

INCLUSIVE HEALTH SERVICES FOR PERSONS WITH DISABILITIES

TABLE OF CONTENTS

1. OVERVIEW	6
2. TECHNICAL CONTENT	8
2.A. Background	8
2.B. Legal Framework	10
2.C. Access to Health for Persons with Disabilities: Areas of Concern	14
Country Checkpoint	33
2.D. Measures to Ensure the Right of Persons with Disabilities to Health Services	26
Country Checkpoint	33
3. SUMMARY & KEY LEARNING POINTS	39
4. USEFUL RESOURCES	40
5. LEARNING ACTIVITIES	42
Session Sheet for the Trainer – The Right to Health, Session 1	33
Learning Activity 2.B.: The Inter-Connected Relationship of Rights	33
Handout: CRPD Article 25	33
Session Sheet for the Trainer – The Right to Health, Session 2	33
Learning Activity 2.D.: A Plan to Address Barriers to Health Care	33
Handout: Barriers to Health Care for Persons with Disabilities	33

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LIST OF ACRONYMS

AT	Assistive Technology
CEDAW	Committee on the Elimination of Discrimination against Women
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CRPD	Convention on the Rights of Persons with Disabilities
CRPD	Convention on the Rights of Persons with Disabilities
CRC	Committee on the Rights of the Child
CRC	Convention on the Rights of the Child
CRC	Convention on the Rights of the Child
DFIs	Development Financing Institutions
DPOs	Disabled Persons Organizations
DISD	Division for Inclusive Social Development/UNDESA
EC	European Commission
G3ICT	Global Initiative for Inclusive ICTs
HIV/AIDS	Human Immunodeficiency virus / Acquired Immunodeficiency Syndrome
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic and Cultural Rights
ICF	International Classification of Function, The World Health Organization
ICT	Information and Communication Technology
ILO	International Labour Organization
ITCILO	International Training Centre of the ILO
IPU	Inter-Parliamentary Union
ITC	Information and Communication Technology
ITU	International Telecommunication Union
MDGs	Millennium Development Goals
MFIs	Microfinance institutions
MSPs	Multi-stakeholder Partnerships
NAPs	National Action Plans
NGO	Non-Governmental Organization
NVDA	Non Visual Desktop Access
OHCHR	Office of the High Commissioner for Human Rights
OSISA	Open Society Initiative for Southern Africa
PCM	Project Cycle Management
PRP	Protracted Relief Programme
SABE	Self-Advocates Becoming Empowered
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
UDHR	Universal Declaration of Human Rights
UN	United Nations
UN DESA	United Nations Department of Economic and Social Affairs

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VOCA	Voice Output Communication Aids
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

1. OVERVIEW

The overview provides information on the objectives, the target audience, the module content, learning outcomes and the module map.

Module Objectives

- ▶ To highlight the barriers to health services for persons with disabilities and to consider actions for removing them.

Who is this module for?

This module is relevant to everyone who has an interest or duty to protect and promote the human rights of persons with disabilities, including persons with disabilities themselves and their representative organizations. The module is especially relevant for decision-makers in the context of health, health professionals, health care providers, governments, academia, and NGOs working on enhancing the access of persons with disabilities to health services.

What is this module about?

The content of this module:

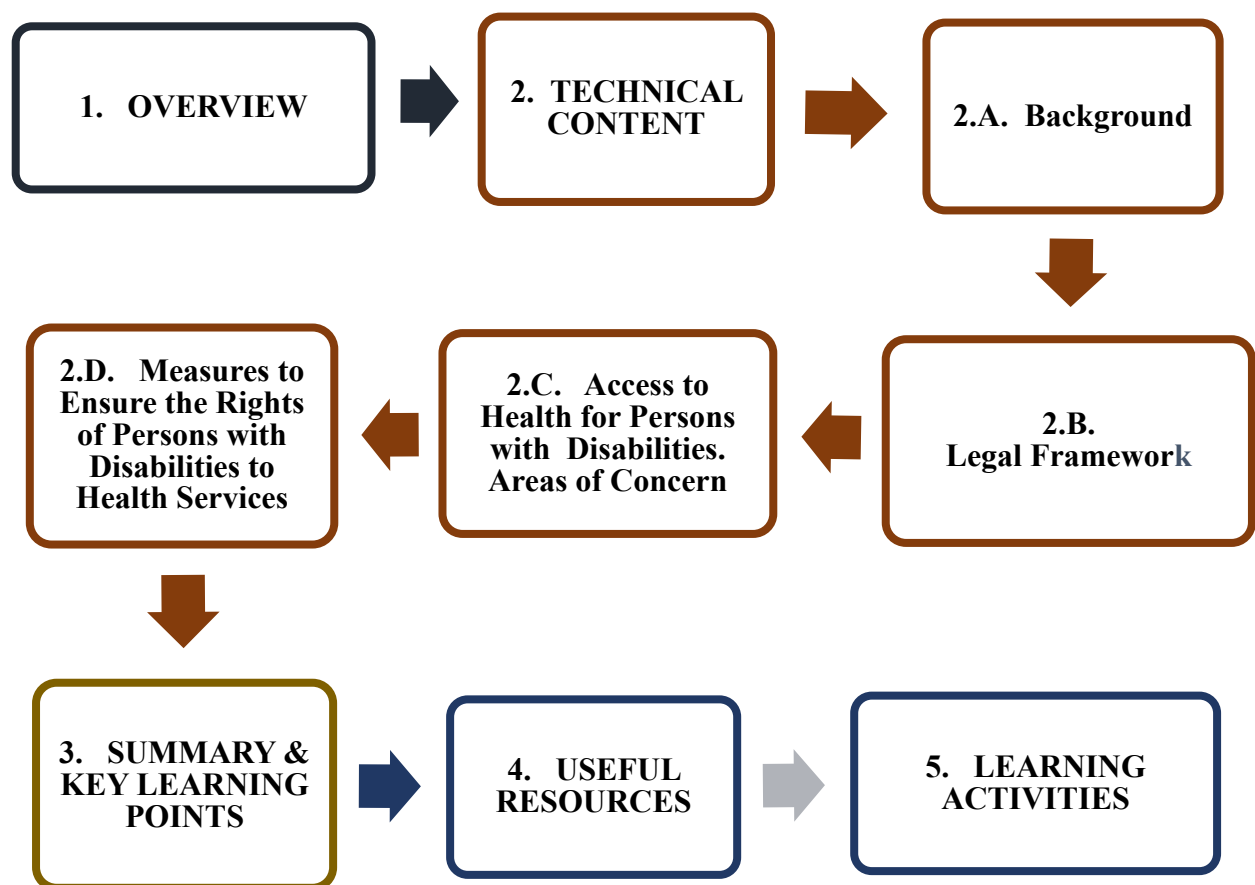
- ▶ explains the linkages between health and disability generally;
- ▶ reviews provisions of the Convention on the Rights of Persons with Disabilities (CRPD) pertaining to health services;
- ▶ reviews specific areas of concern in relation to access to health services;
- ▶ sets out measures for overcoming barriers to the inclusion of persons with disabilities in health services;
- ▶ includes learning exercises to accompany the material;
- ▶ lists key resources for additional reference.

Learning Objectives

On completion of this module, participants will have:

- ▶ reviewed the main provisions of CRPD pertaining to health services;
- ▶ identified specific areas of concern in relation to access to health services;
- ▶ devised a number of strategies for overcoming barriers to the inclusion of persons with disabilities in health services.

Module Map



2. TECHNICAL CONTENT

2.A. Background

The World Health Organization defines health as “a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.¹” It has been said that, while “health is not everything, everything is nothing without health.” This is because good health is a prerequisite for the enjoyment of and participation in many fundamental aspects of life, including education, work and society.

Health is determined by a broad range of factors, most of which are outside the health sector. Social, economic and environmental factors are the main external determinants of health. Persons with disabilities who experience disproportionately high rates of poverty often face conditions that impact negatively on their health, including lack of access to education, sanitary living conditions, clean water and food security, among others. At an individual level, factors such as age, sex, hereditary factors and lifestyle choices are important.

The number of persons living with disabilities is growing due to factors such as population increase, ageing, and medical advances that preserve and prolong life. This has increased the demand for health services. Some persons with disabilities are more susceptible than the general population to secondary health conditions. As a result, persons with disabilities may have greater needs than the general population. Health promotion services for the prevention of further disability and the promotion of health in general are important in determining the quality of life and health status of those with disabilities.

Persons with disabilities experience significant barriers to accessing health care. Barriers, which can be particularly severe for those residing in rural areas, can include the following:

- ▶ physically inaccessible medical clinics and hospitals;
- ▶ lack of appropriate transport to enable them to seek medical care or rehabilitation services; lack of communications and accommodation in health care settings;
- ▶ untrained personnel and inadequate staffing;
- ▶ negative attitudes of health care providers;
- ▶ harmful practices, particularly in relation to persons with psychosocial disabilities;
- ▶ denial of treatment on grounds of disability.

As with all members of the general population, the health needs of persons with disabilities can vary broadly. The range of services available to the general population must also be accessible

¹ Constitution of the World Health Organization. Geneva, World Health Organization, 1948

to persons with all types of disability. Care must also be taken to meet the health needs of those with invisible disabilities, particularly those with psychosocial disabilities and other mental health conditions. Ensuring optimal mental health is an integral part of health service provision, but has received inadequate attention by policy makers and also by society in general. As a result, it imposes an enormous disease burden and an increasing obstacle to development in countries around the world.

While governments cannot offer guarantees against illness or disease, they are responsible for undertaking measures to advance human health, whether in the social, physical, legal or economic environments.

The Medical Model vs. The Social Model of Disability

The Medical Model of Disability:

Perhaps the most significant and widespread myth affecting human rights and disability is the idea that disability is simply a medical problem that needs to be solved or an illness that needs to be “cured.” This notion implies that a person with a disability is somehow “broken” or “sick” and requires fixing or healing. By defining disability as the problem and medical intervention as the solution, individuals, societies, and governments avoid the responsibility for addressing the barriers that exist in the social and physical environment.

Instead, they place the burden of addressing the “problem” in the person with the disability on the health profession. Many governments throughout the world have fueled the medical model by funding extensive medical research that aims to find the “cure” for certain disabilities, while not providing any funding to remove the barriers that create disability in society.

The Social Model of Disability

The social model envisions disability as something that is created by the barriers and attitudes in society, not a trait or characteristic that is inherent in the person. Under the social model, society creates many of the social and physical barriers we consider “disabling,” and this model focuses on eliminating those barriers, not on “fixing” or “curing” disabilities. This includes modifying the created environment, providing information in accessible formats and ensuring that laws and policies support the exercise of full participation and non-discrimination.

2.B. Legal Framework

The right to health is well established in international human rights law, including in the International Covenant on Economic, Social and Cultural Rights², which recognizes the right of all persons to the highest attainable standard of health (Art. 12); and the Convention on the Rights of the Child, which requires State parties to recognize the rights of children with disabilities to specific assistance to ensure their effective access to health care services and rehabilitation services in a manner conducive to the child achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development (Art. 23).

The Constitution of the World Health Organization (WHO) also enshrines the highest attainable standard of health as a fundamental right of every human being. The right to health includes access to timely, acceptable, and affordable health care of appropriate quality. The right to health means that States must generate conditions in which everyone can be as healthy as possible. It does not mean the right to be healthy.

Health as a Resource for Everyday Life

To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is positive concept emphasizing social and personal resources, as well as physical capacities.' (WHO, 1998)

The Convention on the Rights of Persons with Disabilities (CRPD) reinforces and strengthens protection for persons with disabilities in relation to health and rehabilitation. It recognizes that persons with disabilities have the right to the highest attainable standard of health and that State parties must recognize that right without discrimination on the basis of disability (Art. 25) and further guarantees the right of persons with disabilities to access rehabilitation services of all kinds (Art. 26). Moreover, the Convention recognizes the right of persons with disabilities to access, within their communities, a range of in-home, residential and other support services (Art. 19).

² The Universal Declaration of Human Rights, together with the International Covenant on Economic, Social and Cultural Rights, together with the International Covenant on Civil and Political Rights are known as the international bill of rights.

Important

- The right to health includes access to vital public health programmes as well as to rehabilitation services, including residential care, community-based care and support services.
- Services should be provided on an individual or “person-centered” basis, with due regard to the range of support services required (e.g., supportive devices, nursing, personal assistance, respite, rehabilitation, day activities and caring assistance).
- The right to health includes access to basic health services as well as specialized rehabilitation services.

In prohibiting all forms of discrimination, the CRPD also requires that reasonable accommodation be provided. States are therefore required to take measures to:

- ▶ ensure that persons with disabilities are reasonably accommodated in the context of health care services, and
- ▶ ensure accessibility more generally to health care services.

Essential for many individuals with disabilities, the right to health includes access to health-related rehabilitation. The right to rehabilitation is more broadly set forth in Article 26 of the CRPD.

Health and Habilitation/Rehabilitation

“*Habilitation* refers to a process aimed at helping people gain certain new skills, abilities, and knowledge. *Rehabilitation* refers to re-gaining skills, abilities or knowledge that may have been lost or compromised as a result of acquiring a disability, or due to a change in one’s disability or circumstances.

Closely related to the perception of disability in narrow terms as a health issue and reinforced by the medical model of disability is the notion that habilitation and rehabilitation are also medical subjects and therefore part of the health context. Habilitation and rehabilitation include a range of measures – physical, vocational, educational, training-related, and others – necessary to empower persons with disabilities to maximize independence and the ability to participate in society, not simply to achieve physical or mental health. For this reason, the right to health and the right to habilitation and rehabilitation are addressed separately in the CRPD. The exception, of course, is that health-related rehabilitation is recognized as part of the right to health. This would include, for example, physical therapy to strengthen muscles that are affected by an injury, illness, or disability.”

Excerpted from Janet Lord and Allison deFranco, Human Rights Yes! The Convention on the Rights of Persons with Disabilities, Chapters on the Right to Health and the Right to Habilitation and Rehabilitation, available at:

<http://www1.umn.edu/humanrts/edumat/hreduseries/HR-YES/contents.html>

As with other rights addressed in the present toolkit, the rights of persons with disabilities to health is indivisible, interdependent, and interconnected with the other rights enshrined in the CPRD. A bidirectional relationship often exists between one's enjoyment or inability to enjoy one's rights. For example, poor health negatively impacts on one's ability to obtain an education or to work. At the same time lack of access to education or to work impacts on one's ability to access appropriate health care. The present module focuses on the right to health. However, the inter-connected relationships between the rights set out in the CPRD underscore the need for a holistic approach to its implementation.

The *WHO global disability action plan 2014-2021* focuses on achieving optimal health, functioning, well-being and human rights for all persons with disabilities. The action plan calls for WHO Member States to remove barriers and improve access to health services and programmes; strengthen and extend rehabilitation, assistive devices and support services, and community-based rehabilitation; and enhance collection of relevant and internationally comparable data on disability, and research on disability and related services³.

The action plan has the following three objectives:

1. to remove barriers and improve access to health services and programmes;
2. to strengthen and extend rehabilitation, habilitation, assistive technology, assistance and support services, and community-based rehabilitation; and
3. to strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services⁴.

On May 27, 2021, the 74th World Health Assembly adopted Resolution EB148.R6 "The highest attainable standard of health for persons with disabilities."⁵ The resolution aims to make the health sector more inclusive and accessible to persons with disabilities by tackling the significant barriers to health services they face. These include:

- **Access to effective health services:** persons with disabilities often experience barriers that severely affect their rights, including physical barriers that prevent access to health facilities; informational barriers that prevent access to health information and attitudinal barriers that lead to discrimination.
- **Protection during health emergencies:** public health emergencies, such as the COVID-19 pandemic, disproportionately affect persons with disabilities because national health emergency preparedness and response plans often do not consider them.
- **Access to public health interventions across different sectors:** public health interventions do not reach persons with disabilities because the information is not in an accessible format and their specific needs and situations are not reflected in the interventions.

³ WHO: Disability and Rehabilitation Team: www.who.int/disabilities

⁴ Ibid.

⁵ "A New Landmark Resolution on Disability Adopted at the 74th World Health Assembly," May 27, 2021, <https://www.who.int/news/item/27-05-2021-a-new-landmark-resolution-on-disability-adopted-at-the-74th-world-health-assembly>

The Resolution also aims to improve collection and disaggregation of reliable data on disability to inform health policies and programmes⁶.

The [European Disability strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe](#) focuses on eliminating barriers⁷. The Commission has identified eight main areas for action: accessibility, participation, equality, employment, education and training, social protection, health and external action. Section 7 - Health, states:

“People with disabilities may have limited access to health services, including routine medical treatments, leading to health inequalities unrelated to their disabilities. They are entitled to equal access to healthcare, including preventive healthcare, and specific affordable quality health and rehabilitation services which take their needs into account, including gender-based needs. This is mainly the task of the Member States, which are responsible for organising and delivering health services and medical care. The Commission will support policy developments for equal access to healthcare, including quality health and rehabilitation services designed for people with disabilities. It will pay specific attention to people with disabilities when implementing policies to tackle health inequalities; promote action in the field of health and safety at work to reduce risks of disabilities developing during working life and to improve the reintegration of workers with disabilities⁸; and work to prevent those risks.⁹”

The rights of persons with disabilities to health is indivisible, interdependent, and interconnected with the other rights enshrined in the CRPD. A bidirectional relationship often exists between one's enjoyment or inability to enjoy one's rights. For example, poor health negatively impacts on one's ability to obtain an education or to work. At the same time lack of access to education or to work impacts on one's ability to access appropriate health care. The present module focuses on the right to health. However, the inter-connected relationships between the rights set out in the CRPD underscore the need for a holistic approach to its implementation.

⁶ Ibid.

⁷ 2006 Eurobarometer: 91% find that more money should be spent on eliminating physical barriers for people with disabilities

⁸ Health and Safety at Work 2007-2012 – COM (2007) 62.

⁹ EUROPEAN COMMISSION, Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions - European Disability Strategy 2010-2020: A Renewed Commitment to a Barrier-Free Europe <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2010:0636:FIN:EN:PDF>

See Learning Activity 2.B. titled *The Inter-Connected Relation of Rights*

The section that follows considers in more detail the application of these and other CRPD rights in the context of health services.

2.C. Access to Health for Persons with Disabilities: Areas of Concern

Overarching Barriers Faced by Persons with Disabilities in Accessing Health

Challenges to persons with disabilities continue to exist in both developed and developing countries, albeit at varying degrees. These challenges include difficult access to medical care/treatment, therapy, assistive technology, education, neglect, marginalization, exploitation, stigma, humiliation etc.

Although both men and women face barriers to health care, men are less likely than women to consider that they or their children are sick enough to require health care services and to know where to access those services. Men also report more difficulties in accessing health care financing¹⁰.

The health status of persons with disabilities is often poorer than that of the general population. Until relatively recently such differences were frequently viewed as an inevitable consequence of disability, but it is increasingly recognized that they may actually be the result of inequalities and inequities in access to healthcare.

Problems of disability largely manifest in social contexts and social relations, rather than in an individual's medical condition. In the context of health, stigma and prejudice give rise to additional barriers that persons with disabilities then face. These include:

- **physical barriers** that prevent access for persons with disabilities to health clinics and hospitals;
- **informational barriers** that prevent access for persons with disabilities to health literacy and information brochures and leaflets on health promotion, prevention and protection;
- **attitudinal barriers** which give rise to discrimination that can have severe implications for the rights of persons with disabilities, particularly for those with psychosocial disabilities; and

¹⁰ WHO: Disability and Rehabilitation Team: www.who.int/disabilities.

- **institutional barriers** that include legislation, practices and processes that prohibit access to health services for persons with disabilities.

Services for people with physical, sensory or intellectual disabilities have also been the subject of criticism in relation to communication and cultural barriers.

Access to healthcare for persons with disabilities extends well beyond the accessibility factors described above. Differences in access to health and social services may arise due to availability insofar as services may be scarce or simply not be provided to certain groups, quality may vary between groups, and not all groups may be aware of certain services owing to information deficiencies. It is important both to enhance the capacity of persons with disabilities to access the healthcare system and also to ensure that the system is able to respond in an appropriate and timely manner to their needs.

Specialist Services

While ensuring that persons with disabilities have access to general health services, some specialist services, such as rehabilitation services, may be needed. For example, in some cases persons require care or rehabilitation services specific to their impairment. Many countries have a National Rehabilitation Hospital or Centre which provides specialist services to patients from all over the country who, as a result, of accident, illness or injury, have acquired a physical or cognitive disability and require specialist rehabilitation.

The difficulty in many countries is that such facilities are expensive and can only treat a limited number of patients, resulting in denial of treatment or lengthy waiting periods.

EXAMPLES

- ▶ Where access to medical treatments is limited, persons with disabilities may not be prioritized for treatment. For example, in the case of HIV and AIDS persons with disabilities may not receive antiretroviral therapy and post-exposure prophylaxis because of disability-related stigma and discrimination.
- ▶ Privacy and confidentiality may be compromised for persons with disabilities seeking medical treatment or counselling owing to the presence of personal assistants or sign language interpreters.
- ▶ Individuals who provide technical assistance to implement public health programmes often lack disability expertise and therefore leave disability out of their assessments and other work products (e.g. design of household surveys; outreach strategies).
- ▶ Written materials on health matters may not be accessible to persons who are blind. Radio messaging cannot be accessed by persons who are deaf.

Country Checkpoint

What, in your view, are the most important barriers to health and personal social services for persons with disabilities? How may these barriers be reduced?

Barriers to Health and Social Services for Persons with Disabilities

- lack of physical access, including transportation and/or proximity to clinics and, within clinics, lack of ramps, inaccessible scales and examination tables, inaccessible treatment and diagnostic equipment (including infusion chairs, mammography machines, and radiology equipment);
- lack of information and communication materials (e.g. lack of materials in braille, large print, simple language, and pictures; lack of sign language interpreters, lack of materials for the deaf and persons suffering from hearing loss);
- lack of private offices to discuss confidential health and social matters;
- lack of extra time, care and attention to meet the needs of the disabled person;
- lack of suitable water sources, toilets, washroom and restroom facilities;
- lack of awareness, knowledge and understanding of the needs of disabled persons;
- health-care and social service providers' negative attitudes, prejudice and imposed stigma;
- providers' lack of knowledge and skills as regards persons with disabilities;
- lack of coordination among health care providers;
- lack of training of health care personnel; and
- lack of funding, including lack of health-care insurance.

Important

Too often, even well intentioned policies treat persons with disabilities as a 'target', as a passive recipient of health and personal social services. Consultation with disabled persons and DPOs is essential to ensure that programmes meet needs effectively. The AAAQ framework (Availability, Accessibility, Acceptability and Quality) provides a useful framework for identifying obstacles to inclusive health care for persons with disabilities.

Country Checkpoint

What are obstacles to healthcare in your country in terms of the AAAQ Framework?

GLOBAL GOOD PRACTICES: ACCESS TO HEALTH

BANGLADESH

WISH2ACTION: Improving Accessibility of Health Centres through Universal Design and Reasonable Accommodation¹¹

In accordance with Bangladesh's "Rights and Protection of Persons with Disabilities Act, 2013", health services providers are required to make changes or 'reasonable adjustments' to their practices to improve delivery of services for persons with disabilities and protect them from discrimination or disadvantage. As such, the Government of Bangladesh established Union Health and Family Planning centres at the rural community level under the Director-General of Family Planning (DGFP), Ministry of Health and Family Welfare. However, given that universal accessibility design was not considered during their development, the centres initially remained inaccessible for persons with disabilities and vulnerable patients

Handicap International's (HI) FCDO-funded WISH2ACTION project, implemented in the Sitakund Upazila region, aims for a barrier-free environment for persons with disabilities to improve their participation in community facilities, including sexual reproductive and health (SRH) services. Through the WISH2ACTION project, HI partnered with the Government of Bangladesh, local NGOs, and organizations for persons with disabilities (OPDs) to make structural changes to select centres for family planning and SRH services accessible. WISH2ACTION's two-pronged approach comprised disseminating information on accessible SRH services to persons with disabilities, including providing door-to-door counseling on family planning, neonatal services, and adolescent healthcare. Then, WISH2ACTION staff and ODP members encouraged persons with disabilities to visit their local health centres for services once centres were accessible for their assistive devices.

FINLAND

A Disability Card to Support Equal Access¹²

In 2016, the European Union (EU) piloted the "EU Disability Card" in eight countries, including Finland, for persons with disabilities to communicate their needs and access support across the EU Member States. The Finnish Service Foundation for People with an Intellectual Disability (KVPS) coordinated the implementation of the national trial from 2018 to 2020 in collaboration with other NGO partners, the Finnish Disability Forum, and the Social Insurance Institution of Finland to promote the card.

Between June and October 2018, over 4,000 persons with disabilities in Finland requested the card. The Finnish disability card, which includes a photo and braille text, allows people to choose symbols to put on the back of the card, indicating the type of assistance they require. Individuals can also include a QR code linking to information on their condition or the "What Matters to Me" app, developed by the Finnish organization Bester in partnership with persons

¹¹ Excerpted from: STEP TOWARDS DISABILITY INCLUSIVE SEXUAL REPRODUCTIVE HEALTH: LEARNINGS FROM WISH2ACTION PROJECT

¹² Zero project: Innovative Policy 2019 on Independent Living and Political Participation

with disabilities. The app allows people to store information about their support needs to share as necessary.

USA

The Rehabilitation Act of 1973 and Americans with Disabilities Act (ADA) of 1990¹³

Section 504 of the US Rehabilitation Act of 1973 prohibits discrimination on the basis of disability by any program or activity receiving federal financial assistance. It requires compliance with specific standards for design and construction of new facilities and ensures the accessibility of programs as a whole. Furthermore, the Americans with Disabilities Act (ADA) of 1990, Title II (ADA) extends protection against discrimination to the full range of state and local government services, programmes, and activities. It requires covered public entities to provide equal access to programs, services, and activities for persons with disabilities. The Title II regulations and ADA Standards for Accessible Design include specific requirements regarding new construction and alterations to buildings and facilities, including health care facilities, as well as requirements for service animals, communications, and telecommunications. For existing facilities that are not accessible, program access requirements under Title II allow public entities the option to relocate programmes or to provide accessible services at other locations.

Water, Sanitation, and Hygiene (WASH)

Access to water, sanitation and hygiene (WASH) facilities is a precondition of good health for all persons. Article 28 of the Convention ensures ‘equal access by persons with disabilities to clean water services, and to ensure access to appropriate and affordable services, devices and other assistance for disability-related needs’. For many years, the sanitation and hygiene needs of persons with disabilities have been treated as of low priority. Many persons with a disability live without access to basic sanitary services, which can exacerbate impairments and poverty.

Disabled persons are likely to experience increased health risks because of a lack of access to sanitation and hygiene services. The lack of inclusive facilities means that persons with disabilities sometimes must engage in unhygienic and dangerous practices. Access to safe and clean water and sanitation facilities is a basic right of all persons, including persons with disabilities, denial of which can have serious implications for their well-being. For example, inaccessible toilet and water facilities are major contributory factors to school dropouts among children with disabilities, especially girls.

Sanitation and hygiene programmes have to mainstream the needs of persons with disabilities. Further, sanitation projects need to go beyond technical solutions and address attitudinal and institutional barriers to accessible sanitation. Better facilities reduce exposure to disease and

¹³ Americans with Disabilities Act of 1990. <https://www.ada.gov/pubs/adastatute08.pdf>. Title II of the ADA is enforced by the U.S. Department of Justice, Civil Rights Division, Disability Rights Section, and the HHS Office for Civil Rights. The Title II regulations are set forth at 28 C.F.R. Part 35.

illness, thereby increasing opportunities and life chances for disabled persons. To apply successful policies and practices more widely, the participation of persons with disabilities in inclusive sanitation and hygiene programme design is crucial, including sharing successful examples. The benefits far outweigh the cost of improved access for all.

GOOD PRACTICE: WASH

TIMOR-LESTE

*The Multi-stakeholder Partnership for Inclusive Water, Sanitation and Hygiene (2011)*¹⁴

The overall objective of this seven-week inclusive WASH project was to ensure the successful mainstreaming of persons with disabilities' needs into WASH initiatives through multistakeholder partnerships between NGOs and the government. The Leprosy Mission implemented the project in collaboration with WaterAid, Plan International, DWASH, Bee Saneamentu no Igene iha Komunidade (BESIK), and Ra'es Hadomi Timor Oan (RHTO).

Partners worked with The Leprosy Mission to propose projects to all WASH agencies in Timor-Leste, gathered data on challenges facing persons with disabilities, developed sustainable solutions and training workshops for stakeholders, implemented training for stakeholders, and developed prototypes for technical solutions.

Partners also developed a report on recommendations for stakeholders to continue with WASH projects and followed up on the commitment of other stakeholders to continue working towards inclusive WASH in Timor-Leste.

The project achieved the following:

- **Policy:** implementation of guidelines on inclusive standards for water points and public toilets was launched in February 2011, and were integrated into the guidelines for the National Sanitation Policy. All new water points are built in accordance with the accessibility standard developed as part of the project.
- **Capacity Building:** the local DPO now provides training workshops on disability inclusive development for other stakeholders.
- **Advocacy and Awareness:** a member of the local DPO participated in a speaking tour of several Australian cities (Brisbane, Canberra, Melbourne, Townsville) promoting awareness of the challenges faced by persons with disabilities in rural Timor-Leste. The project was promoted through local Timorese radio stations and the international head offices of all agencies involved.
- **Accessibility:** educational brochures of inclusive WASH were produced in local dialects. The venue for the workshop and transportation were accessible to persons with disabilities.

¹⁴ Source: Excerpted from: UN, BEST PRACTICES FOR INCLUDING PERSONS WITH DISABILITIES IN ALL ASPECTS OF DEVELOPMENT EFFORTS, April 2011, page 49

- **Participation:** village engagement was the primary focus and local people were encouraged to share their WASH experiences and challenges during the sessions in the villages.
- **Gender Issues:** Gender experts were actively involved in the project, and the role of women as carers and helpers of persons with disabilities when using WASH facilities was emphasized.

Health and Persons with Psycho-social Disabilities

In some countries, people who are perceived as having a psychosocial disability or a mental health condition often face particular challenges in accessing health care and, worse, often face severe abuses in the context of care or treatment. These can include arbitrary detention in prisons or involuntary commitment to institutions, where residents may experience forced treatments and medication, verbal and physical abuse, poor conditions and overcrowding, and are often chained up for long periods of time¹⁵.

Abuses have also been documented at community level where, due to false perceptions about persons with psychosocial disabilities, local health care providers - including traditional healers - sometimes also engage in abusive practices, often including shackling, even of children¹⁶. Families and relatives are often the main support mechanisms available to individual patients with various psychosocial disabilities, but frequently struggle to provide effective support, given the lack of community-based support facilities such as outpatient medical and rehabilitation services and counselling based on free and informed consent.

Mental and psychosocial disability is a universal disease with universal challenges. No continent, region, nor country is safe. However, remedial responses vary on the basis of culture, traditions, resources, policies and social and community consciousness. The adoption of the 2030 Agenda for Sustainable Development and the recognition therein of mental health as an important part of human health is a measure of much promise in the international mobilization in favour of mental health and well-being¹⁷.

Resulting from the complex nature of mental health conditions, successful treatment requires regular access to health care professionals and a variety of support services. Unfortunately, mental health care services are often not available or are under-utilized, particularly in developing countries. The WHO has estimated that, in developed countries, the treatment gap (the percentage of persons who need mental health care but do not receive treatment) ranges from 44 per cent to 70 per cent; in developing countries, the treatment gap can be as high as 90

¹⁵ Human Rights Watch has, for example, reported on instances of shackling in countries including Ghana, Somaliland and South Sudan. Reports available at: <https://www.hrw.org/topic/disability-rights>

¹⁶ Further information regarding the impacts of negative beliefs on persons with psychosocial disabilities can be found in the Module on “Culture, Beliefs and Disability” of the Toolkit for Africa.

¹⁷ Yamin, A. E. and Rosenthal, E., “Out of the shadows: Using human rights approaches to secure dignity and wellbeing for people with mental disabilities”, PLOS Medicine, Vol. 2(4), 2005, pp. 296–298.

per cent. Common mental health conditions such as depression can be extremely disabling, yet many people with those conditions do not receive treatment¹⁸.

Among the challenges to mental health care access are limited availability and affordability of mental health care services, insufficient mental health care policies, lack of education about mental illness, and stigma. In many countries, the cost of mental health services is a significant barrier to accessing care for persons with mental health conditions. Although many countries have introduced public mental health care, private mental health care, health insurance, and mixtures of these systems, persons with severe mental illness have a high level of economic and social disadvantage. Mental disorders are not covered by insurance policies in many countries, making mental health care unaffordable for many people. The WHO also reports that 25 per cent of all countries do not provide disability benefits to patients with mental disorders, and one-third of the world's population lives in countries that allocate less than 1 per cent of their health budget to mental health. In addition, 31 per cent of countries do not have a specific public budget for mental health illness. This means that cost is, and remains, a significant barrier to accessing mental health services¹⁹.

Another challenge to accessing mental health care is the availability of essential medicines and pharmaceuticals. This is a particularly challenge in many developing countries, and severely restricts access to treatment for mental disorders. The same WHO report highlights that almost 20 per cent of countries do not have at least one common antidepressant, one antipsychotic, and one antiepileptic medication available in primary care settings.

The WHO recommends the integration of specialized mental health services into primary healthcare. This helps to improve access to health care and reduces stigma for people with mental health disorders and their families. Stigma is reduced significantly because primary healthcare services are not associated with any specific health conditions, such as mental health disorders.

Raising awareness among healthcare professionals, social service providers, government officials, security authorities, caregivers, traditional and spiritual healers, and the public on the needs of persons with mental and psychosocial disabilities is very important in addressing and resolving harmful beliefs, negative attitudes, and prejudices. Awareness raising is essential in the building of organizational and individual capacity to deliver the range of health and social services that will enable persons with mental and psychosocial disabilities and their family members to live fully inclusive lives in their communities²⁰.

¹⁸ Lopez A, Mathers CD, Essati M, Jamison DT, Murray CJL, Global Burden of Disease and Risk Factors, 2006, Washington, DC, World Bank.

¹⁹ Lund C, Myer L, Stein DJ, Williams DR, Flisher AJ, "Mental Illness and Lost Income among adult South Africa", 2013, Soc Psychiatry Psychiatr Epidemiol. May;48(5): pp.845-51

²⁰ Jamanetwork.com, "Integrating mental health into primary care: a global perspective", World Health Organization and World Organization of Family Doctors (WONCA), Geneva, 2008, pp. 13 and 19.

Good Practice: Health and Persons with Psychosocial Disabilities

BHUTAN

A Nationwide Strategy to Fight Mental Health Issues²¹

In Bhutan, as in many countries, there has been a lack of awareness, myths, and shame regarding mental health issues. Consequently, many people have had to hide their symptoms and do not access treatment. However, in an attempt to address the situation, the National Mental Health Programme launched in 1997 to provide community-based mental health care services and to educate society about mental health protection, prevention, and treatment. With a well-established national primary health care network, Bhutan is now working to train doctors, health care workers, and nurses on mental health treatment skills; to provide appropriate medication; and to integrate mental health into general primary health care services.

Implementation of the National Mental Health Programme started with visits by a mental health service team to community leaders, local health care personnel (doctors, health care workers, and nurses), and traditional healers to discuss existing practices, understand their perspectives and gain their cooperation. Following these consultations, healthcare personnel offer education and training to introduce modern mental health concepts and their advantages. The mental health team with community leaders, local health care personnel, and traditional healers, identifies potential cases in the community and provides training in basic psychiatric skills, such as diagnosing and treating common mental health issues. After interviewing and diagnosing the identified cases, the team supports the local health workers in creating individual treatment plans, which include consultations with families and gaining their involvement in supervising medications and providing emotional support. Local health workers follow-up on individual cases in clinics or through home visits. At the national level, a core team of mental health specialists visit the primary health centres regularly to monitor activities and to provide clinical supervision.

In 2017, Bhutan had 345 doctors (including specialists), 25 clinical officers, 1,264 nurses, and 600 health assistants. As of 2018, the programme trained about 86 per cent of general doctors, 25 per cent of nurses, and 75 per cent of primary health care workers.

Sexual and Reproductive Health (SRH) of Persons with Disabilities

Reproductive health goes beyond the absence of disease or infirmity. It is a state of complete physical, mental and social wellbeing in all matters relating to the reproductive system, and at all stages of life.

Persons with disabilities have the same sexual and reproductive health needs as other persons. However, although existing services and information can usually be adapted easily to accommodate persons with disabilities, there are often barriers persons with disabilities

²¹ Zero Project.org: Innovative Policy 2019 on Independent Living and Political Participation.

encounter to accessing them. In many cases, barriers are created or sustained as a result of stigma, ignorance and negative attitudes of society and individuals, including health-care providers. For example, it is often assumed that persons with disabilities are not sexually active and therefore do not need sexual and reproductive health services. In working to ensure that all sexual and reproductive health programs reach and serve persons with disabilities, increasing awareness regarding the needs and rights of persons with disabilities is critical.

The need for SRH services for women with disabilities is often heightened, owing to their increased vulnerability to abuse. Women with disabilities experience higher rates of gender-based violence, sexual abuse, neglect, maltreatment and exploitation compared to women without disabilities²². Persons with disabilities are sometimes placed in institutions, group homes, hospitals, and other group living situations, where they may not only be prevented from making informed and independent decisions about their sexual and reproductive health, but also face an increased risk of sexual abuse and violence. Persons with intellectual and mental disabilities are particularly vulnerable in this regard. Violence against women with disabilities can also take the form of forced medical treatment or procedures, including forced sterilization, which many countries and regions have documented incidences.

Women with disabilities have also often been denied the right to establish relationships and to decide whether, when, and with whom to have a family, in some cases being forced to marry. As a result of the increased risk of sexual violence, women with disabilities are also at risk of becoming infected with HIV and other sexually transmitted diseases. In crisis situations, these risks are multiplied.

GOOD PRACTICE: SRH SERVICES

BANGLADESH

WISH2ACTION: Ensuring Safe and Clean Home Delivery in Ulipur Cluster through Flood and COVID-19 Response²³

In 2020, three floods occurred in Ulipur Cluster amidst the COVID-19 crisis. HI's WISH2ACTION project team identified that pregnant women with disabilities were suffering from gaps in SRH services as health and family planning centres became inaccessible for antenatal care or delivery. The WISH2ACTION project team arranged meetings with cluster management committees (CMC), seeking their suggestions to improve the situation. The CMC suggested family welfare centres to update the list of pregnant women and skilled birth attendants (SBA) in their respective areas. SBAs were unable to ensure clean and safe delivery at home due to unavailability of safe delivery kits. Through WISH2ACTION, HI provided

²² In his 2006 *In-Depth Study on All Forms of Violence against Women*, the Secretary-General observed that surveys conducted in Europe, North America and Australia have shown that over half of women with disabilities have experienced physical abuse, compared to one third of non-disabled women. A/61/122/Add.1, para. 152, citing to Human Rights Watch, "Women and girls with disabilities", available at: <http://hrw.org/women/disabled.html>

²³ Excerpted from: STEP TOWARDS DISABILITY INCLUSIVE SEXUAL REPRODUCTIVE HEALTH: LEARNINGS FROM WISH2ACTION PROJECT

family planning centres in 11 sub districts (used by the SBAs) with safe delivery kits containing sterile stitch, blade, rubber sheet, gloves and clamp materials. Additionally, district health and family planning authorities, local administration played a great role in facilitating the implementation of the initiative, which led to safe and clean home deliveries and a decrease in maternal mortality and morbidity.

WISH2ACTION: Inclusive SRH Services in Different Health Facilities to Help Persons with Disabilities Make Right Decisions²⁴

HI's data collection from beneficiaries, follow-up visits, referral activities, courtyard, and one-on-one awareness sessions through WISH2ACTION found that most persons with disabilities were unaware of their SRH rights, availability of services and health centres, and depended on private health facilities. In response, the WISH2ACTION project team disseminated accurate information on available SRH services and centres, such as Union Health and Family Welfare Centres, Community Clinics, and Upazila Health Complex. As a result, the number of persons with disabilities seeking SRH and family planning services from government facilities, which are free of cost, increased.

Disability Inclusion in HIV and AIDS Response

Evidence suggests that persons with disabilities are at equal, if not increased, risk of exposure to HIV. While data is scarce, a 2014 analysis of data from Sub-Saharan African countries showed that persons with disabilities are 1.3 times (1.48 for women) more at risk of contracting HIV than people without disabilities²⁵. In addition, evidence suggests that persons living with HIV or those with AIDS are also at risk of developing disabilities due to illness or related treatments²⁶.

Yet, UNAIDS has found that persons with disabilities “represent one of the largest and most underserved populations” when it comes to health and HIV services²⁷. Barriers faced by persons with disabilities in this regard are similar to those faced in relation to access to health services generally, including lack of accessible information or education regarding HIV prevention, treatment, care and other matters and the inaccessibility of HIV testing and treatment centres due to physical barriers, poor coordination of health services and lack of accessible transport. For individuals with disabilities who are HIV-infected, poverty and barriers such as lack of transport to medical treatment centres hamper effective access to care and treatment, including antiretroviral and other medications for related infections. Persons with disabilities also experience disproportionately high levels of poverty, further limiting access to HIV prevention, treatment, care and support.

²⁴ Ibid.

²⁵ UN IRIN news, Heightened HIV risk for people with disabilities, available at:

<http://www.irinnews.org/report/100414/heightened-hiv-risk-for-people-with-disabilities>

²⁶ Dr. Jill Hanass-Hancock (HEARD, IDDC), Dr. Paul Chappell (University of Johannesburg, IDDC) and Leandri Pretorius (HEARD), Discussion Paper of UNAIDS Strategy Brief for Integrating Disability into AIDS Programming (2014).

²⁷ UNAIDS, The Gap Report: People with Disabilities (2014).

Lack of Availability: HIV-related facilities, goods, and services, including HIV prevention, treatment, care and support are often not available to persons with disabilities; health care providers are not qualified in sufficient numbers to provide disability-specific support and accommodation in HIV prevention, treatment, care and support services.

Barriers to Accessibility: Accessibility requires attention to discriminatory attitudes as well as to physical, economic and informational barriers.

- **Discrimination:** Stigma and discrimination create barriers to HIV prevention, treatment, care and support for persons with disabilities.
- **Physical inaccessibility:** HIV and AIDS prevention, treatment, care and support are often inaccessible to persons with disabilities, including HIV testing and treatment centres, because of physical barriers, poor coordination of health services or lack of accessible transport.
- **Economic inaccessibility:** Consumers with disabilities often live in poverty, which limits their access to HIV prevention, treatment, care and support; persons with disabilities may not enjoy equal access to health facilities, goods and services, including medicines and supportive devices.
- **Information inaccessibility:** Information relating to HIV prevention, treatment, care and other matters, is inaccessible to persons with disabilities; and persons with disabilities are often wrongly judged to lack the capacity to make or participate in decisions about their treatment and care.

• **Unacceptable HIV and AIDS facilities, goods, and services:** Persons with disabilities often experience disrespectful treatment in the context of HIV and AIDS; informed consent procedures are often not respected for persons with disabilities; confidentiality and privacy of persons with disabilities is often breached.

Poor quality HIV and AIDS facilities, goods and services: Persons with disabilities are entitled to quality facilities, goods and services.

Source: One Billion Strong, HIV/AIDS, Disability and Discrimination: A Thematic Guide to Law, Policy and Programming (2012).

Important

Just as disability should be mainstreamed across health services generally, the rights and needs of persons with disabilities should be mainstreamed in national responses to HIV and AIDS, including national strategic plans. In many countries, this has not been done.

Good Practice Examples

Persons with disabilities – and the organizations they form – can meaningfully and fully engage in HIV and AIDS programming. The forms of engagement include the following types of intervention:

- ▶ educating persons about HIV;
- ▶ providing HIV prevention commodities, services, and treatment;
- ▶ providing protection from discrimination and sexual violence; and
- ▶ empowering persons to participate in the HIV response.

Disability, HIV, and AIDS Trust (DHAT)

The Disability, HIV and AIDS Trust (DHAT) promotes the rights and capacity-building of Persons with Disabilities with cervical cancer, TB, HIV and AIDS-related infections; and aims at achieving inclusion and full participation of Persons with Disabilities in the context of disability rights, cervical cancer, tuberculosis, sexual reproductive health rights (SRHR), HIV and AIDS interventions.

The Disability HIV and AIDS Trust (DHAT) is a non-profit regional organization, registered in Harare, Zimbabwe.
Website: www.DHATRegional.org

2.D. Measures to Ensure the Right of Persons with Disabilities to Health Services

The present section explores approaches to ensuring the right to health services for persons with disabilities. As with the implementation of other rights enshrined in the CRPD, there are a range of measures that can be taken by countries and other stakeholders to ensure the right to health services for persons with disabilities.

See Learning Activity 2.D. titled *A Plan to Address Barriers to Health Care*

Legislative and Policy Frameworks

Countries have specific obligations under international law to respect, protect and ensure the right to health for persons with disabilities. States, in cooperation with persons with disabilities and their representative organizations, should conduct a review or scoping of all relevant

legislation and policy that touches on the right of persons with disabilities to health care. Through this process, State parties can identify areas in need of reform or development, which can provide a foundation for establishing a comprehensive legislative and policy framework for the right to health for persons with disabilities. In developing new legislation and policy frameworks, it is essential that an implementation plan be established and that monitoring and evaluation processes are included. (*See Module on National Action Plans*).

In evaluating legislative and policy frameworks the following areas, among others, should be considered.

The Role of Doctors, Nurses, and Administrators

As members of the caring professions, health professionals have a particularly important role. Awareness among health service professionals of the needs of persons with disabilities in health care settings is, therefore, of paramount importance. Beyond understanding the rights and concerns of persons with disabilities, organizations representing persons with disabilities have reiterated the continuing attitudinal barriers in health care, including patronizing and ignorant front-line staff. Negative attitudes and harmful beliefs create significant barriers to the provision of health services for persons with disabilities. Measures to achieve genuinely inclusive health services must address attitudinal barriers including the education of health care professionals on the rights of persons with disabilities. Attitudinal barriers can have a devastating impact on the quality of health care particularly for people with learning and mental health disabilities who have a long history of misunderstanding, fear and stigma.

In the area of health services it is of utmost importance to involve frontline healthcare providers in daily contact with persons with disabilities in awareness-raising. Awareness-raising is essential to the building of organizational and individual capacity to deliver the range of health services that will enable persons with disabilities to live fully inclusive lives in their communities.

Physical Accessibility

Persons with disabilities with health problems cannot visit hospitals or health clinics if buildings are physically inaccessible to them. To ensure enjoyment of the right of persons with disabilities to health services, accessibility must therefore be addressed broadly, for example in relation to entrances to buildings and healthcare facilities, appropriate equipment, restroom facilities, and to transportation to the health care facility. Accessibility should be focused mainly on the difficulties of orientation to the health care setting, including completion of registration forms, location of a seat in the waiting area, and realization of when to enter the examination room.

Informational Barriers

Health service information is rarely available in formats that are accessible to persons with disabilities. This limits people's understanding of what services are available and how to access them, raising questions about:

1. whether the uptake of disability, mental health and general services by persons with disabilities is an accurate reflection of real need; and
2. the quality of informed consent to treatment that is being secured.

Health outreach and health promotion efforts also often fail to reach persons with disabilities.

Economic Barriers

Economic and financial factors are real barriers in relation to health service for persons with disabilities. While financial barriers within the health care system can affect members of the general population in accessing health care, persons with disabilities may experience additional disadvantages in their health and well-being. Low-income persons with disabilities are more likely to experience financial barriers to care. There are significant differences in the availability of services between those who are able to pay for services and those who do not have the resources to do so. In many countries, only those who can afford to pay for supportive devices such as crutches, hearing aids and reading glasses are able to receive them.

Ensuring DPOs' Participation

Health and social services support should be provided, organised and designed around what is important to service users from their own perspectives. User involvement and participation remains limited in the health sector, although there is now a greater awareness of the importance of developing effective forms of participation. This is consistent with the CRPD, which provides that persons with disabilities and their representative organizations should be consulted in law, policy and programming decisions (Art. 4(3)).

In order to ensure a fully inclusive health sector, it is essential for government officials to consult with and ensure the participation - at all stages of health-related policy development, implementation, monitoring and evaluation - of persons with disabilities across the full range of disability, along with their representative organizations. It is recognized in relation to health services that there is no 'one size fits all', and that the services and situations in each community and country are unique and different.

DPOs may have valuable contributions to make in areas including the following:

- ▶ training of doctors, nurses and health professionals;
- ▶ design of accessible health services;
- ▶ advice on accessibility to the created environment;
- ▶ advice on communication access;
- ▶ identification of strategies for inclusion; and
- ▶ provision of support to families of persons and patients with disabilities.

A disability access focal point could be designated within each hospital or health clinic to serve as a resource and to interface with the disability community, with the families of patients with disabilities, and with others. DPOs should be included in all outreach to civil

society organizations in relation to health service utilization.

Supporting DPOs

Many disabled persons' organizations have managed to develop without any consistent support for the development of their staff and organizational structures. Health and social ministries and agencies working in partnership with disabled persons' organizations, can support DPOs in ensuring that management processes such as strategic planning, governance and financial accounting are put in place for each organization and collectively.

GOOD PRACTICE: SUPPORTING AND ENSURING DPOs PARTICIPATION

BANGLADESH

WISH2ACTION: Organisation for Persons with Disabilities (OPDs) Championing on Disability Inclusive Sexual and Reproductive Health and Rights (SRHR) Services²⁸

From September 2018 to August 2021, HI implemented its WISH2ACTION project in Bangladesh to include persons with disabilities in SRHR services through community engagement and national policy changes. Instead of establishing new networks, WISH2ACTION leveraged ODPs existing structures at the national and community level to implement project activities, including:

- disseminating SRHR information on services to persons with disabilities;
- lobbying to create community outreaches so that the services are accessible in the communities;
- advocating for and facilitating training of disability-inclusive SRHR services.
- advocating at the health facility level to make the health facility infrastructure and services disability inclusive; and
- offering representation of persons with disabilities in community structures (e.g., CMCs) to share the challenges faced by persons with disabilities in accessing SRHR services, and support in identifying possible solutions.

Through working with ODPs, WISH2ACTION increased the number of persons with disabilities receiving SRHR services. Additionally, ODPs enhanced their ability to advocate actively for SRHR services for persons with disabilities, resulting in behavioral changes within communities and empowering women with disabilities to confidently, "speak up on SRHR issues and their rights." In training ODP members on SRHR, WISH2ACTION also addressed common resource restraints, such as limited access to funding and training that helped groups expand the scope of their work and support to persons with disabilities.

²⁸ Excerpted from: Faruk Ahmed Jalal et al., Step Towards Disability Inclusive Sexual Reproductive Health: Learnings from WISH2ACTION Project (Bangladesh), August 2021). © Handicap International – Humanity & Inclusion, Bangladesh

Institutional Structures to Support Access to Health Services

Persons with disabilities should be able to access health services within the general health system. Institutional structures at national level must work to ensure the adequate provision of health services for persons with disabilities. In many cases disability issues are addressed primarily by a focal ministry, often a ministry for social affairs. The Health Ministry in many countries has responsibility for mainstreaming disability across all relevant parts of the health services and for rolling out the latest medical and surgical advances to help persons with disabilities lead fuller and more active lives.

Mainstreaming in the context of health promotes inclusion and addresses the barriers that exclude persons with disabilities from accessing health services open to the general population. Mainstreaming is about making appropriate adjustments to healthcare services, policies, practice, facilities and delivery so that persons with disabilities can achieve full inclusion and active, barrier-free participation in health care and enjoy the benefits of advances in medical science and technology. Moreover, as disability is present throughout the entire life cycle, so health services must be available and accessible to persons with disabilities at all stages of life.

The CRPD calls for the establishment of (i) a national framework for its implementation and monitoring (Art. 33), consisting of one or more ‘focal points’ within government, (ii) the possible establishment of a ‘coordination mechanism’ to promote, protect and monitor implementation, and (iii) the designation or establishment of an independent monitoring mechanism. This framework, which must also include the participation of persons with disabilities and their representative organizations, should be harnessed to advance implementation of health rights, and to ensure that efforts in this regard are harmonized across the government.

Budgeting

The non-affordability of health services and transport accounts for two of the main reasons why persons with disabilities do not receive needed health care in low-income countries. Many governments around the world have difficulty providing adequate resources for the health services. There is often very severe competing pressure within health budgets for limited resources, and services such as those provided by general hospitals do not cover the needs of persons with disabilities. In many countries current budgetary allocations are not enough to make significant impacts in the field of services for persons with disabilities. Nonetheless, governments can improve health outcomes for persons with disabilities by making health services affordable, within the best use of the available resources.

In many countries in both the developed and developing worlds, there has been a significant increase in the range and diversity of health and personal social services provided by private health care providers. Where private health insurance dominates private health markets and care financing, governments should ensure that persons with disabilities are covered and consider measures to make health premiums affordable. Governments should use financial incentives to encourage health care providers to make services accessible and provide

comprehensive assessments, treatment, and follow-up. Governments should also consider options for reducing or removing out-of-pocket payments for people with disabilities who do not have other means of financing their need for health care services.

Collecting Data on the Provision of Health Care Services for Persons with Disabilities

Data on the rate at which persons with disabilities use health services is often not readily available in many countries. The uptake of health services by persons with disabilities is rarely measured in several countries. General surveys do not fully or consistently disaggregate data on disability in such a way that a distinct analysis of the social, economic and demographic factors relating to disability in health services can be made. The CRPD requires States to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to inclusive health services and other rights guaranteed in the treaty.

According to WHO, there are “insufficient rigorous and comparable data and research related to disability and health care systems nationally and globally. Data are collected on mortality, but policy-relevant data on functioning and disability are lacking. National data collection systems, which may include censuses, population surveys and administrative data registries, do not often collect data on disability. People with disability are often excluded from trials that seek scientific evidence for the outcomes of a health intervention. The lack of evidence is a significant barrier for decision-making and in turn impacts on access to mainstream health care and specialized services for people with disability.”²⁹

Per WHO, Data needed to strengthen health care systems include: number of people and health status of people with disability; social and environmental barriers, including discrimination; responsiveness of health care systems to persons with disabilities; use of health care services by people with disability; rehabilitation and habilitation needs and the extent of the need, both met and unmet, for care. Disaggregating these data further by sex, age, income or occupation is important for uncovering patterns, trends and other information about “subgroups” of people with disability³⁰.

GOOD PRACTICE: DATA COLLECTION

BANGLADESH

*Local Authorities Using WISH2ACTION Beneficiary Database to Support Persons with Disabilities*³¹

²⁹ See WHO: Objective 3: To strengthen collection of relevant and internationally comparable data on disability and support research on disability and related services.

³⁰ WHO: Disability and Rehabilitation Team: www.who.int/disabilities.

³¹ Faruk Ahmed Jalal et al., Step Towards Disability Inclusive Sexual Reproductive Health: Learnings from WISH2ACTION Project (Bangladesh), August 2021. © Handicap International – Humanity & Inclusion, Bangladesh

Meetings between the Upazila Social Welfare Officer and the Chairman of Salimpur Union Parishad of Sitakunda Upazila revealed gaps regarding accurate data available for persons with disabilities in the area. To minimize these gaps, Handicap International (HI) provided a list of its beneficiaries to authorities and other relevant stakeholders through the WISH2ACTION project, which the project team prepared with data collected using the Washington Group Questionnaire (WGQ). Local government offices and other stakeholders have since used the database in their initiatives to support persons with disabilities.

Advances in Medical Science and Technology: Gaining Access to Supportive Devices and Technologies

In accordance with the CRPD, State parties are to promote the availability, knowledge and use of supportive devices and technologies designed for persons with disabilities, as they relate to habilitation and rehabilitation.

According to WHO, habilitation and rehabilitation can reduce the impact of a broad range of health conditions (such as diseases and injuries). The World report on disability defines them as sets of measures that assist individuals who experience, or are likely to experience, disability to achieve and maintain optimal functioning in interaction with their environments. Encompassing medical care, therapy and assistive technologies, such measures should begin as early as possible and be made available as close as possible to where people with disability live.

In recent years there have been significant improvements in supportive technologies available for persons with disabilities:

- ▶ People with physical disabilities that affect movement can use mobility aids such as wheelchairs, scooters, walkers, canes, crutches, prosthetic devices, and orthotic devices to enhance their mobility.
- ▶ Hearing aids can improve hearing ability in persons with hearing impairments.
- ▶ Cognitive assistance, including computer or electrical supportive devices, can help people function following brain injury.
- ▶ Computer software and hardware, such as voice recognition programmes, screen readers, and screen enlargement applications, help people with mobility and sensory impairments to use computer technology³².
- ▶ In the classroom and elsewhere, supportive devices, such as automatic page- turners, book holders, and adapted pencil grips, allow learners with disabilities to participate in educational activities.
- ▶ Closed captioning allows people with hearing impairments to enjoy movies and television programmes.
- ▶ Barriers in community buildings, businesses, and workplaces can be removed or modified to improve accessibility. Such modifications include ramps, automatic door

³² For more examples on supportive IT see the Module on Information and Communication Technology (ICT) and Disability

openers, grab bars and wider doorways.

- ▶ Adaptive switches make it possible for a child with limited motor skills to play with toys and games.
- ▶ Many types of devices help people with disabilities perform such tasks as cooking, dressing and grooming. Kitchen implements are available with large, cushioned grips to help people with weaknesses or arthritis in their hands. Medication dispensers with alarms can help people remember to take their medicine on time. People who use wheelchairs for mobility can use extendable reaching devices to reach items on shelves.
- ▶ When afforded access to such supportive technologies, persons with disabilities may be better able to live independently and participate in their societies. It has been estimated, however, that in many low-income and middle-income countries only 5 per cent to 15 per cent of people who require assistive devices and technologies have access to them³³.

Community-Based Rehabilitation

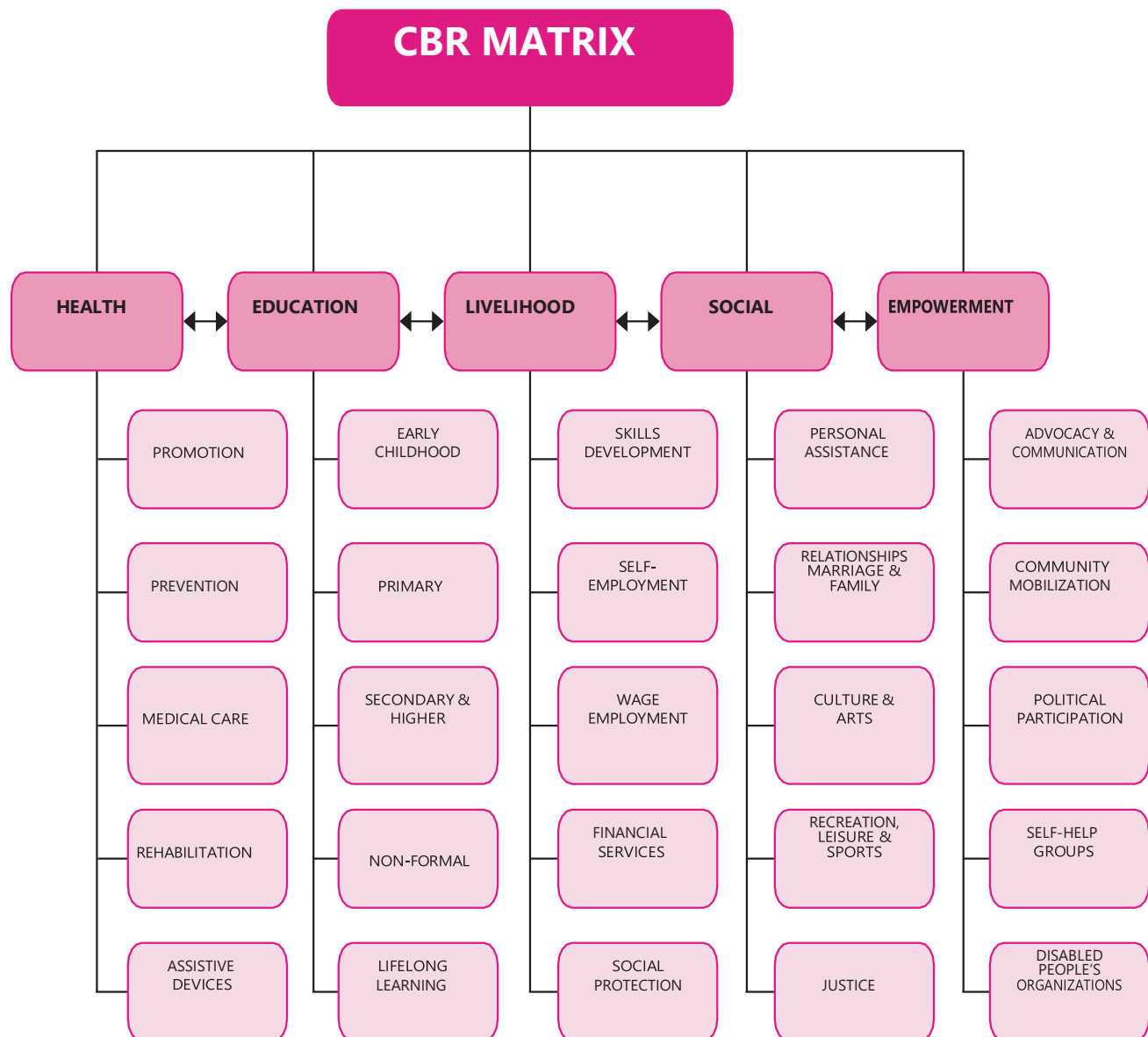
The CRPD specifies the right of persons with disabilities to live within their communities (Art. 19). Community Based Rehabilitation (CBR) focuses on enhancing the quality of life for people with disabilities and their families; meeting basic needs; and ensuring inclusion and participation. It is a multi-sectoral strategy that empowers persons with disabilities to access and benefit from education, employment, health and social services. It is a strategy within general community development targeted on rehabilitation, equalization of opportunities and social inclusion of all children and adults with disabilities.

CBR is implemented through the combined efforts of persons with disabilities themselves, their families and communities, and the appropriate health, education, vocational and social services³⁴. CBR has developed from a medical approach to one based on the human rights of persons with disabilities. Thus, the focus of CBR has evolved from medical rehabilitation towards more comprehensive multi-sector approaches such as access to health care, education, vocational training, income generation programmes and community participation and inclusion. Again, it is essential to have (i) the direct participation of persons with disabilities in planning and implementation of CBR programmes, (ii) increased collaboration between sectors providing services, and (iii) government support in development of national policies. However, as all communities differ in their socio-economic conditions, terrain, cultures and political systems, no single model of CBR is appropriate for all countries or for all parts of an individual country. CBR is an essential component of community development³⁵.

³³ WHO (2012). (2)Assistive devices/technologies: what WHO is doing: World Health Organization; 2012 [19 June 2012]. Available from: <http://www.who.int/disabilities/technology/activities/en/#>

³⁴ ILO, UNESCO, WHO, CBR: A Strategy for Rehabilitation, Equalization of Opportunities, Poverty Reduction and Social Inclusion of Persons with Disabilities, Joint Position Paper (2004), p. 2, available at: http://apps.who.int/iris/bitstream/10665/43060/1/9241592389_eng.pdf

³⁵ See WHO, UNESCO, ILO, IDDC, Community-Based Rehabilitation Guidelines, available at: www.who.int/disabilities



Key Community-Based Rehabilitation (CBR) Elements for Africa

CBR must:

1. adopt a rights-based approach, empowering persons with disabilities and their families;
2. involve persons with disabilities, parents and their organizations from the start;
3. enable key stakeholders to access information on all issues, including HIV and AIDS;
4. look at persons with disabilities holistically;
5. advocate for appropriate legislation and policies;
6. enhance self-advocacy of disabled persons;
7. develop long-term and short-term plans together with all stakeholders, i.e. it must 'be strategic';
8. ensure inclusion of disability issues in all development programmes, collaborating in all sectors;
9. take into consideration local cultures, resources and practices;
10. address issues of poverty among persons with disabilities and their families.

These elements can also be applied in other countries.

Source: *Community-Based Rehabilitation (CBR) as a Participatory Strategy in Africa*, Cornell University ILR School, 2002, available at: <http://digitalcommons.ilr.cornell.edu/gladnetcollect/60>.

Community care and personal social services can be broadly defined as those designed to enable people to remain living in their communities, especially when they have difficulties doing so because of illness, disability or age. The key to ensuring non-discrimination and equal access to health and personal social services is raising the level of awareness of the needs and rights of persons with disabilities. This requires consultation and participation with persons with disabilities at all stages of policy development, programme planning and implementation. Policies and programmes at all levels are consistently better when organizations of persons with disabilities take part in planning from the outset.

GOOD PRACTICES: CBR

ISRAEL

Ministry of Health – SES Programme³⁶

In 2010, the Israeli Ministry of Health launched the Support Education Services (SES) programme for persons between 18 and 55 with severe mental health issues as part of its rehabilitation package. Operated by various service providers and universities, the SES programme tasks individuals to develop a personal rehabilitation plan and work with professional coordinators on academic, emotional, and social challenges encountered during their studies.

The SES programme is the outcome of various mental health laws and policies Israel developed following the passing of the country's 2000 mental health rehabilitation act. As outlined under the law, SES is a four-part programme including:

³⁶ [Zero Project Report 2020: Inclusive education. 75 Innovative Practices and 11 Innovative Policies from 54 countries](#), BUTCHER, Thomas et al, January 2020.

- higher education mentoring geared towards students already in higher education;
- supplementary education services that provide coursework for improving Hebrew language skills and basic computer knowledge;
- preparation course for higher education, and
- integrating individuals into their communities to reduce the digital divide.

The Ministry monitors service standards every month. Additionally, service recipients complete a questionnaire to evaluate outcomes annually. The Ministry then enters the data into a Quality Basket Model aimed at incentivizing quality from service providers.

JDC Israel, the National Insurance Institute, and the Ministry of Social Affairs are currently building similar projects for other disabilities.

JORDAN

Al Hussein Society: School Preparation Programme³⁷

The Jordanian NGO, the Al Hussein Society, runs an intensive one-year course preparing children aged 6 to 10 with disabilities to join mainstream schools. The School Preparation Programme consists of a multi-disciplinary team providing tailored services to support children's learning, such as therapy and assistive technology. The programme's special educational experts work with families to create individual education plans to help children prepare for and pass the required entrance exams that students with disabilities must take for mainstream schools to admit them into Grade 1. However, the programme does not solely focus on school admittance but strives to improve students' participation in society, and social skills development. Since its launch in 2009, the programme has successfully integrated an average of 65 per cent of children into mainstream schools. During the 2018/19 academic year, this rate rose to almost 85 per cent.

GAZA, PALESTINIAN OCCUPIED TERRITORIES

Palestinian Red Crescent Society (PRCS) Rehabilitation Centre: khan Younis³⁸

The Palestinian Red Crescent Society (PRCS) rehabilitation centres' medical and health services have positively affected the lives of thousands of persons with disabilities. In addition to medical programmes for persons with disabilities or people with injuries, the PRCS offers services such as rehabilitation, education, vocational training, recreation and other social programmes. PRCS centers organize community-based rehabilitation offerings into four thematic units:

- **Parent and Baby Program:** offers early intervention and skills for parents to manage at home and facilitate the development of their child with a disability;

³⁷ [Zero Project Report 2020: Inclusive education. 75 Innovative Practices and 11 Innovative Policies from 54 countries](#), BUTCHER, Thomas et al, January 2020.

³⁸ Excerpted from: Access to Social Services for Persons with Disabilities in the Middle East, 2009). [www.makingitwork-crp.org/sites/default/Access to Social Services for Persons with Disabilities in the Middle East](http://www.makingitwork-crp.org/sites/default/Access%20to%20Social%20Services%20for%20Persons%20with%20Disabilities%20in%20the%20Middle%20East).

- **Special Training Programs for Children with Multiple and Severe Disabilities:** provides home visits or centre-based activities in the areas of life skills and activities of daily living;
- **Vocational Training:** provides centre-based activities with links to community training, skills for writing, money management, and daily living; and
- **Special Kindergarten:** includes programs for children who can enroll in mainstream schools and for children who are unlikely to attain a mainstreamed education.

The center's kindergarten is registered with the Ministry of Education. All other units are certified by the Ministry of Social Affairs. The PRCS does not require service fees. However, the centre does charge nominal fees to physiotherapy and speech therapy service users, in addition to a bus service to help recipients get to the centre. Professionals work with families to develop treatment plans. Additionally, the centre has good networks with other disability stakeholders and complementary service providers and inputs in regional networks and training activities.

DOMINICAN REPUBLIC

Innovative Policy 2020 on Inclusive Education and ICT: 700 Early Childhood Centres across a Whole Country³⁹

Since 2015, the National Institute for Comprehensive Early Childhood Care's (INAIPI) Integrated Early Childhood Care Model has provided education, health, and nutrition services to families of children (ages 45 days to 5 years) with and without disabilities through numerous childhood care centres. Due to a lack of awareness, follow-up by parents and medical staff, specialists, and few facilities to provide them with care, many young children with disabilities in the Dominican Republic do not benefit from early diagnosis. Two of the centre's objectives are to detect disabilities and ensure that children with disabilities receive support and equal opportunities. Specifically, assistants and education coordinators observe for early signs of deviation from regular development and make appropriate referrals for adequate support (e.g., therapeutic support, special equipment). Through training and education for parents, the centre also aims to prevent violence and facilitate families' greater awareness and acceptance of children with disabilities.

INDIA

Amar Seva Sangam: Training of Community Rehabilitation Workers⁴⁰

Recognizing that a lack of trained professionals and long distances to urban areas resulted in insufficient access to early intervention therapy services for children in India's rural areas, Amar Seva Sangam launched a training programme and resource app for community rehabilitation workers. To date, the NGO has trained over 1,800 community rehabilitation

³⁹ Zero Project Report 2020: Inclusive education. 75 Innovative Practices and 11 Innovative Policies from 54 countries, BUTCHER, Thomas et al, January 2020.

⁴⁰ Zero Project Report 2020: Inclusive education. 75 Innovative Practices and 11 Innovative Policies from 54 countries, BUTCHER, Thomas et al, January 2020

workers (CRW) to provide early intervention therapy in the homes of children aged 0 to 6. CRW's receive first a three-day orientation, followed by a ten-day base training programme where rehabilitation specialists including physiotherapists and special educators teach basic knowledge and give demonstrations. Additionally, rehabilitation specialists and CRW jointly visit each child monthly to provide therapy for the child and training for both CRW and parents. The Mobile Village-Based Rehabilitation – Early Intervention app allows for community rehabilitation, childcare, and health workers to access ongoing support from rehabilitation specialists and learning modules to educate themselves and the family members of the children they support. The app also allows CRWs to implement treatment plan while specialists track progress for motor, cognitive, mobility, and speech skills.

Country Checkpoint

Thinking about your own local context, what could be alternative models to the following practices?

- Placing in orphanages children with disabilities or orphaned as a result of infectious diseases such as malaria and HIV/AIDS; what is a community-based alternative?
- Keeping children with disabilities at home and out of schools because of fears of abuse or inaccessible schools; what options exist for tackling isolation from the community and schooling?
- Separating adults with mental disabilities in isolated camps or psychiatric hospitals with little or no support: what is a community-based alternative?

3. SUMMARY & KEY LEARNING POINTS

The emphasis now placed on the full inclusion of persons with disabilities and on anti-discrimination has provided an important backdrop to the development of more inclusive health services for persons with disabilities. The demands of persons with disabilities, disabled persons' organizations, their advocates and families for better quality and more accessible and appropriate services has challenged service providers to consider how services can be mainstreamed and how the integration and inclusion of persons with disabilities in all areas of society can be promoted and supported. This also reflects a greater understanding and awareness of the experience of persons with disabilities in accessing health services and of the impact of disabling barriers on their independence, autonomy, health and well-being. As a result, health service providers have had to address the issues of consultation with and participation of persons with disability in planning and service delivery.

Substantial action needs to be taken by all stakeholders in order to realize the mainstreaming of health service provision, the reorientation of health services towards a social model of disability, and the inclusion of people with disabilities not only as active participants in their health care but in strategic decisions regarding the funding and planning of health care services.

4. USEFUL RESOURCES

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- World Bank and World Health Organization: The World Report on Disability (2011).
- Zero Project Report 2020: Inclusive education. 75 Innovative Practices and 11 Innovative Policies from 54 countries, BUTCHER, Thomas et al, January 2020

5. LEARNING ACTIVITIES

Session Sheet for the Trainer – The Right to Health, Session 1

Technical Content 2.B.: Legal Framework

Learning Activity 2.B. The Inter-Connected Relation of Rights

Handout: CRPD Article 25

Session Sheet for the Trainer – The Right to Health, Session 2

Session Sheet for the Trainer – The Right to Health, Session 2

Learning Activity 2.D. A Plan to Address Barriers to Health Care

Handout: Barriers to Health Care for Persons with Disabilities

Session Sheet for the Trainer – The Right to Health, Session 1

Key Messages	See the summary and key learning points.
Objectives	By the end of this session, participants will have reviewed the main provisions of CRPD pertaining to health services.
Room Arrangement	Tables for small groups of 4 Round table/chair circle for plenary discussion
Activity	30 mins – Introduction to topic and technical input. 30 mins – Group work around Learning Activity 2.B. 30 mins – Plenary feedback and discussion
Duration	90 minutes
Notes for a Training Team	Make sure to use the follow-up conversation to group work to draw out country- and context-specific examples to encourage learning from each other.
Task Sheets	Learning Activity 2.B.: The Inter-Connected Relation of Rights
Handouts	Handout: CRPD Article 25

Learning Activity 2.B.: The Inter-Connected Relation of Rights

Objective: To review the main provisions of CRPD pertaining to health services.

In the CRPD, the word “health” is mentioned 20 times: outside Articles 25 and 26 on Health, Habilitation and Rehabilitation, the word appears once in the preamble, where the importance “of accessibility to the physical, social, economic and cultural environment, to health and education and to information and communication, in enabling persons with disabilities to fully enjoy all human rights and fundamental freedoms” is recognized. It is also mentioned in Article 16 on Freedom from Exploitation, Violence and Abuse, in Article 22 on Respect for Privacy, and in Article 27 on Work and Employment.

In your groups, study Article 25 closely and think about the following questions:

1. What human rights contribute to ensuring the right to health for persons with disabilities?
2. What human rights may be an outcome of successful pursuit of the right to health for persons with disabilities?
3. What frameworks (legal or policy) exist in your countries or within your organizations that can effectively support the implementation of the right to health for persons with disabilities?

You have 30 minutes to discuss this in your groups. Be ready to provide short feedback to plenary.

Handout: CRPD Article 25

State parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. State parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular State parties shall:

- a. provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the areas of sexual and reproductive health and population-based public health programmes;
- b. provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, along with services designed to minimize and prevent further disabilities, including among children and older persons;
- c. provide these health services as close as possible to people's own communities, including in rural areas;
- d. require health professionals to provide care to persons with disabilities of the same quality as that provided to others, including on the basis of free and informed consent by *inter alia* raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards in public and private health care;
- e. prohibit discrimination against persons with disabilities in the provision of health insurance, and also of life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
- f. prevent discriminatory denial of health care, health services; or food and fluids on the basis of disability.

Session Sheet for the Trainer – The Right to Health, Session 2

Key Messages	See the summary and key learning points.
Objectives	By the end of this session, participants will have devised a number of strategies to overcome barriers to the inclusion of persons with disabilities in health services.
Room Arrangement	Tables for small groups of 4 Round table/chair circle for plenary discussion
Activity	40 mins – Group work around LA 2.D. 20 mins – Presentations (4 x 5mins) 30 mins – Q&A and discussion.
Duration	90 minutes
Notes for a Training Team	<p>On the handout, there are four listed barriers to health services for persons with disabilities. Assign one to each group.</p> <p>After the group presentation, use the final 30 minutes to discuss each group's work and fill in any learning gaps you have identified.</p> <p>Use: http://www.who.int/mediacentre/factsheets/fs352/en/ for further support.</p>
Task Sheets	Learning Activity 2.D: A Plan to Address Barriers to Health Care
Handouts	Handout: Barriers to Health Care for Persons with Disabilities

Learning Activity 2.D. A Plan to Address Barriers to Health Care

Objective: To devise a number of strategies to overcome barriers to the inclusion of persons with disabilities in health services.

Part 1

In your group, you have been assigned one specific barrier to health care. Imagine you are in charge of convening a meeting to find solutions to this barrier – this meeting may be held at local level with DPOs and community leaders, within an organization such as a hospital or clinic, or at national level with policy-makers

Together, and focusing on your assigned issue, develop an invitation list, an agenda, and proposed solutions to this barrier. Use the following questions to guide your discussion:

1. What is the barrier at hand? How does this affect persons with disabilities?
2. What objective(s) do you hope to attain through the outcome of this meeting?
3. Who should you invite to this meeting? What might be their contributions towards achieving the objective?
4. What solutions will you propose for addressing this barrier? Who can be assigned to each specific part of the solution in order to ensure its implementation and effectiveness?

Part 2

You will be expected to present your plan back to plenary, so use the materials available to create a visual support for your presentation.

Be sure to provide the answers to all of the above questions in your presentation.

You have 40 minutes to complete Part 1. Your presentation should be no longer than 5 minutes.

Handout: Barriers to Health Care for Persons with Disabilities

For further reading, see: Fact Sheet 352, WHO:
<http://www.who.int/mediacentre/factsheets/fs352/en/>

Prohibitive Costs

Affordability of health services and transportation are two main reasons why people with disabilities do not receive the required health care in low-income countries; 32-33% of non-disabled people are unable to afford health care as compared to 51-53% of people with disabilities.

Limited Availability of Services

The lack of appropriate services for people with disabilities is a significant barrier to health care. For example, research in India's Uttar Pradesh and Tamil Nadu States found that, the lack of services in the area was the second most significant barrier to using health facilities after cost considerations.

Physical Barriers

Uneven access to buildings (hospitals, health centres), inaccessible medical equipment, poor signage, narrow doorways and internal steps, inadequate bathroom facilities, and inaccessible parking areas create barriers to health care facilities. For example, women with mobility difficulties are often unable to access breast and cervical cancer screening because examination tables are not height-adjustable and mammography equipment only accommodates women who are able to stand.

Inadequate Skills and Knowledge of Health Worker

People with disabilities were more than twice as likely to report finding health care providers' skills inadequate to meet their needs; four times more likely to report being treated badly; and nearly three times more likely to report being denied care.

WHO: What to do to keep yourself and others safe from COVID-19

- **Maintain at least a 1-metre distance between yourself and others** to reduce your risk of infection when they cough, sneeze or speak. Maintain an even greater distance between yourself and others when indoors. The further away, the better.
- **Make wearing a mask a normal part of being around other people.** The appropriate use, storage and cleaning or disposal are essential to make masks as effective as possible.

Here are the basics of **how to wear a mask**:

- Clean your hands before you put your mask on, as well as before and after you take it off, and after you touch it at any time.
- Make sure it covers both your nose, mouth and chin.
- When you take off a mask, store it in a clean plastic bag, and every day either wash it if it's a fabric mask, or dispose of a medical mask in a trash bin.
- Don't use masks with valves.
 - *For specifics on what type of mask to wear and when, read our [Q&A](#) and watch our [videos](#). There is also a Q&A focused on [masks and children](#).*
 - *Find out more about the science of how COVID-19 infects people and our bodies react by watching or reading this [interview](#).*
 - *For specific advice for decision makers, see [WHO's technical guidance](#).*

How to make your environment safer

- **Avoid the 3Cs: spaces that are closed, crowded or involve close contact.**
 - Outbreaks have been reported in restaurants, choir practices, fitness classes, nightclubs, offices and places of worship where people have gathered, often in crowded indoor settings where they talk loudly, shout, breathe heavily or sing.
 - The risks of getting COVID-19 are higher in crowded and inadequately ventilated spaces where infected people spend long periods of time together in close proximity. These environments are where the virus appears to spread by respiratory droplets or aerosols more efficiently, so taking precautions is even more important.
- **Meet people outside.** Outdoor gatherings are safer than indoor ones, particularly if indoor spaces are small and without outdoor air coming in.
 - *For more information on how to hold events like family gatherings, children's football games and family occasions, read our [Q&A on small public gatherings](#).*
- **Avoid crowded or indoor settings** but if you can't, then take precautions:
 - **Open a window.** Increase the amount of 'natural ventilation' when indoors.
 - *WHO has published Q&As on ventilation and air conditioning for both the [general public](#) and [people who manage public spaces and buildings](#).*
 - **Wear a mask** (see above for more details).

Don't forget the basics of good hygiene

- **Regularly and thoroughly clean your hands with an alcohol-based hand rub or wash them with soap and water.** This eliminates germs including viruses that may be on your hands.
- **Avoid touching your eyes, nose and mouth.** Hands touch many surfaces and can pick up viruses. Once contaminated, hands can transfer the virus to your eyes, nose or mouth. From there, the virus can enter your body and infect you.
- **Cover your mouth and nose with your bent elbow or tissue when you cough or sneeze.** Then dispose of the used tissue immediately into a closed bin and wash your hands. By following good 'respiratory hygiene', you protect the people around you from viruses, which cause colds, flu and COVID-19.
- **Clean and disinfect surfaces frequently especially those which are regularly touched,** such as door handles, faucets and phone screens.

What to do if you feel unwell

- **Know the full range of symptoms of COVID-19.** The most common symptoms of COVID-19 are fever, dry cough, and tiredness. Other symptoms that are less common and may affect some patients include loss of taste or smell, aches and pains, headache, sore throat, nasal congestion, red eyes, diarrhoea, or a skin rash.
- **Stay home and self-isolate even if you have minor symptoms such as cough, headache, mild fever,** until you recover. Call your health care provider or hotline for advice. Have someone bring you supplies. If you need to leave your house or have someone near you, wear a medical mask to avoid infecting others.
- **If you have a fever, cough and difficulty breathing, seek medical attention immediately. Call by telephone first, if you can** and follow the directions of your local health authority.
- **Keep up to date on the latest information from trusted sources, such as WHO or your local and national health authorities.** Local and national authorities and public health units are best placed to advise on what people in your area should be doing to protect themselves.

**Source: WHO (www.WHO.int), WHO: Disability and Rehabilitation Team.
www.who.int/disabilities**