indicates a persistent need to challenge and remove abelist assumptions that create barriers for persons with disabilities in a pandemic response, including: assumptions about the overall health status of persons with disabilities and that impairments go hand-in-hand with compromised health and negative assumptions about the quality of life of persons with disabilities that may impact predictions around clinical outcomes.
* Disability-disaggregated morbidity and mortality data facilitates a greater understanding of the impact of health crises on persons with disabilities that can strengthen policy development and decision-making.
* Public bodies need targeted support and close monitoring to ensure they respect the rights of persons with disabilities, including the right to equal access to health care (Article 25, CRPD) and the right to non-discrimination (Article 5, CRPD) when public health guidance and protocols are developed.[[60]](#footnote-60)
* In the development and monitoring of public health guidelines and protocols OPDs must be meaningfully consulted.

### Annex II. Belarus

As part of a multi-agency UNPRPD project, the OHCHR commissioned an independent consultant to undertake a study into the impact of COVID19 on persons with disabilities in Belarus. The case study is the result of desk research as well as semi-structured interviews with stakeholders, including organisations of persons with disabilities. All information contained is correct as of February 2021.

Historically persons with disabilities in Belarus have experienced systematic discrimination and exclusion from all aspects of society. The COVID19 pandemic has exacerbated denial of their rights and marginalisation. The on-going political situation characterised by the shrinking space occupied by organisations of persons with disabilities (OPDs) (as well as other human rights defenders) has further contributed to the failure to realise the rights of persons with disabilities. Constructive dialogue between the State and OPDs has ceased. Bilateral meetings between OPDs and ministry officials have not been held since March 2020.

Overall the response to COVID19 in Belarus has not been inclusive of persons with disabilities. The government to date has decided not to define persons with disabilities as a group particularly vulnerable to COVID19 and the negative impacts of the crisis. This has resulted in a lack of targeted action to mitigate the disproportionate impact of the pandemic on persons with disabilities. Approximately 620 official documents on the COVID19 response were analysed for this research and it was found that only one addressed the impact on persons with disabilities (see below, ‘Good Practices’).

# Good practice

Extension of formal documents

An important good practice that was identified in the course of this research was the time extension of validity of certain official documents that allow persons with disabilities to access social services and certain benefits. The extension reduces the exposure to COVID19 infection when applying for renewal of these certificates, which has to be done in person.

## Lack of reliable disaggregated data

A general lack of transparency and scarcity of verifiable information in Belarus is an on-going concern and makes it extremely difficult to evaluate the impact of COVID19 on any specific group, including persons with disabilities. The government has not gathered any data disaggregated by disability status (nor gender identity or age) on the impact of COVID19. Therefore the health outcome and mortality rate amongst the population of persons with disabilities is not known. However it is known that factors that persist in Belarus including lack of access to health and prevention information, insufficient social support and denial of access to health care all increase the vulnerability of persons with disabilities to catching COVID19 and suffering poorer health outcomes.

There are concerns that the lack of reliable data concerning persons with disabilities and COVID19 is being optimised by the government to minimise the significance of the problem and justify its refusal to take the necessary disability-specific response measures.

Access to information

COVID19 information, including guidance on prevention, has not been uniformly and consistently provided in accessible formats, leading to the exclusion of persons with sensory and/or intellectual impairments in particular. The limited national accessibility standards are not sufficiently enforced and measures have not been taken to ensure broadcasters systematically implement accessibility features.

Government officials claim that information has been disseminated to persons with disabilities through targeted telephone calls. However, OPDs and persons with disabilities claim these calls did not reach the vast majority of persons in need of access to information. A video hotline with sign interpreters established before the pandemic to support communication between deaf persons and public services has allowed a limited number of persons who are deaf to access COVID19 health and prevention information. The video hotline has received an increase in call volume by 20-25% however the resources allocated to this service have not been increased in response to this increased demand. The lack of trained sign language interpreters is also a significant barrier; there are approximately only 70 in the entirety of the country.

Instead OPDs have used their own resources and stepped in try to fill the significant accessibility gap including by providing information in Easy to Read. Media outlets have published some of these accessible materials.

## Access to health care

Health care facilities remain largely inaccessible resulting in persons with disabilities being denied access to COVID19 testing and treatment. Persons with disabilities and OPDs identified widespread discriminatory and negative attitudes towards persons with disabilities by health care professionals as a particularly prominent and persistent barrier to accessing health care. Furthermore, as confirmed by the Ministry of Health, many health facilities and particularly those outside urban areas are not physically accessible preventing persons with physical impairments from access regular health care as well as COVID19 treatment.

The Ministry of Health has stated that there have been no instances of refusal of health care to COVID19 patients who have an impairment and there is no medical triage policy. However persons with psychosocial disabilities infected with COVID19 and seeking hospital treatment have been denied access to COVID19 wards and instead referred to psychiatric wards, which are not equipped for COVID19 treatment. Referrals were based on the argument that patients would receive better care should their mental health condition become more acute. This policy does amount to denial of health care on the basis of disability. Furthermore, rigid non-inclusive hospital protocols, such as patient only access in COVID19 cases prevented many persons with disabilities who require support from a personal assistant seeking treatment.

Persons with disabilities report a reduction in their access to general health care and rehabilitation services and this having a negative impact on both their physical and mental health. Attempts to provide digital health services have been limited in their success owing to low digital literacy, especial in more rural communities. One positive practice noted was the development of online pharmacies and home delivery of essential medicines.

## Institutionalization

Despite an on-going deinstitutionalisation process in Belarus, a lack of adequate community based services means that institutionalisation of children and adults with disabilities continues. The situation of persons with disabilities living in institutional settings remains a grave concern. There is no data and a lack of transparency regarding the situation within institutionalised settings therefore it is impossible to ascertain the full gravity of the situation. One factor that may incentivise not collecting data and maintaining secrecy on the conditions within institutions is the penalties alleged to be imposed on directors of institutions if a resident or member of staff tests positive for COVID19. This penalty policy may also deter those running institutions from seeking testing for suspected cases.

The official data on COVID19 in institutionalized settings only includes persons who have been hospitalised outside of institutions but not those who have died or convalesced in institutionalisation care. This grossly distorted data set has led to dangerous and false claims by public officials that “*people in institutions have been better off than people in the general population. This shows that the institutions are a useful facility during the pandemic and beyond”.*

Following the outbreak of the pandemic in April 2020 there has been a de facto blanket ban on any movements in and out of institutionalized settings, leaving residents extremely isolated and without access to external services. The ban on receiving packages and the replacement of communal meals with packaged meals to be consumed alone in residents’ rooms have added to their isolation.

A further serious consequence on the ban on persons visiting institutionalized settings is that the limited monitoring that was taking place before the pandemic has been indefinitely suspended leaving residence particularly vulnerable to undetected abuse.

## Access to community based support services

Access to community-based services has been negatively impacted by the pandemic, including access to day-support centres. In-person support services have been suspended and alternatives including online services have not been put in place. Notwithstanding the negative impact of COVID19, community based services were not widely available before the pandemic and were not usually provided for free. Personal assistants for example, are paid below the minimum wage and are prohibited from seeking other sources of income making their profession untenable and the number of trained personal assistance extremely small.

Overall the pandemic has exacerbated the inadequacies of support services that discriminate against persons with intellectual disabilities in particular. Persons whose personal assistant have been incapacitated with COVID19 and are as a result left without support have been particularly exposed to the inadequacy of the current community based services.

# Key recommendations

**Disability-specific strategy**

* A comprehensive and coordinated response to COVID19 that includes targeted measures to mitigate the disproportionate impact of COVID19 on persons with disabilities should be taken. Specifically, COVID19 health and prevention information must be provided in accessible formats, including national sign language and Easy Read. Government and other public websites should be accessible to screen readers.

**Free COVID19 testing**

* Free COVID19 testing should be provided in the community and be fully accessible to person’s with disabilities. Free testing should also be provided to those within institutionalised settings.

**Disability disaggregated data**

* COVID19 infection and mortality data disaggregated by disability (as well as age and gender), should be collected and published daily. Data collection should include all persons with disabilities including those in residential settings. Noting that States Parties to the CRPD are required to collect data to enable them to formulate and implement law and policy that gives effect to the rights of persons with disabilities (article 31), disaggregated data should inform public health and economic responses and as well as recovery planning.

**Vaccination**

* Vaccination programs must be inclusive and priorities persons with disabilities, including those living in institutionalised settings. Vaccination information should be disseminated in accessible formats and vaccination sites must be physically accessible. Vaccinations must be given only on the basis of free and informed consent.

**Deinstitutionalisation and community based services**

* The pandemic has exacerbated the negative consequences of institutionalisation on persons with disabilities. A program of ending institutionalisation in favour of inclusive community based support is ever more pressing and efforts in this regard should be accelerated.

**COVID19 response measures within institutions**

* *Data collection*

Whilst the goal of deinstitutionalisation is being actively sought, transparent and regular data collection should be carried out on the infection rates in institutions. Persons in institutions should be prioritised in vaccination plans.

* *Freedom of movement*

Alternatives to the disproportionate de facto ban on movements to and from institutions should be implemented, including access to free testing for those wishing to visit or leave institutionalised settings.

* *Communication with family and friends*

Measures should be taken to ensure the availability of equipment, technology and skills to enable persons in institutions to stay in touch with their families and friends. Respecting the right to privacy of residents should be an immediate propriety.

**Participation**

* OPDs and persons with disabilities must be meaningfully and consistently consulted on the development of all aspects of COID19 response and recovery policies.

**Economic recovery**

* In accordance with SDGs, Goal 8 in particular, all economic recovery programs should be disability-inclusive and sustainable.[[61]](#footnote-61) Targeted measures should be taken to ensure that persons with disabilities are not left behind in the economic recovery. Education and retraining programs, including IT training, should be developed to allow persons with disabilities to increase their skill set and opportunities to access employment.

### Annex III. Montenegro

As part of a multi-agency UNPRPD project, the OHCHR commissioned the Association of Youth with Disabilities in Montenegro (AYDM) to undertake a study into the socioeconomic impact of COVID19 on persons with disabilities, with a particular focus on youth. The case study is the result of desk research, questionnaires, interviews and focus groups with stakeholders. AYDM collaborated with the Union of the Blind in the research for the case study.

Persons with disabilities in Montenegro face numerous barriers in accessing their rights. Before the pandemic, they faced barriers in the physical environment and in accessing facilities, information, communication and technology, transport and public services. In addition, the absence of well-resourced and diverse community services to support independent living continues to limit the choices and equal opportunities of all persons with disabilities, including youth. The COVID19 pandemic has exacerbated the barriers that persons with disabilities face in accessing their rights. Restrictive measures adopted since March 2020 to prevent the spread of infection have negatively affected the economy and the standard of living of most people. The Government has adopted several packages to support people and businesses affected by the pandemic. However, response and recovery measures have largely not been inclusive, and none have directly targeted persons with disabilities.

# Good Practice

Targeted easing of restrictions to accommodate the needs of persons with disabilities

As a result of advocacy by OPDs, several exemptions to COVID19 prevention measures were introduced to mitigate the disproportionate impact of the measures on persons with disabilities. The one-person rule (unless family) to allow movement in public spaces was eased to allow for personal assistance to resume support services following calls from person with disabilities and their representative organisations that the rule was having a severe negative impact on their welfare. Movement restrictions were also eased at certain timesof the day for wheelchair users and persons with autism. This targeted easing of restrictions demonstrates that states can take positive measures to accommodate the needs of persons with disabilities in public emergency responses.

## Lack of disaggregated data

The health outcomes and mortality rate among the population of persons with disabilities is not known. Montenegro has no systematized data on persons with disabilities, in breach of data collection requirements under the Convention on the Rights of Persons with Disabilities (CRPD). States Parties to the CRPD are required to collect such data to enable them to formulate and implement law and policy that gives effect to the rights of persons with disabilities (article 31).

## Impact on Health

Of the 90 persons with disabilities who responded to a questionnaire prepared by AYDM on the impact of COVID19 on their lives, 62% experienced negative impact on their health.[[62]](#footnote-62) The deterioration in respondents’ physical and mental health was attributed to: deterioration in existing conditions because of reduction in access to regular health care, medication, medical equipment and/or assistive devices; COVID19 infection; and increased feelings of isolation, depression and anxiety. Persons with respiratory system limitations reported additional health problems when wearing a facemask, which, except for a short period, was mandatory in public spaces, without exception.

**Testimony: Male aged 32**

“The medication approved by the Ministry of Health was either supplied late or was not supplied at all in Montenegro, which meant the therapy I needed was also administered with delays.“

**Testimony: Female aged 25**

“Because of disruptions in the medical supply chain, I had to halve the tablets or had my dosage reduced by my doctor for the medication to last until it came from suppliers abroad“.

## Access to Assistive Devices

Disruptions in access to assistive devices negatively impacted physical and mental health, personal mobility and independence, and interrupted access to information, education (including remote learning), and employment. Import and movement restrictions and the suspension of some public services resulted in disruptions in access and maintenance of assistive devices. Furthermore, persons with disabilities were reluctant to access services that continued owing to the increased risk of infection posed by the multiple face-to-face appointments required. For example, to apply for an assistive device a person may have to attend appointments with a general practitioner, specialists and/or consultants, the Health Insurance Fund and suppliers of assistive devices.

## Impact of preventative measures

Movement restrictions, social distancing and compulsory wearing of facemasks in public spaces, introduced to prevent the spread of COVID19, had a negative impact on some respondents’ physical and mental health. Persons with hearing impairments highlighted the communication barrier resulting from the compulsory wearing of facemasks, which impeded their interactions with others and resulted in further isolation. The one-person rule (unless family) for movement in public spaces meant that persons with disabilities, including persons with visual impairments, who relied on non-family member assistance, were left without support to carry out day-to-day necessities, such as buying groceries. Following lobbying from persons with disabilities and OPDs, authorities amended the one-person restriction to allow for support by personal assistants who were not family members.

Taxi services were suspended and public transport systems significantly reduced as part of prevention measures. Although travel permits from an employer or doctor did override movement restrictions, these permits did not extend to drivers. As a result, persons with disabilities who do not have a driving licence and are reliant on others to drive them where left without transportation.

Following advocacy efforts by OPDs, movement restrictions were eased during certain times of the dayfor two categories of persons with disabilities, wheelchair users and those with autism. Nevertheless, the restrictions remained in place for all other persons with disabilities. Parents of young persons with intellectual and psychosocial impairments reported finding the movement restrictions impossible to observe without having a severe negative impact on their child’s wellbeing.

## Institutionalised Settings

There is no official data on the number of persons with disabilities living in institutionalised settings in Montenegro. OPDs report that youth with disabilities living in institutional settings were left particularly vulnerable and isolated as a result of the movement restrictions. All visits were suspended, including by family members. Authorities argue that these measures helped contain the virus. Families suggest that visits should have been allowed to continue upon a negative COVID19 screening test and report that the blanket ban on visitors has had an extremely negative impact on the mental health of those living in institutions.

## Economic Impact

Almost half of persons with disabilities surveyed by the AYDM experienced negative economic impact as a result of the pandemic, meaning a decrease in income or an increase in the cost of living, or both. Most respondents reported that their general expenses were greater than their income. Persons with disabilities reported increased health costs having a negative impact on their overall economic stability. Health costs increased owing to having to source alternative, often more expensive, medical supplies because regular supplies were interrupted. Increased costs also included assistive devices to allow for remote working and online education, accommodation, personal protective equipment (PPE), and higher transport costs. Respondents also reported an increase in their grocery expenses as they chose to shop in small local markets at higher prices to mitigate communication and access barriers (such as facemasks) as they could more easily communicate with shop assistants who they knew in person.

8.3% of youth with disabilities surveyed did not receive regular income during the first and second waves of the pandemic, either because their place of employment closed, they were self-employed and their business operations slowed down, or because they were paid their wages late. The Government provides wage subsidies to employers who employ persons with disabilities. However during the pandemic subsidies were paid up to three months late and some employers passed on this delay to employees.

Students with disabilities experienced not only interruptions in their education but also a loss of housing and food support. Programs for students with disabilities that provide both dormitory accommodation and meals free of charge were closed to prevent the spread of infection. Students with disabilities who were residing in these dormitorieswere forced to find private accessible accommodation and cover unforeseen expenses for food as a result.

## Economic Impact on OPDs

OPDs report being severely impacted financially by the crisis. There has been little to no financial or resource support from the state (including PPE), meaning some OPDs and NGOs have had to suspend their activities. OPDs and NGOs were not covered by financial support measures, as they were not categorised as ‘entities affected by the outbreak’. Therefore, their employees were not entitled to a subsidised income. Representatives of OPDs and NGOs report that the pressure from beneficiaries and expectations for assistance were at their highest (owing to the suspension of public services), right at a time when their own resources were most stretched.

## Education

To limit the spread of COVID19, schools and other educational establishments were closed and education was moved to remote learning. However,no assessment was undertaken of the impact this would have on children and youth with disabilities and the barriers they may experience in accessing online education. Those surveyed by AYDM reported that children and youth with disabilities were largely excluded from online education, as they were not provided with assistive devices, internet connection and adequate support in the teaching process. Parents and students reported having to buy internet packages and additional equipment including assistive devices. Students in rural areas received print materials, owing to poor internet coverage, however these materials were not developed in accessible formats.

## Social Protection

Despite being entitled to certain social protection-benefits, complex, lengthy and costly mandatory administration procedures prevented many persons with disabilities from accessing this support. The risk of infection while going through the procedural requirements which involved multiple face-to-face appointments, were stated as further reasons that those surveyed did not try to access social protection-benefits. For some, the cost of these mandatory procedures (including travel costs to appointments) prevented them from applying for support. Where support could be applied for online, computer illiteracy, lack of support and access to electronic devices were additional barriers.

Of the 90 persons with disabilities survey by AYDM, 16 applied for social protection-benefits during the crisis, 9 of which were youth. Of the 16, four did receive financial support and 12 had not received a response to their request at the time of the survey.

## Participation of Person with Disabilities and their Representative Organisations

There is no formal mechanism for the meaningful consultation of persons with disabilities and OPDs in COVID19 response and recovery development and planning in Montenegro, nor in general legislative and policy development. Therefore, OPDs had no formal opportunity to participate in decision-making in the COVID19 response and recovery, despite numerous appeals to be included.

# Key Recommendations

**Develop and maintain a disability register**

* Official data on persons with disabilities in Montenegro, disaggregated by the type of impairment, as well as age and gender identity, should be collected and systematized. Data collection should include all persons with disabilities including those in residential settings. This data source would facilitate appropriate needs assessments and inclusive provision of support. Data collection and administration protocols should ensure confidentiality and privacy.

**Disability-specific strategy**

* A comprehensive and coordinated response to COVID19 that includes targeted measures to mitigate the disproportionate impact of COVID19 on persons with disabilities should be taken. COVID19 health and prevention information must be provided in accessible formats, including national sign language and Easy Read.

**Participation**

* It is only with the meaningful participation of persons with disabilities and OPDs, that inclusive COVID19 response and recovery plans can be developed. Persons with disabilities and OPDs must be meaningfully and consistently consulted on the development, implementation and monitoring of all aspects of COVID19 response and recovery planning and policy.

**Social Protection**

* Ensuring that persons with disabilities can access social protection schemes is vital to prevent the widening of inequalities and to ensuring an inclusive economic recovery.[[63]](#footnote-63) Application processes and procedures should be free, efficient, with responses to applications given in a timely manner. Targeted social protection measures should be taken to ensure that during the pandemic, persons with disabilities have access to assistive devices, health care and an adequate living standard including food and accommodation, including through cash-transfers.

**Economic recovery**

* In accordance with SDGs, Goal 8 in particular, all economic recovery programs should be disability-inclusive and sustainable.[[64]](#footnote-64) Targeted measures should be taken to ensure that persons with disabilities are not left behind in the economic recovery. Education and retraining programs, including IT training, should be developed to allow persons with disabilities to increase their skill set and opportunities to access employment.

### Annex IV. South Africa

OHCHR and the South African Department of Women, Youth and Persons with Disabilities commissioned a study into the socioeconomic impact of COVID19 on persons with disabilities in South Africa. The case study is the result of desk research as well as questionnaires and interviews with focus groups (totalling of 192 participants). All information contained is correct as of February 2021.

According to the South African census of 2011, persons with disabilities represent 7.5% of the population. However this figure is less than the 15% average found in most countries suggesting that the census figure is under-inclusive. South Africa has been severely impacted by COVID19 with over 42’000 deaths recorded. Infection and mortality data is not disaggregated by disability therefore the impact on the population of persons with disabilities is unknown. Furthermore, many testing sites are not accessible; therefore persons with disabilities are not tested at the same rate as others. As a result data collected does not reflect the actual number of infections within the population of persons with disabilities.

Significant inequalities regarding wealth and welfare distribution remain in South Africa. Persons with disabilities are disproportionately represented amongst those living in poverty. Race, gender and class will further increase the level of exclusion that persons with disabilities face. The COVID19 pandemic has exacerbated the level of exclusion that persons with disabilities continue to experience in enjoying their fundamental rights and accessing education, health care, employment, and has increased their risk of being exposed to violence.

# Good Practice

## Emergency support

**Financial support**

* Over six million people received a ‘special COVID19 social relief of distress grant’ of R350.00 to help cover the cost of essentials including food.

**Emergency supplies**

* Working with donors, the State was able to deliver food hampers and sanitation packages to day-care centres and OPDs to be distributed to persons with disabilities and their families.

## Access to information

The initial COVID19 public information announcements were not accompanied with captioning nor sign interpretation. Following lobbing by OPDs regarding the inaccessibility of public health information sign interpretation began to be provided but on an inconsistent basis. As a result persons with hearing impairments continue to be denied access to official sources of information including official guidelines developed to prevent the spread of infection within places of education and employment. Furthermore, public health information has not been made available in plain language and easy read formats resulting in some persons with intellectual impairments being denied their right to access this information (Article 21, CRPD).

**Testimony from a person with an intellectual impairment:**

I wish they used more simple and easy to understand words so we can follow as I don’t understand some of what people are saying.

## Access to testing

A significant number of participants shared that they had not sought a COVID19 test despite experiencing symptoms owing to inaccessible testing sites, lack of and inaccessible public transport, long waits at testing sites and the high cost of private testing. Persons with physical impairments, including wheelchair users, reported that the drive through testing sites made accessing a test easier. Persons with hearing impairments reported that communication with staff at testing sites was a major challenge as facemasks made lip-reading impossible and sign interpretation was not provided.

Of those who did access a COVID19 test within the sample group, 75% received and understood the result via SMS, 17% never received a result and 4% said that they did not understand the SMS that they received. The results suggest that measures need to be taken to ensure that results are delivered in accessible formats including plain language.

## Participation

Persons with disabilities and OPDs were not meaningfully consulted on the development and monitoring of COVID19 response measures. This contributed to measures being implemented that excluded and discriminated against persons with disabilities. As a result, OPDs are retrospectively lobbing for the removal or amendment of policies that were and continue to have harmful impacts on the rights of persons with disabilities.

## Access to education

Students with disabilities faced a detrimental impact on their education and mental health, as consequence of the closure of schools. Schools were closed across South Africa in March 2020, while mainstream schools were reopen after the development of general guidelines, special schools remained closed because no guidelines were developed for them. Lack of access to electronic devices and Wi-Fi made remote learning a significant challenge and only 20% of all students had continued access to education during school closures.[[65]](#footnote-65) Upon the easing of restrictions in June 2020 the Department of Basic Education (DBE) drafted guidelines and protocols for mainstream schools to allow them to safely reopened. However, no such guidance was provided to special schools for children with disabilities and as such they remained closed, resulting in children with disabilities being denied their right to education (Article 24, CRPD). As well as a detrimental impact on their education many parents and teachers reported a negative impact on students with disabilities’ mental health owing to prolonged school closures.

Following lobbying by civil society the DBE did produce guidance on COVID19 prevention measures whilst teaching students with visual and hearing impairments and autism but not those with physical or intellectual impairments. The DBE, as a result of legal action taken against them, in September 2020 amended previous guidance to include all students.[[66]](#footnote-66) OPDs, teacher unions and parent groups remain concerned regarding the implementation and monitoring of the guidance. Some special schools remain closed as they do not have the resources, including PPE, or support to implement the guidance.

## Access to health care

**Triage policy**

Concerns have been raised that South Africa’s COVID19 critical care triage policy,[[67]](#footnote-67) which was designed to assists healthcare workers in prioritising ICU access and ventilator support, discriminates against persons with disabilities.[[68]](#footnote-68) According to the triage policy persons with physical or intellectual impairments are likely to be classified on the Clinical Frailty Scale as being ‘vulnerable’ and therefore being denied access to ICU care or ventilators. As disaggregated data is not collected on infection and mortality rates, the health outcomes and impact of this triage policy for persons with disabilities in South Africa remains unknown. All persons with disabilities have the right to an equal access to health care (Article 25, CRPD) and the right to non-discrimination (Article 5, CRPD), these rights must be respected when developing and monitoring public health guidance and protocols.

**Access to medical practitioners and medication**

Persons with disabilities experienced barriers in accessing healthcare during the lockdown. Persons with hearing impairments report telephone and online consultations were not accessible as no support was provided to ensure that they could communicate in an effective manner with their healthcare professional.

20% of participants reported that they could not access their regular medication and had to source alternative medications that were often more expensive, or go without their medication and experience a resulting decline in their health. Access to medication was disrupted owing to the restriction in movements, including border closures. Lack of access to regular medications was a source of great distress and anxiety for many persons with disabilities. One participant commented ‘*That (not having access to regular medication) was very scary and, you know, we would go to the clinic to collect our medication. Then they would always be IOU, which means certain meds weren’t in stock and you need to come back later and collected. But, you know, we would we would go back with our IOU letters and that would be like, ‘Well, you know, there's no stock and we don't know when it's going to get any better.’*

**Rehabilitation**

Many persons with disabilities who are dependent on therapy reported a decline in their physical health owing to rehabilitation and therapy service centres closed during the lock-down. Some therapists provided therapy sessions online for those that had access to electronic devices with mixed success.

Access to therapy was also interrupted owing to increased financial pressure on persons with disabilities and their families. One mother reported her son has not been able to access the therapy that he require since June 2020:*‘My son used to have physical therapy once a week and swimming therapy once a week. Although he had some therapy at first lockdown in March, it was far less than usual as his physical therapist came to the house but he couldn't go for aqua therapy. Then funds ran out myself and my partner lost our jobs and medical aid ran out.’*

## Access to assistive devices

For persons with disabilities on the waiting list for new or replacement assistive devices the pandemic has resulted in lengthy delays in their access to these devices. Rehabilitation centres, which are responsible for the distribution of mobility devices, were closed. Participants reported that they have now been waiting over a year for any news on the delivery of their assistive device, and this has had a severe negative impact on their mental health and personal mobility.

## Disability-, gender-based and interpersonal violence

Predating the pandemic gender based and interpersonal violence levels in South Africa were extremely high and persons with disabilities faced an increased risk of violence. The lock-down, where victims are in close confinement with their abuser and suspension of services, has heightened risk of women and children with disabilities experiencing abuse. One mother interviewed stated that her child with disability had been assaulted by her partner during lockdown: ‘*He has a drug and alcohol problem, and he was becoming more and more aggressive and verbally abusive with everybody. Eventually he hit my son* [with disability] *in the face*.’

Owing to services being suspended during lockdown many survivors found that they had no avenue to seek help and support. A woman with disability interviewed reported that she could not obtain the support that she required in order to leave an abusive partner from government departments during COVID19 and instead had to rely on friends to assist her.

Persons with disabilities reported that they did not report abuse as police stations are often not physically accessible, and communication barriers and lack of diversity training of police officers means attempts to report abuse often futile. Furthermore, participants said they were hesitant to report abuse owing to the increased risk of infection in travelling to and going into a police station. On an ad hoc basis police officers did take steps to mitigate this risk through home visits. A participant shared that he was requested to physically go to his local police station to open a case of assault. When he explained to the officer that he had a physical impairment and had concerns about using public transportation during COVID19, the officer agreed to come to his house: *‘The detective phoned and he wanted me to come down to the police station to do an interview. I said I am disabled. He came to me which was good.’*

## Social protection

Over 90% of persons with disabilities in South Africa are unemployed and as a result, many are reliant on the disability grant. In December 2020, owing to lack of funds, over 430,000 grants were suspended, leaving beneficiaries without financial means to pay for essentials including food and medicines. Those whose grants were suspended were requested to reapply and carryout the required medical assessments at the same time that infection rates were peaking within the second wave. The result was thousands of people ignoring social distancing requirements and descending on medical practitioners to try to have their suspended disability grants reactivated.[[69]](#footnote-69)

One participant who receives the disability grant stated:

I didn’t receive my disability grant for six months during the lockdown and when I finally got my paperwork resubmitted the clerk at SASSA just said that my six months of disability grants fell away with no reason why.

In an attempt to ensure access to food and other essentials, three provenances did distribute food parcels and ‘dignity’ sanitary packs on an ad hoc basis. However, the number of packs distributed and the details of recipients, including their disability status, are not known.

# Recommendations

**Data**

* Data, disaggregated by disability, on infection rates, health outcomes, access to essentials including food and medical provisions, and access to education and social protections is essential to understanding the impact that COVID19 and response measures are having on the rights of persons with disabilities. Effective policy to mitigate the disproportionate harm that persons with disabilities have experienced during the pandemic cannot be developed without disaggregated data.
* In recovering back better, data collection, that captures all persons with disabilities (including those with physical, psychosocial, sensory, and intellectual impairments and those living in remote areas as required by the CRPD, Article 31) should be a priority for the State.

**Participation**

* OPDs and persons with disabilities must be meaningfully and consistently consulted on the development and monitoring of all aspects of COVID19 response and recovery policies.

**Access to information**

* All public information delivered on TV and social media should include captioning and sign interpretation. Public information on COVID-19 should be converted into a range of formats to ensure that they are accessible to persons with intellectual disabilities.

**Free COVID19 testing**

* Free COVID19 testing should be provided in the community and be fully accessible to all person’s with disabilities. Test results should be provided in accessible formats and support provided to persons with intellectual disabilities that may need assistance in understanding the results and their consequences.

**Disability, gender-based and interpersonal violence**

* Protecting the safety of persons with disabilities from violence should be a priority of the State at all times and especially during the pandemic when the risk increases. Safe houses and other emergency response services should remain open and be accessible to all persons with disabilities. Police and other first responders should be trained on the rights of persons with disabilities and how to ensure their safe access to reporting abuse.
* Complaint mechanisms and investigations must be accessible, gender-responsive and disability-inclusive and enable the possibility to file complaints on the basis of multiple and intersecting forms of discrimination.[[70]](#footnote-70)

**Social protection**

* Essential financial support to person with disabilities, such as the disability grant, must be ring-fenced so that funds are not impacted by crisis. Ensuring that persons with disabilities have continued access to social protections must be a priority to reduce the likelihood of them being pushed further into poverty, [[71]](#footnote-71) and being left without access to essentials including food, sanitation and medical supplies.

**Health**

* Persons with disabilities have the right to access health care, including COVID19 treatment, on an equal basis with others. Triage policies that deny access to lifesaving treatment on the basis of disability amount to unlawful discrimination and should be immediately repealed.
* To prevent a decline in both physical and mental health, all efforts should be made to ensure that regular access to medication, medical supplies, healthcare professionals including therapists, and assistive devices is maintained.

**Education**

* All necessary measures should be taken to ensure that students with disabilities have full and equal access to education, including during periods of remote learning. In building back better, efforts should be made to move towards an inclusive education system as required by the CRPD (Article 24) and in the implementation of the Sustainable Development Goal (SDG) 4.[[72]](#footnote-72)

### Annex V. Democratic Republic of Congo

As part of a multi-agency UNPRPD project, the OHCHR commissioned REGED (Réseau Gouvernance Economique et Démocratie), a civil society organization specialized in economic governance to undertake a study into the economic impact of COVID19 on persons with disabilities in the Province of Kinshasa, Democratic Republic of Congo (DRC), as well as on the inclusion of persons with disabilities in the deployment of international aid. Following a desk review of existing materials, 80 persons with disabilities and 29 representatives of NGOs and OPDs were interviewed for this study.

The COVID19 pandemic hit the DRC at a time when the health system was already stretched and responding to several on-going epidemics including Ebola, malaria, cholera and measles. An acute lack of funding and resources means that, across the DRC, the health system is fragile with low coverage of just 0.09 doctors per 1’000 people. In Kinshasa, 12 million inhabitants are served by just 5 hospitals.

There is a gap in reliable data regarding the population of persons with disabilities in the DRC. The last national census took place in 1984. A recent study suggested that approximately 18% of the population are persons with disabilities.[[73]](#footnote-73) Owing to acute social stigma and discrimination, they remain a vulnerable and marginalised group who experience widespread exclusion from education, employment and public services (in particular health care, information and transport). According to a UNICEF study, only 18% of children with disabilities aged between 5-17 attend school.[[74]](#footnote-74) As a result, 90% of adults with disabilities have not reached basic literacy levels.[[75]](#footnote-75) More than 80% of adults with disabilities are forced to resort to begging.[[76]](#footnote-76)

# Good practice

## Emergency support

A number of emergency support measures were put in place to ensure continued access to food, water and shelter. These included the establishment of an emergency food programme and the free provision of water and electricity between March and June 2020.

## Inclusion of persons with disabilities in Government responses

Persons with disabilities and OPDs interviewed reported that persons with disabilities are not being included within Government prevention and response measures in Kinshasa. For example, the Government provided free screening at the Martyrs Stadium, (funded by the Israeli NGO Magen David Adom). However, the stadium is not accessible to persons with physical impairments.

Prevention and public health information provided by the State was limited and was not provided in formats that are accessible to persons with hearing and/or visual impairments. 85% of persons interviewed could only name two of the six official prevention measures endorsed by the Ministry of Health. Persons with disabilities interviewed stated that they received prevention and public health information through friends and family, OPDs, and private companies such as telephone networks. Owing to a lack of official information, fake news and incorrect information has spread. Persons with albinism had to flee the commune of N’djill following the false rumour that persons with white skin are more likely to carry COVID19.

## Economic impact and support

COVID19 has pushed many persons with disabilities in Kinshasa further into poverty. Of the 80 persons with disabilities interviewed for this case study, 27.5% are now economically active compared to the 64% who were economically active prior to the pandemic. The decline in economic activity was attributed to the curfew and travel restrictions that prevented respondents from travelling to city centers where they undertake economic activity including formal employment as well as activity in the informal economy, such as shoe cleaning and repair and begging.

The majority of persons with disabilities interviewed said that they had not received any support to help mitigate the negative economic impact of the pandemic on their lives. Of those that had received support (namely food, sanitation materials and PPE) 83% reported the aid came from civil society and 17% from the State.

## Access to healthcare

Movement restrictions, imposed to prevent the spread of COVID19, had a negative impact on access by persons with disabilities to healthcare. 55% of respondents stated that movement restrictions had negatively impacted their access to regular health care. In particular, respondents cited that movement restrictions prevented them from travelling to the Mama Yemo Hospital where they are able to access free health care and access to mobility devices offered by the ICRC.

Persons with albinism and representative organizations report that the lockdown and movement restrictions have hindered access to dermatologists and essential products, including owing to the cost increase of these products. As a result they are without protection from the preventable health risks of their condition.

## Participation of persons with disabilities and OPD

Persons with disabilities and OPDs are not meaningfully consulted on the development of policy and practice. Although the situation has improved slightly since the establishment of a Ministry for Persons with Disabilities, OPDs report that they are often ignored when they try to engage the State in policy development or reform and face significant financial and administrative barriers. To participate in decision-making OPDs (like other NGOs) have to undergo a laborious administration process to register as a legal entity. If they are given this status, they may engage with the State, but their freedom to develop and promote their own agenda is limited by legal restrictions including the requirement to to contribute to the implementation of the Government's development policy and to “comply with the Government's position”.

## Inclusion of persons with disabilities in foreign aid

Persons with disabilities are not expressly included within COVID19 foreign aid programmes and are therefore often excluded from the benefits of this support. To help support efforts in the DRC to respond to the pandemic, large amounts of foreign aid have been given by international and national donors and agencies. According to the Ministry of Planning, the DRC has received over 144 million USD in aid to respond to COVID19, spread across 31 different projects. Donors include the African Development Bank, Canada’s Department of Foreign Affairs Trade and Development, German Society for International Cooperation, the European Commission, the Swiss Agency for Development and Cooperation, and the Swedish Embassy. Projects include activities on COVID19 prevention such as awareness raising campaigns and the provision of PPE, the provision of medical supplies to hospitals, support services for survivors of gender based violence and radio education programs that target girls in particular. However, analysis of these 31 projects suggests little attention has been paid to ensuring that persons with disabilities are included in the dissemination of this support. For example, the ‘COVID Strategic Preparedness and Response Program’, funded by the World Bank, has provided 37 million USD to support prevention strategies, coordination between national and provincial agencies and support to hospitals and a further 7.2 million USD for communication campaigns and community engagement on prevention and detection of COVID19. However, while indigenous people, the poor and the displaced are recognised as vulnerable groups warranting particular action-orientated attention, persons with disabilities are not expressly targeted.

Of the 31 projects identified only one expressly includes persons with disabilities. The Embassy of Canada provided 384,778 USD, to support the most vulnerable during the crisis including minors, women, the elderly, people with disabilities, survivors of violence and minority groups. However, OPDs and NGOs interviewed for this study reported that they were not aware of any attempts to ensure that persons with disabilities had access to the funds identified in the 31 projects and affirmed that much of the support provided in not accessible.

# Recommendations

#### Disability-specific response strategy

* Targeted action should be taken by the State to ensure that response measures to prevent infection are equally benefitting persons with disabilities. COVID19 health and prevention information must be provided in accessible formats, including national sign language. COVID19 screening should be conducted in the community to ensure that persons with disabilities can access this service.

#### Access to health care

* Ensuring continued access to healthcare should be a priority. Measures such as travel passes that allow persons with disabilities to continue to travel to health service providers despite lockdowns should be implemented.

#### Participation

* It is only with the meaningful participation of persons with disabilities and OPDs, that inclusive COVID19 response and recovery plans can be developed. Administrative barriers that prevent OPDs from meaningfully participating in policy development must be removed, as well as legal requirements that impede their independence.

#### Inclusion of persons with disabilities in foreign aid

* When providing aid for COVID19 response and recovery donors should ensure that programs are developed to ensure equal access of persons with disabilities to the support provided. It should also be ensured that aid is not used in manner that contributes to a violation(s) of the rights of persons with disabilities. Equal access to humanitarian assistance is not only a requirement under the CRPD (articles 32 and 11) but also essential to achieve the 2030 Agenda for Sustainable Development and its commitment to leaving no one behind. Through the use of indicators, aid programs should be monitored to ensure access barriers that persons with disabilities are experiencing are identified and remedied.
* Within evaluation activities undertaken at the end of funding, donors must ensure that the access of persons with disabilities to the response or recovery program is included within the programme’s evaluation and that data, disaggregated by disability, is provided to evidence equal access.

#### Building back better

* In building back better measures, including awareness raising, must be taken to tackle the social stigma and discrimination that persons with disabilities continue to experience. Ensuring greater integration, including through the provision of education to all students with disabilities in inclusive schools will also assist in breaking down the attitudinal barriers that persons with disabilities in the DRC experience. Furthermore, national law should be adopted that fully integrates the CRPD, enshrines and gives effect to the rights of persons with disabilities in the DRC.

### Annex VI. Niger

As part of a multi-agency UNPRPD project, the OHCHR commissioned an independent consultant to undertake a study into the socioeconomic impact of COVID19 on persons with disabilities in Niger with a focus on the city of Niamey. Following a desk review of existing materials, 50 persons with disabilities completed a questionnaire and representatives of organisations of persons with disabilities (OPDs) were interviewed for this study. All information contained is correct as of February 2021.

Although there has been significant improvement in the past decade, 41% of the population in Niger still lives in extreme poverty and persons with disabilities are more likely to be living in poverty than others.[[77]](#footnote-77) Despite the positive step of the adoption by Niger of a national legislation on the rights of persons with disabilities, they continue to face widespread, entrenched discrimination and social stigma. As a result, persons with disabilities are more likely to be vulnerable to exclusion from education and employment, and participation in society on an equal basis with others. The COVID19 pandemic has exacerbated the exclusion that persons with disabilities in Niger experience, and compounded their economic vulnerability.

# Good practice

## Emergency support

The State of Niger, mainly through collaboration with national and international donors, has provided emergency support to vulnerable groups including persons with disabilities. Support provided included food, sanitary materials, PPE, and cash transfers. Some respondents to the survey reported that their access to these essential goods and services had actually increased due to emergency support provided in response to COVID19.

## Access to COVID19 testing

COVID19 testing is provided free of charge to anyone that has symptoms. However, physical, financial and communication barriers prevent persons with disabilities from accessing this service. In Niamey, testing is only available at one site, the Medical and Health Research Centre. Respondents to the survey reported that they did not seek testing despite having symptoms as transport to the Medical and Health Research Centre was not accessible and/or was too expensive. Furthermore, OPDs report that clear information regarding testing has not been made readily available to the general public, including persons with disabilities. Persons with disabilities and OPDs also report reluctance to access testing owing to mistrust of health care professionals based on past negative experiences.

## Access to health care

The majority of persons with disabilities surveyed reported that their access to regular health care had been negatively impacted by the pandemic. Significant barriers that persons with disabilities experienced in accessing health care included unavailability of medications and health care professionals (as they were only taking COVID19 appointments) and a reduction in their income that prevented them to pay for healthcare services and medication.

## Employment

Persons with disabilities in Niger are more likely to be working in the informal sector where they do not have access to employment rights and social security, thereby making them more vulnerable to the negative economic impact of COVID19. The majority of persons surveyed for this case study (69%) reported a reduction in their income owing to job loss, reduction in salary, reduction in profits and loosing financial support from family. The closure or reduction in hours of market places in Niamey where a number of persons surveyed made and sold goods on a self-employed basis had a severe economic impact. The suspension of activities led by charitable organisations selling and distributing goods made by persons with disabilities (such as chairs, cushions, balls and pots) also had a negative impact on those surveyed.

## Social protection

Financial support provided by the State often does not meet the needs of persons with disabilities. Respondents to the survey who were able to receive social security benefits reported that this support was not enough to allow them to meet their basic needs including food, water, shelter and medication. Respondents also reported that the selection of those who have access to social security benefits appears to be arbitrary with some groups being selected for support (for example those with leprosy) before others without any transparent and justified explanation.

# Recommendations

#### Access to COVID19 testing

* Clear information on how and when to access COVID19 testing should be widely disseminated in accessible formats.
* Free travel passes to allow people with disabilities to travel to testing sites should be introduced to increase testing uptake. Availability of testing within the community will also increase access by persons with disabilities.
* Health care professionals should be trained on the rights of persons with disabilities to increase their access to COVID19 testing and treatment, to prevent discriminatory treatment, reduce the negative incidents that persons with disabilities experience, and help build the trust of persons with disabilities in the medical profession.

#### Access to health care

* Ensuring that persons with disabilities have continued access to their regular health care at all times, including during the COVID19 pandemic, must be a priority for the State.
* Ensuring that health care and medication is available for all, including persons with disabilities and low-income individuals with or without disabilities.
* Ensuring that border closures do not further disrupt access to medical supplies.

#### Social protection

* Social security benefits should be granted to persons with disabilities whose economic activities have been negatively impacted by COVID19, including those who are self-employed and/or work in the informal economy.
* The amount of social security benefits should be sufficient to ensure that persons with disabilities can access basic services and goods including food, water, electricity, shelter, education, clothing, transport and medical supplies.
* Social protection should be equally available to all persons with disabilities based on need rather than on having a particular impairment such as leprosy.

#### Recovering better

* Based on the objectives of the 2030 Agenda for Sustainable Development and its commitment to leave no one behind,[[78]](#footnote-78) measures must be taken, including awareness raising, to tackle the social stigma and discrimination that persons with disabilities continue to experience.
* Ensuring greater inclusion, including through access to education to all students with disabilities in inclusive schools, is needed to eliminate the discrimination that persons with disabilities in Niger experience.
* Furthermore, the national laws on the rights of persons with disabilities that have been adopted should be fully implemented to protect the rights of persons with disabilities in Niger.

### Annex VII. Argentina

As part of an UNPRPD project, the OHCHR commissioned an independent consultant to undertake a study into the socioeconomic impact of COVID19 on persons with disabilities in Argentina. Following a desk review of existing materials, persons with disabilities and representatives of the State, NGOs and OPDs were interviewed for this study. All information contained is correct as of February 2021.

COVID19 has worsened Argentina’s already declining economy with GDP falling by over 10% in 2020. Approximately 40% of the population are now living in poverty. According to Argentina’s 2010 census 12.9% of the population are persons with disabilities, approximately 5 million people. However, this figure is likely to under-represent persons with psychosocial or intellectual impairments.

# Good practice

## Recognition of persons with disabilities as an at risk group

The Ministry of Health recognised persons with disabilities as a group particularly at risk of COVID19 infection. As such, they were not required to attend work in person, even if they were essential workers.

**Extension of disability certificates**

Disability cards (CUDs) that were due to expire in 2020 were automatically extended to reduce exposure to COVID19 infection during the reapplication process.

**Emergency support**

Additional emergency financial support was provided to mitigate the negative financial impact of the pandemic on recipients of the disability non-contributory pension.

Alimentar Cards, which can be used to buy food, where given to families of vulnerable children, including children with disabilities or persons with disabilities who had dependent children.

**Video call and WhatsApp information service**

A free video call and WhatsApp service was established to ensure that persons with hearing impairments could access information and ask questions regarding the latest public guidance.

## Data and infection rates

Official data on COVID19 infection and mortality rates is not disaggregated by disability. Nevertheless, the limited data that is available does suggest a higher death rate among persons with disabilities. During September 2020, the death rate among persons with disabilities with a CUD was 7% compared to 2.2% for the general population.[[79]](#footnote-79) Recovery rates are lower among persons with disabilities with a CUD at 70.2% compared with 77.8% for the general population and active cases are 3 points higher.[[80]](#footnote-80) Evidence further suggests higher infection rates amongst those living in institutionalised settings.[[81]](#footnote-81) In November 2020, in the city of Buenos Aires, the infection rate among residents in psychiatric institutions was 15.13% compared with 4.9% for the general population.

## Institutionalised settings

As well as being exposed to an increased infection rate (see above) persons with disabilities living in institutionalised settings have experienced increased levels of isolation, anxiety and a general decline in mental health. All movements in and out of institutions were suspended. OPDs report that measures were stricter and imposed for a longer period for residents who were not permitted to leave institutionalised settings at all, compared to the general population who were permitted to leave their homes to carry out errands. Insufficient working telephones, assistive devices, Internet access and support meant that many people living in institutionalised settings were denied communication with the outside world. A representative of an OPD interviewed for this case study reported that in one institution there was just one working telephone for 50 residents.

The suspension of visitation rights, including for welfare monitoring and inadequate access to communication with the outside world; also resulted in persons within institutionalised settings being particularly vulnerable to undetected harm and abuse. There are reports of persons in psychiatric hospitals being heavily medicated to prevent them moving around hospitals and of residents being confined to one room for hours on end. Monitoring was conducted via telephone interviews with residents in some locations but OPDs raised concerns about the effectiveness of remote monitoring.

## Mental health budgeting

A review of official data suggests that Argentina will not meet its target of allocating 10% of total health spending on mental health services. Approximately 1.47% of total health expenditure in 2021 is expected to be spent on mental health. This funding limitation is of particular concern for efforts to move from an institutionalised format of service provision to community-based services that respect the rights of persons with disabilities to live in the community (Article 19, CRPD).

## Access to employment

Official data on employment rates is not disaggregated by disability therefore the number of persons with disabilities in employment and the impact of COVID19 on their employment status cannot be assessed. Nevertheless, persons with disabilities are more likely to be unemployed than others and are disproportionately represented in the informal sector where they do not have access to social security and labour rights. Furthermore persons with disabilities continue to work in sheltered workshops, where they receive a low wage and are at risk of exploitation. The economic downturn resulting from COVID19 significantly impacted sheltered workshops. In a survey of 90 sheltered workshops, more than 50% reported that they could not meet monthly wages despite the National Agency for Disability (ANDIS) providing financial support to cover their running costs during the lockdown period.

## Access to social protection

Access to CUDs has been negatively impacted by COVID19 as the necessary medical appointments and meeting of a medical board to consider applications were suspended. In 2020 the number of new CUDs granted decreased by roughly half compared to the previous year. Having a CUD is a requirement to access most social benefits and support, such as free public transport and partial to full medical coverage. Persons with disabilities with a CUD represent 2.93% of the general population. When compared to the 2010 census figure that 12.9% of the general population are persons with disabilities, this means only 22% of persons with disabilities have a CUD.

The significant gap in coverage of the CUD is due to several factors including the restrictive criteria that applicants must meet, significant administrative barriers and a lack of information and support in the application process. According to OPDs persons with disabilities living in poverty are particularly unlikely to have access to a CUD because of a lack of support, including financial support, to undertake the application process. Attempts were made to carry out the medical certification process through video calls but lack of electronic devices and poor Internet connection constituted a significant barrier for many people.

The disability non-contributory pension, a further form of social protection is also limited in its coverage owing to complex and lengthy application process. As a result many persons with disabilities who are unable to work do not have access to this support nor the corresponding COVID19 emergency financial support.

## Impact of budget cuts on access to social protection

Owing to the pre-existing financial decline, which has been exacerbated by COVID19, a number of budgetary cuts have been made that negatively affect access to social protections at a time when the pandemic has increased many persons’ with disabilities need for support. The ‘Incluir Salud’ program, which supports access to health care across the provinces, for example, is expected to incur an 8% budgetary cut in 2021. The reduction of funds allocated to this program, in a context of increasing poverty and unemployment, will mean that many people will not have access to health services, such as the provision of medication, rehabilitation and support services. The Financial Assistance to Health Insurance Agents is also expected to receive a significant budget cut which will have a negative impact on persons with disabilities’ access to medication and medical supplies.

## Access to education

The pandemic has exacerbated the barriers that students with disabilities experience in accessing education. Following school closures in March, lack of Internet connectivity (30% of households do not have Internet access) and access to digital devices were significant barriers to all students accessing remote learning. However, OPDs report that students with disabilities have been further excluded, as official materials, including on the Ministry of Education’s remote portal as well as television networks, are not accessible to students with visual and/or hearing impairments. OPDs also report that funding cuts have reduced access to personal assistance that provide support to students with disabilities.

The ministry of Education conducted a survey in July 2020 to assess the impact of the suspension of face-to-face education on students. The survey did not include students with disabilities as a specific group and therefore did not disaggregate data accordingly. A follow-up survey was initiated in November on access to education for students with disabilities the results of which are due to be published in March 2021. However, the survey does not include students in early and secondary education nor the large number of students who attend special schools (Argentina maintains a segregated education system in contravention of the CRPD, Article 24, which obligates States Parties to provide inclusive education). Without conducting holistic research into the experiences of all students with disabilities in accessing remote learning, the barriers they face and the measures needed to dismantle these barriers cannot be identified.

## Vaccination

Despite evidence of an increased risk of infection and death, persons with disabilities are currently not recognised as a priority group within Argentina’s vaccination program.

## Women and girls with disabilities

Women and girls with disabilities in Argentina face intersectional discrimination which results in them being further left behind in accessing health, education and employment, it also results in their increased vulnerability to gender and disability based violence. COVID19 has exacerbated that risk.

# Recommendations

#### Data collection

* Accurate data, disaggregated by disability, on infection and mortality rates covering the whole population with disability is essential to understand the impact that COVID19 and response measures are having on the rights of persons with disabilities. Quality, disaggregated data will facilitate the development of effective policy to mitigate the disproportionate harm that persons with disabilities have experienced during the pandemic.
* In building back better, data collection, that captures all persons with disabilities (including those living in remote areas), as required by Article 31 of the CRPD, should be a priority for the State. This data will allow for equality gaps to be clearly identified and targeted remedial action to be taken, including the intersectional discrimination that women and girls with disabilities experience.

#### Vaccination

* Considering the increased risk of infection and high mortality rate that persons with disabilities appear to experience they should be considered a priority group within vaccination programing. Registration for vaccination should be through accessible formats and not limited to online portals where the digital divide will pose a barrier to many.

#### Ensuring equal and sustainable opportunities for persons with disabilities

* In accordance with SDGs, Goal 8 in particular, all economic recovery programs should be disability-inclusive and sustainable.[[82]](#footnote-82) Targeted measures should be taken to ensure that persons with disabilities are not left behind in the economic recovery. Particular attention should be paid to ensuring that women with disabilities are included in economic policy and targeted measures taken to reduce the inequality they continue to experience. Education and retraining programs, including IT training, should be developed to allow persons with disabilities to increase their skill set and opportunities to access employment.

#### Social Protections

* Efforts should be made to increase access to existing social protection measures available to persons with disabilities including the CUD and the disability non-contributory pension. Accessible media campaigns that explain the benefits of having a CUD and simplification of the application process will increase coverage of the CUD from the 22% of persons with disabilities that currently have the card.
* Social protections should ensure an adequate standard of living in accordance with Article 28 of the CRPD. Ensuring that persons with disabilities have continued access to social protections must be a priority to reduce the likelihood of them being pushed further into poverty. [[83]](#footnote-83)

#### Women and girls with disabilities

* Although the Ministry of Women is increasing its focus on women and girls with disabilities, every effort needs to be made to ensure that all mainstream services, including interpersonal violence reporting and support mechanisms are fully accessible. Targeted action also needs to be taken to ensure that women and girls with disabilities have equal opportunities to access education and employment.

#### Deinstitutionalization

* COVID19 has highlighted and increased the harms that people living within institutionalised setting often experience. Priority should be given to the provision of community-based support, and budget allocations should adequately reflect this, so that persons with disabilities have the opportunity to move from institutionalised settings into the community.

#### COVID19 response measures within institutions

* *Response measures within institutions*

Whilst the goal of deinstitutionalisation is being actively sought, transparent and regular data collection should be carried out on the infection and mortality rates in institutions. As part of preventative measures, PPE and free testing should also be provided to those living and working within institutionalised settings.

* *Vaccination*

Persons living in institutions should be prioritised in vaccination plans.

* *Freedom of movement*

Alternatives to total bans on movements to and from institutions should be implemented, including access to free testing for those wishing to visit or leave institutionalised settings.

* *Communication with family and friends*

Measures should be taken to ensure the availability of equipment and support to enable persons in institutions to stay in touch with their families and friends in a manner that respects their right to privacy.

* *Monitoring*

Priority should be given to ensuring continuous independent monitoring of institutionalised settings, including safeguarding protocols should be developed with OPDs that ensure residents living in institutions have safe and confidential avenues for reporting abuses.

### Annex VIII. Ecuador

As part of a multi-agency UNPRPD project, the OHCHR commissioned an independent consultant to undertake a study into the economic impact of COVID19 on persons with disabilities in Ecuador. Information was gathered by desk review of existing materials, as well as interviews with national experts, NGOs and OPDs. All information contained is correct as of February 2021.

Predating the pandemic, Ecuador was experiencing a period of economic decline and as a result a series of austerity measures were introduced in 2020. The austerity measures have further exacerbated the negative impact that COVID19 has had on persons with disabilities who were already living in poverty at a higher rate than others.

# Good Practice

## Emergency support

The government has created a number of emergency social assistance programs to try to reduce the negative impact of the pandemic on the most vulnerable groups. For example, between March 2020 and August 2020, 38’184 food kits were distributed to persons with disabilities, a program designed to ensure access to food for those living in extreme poverty.

The Family Protection Bonus, a 120USD cash transfer to help with day-to-day living expenses, including health care costs was paid to approximately 950,000 people in 2020, according to the National Council for Equality for Disability (CONADIS), 18,801 of the beneficiaries were persons with disabilities.

**Extension of disability certificates**

Disability certificates that were due to expire have been extended to reduce both exposure to COVID19 infection during the reapplication process and further economic insecurity.

## Measures to increase job security and employment safety

Targeted measures were introduced to support job security and prevent infection amongst employed persons with disabilities. For example, in May 2020 CONADIS sent a letter to over 23,709 companies urging compliance with Ministry of Labour’s guidance on teleworking and asking employees to guarantee job security for persons with disabilities. In addition, the Ministry of Labour instructed public sector employers that people with disabilities should not be fired during the crisis.

CONADIS and the Ministry of Labour, published the mandatory ‘Guidelines for the Prevention and Protection of Workers and Public Servants that are part of the Priority Attention Groups and Groups with Risk Factors against COVID-19’. In accordance with the guidelines, employers must carry out infection risk assessments and support remote working in order to minimise the exposure of high-risk employees, including employees with disabilities.

## Targeted prevention and health care guidance

CONADIS issued the ‘Guide for the Prevention and Care for Contagion of COVID-19 for People with Disabilities and their Families". The Guidance provides advice on infection prevention, as well as measures for the care and support of persons with disabilities including in relation to hygiene, healthy eating, and mental health.

## Data and infection rates

Official data on the population of persons with disabilities in Ecuador is not representative of prevalence of persons with disabilities in other countries in the region. The last national population census took place in 2010 and adopted a methodology that resulted in under-inclusive prevalence, 5.6% of the population identified as persons with disabilities.

The infographic published daily on COVID19 infection and mortality rates does not disaggregate the information according to disability. CONADIS collected limited disaggregated data until 14 May 2020, at which point 2’338 people had died, 409 of whom were people with disabilities, (129 women (32%), and 280 men (68%)).[[84]](#footnote-84) As a percentage this equates to persons with disabilities representing 17.49% of all COVID19 deaths.

## Impact of austerity measures

Departmental budget cuts have been made across public bodies. Many of these cuts have negatively impacted the provision of social protection and support services available to persons with disabilities. By way of example, an analysis of official data published by the Ministry of Finance shows a budget cut of nearly 55% from 2019 to 2020 for the provision of assistive devices. The 2020 budget for the CONADIS, which formulates, monitors and evaluates public policy from a disability rights perspective, was reduced by over 16% compared to the previous year. This has had a negative impact on the capacity of the CONADIS to support the development and monitoring of COVID19 response and recovery policy that is inclusive of the rights of persons with disabilities.

## Access to social protection

The Ecuadorian Ministry of Health issues disability certificates, which allow the certified person to access certain benefits and services. However the certificate is difficult to obtain owing to laborious and slow administration processes. Only 2.74% of the population have a disability certificate despite persons with disabilities representing 5.6% of the population. Those with low income without a disability certificate will not be able to access disability-specific social protections and are at higher risk of poverty.

The delays in obtaining a disability certificate have been further exacerbated by COVID19 as public health units that are integral to the issuing of certificates were either closed or reutilised for COVID19. Persons who already receive social protection benefits are not entitled to the majority of the COVID19 emergency assistance programs thereby automatically excluding a high proportion of those who may need this emergency support.

## Economic vulnerability and infection risks

The economic vulnerability of persons with disabilities in Ecuador makes this group particularly vulnerable both to COVI19 infection and the declining economy. Owing to poverty, persons with disabilities are more likely to be living in overcrowded housing where infection risks are high and they are less likely to have access to adequate sanitation and PPE. Furthermore persons with disabilities and OPDs, report that because they are economically disadvantaged and without access to adequate social protection, they have had to continue working throughout the pandemic thereby increasing their exposure to infection.

Persons with disabilities are disproportionately represented among the unemployed and, as of September 2020, according to analysis of official data, represented just 0.86% of the employed population.[[85]](#footnote-85) Despite positive measures taken by the State to increase employment security, 7.2% of persons with disabilities in official employment lost their jobs during the period of March – October 2020.[[86]](#footnote-86) Furthermore, persons with disabilities are more likely to work in the informal economy and therefore do not have access to social security (including health benefits, unemployment insurance and pension). Approximately 60% of persons with disabilities do not have social security.[[87]](#footnote-87) Women with disabilities are particularly unlikely to have access to employment compared to men with disabilities, and are disproportionately represented in the informal economy.

# Recommendations

#### Data collection

* Accurate data, disaggregated by disability, on infection and mortality rates is essential to understanding the impact that COVID19 and response measures are having on the rights of persons with disabilities. Quality data can support efficacy and efficiency in COVID19 response policy implementation. In building back better, data collection, that captures all persons with disabilities (including those living in remote areas), as required by Article 31 of the CRPD, should be a priority for the State. This data will allow for equality gaps to be clearly identified and targeted remedial action to be taken.

#### Vaccination

* Considering the increased risk of infection and high mortality rate that persons with disabilities experience they should be considered a priority group within vaccination programing.

#### Access to social protections

* All available resources should be used to secure access to social protections that ensure an adequate standard of living in accordance with Article 28 of the CRPD. Efforts should be made to increase access to the disability certificate, including simplification of the application process and additional support for applicants.
* Ensuring that persons with disabilities have continuing access to social protections as well as emergency support must be a priority to reduce the likelihood of them being pushed further into poverty and/or exposing themselves to infection by continuing to work throughout the pandemic.

#### Budget allocation

* Budget allocation should be on the basis of non-discrimination and respect the rights of persons with disabilities. Budgets that provide for essential support to persons with disabilities, including assistive devices, should be ring-fenced and not subject to austerity measures.

#### Ensuring equal and sustainable opportunities for persons with disabilities

* In building back better, and in accordance with SDGs, Goal 8 in particular, all economic recovery programs should be disability-inclusive and sustainable.[[88]](#footnote-88)  Economic recovery plans should be developed in consultation with OPDs and should include measures that ensure persons with disabilities have equal access to education and training to increase their access to official sources of employment and the corresponding social security.

### Annex IX. Monitoring the inclusion of persons with disabilities in COVID19 response and recovery funding for mainstream programs

This monitoring guide should be read in conjunction with ‘Disability Inclusion in COVID19 Funding Checklist’ (the Checklist). Once funding has been provided to a COVID19 response and recovery program monitoring should be undertaken to ensure that persons with disabilities have equal access to the funded program and to ensure that funds are being used in a way that does not negatively impact upon the rights of persons with disabilities.

# Target audience

This monitoring framework, which comprises of seven Action Points, is aimed at donors, funding mechanisms and UN Country Teams.

# Rationale for monitoring

## Right to equal access

Due to attitudinal and environmental barriers, persons with disabilities are not accessing mainstream services on an equal basis with others. Equal access is a right under the UN Convention on the Rights of Persons with Disabilities (CRPD). Article 32 of the CRPD requires from States, both in their capacity as donors and recipients of international cooperation, including humanitarian assistance and international development programs, to be inclusive and accessible to persons with disabilities. This includes all COVID19 response and recovery measures. Monitoring is essential to identify and remedy the barriers that persons with disabilities face, and also to achieve the 2030 Agenda for Sustainable Development and its commitment to leaving no one behind.

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| --- |
| *Attitudinal and environmental barriers that persons with disabilities may experience in accessing COVID19 response and recovery funding*  By way of example, funding may be allocated to provide remote consultations with sexual and reproductive health service providers. An attitudinal barrier would exist if those designing the program incorrectly assume that persons with disabilities are asexual and therefore do not include them in the programs’ target population and design. An environmental barrier would exist if online consultations do not permit the use of cameras and are therefore not accessible to persons that rely on visual communication, such as sign language. |

## Do no harm and due diligence

Monitoring is essential to the principle of ‘do no harm’. Donors and recipients of funding must commit to respect the human rights of persons with disabilities by at a very minimum ensuring they do not exacerbate or contribute to human rights violations through funding activities. This commitment is only attainable if it is coupled with due diligence through monitoring, and identifying and responding to human rights risks. At the outset of funding activities, donors should undertake a human rights impact assessment that considers how the funding may create or exacerbate existing negative human rights impacts. This will allow the donor to determine how to proactively mitigate those risks. Human rights impact assessments must include assessing compliance with the CRPD of the project to be funded.

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| --- |
| *Harm*  Examples of funding programs that may violate the rights of persons with disabilities, and therefore the principle of do no harm, include funding mainstreaming programs that are not accessible to persons with disabilities. Taking the earlier example of remote consultations on sexual and reproductive health, funding this program if it is not accessible to persons with disabilities is a rights violation in itself and will result in a violation of the right to health (Articles 5 and 25(a) CRPD) for those who are denied access.  A human rights violation may also be directly caused by funding programs that involve activities contrary to the CRPD, e.g. those that reinforce institutionalisation, (i.e. the deprivation of liberty based on disability, as prohibited by Article 14 (1)(b) of the CRPD). |

# Monitoring implementation of funding

## Action One: A monitoring commitment

At the outset of any funding allocation it should be agreed in the terms of reference and/or contract, signed by the donor and recipient, that monitoring and evaluation of activities will be undertaken to ensure that the funded program is equally accessible to persons with disabilities and to ensure that funds are not being used in manner that contributes to a violation/s of the rights of persons with disabilities, but rather that the funds are promoting the inclusion and promotion of the rights of persons with disabilities.

## Action Two: Budget allocation

A dedicated budget line, within all mainstream COVID19 response and recovery projects, proportionate to the funding, should be allocated to monitoring and evaluation activities. Costs of monitoring and evaluation are to be borne by the donor.

## Action Three: Indicators and data collection

**Indicators**

Indicators should be developed to measure the level of access to the program that persons with disabilities are experiencing, (allowing for any barriers to access to be detected) and the impact that the program is having on the rights of persons with disabilities. Indicators should be disaggregated by disability as well as sex and age. Indicators will need to be sensitive to the evolving nature of the COVID19 pandemic and that the needs of target populations under mainstream response and recovery programming, including persons with disabilities, may evolve.

Indicators should ensure a human rights-based approach to international cooperation, including that:

* Persons with disabilities and their representative organizations (OPDs)[[89]](#footnote-89) participate in the design, implementation, monitoring and evaluation of a program;
* Procurement ensures that relevant goods and services acquired are accessible and do not create new barriers;
* The program staff has appropriate capacity to implement both operational and programmatic aspects in the area of work according to human rights standards;
* Persons with disabilities accessing the program are proportionally represented compared to the disability prevalence in the geographic area;[[90]](#footnote-90)
* The program ensures inclusion of all groups of persons with disabilities, including underrepresented groups;
* Programme evaluation reflects the level of satisfaction of persons with disabilities.

**Data collection**

The Washington Group on Disability Statistics has developed a number of data collection tools for use in collecting data from and about persons with disabilities. One tool is the Washington Group Short Set of Questions, which is an internationally recognized and internationally comparable method for collecting primary data about persons with disabilities and is easy to incorporate into ongoing data collection of national statistical systems. More information on the tools can be found at the Washington Groups’ website [www.washingtongroup-disability.com](http://www.washingtongroup-disability.com).

The report ‘Using the Washington Group Tools to Assess the Impact of COVID19 on Persons with Disability’ (21 June 2020) offers guidance on strategies and approaches to gathering primary data in the context of COVID19 related movement restrictions. Humanity and Inclusion have developed e-learning modules on the use of the Washington Group questions that can be found at [www.humanity-inclusion.org](http://www.humanity-inclusion.org).

Case studies, focus group discussions and community-driven data could be used to produce evidence of the experiences of persons with disabilities in accessing services (including where it is not possible to collect primary disaggregated data) and the barriers they face. Focus groups and case studies can also be used to identify any negative human rights impacts of the program under due diligence activities.

## Action Four: Early warning

An impact assessment, as part of due diligence activities, should be undertaken at the beginning of the project to ensure early detection of any unforeseen negative human rights impact of the project.

## Action Five: Participation

The participation of persons with disabilities and their representative organisations in the design, implementation, monitoring and evaluation of a program must be promoted. This should include the provision of reasonable accommodations and funding allocation to allow persons with disabilities (that represent the diversity of disability and intersecting identities) or OPDs to undertake monitoring and evaluation activities. Budget allocations should include a reasonable accommodation provision proportional to the participation of persons with disabilities. OPDs should also be supported to participate within monitoring mechanisms overseeing programmes.

## Action Six: Evaluation

Within evaluation activities undertaken at the end of funding, donors must ensure that the access of persons with disabilities to the response or recovery program is included within the program’s evaluation by recipients, and that data, disaggregated by disability (as well as gender and age) is provided to evidence equal access. Descriptions and analyses of how persons with disabilities were reached and impacted by the program should be included, and best practices and lessons learnt identified. Evaluation activities should also include broader analysis of the human rights impact of the project. Programmes should evaluate empowerment of persons with disabilities, by means of raised awareness on their rights, increased capacity to participate in the programme and/or the programme’s contribution to access other rights.

## Action Seven: Accountability

The program should include an accountability mechanism through which persons with disabilities and their representative organization can safely collect evidence and report on human rights violations, and where appropriate obtain redress and compensation.

Disability rights defenders protection protocols must be integrated into project designs to ensure that those who identify and report suspected human rights violations are protected and that those who engage with the project are aware of the avenues for reporting and the safety protocols that apply.

# Terminology

**Disability**

* Disability is an evolving concept that results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others. Disability is a social construct, which is different to the persons impairment.

#### Persons with disabilities

* Persons with disabilities include persons with long-term physical, mental, intellectual or sensory impairments that, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others (Article 1, CRPD).

#### Accessibility

* Accessibility is a precondition for persons with disabilities to live independently and participate fully and equally in society. Accessibility is both a principle and a right under the CRPD.[[91]](#footnote-91) Appropriate measures must be taken to ensure that persons with disabilities have access, on an equal basis with others, to ‘the physical environment, to transport, to information and communications, including information and communications technologies and systems, and to facilities and services provided to the public’ (Article 9, CRPD). Accessibility should especially take into account the gender and age perspectives of persons with disabilities across the life course. Denial of equal access constitutes a discriminatory act. For further information and guidance on accessibility see General Comment No 2 of the CRPD Committee, Article 9: Accessibility, UN Doc CRPD/C/GC/2 (2014).

#### Reasonable accommodation

* Reasonable accommodation is an individualized measure to prevent discrimination. It applies on demand and it is subject to an objective proportionality test (Article 2, CRPD). Reasonable accommodation can provide for accessibility, travel arrangements, support services or any other accommodation or adjustment that may be required to ensure participation and access to persons with disabilities to a programme. It applies as a way of mitigating barriers that exist and cannot be immediately addressed because they may require time or additional resources. E.g. a wheelchair user requires a ramp to access a building, to build a ramp construction permits may be required, a procurement process, unforeseen budget, among others; until this is solved an immediate accommodation would be a portable ramp.

#### Inclusion

* Inclusion is when all people participate in all aspects of civil, political, social, and economic life. At the country level it is the process by which traditionally marginalized groups are consulted and considered in all policy and budgetary decisions. The disability movement advocates strongly for inclusion of persons with disabilities at all levels, and especially in compliance with CRPD that States meet their obligations for all government public policy at national and district levels.

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22. See for example the  ***Democratic Republic of Congo*** case study in annex to this report. [↑](#footnote-ref-22)
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