



COVID-19 in humanitarian contexts: no excuses to leave persons with disabilities behind!

Evidence from HI's operations in humanitarian settings

Acknowledgement

In the midst of an unprecedented global health crisis, this report was only made possible thanks to the dedication of colleagues and partners, who collected data and testimonies in the different countries of intervention. Our heartfelt thanks to all the colleagues, partners and persons with disabilities who shared their testimonies and insights with us.

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This collection and review of evidence aims to illustrate how the COVID-19 crisis triggers disproportionate risks and barriers for men, women, boys and girls with disabilities living in humanitarian settings. It highlights recommendations for humanitarian actors to enhance inclusive action, aligned with existing guidance and learnings on disability inclusion. It is based on evidence, including testimonies, collected by HI programs in 19 countries of intervention. Special efforts were made to reflect the voices of persons with different types of disabilities, genders and ages, residing in different geographical areas and living circumstances, including refugee and internally displaced persons' settlements and host-communities.

*“Persons with disabilities are affected psychologically and physically by the COVID-19 crisis. They are negatively impacted by protective measures; they spend all the day at home because some of them, especially children with disabilities, older persons and persons with some physical impairments, have underlying health issues or poor immune systems”, says Reham, HI Rehabilitation Technical Advisor in the **Gaza Strip (Palestine)**.*

Reham's account on the situation of persons with disabilities in the midst of the pandemic highlights the impact on the physical and psychological wellbeing of persons with disabilities, as well as their protection, in at-risk countries affected by the COVID-19 pandemic. *“Being at home for a long period of time, unable to access services, can cause stress and depression. Persons with disabilities might feel anxious and fear catching the virus, especially when they cannot afford protective equipment or depend on a support person for daily activities. Children with disabilities who stopped going to schools can face domestic violence at home due to their isolation or change in routine”.*

Reham is also witnessing the economic impact of the pandemic on the livelihoods of persons with disabilities: *“Daily workers and those with temporary contracts have lost their source of income. This creates a lot of distress as they do not know how to support their families or buy their medications.”*

While persons with disabilities are estimated to represent 15% of the world's population,¹ in countries where conflicts and humanitarian crises are ongoing, these figures may be much higher. In Syria for instance, this figure doubles as the latest estimates show that 30% of the population aged 12 are persons with disabilities.² In Aleppo governorate, 59% of women and 27% of men are persons with disabilities. Across the country, 99% of women and 94% of men over the age of 65 years have a disability³.

In conflict, disaster affected or fragile countries, the pandemic increases the risks and discrimination against certain groups. The pandemic, including public restriction plans, leads to the collapse of health and social support systems (such as home-based assistance or community support for accessing distributions). Persons with disabilities face additional risks and challenges to access information and assistance. Structural inequalities in interaction with

¹ World Health Organization, Global Report on Disability, 2011.

² Humanitarian Needs Assessment Programme (HNAP) - Syria, Spring 2020 report series, Disability overview.

³ Syria Protection Cluster (Turkey)'s note “A disability-inclusive COVID-19 response”, April 2020.

crisis-specific barriers lead to **higher risks of contracting the virus and developing severe cases of COVID-19** for certain groups. According to the UN Secretary General, “persons with disabilities generally have more health-care needs than others – both standard needs and needs linked to impairments – and are therefore more vulnerable to the impact of low quality or inaccessible health-care services than others. Compared to persons without disabilities, persons with disabilities are more likely to have poor health: among 43 countries, 42% of persons with disabilities versus 6% of persons without disabilities perceive their health as poor”.⁴

Moreover, evidence from the Ebola outbreak in 2014 shows that the diversion of resources towards the fight against the epidemic may hamper the provision of critical humanitarian assistance and have negative consequences on public health. The Ebola response, for example, detracted resources dedicated to care for other health issues or diseases such as cholera, malaria or HIV/Aids.⁵

COVID-19 exacerbates barriers faced by the most at risk groups, especially persons with disabilities, to access services, such as health, water, sanitation, shelter and food, and to stay safe. The Global Humanitarian Response Plan on COVID-19 has identified persons with disabilities as the most affected population groups in the 63 countries covered by the plan⁶. Moreover, as a humanitarian organisation engaged in the response in more than 20 countries experiencing humanitarian crises, we often witness that **men, women and children with disabilities fall between the cracks of humanitarian response. Multiple risks are created by the intersection of disability, gender and age factors**, such as women and girls with disabilities facing particular protection risks or older persons with disabilities facing denial of access to health services. Other risk factors include ethnicity, displacement, access to documentation, or health status.

Various legal instruments and policy frameworks call for humanitarian actors to identify and respond to the needs and rights of persons with disabilities who are particularly at risk of being left behind in humanitarian settings, including during the COVID-19 crisis. **Today, these commitments and recommendations must be put into action to scale up an inclusive preparedness and responses to COVID-19, during all stages and at all levels of intervention.**

Legal instruments and policy frameworks on inclusion of persons with disabilities in humanitarian settings

The **UN Convention of Rights of Persons with Disabilities (CRPD)**, together with **International Humanitarian Law** and other legal frameworks applicable to humanitarian settings, such as International Refugee Law, require all humanitarian assistance and protection efforts to be inclusive of persons with disabilities.

⁴ United Nations Secretary General, May 6 2020. Available: <https://www.un.org/development/desa/disabilities/covid-19.html>

⁵ Groupe URD, Epidemics, pandemics and humanitarian challenges: lessons from a number of health crisis, March 2020.

⁶ United Nations, “Global Humanitarian Response Plan COVID-19 (April – December 2020)”, May 2020 Update, Available: https://www.unocha.org/sites/unocha/files/GHRP-COVID19_May_Update.pdf

The **Charter on Inclusion of Persons with Disabilities in Humanitarian Action**, launched at the 2016 World Humanitarian Summit, calls on all States and non-state actors engaged in the humanitarian response (UN agencies, humanitarian actors and organisations of persons with disabilities - OPDs) to “take all steps to meet the essential needs and promote the protection, safety and respect for the dignity of persons with disabilities in situations of risk.”⁷

The **UN Security Council resolution 2475 to protect persons with disabilities in armed conflict** was adopted in June 2019 to ensure that they have equal access to protection and humanitarian assistance in situations of armed conflict.⁸

The **Inter-Agency Standing Committee (IASC) Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action**⁹, endorsed in October 2019, provide practical strategies to effectively identify and respond to the needs and rights of persons with disabilities who are particularly at risk of being left behind in humanitarian settings, including during the COVID-19 crisis.

Method & Limitations

Evidence has been collected through primary data collection amongst HI teams and partners working in countries impacted by the COVID-19 pandemic in April/May 2020. Data was extracted from assessments conducted by HI and partners in Bangladesh, Egypt, Haïti, Indonesia, Philippines, Jordan, Lebanon, Somaliland and Togo. Testimonies from affected communities, staff and partners were collected in Kenya, Myanmar, Pakistan, Palestine, Philippines, Somaliland, South Sudan, Rwanda, Thailand, Uganda and Yemen. Some names have been changed to preserve the safety of the persons concerned.

Due to the nature of the outbreak and its specificity, limited evidence is available on the impact of COVID-19 on persons with disabilities. The recent nature of the outbreak in countries already affected by humanitarian crises, in addition to pre-existing poor data collection practices inclusive of persons with disabilities, leads to the lack of evidence based on disability. Even though data is fragmented, localized and not representative of the whole population of persons with disabilities affected by the COVID-19 pandemic, it illustrates common difficulties faced by men, women and children with different types of disabilities from different ages, genders, geographical areas and living circumstances, to cope with and recover from the impact of COVID-19 in humanitarian contexts.

I. COVID-19: Persons with disabilities face exacerbated barriers

Multiple factors can preclude persons with disabilities, as well as other groups at risk, from enjoying their rights, including accessing COVID-19 related health and non-health services

⁷ The Charter on inclusion of persons with disabilities in humanitarian action, launched in May 2016. Available: <http://humanitariandisabilitycharter.org/>

⁸ Resolution 2475 (2019) / adopted by the Security Council at its 8556th meeting, on 20 June 2019. Available: <https://digitallibrary.un.org/record/3810148?ln=fr>

⁹ IASC (Inter-Agency Standing Committee), “Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action”, July 2019. Available: <https://interagencystandingcommittee.org/system/files/2019-11/IASC%20Guidelines%20on%20the%20Inclusion%20of%20Persons%20with%20Disabilities%20in%20Humanitarian%20Action%2C%202019.pdf>

on an equal basis with others. Pre-existing inequalities are often exacerbated in times of crisis, and are further aggravated by new risk factors, due to changing environments and shifting needs. In contexts where persons with disabilities already face structural inequalities and inaccessible service delivery, they are now confronted by increased challenges when attempting to access services such as healthcare, livelihood and social protection programs due to the COVID-19 outbreak.

Humanitarian actors active in affected countries are insufficiently prepared to adapt their processes and interventions to be inclusive of persons with disabilities, and to accompany their staff for inclusive service delivery. Additionally, we see that persons with disabilities and their representative organisations have limited opportunities of consultation and participation in decision-making processes regarding the response, resulting in the de-prioritisation of their needs and an increase in barriers.

1.1 Persons with disabilities face inaccessible environments and barriers to information hindering their ability to protect themselves and stay healthy

Persons with disabilities may face difficulties to implement preventive measures to protect themselves and their families from the disease due to gaps in humanitarian preparedness and response programming. Barriers identified in countries of intervention include the use of inaccessible communication channels and formats, as well the lack of access to information useful for persons with disabilities (such as how to protect themselves, where to access assistance, report violence). Furthermore, methods to reach out to more isolated and remote communities have been strongly absent, impacting persons with disabilities in remote locations, as well as those without family or community networks.

In Egypt, 77% of households surveyed said they are not aware of hotlines for COVID-19 psychosocial support¹⁰.

In Haïti, persons with disabilities surveyed reported that the information provided is not accessible enough (11%), are not adapted to their needs (14%), or that they do not know where to find the information (8%).¹¹

In Ethiopia, 9.9% of adults with disabilities and 16.6% of children with disabilities reported not having access to public information on COVID-19; 20% of adults and 19.7% of children reported that the information provided on COVID-19 was difficult to understand as the messages included too many words, while 6.5% of adults and 8.1% of children reported that the format was inaccessible.¹²

¹⁰ Basic Rapid Survey on the Socio-Economic Impact of COVID-19 on HI's Beneficiaries in Egypt. 240 respondents of all ages, among which 49% of direct respondents have disabilities. 58% are female and 42% male.

¹¹ Rapport de l'enquête rapide sur les connaissances, attitudes et pratiques des personnes handicapées et de leurs familles en lien avec le mécanisme de réponse de la COVID-19 (Réalisée du 21 au 24 Avril 2020 à Port-au-Prince – HAÏTI) sur 37 ménages.

¹² HI, Survey Report, Persons with disabilities and COVID-19 in Ethiopia: Knowledge and impact, May 2020. A total of 895 adults and children with disabilities participated to the survey. Out of these, 446 are adults (258 women and 188 men), and 449 are children from 5 to 18 yo (286 girls and 163 boys). 40% are displaced or refugees, 60% are from the host community.

In South Sudan, Caroline, a deaf person and a member of the South Sudanese Women with Disabilities Network (SSWDN), explains how the lack of access to information about COVID-19 negatively impacted her wellbeing: **“I am scared because there is no clear information about the Coronavirus and the response organised by the government of South Sudan does not include persons with disabilities.** I cannot hear the prevention messages about the virus on TV, and there is no sign language interpretation. They are broadcasting messages on the radio every day, but these are also inaccessible for persons with hearing impairments. There is a lack of awareness through social media, which poses great challenges. I get very scared when I use public transport, as I don't know who has symptoms and who has none.”

In Rwanda, Sabiti, 41, lives in Kiziba refugee camp. He has a hearing and speech impairment, and works as a shoe repairman. He was struggling to obtain concrete information about COVID-19 as there was no sign language interpretation at the beginning of the outbreak. In the camp, there are around 70 persons with hearing and speech impairments who were left without any information. **“I could have contracted COVID-19 without knowing it.** People started staying home... My family told me that I could not go out and move around, but they could not explain clearly why I could not go to work”.

1.2 Negative perceptions and stigma against persons with disabilities impacts their safety and access to health, protection and livelihood services

Prejudices and inaccurate beliefs about persons with disabilities and their families aggravates the risk of being discriminated against and increases the impact of the pandemic. Attitudinal barriers and violence against persons with disabilities intensified by the pandemic hinders access to health, protection and livelihood services, and influences the autonomy of persons with disabilities and their capacity to make their own decisions to contribute to an effective response to the pandemic.

Persons with disabilities and other persons with under-lying health concerns can be associated with the pandemic, which particularly accelerates violent and discriminatory behaviours against certain groups.

In Haiti, 81% of households led by or including persons with disabilities reported that the pandemic could result in increased stigmatisation within the communities of older persons, persons with disabilities and persons living with HIV or AIDS. Pre-existing beliefs and traditional practices are leading to more discrimination and violence against these groups.^{xi}

In Yemen, Ahmed, a physiotherapist working for HI, says: **“Discrimination will affect persons with disabilities. Many persons with disabilities do not have access to hygiene supplies, due to a lack of financial resources or information. When they are in need of help, many people will refuse to help them because they fear that persons with disabilities are sick or dirty.”**

II. Spotlight on the growing needs of persons with disabilities in humanitarian crises

The specificities of the impact of this pandemic are challenging due to its unique scale, as a global crisis, and the double impact of the virus as well as the protective and preventative measures implemented by governments in fragile countries.

Persons with disabilities face higher health risks, as they are more susceptible to contract the virus, develop severe consequences or face multiple risks due to environmental changes. Changes in service delivery also impact those in need of assistance, such as social support, health care including rehabilitation, or protection.

2.1 Persons with disabilities face higher health risks

Persons with disabilities are challenged to access health care, in particular to maintain medical treatment, access rehabilitation care or social support services. Health care rationing or the redirection of resources towards the COVID-19 response can also lead to poor health outcomes and reduced healthcare-seeking behaviour from persons with disabilities, who assume that they will be discriminated against and denied access to services.

In many countries, this leads to persons with disabilities reporting unmet health needs and the aggravation of their situation. Due to lack of access to healthcare and rehabilitation, persons with disabilities see their health status worsening, risking complications and additional permanent impairments or reduced functional ability.

In the Philippines, Manila, 49% of youths with disabilities have reported the need for healthcare support such as regular medication, support for hospitalisation costs, and medical consultations. 41% reported a need for accessible information about COVID-19 and community quarantine¹³.

In Jordan, 88% of persons with a physical impairment and with current medical needs reported that they could not go to the hospital either for their regular checks or for their additional medical needs.¹⁴

In Bangladesh, 36% of caregivers face challenges to provide rehabilitation due to COVID-19, and 19% face challenges in getting masks. In a context where rehabilitation services are unavailable, 55% of persons with a physical impairment using assistive devices reported that their devices did not work well. Among them, 93% reported that their devices needed replacing.¹⁵

¹³ Survey on the Impact of Enhanced Community Quarantine on persons with disabilities in Manila, Philippines and Jakarta, Indonesia, April 2020. Surveyed 73 youth with disabilities from Manila and Jakarta, beneficiaries of HI project 'Forward Together'. The respondents are between ages 18-39. 44% are female and 56% are male.

¹⁴ HI, Needs Assessment, impact of COVID-19 on People with Disabilities and their Families in Jordan, April 2020.

¹⁵ HI, Rapid Need Assessment of Persons with Disabilities in COVID-19 crisis UKAID Direct Project, April 2020. 91 persons with disabilities were surveyed. The gender ratio Male to Female was 3:2.

In Lebanon, 68% of households who have with at least one member of the household a disability, reported having difficulty finding medications over the 30 days previous to the assessment. 59% of households also have difficulties procuring hygiene items. Access barriers include limited access to information about service delivery: 41% reported a need for accessible information about COVID-19 and community quarantine.¹⁶

In Yemen, Ahmed, a physiotherapist working for HI, explains: “Since COVID-19, hospitals now only receive emergency cases. Some persons with disabilities have respiratory problems, for example because of paralysis. They might not be able to reach the hospital if they need ventilation. And ventilation will no longer be available at the hospital, because ventilators are for COVID cases only. The prosthetics centre is still working but beneficiaries are not allowed to come for daily check-ups, like they used to. Only priority patients can still come and receive rehabilitation advice. Many patients are being told to wait until after Eid (end of May 2020).”

In Yemen, Khadija works with internally displaced persons as a Case Management Officer for HI. She adds: “The COVID-19 situation is disturbing. In hospitals, oxygen treatments are reserved to COVID patients, so people with asthma or heart diseases may not receive care.”

In Ethiopia, Meryam, 40, is mother to 10 children; she lives in a rural town in Somaliland. She has physical impairments in both legs. She received support from HI in the form of hygiene kits and awareness. However, **rehabilitation services and referrals have become more difficult**, as health care workers are subject to travel restrictions and prioritise COVID-19 cases. Her eldest daughter had severe stomach ache and could be treated, but after a delay.

In Palestine, Ihab, 28, lives with his wife and children. In 2019, he was injured by gunshot and had complex fractures in both legs. Since the injury, Ihab needs psychosocial support and rehabilitation services, as he feels anxious most of the time and cannot walk or stand for long periods. Since COVID-19, **he cannot receive rehabilitation and medical services as he did before, as he is consulted only by phone for physiotherapy and wound care. He is worried that he does not have the skills to care for his wounds. The visits of the rehabilitation team were also an opportunity to meet and talk with people - now he feels very isolated.**

In Jordan, Sofia is a Syrian refugee. She has back-pain and severe knee pain, which limits her mobility. Sofia has developed new symptoms during the lockdown, such as hypertension. Her doctor attributes the degradation of her health to the stress she experienced during the lockdown period. She came to Jordan with her 21 year old nephew, Ahmad, who has a psychosocial disability for which he receives psychosocial support and medication regularly from HI and partners. Since the lock-down, **Ahmad has not been able to get this support, which has affected his stress and behaviour.**

In Yemen, Khadija explains that people who need assistive devices and rehabilitative care, without hospitalisation, cannot be admitted or access services. **“Patients who need to return to hospital for follow-up rehabilitative care through out-patient services are no longer**

¹⁶ HI, Impact Assessment. Understanding the impact of the financial crisis and COVID-19 on the households of Users accessing specialized services, April 2020. 197 members of households with at least one user with at least one impairment, including 82 females and 115 males, from 18 to 60+ years.

allowed to return. Services are being limited and some organizations are excluding persons with disabilities from local services.” She adds: **“Buses won't even stop for persons with disabilities to get in, as in general persons with disabilities don't get much respect or consideration in our society.”**

In Palestine, Batool, 13, lives in Gaza City with her parents and 4 brothers and sisters, and has cerebral palsy. She has a deformation of the spine that affects her breath and digestion. Before the COVID-19 lockdown, Batool had access to speech therapy services. However, since the quarantine has been declared, **the rehabilitation and medical services that she needs are not provided. She was also supposed to travel to the West Bank for medical follow-up; this will not happen because of travel restrictions.** Batool and her mother were also placed in compulsory quarantine for 21 days.

Health services disruption due to COVID-19 might also lead to the reduced capacity of essential services for women and children with and without disabilities, such as family planning, maternal and child care, clinical management of rape and psychosocial support for survivors. In countries with active crises and conflicts, where these services were already scarce and concentrated in major cities, the additional barriers due to COVID-19 protective measures, such as the limitation of movement, results in the complete unavailability of these services, resulting in the deterioration of health status, well-being and safety of women and children with disabilities.

2.2 Persons with disabilities, especially women and displaced persons, are more exposed to economic shock

According to UN estimates, half a billion people, or 8% of the world’s population, could be pushed into poverty by the end of the year, largely due to the pandemic. The fight against poverty could see a set back by as much as 30 years.¹⁷ Some preventive measures to curb the spread of the COVID-19 pandemic, such as lockdowns, have increased the already negative effect of the pandemic on groups already at socio-economic risk.

The lack of access to the informal and formal economy, the lack of disability-inclusive social support systems and protection schemes and the public restrictions due to the crisis disproportionately expose persons with disabilities and their family to loss of income and food insecurity. Many countries do not have disaggregated data of the socio-economic impact on persons with disabilities, and do not implement specific measures to ensure their protection. Moreover, the loss of socio-economic resources can induce negative coping strategies.

In the Philippines (Manila), 95% of youths with disabilities surveyed need urgent financial aid. 74% are worried about insufficient food supply, 69% about loss of employment or income, and 64% about the lack of availability of transportation. For residents of poor communities in Manila who are already experiencing high levels of vulnerability, the lockdown means they are

¹⁷ United Nations University, WIDER Working Paper 43/2020, April 2020. Available: <https://doi.org/10.35188/UNU-WIDER/2020/800-9>

receiving less to no income. Some of them get food packs from the local government, but they highlighted the fact that these food packs arrive arbitrarily and the rationed items do not meet the basic nutritional needs adapted to the size and composition of the families.^{xiii}

In Jordan, 79% of households which have children or adults with disabilities did not receive external support in the last 3 months and another 79% designated food as their top need, mostly because of a lack of money.¹⁸

In Haiti, 65% of respondents with disabilities said that the economic support that they received has been greatly disrupted since the declaration of the state of health emergency. Quarantine measures negatively impacts the socio-economic situation of households with at least one member of the household with a disability, as those offering economic support, most often family members, are no longer able to contribute.^{xi}

In Lebanon, households with at least one member of the household with a disability reported purchasing food on credit (74%), reducing spending on essential non-food items including hygiene products (53%), using savings (28%) and selling household assets such as jewellery and phones to purchase food (23%). Moreover, 62% of them, regardless of nationality (Lebanese, Palestinian and Syrian living in Lebanon), stated that they planned to seek assistance and charity in the month of May 2020 to meet their needs. The assessment shows greater impact of COVID-19 on refugees and displaced persons with disabilities as food insecurity rates are increased according to nationality of the household with 69% of Lebanese households, compared to 78% of Palestinian households and 93% of Syrian households respectively, reporting that they were not being able to meet all their needs in April 2020.^{xvi}

In Pakistan, Saima has used a wheelchair since childhood. She lives with her family in a shantytown in Karachi. **The pandemic and lockdown have made their daily lives almost impossible to bear.** When Saima's husband, a day labourer, stopped working in March, this family with three children found itself without enough to eat. "**Finding food is now an ordeal**", said Saima. They **must travel to a food distribution point two hours from their home** to find enough to eat for a month, and depend entirely on humanitarian assistance.

In Pakistan, Abdul Baqi, 50, lives in the Jalala Afghan Mardan refugee camp with his wife and 10 children. After fleeing Afghanistan in 1986, he was injured by a landmine explosion and lost his leg. Following the outbreak of COVID-19, Abdul Baqi had to close his shop near the refugee camp. As a result, he was deprived of his only source of income that allowed him to feed his family. "*I am not afraid that my children will catch COVID-19. My worry is that I won't be able to feed them,*" he says. Abdul is also worried about his house: the heavy rain has damaged the roof, which is in danger of collapsing while they sleep.

In Kenya, Jemale, 52, is a refugee in Kakuma camp. He lost his wife a few years ago and has 7 children. He has mobility limitations due to a club foot. He shares: "*The camp is very big, with many people occupying it, and with few medical health practitioners. So, if the virus is*

¹⁸ HI, Needs Assessment, impact of COVID-19 on People with Disabilities and their Families in Jordan, April 2020. 942 households including 524 households having adults with disabilities and 418 households having children with disabilities.

found here, it would be very dangerous for us.” “There are many challenges, especially the fact that Kakuma is isolated from big towns with better services and opportunities. **Poverty levels are high and most refugees do not have jobs to sustain a decent life at the camp**”. He adds “A lot has changed in the camps [due to COVID-19], especially regarding the movement of people and supplies from Nairobi [...]. **Most organizations and government institutions have adopted new ways of working and implementing activities, which makes it very difficult for services to be accessed.**”

In Uganda, Winifred is Executive director of MUDIWA, an organization of women and girls with disabilities in Uganda. She explains how the measures of lockdown have impacted the livelihood of the members: “**Over 30 women with disabilities were working on the roadside markets, selling clothes, household utensils and food.** (...) Due to the drastic measures of social distancing, they were sent back home, with no other choice than to **use their available capital to buy food and other necessities.** Since the lockdown, the price of a bunch of bananas has decreased from between 20,000-35,000 shillings to between 4,000- 8,000 shillings. As a result, many women with disabilities who were involved in agriculture are discouraged from continuing to sell .”

In Somaliland, Ethiopia, Mohamed, 45, lives with his wife and his 10 children in a 3-room house. He has a physical impairment in his left leg. His wife manages a small restaurant established with the support of an HI community-based rehabilitation project. He works as an electronic maintenance technician. “I want to be a role model in my community, to show that persons with disabilities are capable and strong enough to manage their daily life. **Before COVID-19, we managed to meet the daily needs of our family, but now our income from the restaurant and electronic maintenance is at risk as customer demand has declined.**” His family has difficulty securing enough income to cover their daily expenditure. They are very worried and fear the social and economic consequences of the COVID-19 pandemic.

In Myanmar, Min Min, 42, a mine survivor, works as a social worker and carpenter. He often faces difficulties in finding regular employment as he has a prosthetic leg . Employment opportunities have been reduced due to the lockdown measures: “In this situation, as the government prohibits gatherings of more than 5 people, the **employers only give work to persons without disabilities**, which affects my income”.

2.3. Preventive measures often do not take into account particular needs of persons with disabilities and negatively impacts their safety, physical and psychological wellbeing

In several humanitarian contexts, persons with disabilities are sharing concerns about access resulting from COVID-19 preventive and protective measures. These measures are not inclusive of the needs of persons with disabilities and therefore they report additional challenges for their health and social situations.

In Myanmar, Noor Jann, 40, lives in an internally displaced persons (IDP) camp in Rakhine State. She has 8 children, including a son with a disability who requires regular rehabilitation

exercises and her husband who has tuberculosis. “We are living in a formal refugee camp. **We cannot maintain social distancing and it is very difficult to access health care services.**”

In Palestine, Batool, 13, reports that the quarantine was not adapted to the needs of children, especially children with disabilities. They had to purchase masks, gloves and disinfection materials, as well as limiting their movements. She experienced a lot of distress, as she felt imprisoned. Compulsory quarantine and isolation often imposes several challenges to persons with disabilities as support plans are not prepared and procedures and the environment are not made accessible.

In Thailand, Aye Aye, 50, has mobility limitations due to an amputation. She is the chairwoman of the Self-Help Group of persons with disabilities along the border between Thailand and Myanmar. “Before the COVID 19 crisis, I could move freely inside the camp to visit other persons with disabilities and provide them with peer support at home or in the hospital. We had monthly meetings with the other members of the self-help group to share general information, update each other on our monthly activities and future plans. When the lockdown started, the camp committee did not allow traveling around and inside the temporary shelter. I had to explain my situation to them and the fact that I needed to continue to support other persons with disabilities. They understood and allowed me to pursue my activities, with preventative measures such as physical distancing, wearing masks and hand washing. Persons with disabilities should not be abandoned. It is my duty to support them.”

2.4. Persons with disabilities and their caregivers, particularly women and children with disabilities, face heightened protection risks such as abuse or violence

Evidence shows that the risk of violence to children and adults with disabilities is **routinely three to four times higher than for those without disabilities.**¹⁹ Women with disabilities are 10 times more likely than women without disabilities to experience sexual violence.²⁰

In the current circumstances, public restrictions, self-isolation of households and disruption of community life, services and social support may lead to increased protection risks for persons with disabilities and their caregivers. Those include separation from families and caregivers, domestic violence, gender-based violence (GBV), sexual exploitation abuse and harassment (SEAH). It can also push some households and individuals to adopt negative coping mechanisms such as child labour, forced isolation and early or forced marriages.

Persons with disabilities and their relatives are also less likely to disclose or report violence because of shame, fear of family/community members who are often the perpetrators, or

¹⁹ Review on the prevalence and risk of violence against children with disabilities, published by Lancet in July 2012 and carried out by Liverpool John Moores University’s Centre for Public Health, a WHO Collaborating Centre for Violence Prevention, and WHO’s Department of Violence and Injury Prevention and Disability.

²⁰ UNFPA, We decide initiative. Available: https://www.msh.org/sites/msh.org/files/we_decide_infographic.pdf

because the subject is still perceived as a taboo. **These cases of violence therefore go largely unreported.**

In Togo (Lomé), 20.9% of homeless persons surveyed are persons with disabilities. During the confinement, homeless people, especially women, have been exposed to increased physical and sexual violence (19 women and girls reported cases, 14 men). This violence includes aggression and abuse committed by individuals, including law enforcement agencies, sexual violence and exploitation.²¹

In Ethiopia, 22% of adult respondents with disabilities felt unsafe in periods of prolonged work closure and movement restrictions. 11.2% reported that they felt less safe and protected from violence and abuse since Covid-19. 41.6% of child respondents with disabilities reported experiencing fears/ anxiety/ feeling unsafe and able to express their feelings to family / caregiver; 4.9% reported experiencing same, though not able to express their feelings to family / caregiver.^{xii}

In the Philippines, Joanna, a Personalized Support Officer for HI, says: “In the midst of the COVID-19 pandemic, (...) **discrimination and violence towards persons with disabilities continues to persist even inside our homes — a place where we are supposed to find safety and comfort.** During times like this, persons with disabilities display resilience and increase their tolerance for unjust circumstances; it shows us that a disability-inclusive response is imperative especially when the usual support systems become dysfunctional.”

In the Philippines, V. (name withheld) is a young woman with hearing impairment. Prior to the quarantine she had completed a short sewing training and was applying for jobs. In the meantime, she is helping actively in the family-owned tailoring shop. Due to quarantine tensions increasing, V. reached out to HI and **sought assistance about the threats of violence and the physical abuse inflicted by a family member, who intimidated and insulted her.** V.’s case was reported. However access to protection reporting mechanisms was challenging.

In Uganda, Achayo Rose Obol, Chairperson of the Board of Directors of the National Union of Women with Disabilities of Uganda (NUWODU), explains that women and girls with disabilities, living in rural contexts have been severely impacted by the COVID-19 lockdown. The majority of them are single mothers, and they struggle to provide food and protective equipment for their families due to the disruption of their livelihoods. “*The occurrence of sexual and gender-based violence against women and girls with disabilities has increased. During the lockdown, they cannot flee from abusive partners. They also cannot access sexual and reproductive health services or justice, because of transport restriction and lack of financial means.*”

In Jordan, Mousa, 27, has a congenital condition which led to an amputation in his lower limbs as a child and means that he has a prostheses. He is the head of the household and the breadwinner of a family of five. At the beginning of the COVID-19 lockdown in March, his

²¹ FODDET, WAO-Afrique, Humanity & Inclusion, Halsa international, UNICEF, Rapport du diagnostic et analyse rapide de l’impact de la crise liée au COVID-19 auprès des populations sans domicile, May 2020. Survey conducted in May 2020 of 2080 homeless persons in Lomé, including 44% of women and 20% of persons with disabilities, of all ages.

employer started to push him to submit his resignation as, according to his employer, his mobility limitations were a barrier for him to accomplish his tasks. As the authorities provided flexible measures for employers to respond to the economic impact of the pandemic, **his employer took the opportunity to fire him**. Meanwhile the landlord of the apartment he rented pressured him for rent arrears, knowing that he was jobless. **To flee the verbal and psychological violence he was experiencing, he was forced to leave the house** with his family.

III. Recommendations towards an inclusive humanitarian response

All State parties to the UN Convention on the Rights of Persons with Disabilities have the obligation to take “all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk”, Article 11.

Ensuring that all the rights of persons with disabilities apply to crisis contexts requires inclusive and accessible COVID-19 preparedness and response plans, across all sectors and without any forms of discrimination on the basis of disability, age, gender, and health status, amongst others. It requires coordination and collaboration across governmental services/branches and civil society organisations to identify and mitigate risks faced by persons with disabilities.

More precisely, HI recommends all humanitarian actors to:

- **Ensure meaningful participation of persons with disabilities, their representative organisations (OPDs) and other local organisations**, as they should play a key role in all stages of the response. Men, women, boys and girls with different types of disabilities should be consulted in assessments, project design phases, in particular to discuss the impact of public restrictions, and recommendations to enhance safety and access to services.
- **Collect, analyse and monitor needs assessment data, disaggregated by sex, age and disability**, using the Washington Group Set of Questions, as well as collecting information on the barriers to and the facilitators of access and participation.
- **Collaborate with organisations of persons with disabilities and disability specific actors** to assess the impact of public restrictions, the collapse of the informal labour market, informal social services and rehabilitative care, situations of isolation, and the related impact on physical and psychological wellbeing, socio-economic status and safety, such as disability-specific protection risks.
- **Design and share disability, gender and age sensitive information on COVID-19 prevention and response, through a diverse number of accessible formats with the use of accessible technologies, to reach people with visual, hearing and intellectual disabilities** (sign language, Easy Read, plain language, audio, captioned media, Braille). Public communication should also avoid stereotyping messages and images. Share information to persons with disabilities on how to stay safe and healthy and how to access assistance or submit concerns.

- **When designing responses, refer to the IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action²² while designing inclusive strategies and key actions** as well as to WHO considerations on disability during the COVID-19 outbreak²³, to remove attitudinal, environmental and institutional barriers **in order to ensure that the rights and needs of persons with disabilities are met in operational plans.**

²² IASC (Inter-Agency Standing Committee), “Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action”, July 2019. Available: <https://interagencystandingcommittee.org/system/files/2019-11/IASC%20Guidelines%20on%20the%20Inclusion%20of%20Persons%20with%20Disabilities%20in%20Humanitarian%20Action%2C%202019.pdf>

²³ WHO, Disability considerations during the COVID-19 outbreak, March 2020. Available: <https://www.who.int/publications/i/item/disability-considerations-during-the-covid-19-outbreak>