Australian Government

INDO-PACIFIC CENTRE FOR HEALTH SECURITY

Health Security Initiative Guidance Note

Supporting disability inclusion through DFAT health security investments

PEOPLE WITH DISABILITIES

- Experience barriers accessing health services and public health information
- Are often at a higher risk of acquiring infectious disease due to:
  - Living arrangements – more likely to live in poverty and crowded conditions
  - A lack of adequate or accessible water, sanitation and hygiene (WASH) infrastructure
  - Lower access to vaccines
  - Challenges in infection prevention and control, e.g. for those relying on personal assistance or sign language interpretation

INFECTIOUS DISEASE RISK FACTORS AND BARRIERS FOR PEOPLE WITH DISABILITIES	POTENTIAL SOLUTIONS
Health information is not accessible	Use multiple health and risk communication strategies and formats (for example, e.g. to ensure access for people with communication impairments)
Difficulty travelling and accessing a health facility	Ensure that health facilities have accessible buildings, pathways, toilets and equipment Consider mobile clinics to reach people
Negative attitudes and low knowledge of rights and health needs from healthcare providers	Implement training programs and policies for health workforce and society to reduce stigma and discrimination experienced by people with disabilities
Unaffordable health services	Offer free or subsidised services for at-risk groups, including people with disabilities

Disability inclusion is a cross-cutting priority for investments under DFAT's Health Security Initiative (HSI) and the broader aid program. People with disabilities are the largest and most disadvantaged minority in the world. Women and girls with disabilities experience multiple disadvantages resulting from the interplay between poverty and discrimination (based on gender and disability).[1]This guidance note on disability inclusion in DFAT's health security investments has been developed to assist DFAT program managers and implementing partners ensure projects in the region are contributing to greater health outcomes for people with disabilities. For more information about disability inclusion in DFAT's investments, see DFAT's disability inclusion strategy Development for All (in place until 2021) and Good Practice Note.

Checklist for disability-inclusive health security programs

This checklist identifies opportunities for disability inclusion across the program cycle and should be adapted to your project's context.

KEY GUIDING QUESTIONS	
1. Consult and actively engage with people with disabilities throughout the program and/or research cycle. *This is an important first step to strengthen disability inclusion. Engaging people with disabilities and their representative organisations is a core principle of the Australian Government's approach to disability-inclusive development. People with disabilities are experts in their own lives and can help ensure your efforts to improve access are relevant and practical. For more information about participation of people with disabilities see the CBM & DFAT resource on DPO engagement and the Plan & CBM Practice Note.*	• Have efforts been made to ensure **community consultations are inclusive and accessible** (e.g. accessible locations, convenient times, and providing sign-language interpreters)? • Has **local understanding of disability** been identified through the consultations and reflected in relevant program activities? • Are people with disabilities and **their representative organisations (DPOs)[2]** involved in health security programs? *For example, consulted during program design, involved in evaluations.* • Have **diverse perspectives** from people with disabilities been sought? *For example, the needs of women, children, older people, and people with diverse impairments.* • Have **organisational policies been reviewed** to ensure they do not exclude people with disabilities from working within services and programs, and include provisions for reasonable accommodation?
2. Ensure that public health information and communications produced by your project/program are in formats that are accessible to all	• Has public health information been provided in a variety of **accessible formats and channels**? *For example, in large print and in Braille (where appropriate), use of clear and simple language and images, sign language interpreters used in*

[1] Globally, just over one billion people (15 per cent of the global population) have a disability. About 70 per cent (690 million) of these live in the Asia Pacific region. Women comprise around 75 per cent of people with disabilities in low and middle-income countries. Compared to men without disabilities, women with disabilities are three times more likely to have unmet needs for health care, three times more likely to be illiterate; two times less likely to be employed; and two times less likely to use the internet (sources: World Bank and WHO, World Report on Disability, 2011, p.261 and UN Disability Inclusion Strategy 2019; UN Enable, Factsheet on Persons with Disabilities; UN Flagship Report on Disability and Development 2018, Realization of the Sustainable Development Goals by, for and with Persons with Disabilities – see https://social.un.org/publications/UN-Flagship-Report-Disability-Final.pdf),

[2] **Disabled People's Organisations (DPOs)** are organisations that are representative of people with disabilities. They are run by and for people with disabilities. Their existence is encapsulated by the slogan of the disability movement, 'nothing about us without us'.

KEY GUIDING QUESTIONS	
People with disabilities frequently experience difficulties obtaining essential information on disease prevention and control due to inaccessible communication formats, and barriers to communication during interactions with health personnel. This can be caused by negative staff attitudes or lack of knowledge about how to communicate with people with disabilities.	*community meetings and in public health announcements, captioning providing in videos, accessible online content, telephone and web chat hotlines.* • Have **people with disabilities and DPOs been consulted** on accessibility of communication material? • Are DPOs engaged to ensure **communications are reaching people** with disabilities, their families, and caregivers of people with disabilities?
3. Ensure that any training for health workers and other staff provided through your project/program addresses disability inclusion *Negative attitudes have a serious impact on the level of access and quality of health care for people with disabilities. For example, health workers may be less likely to advise parents of children with disabilities about vaccinations, and families and communities may be less likely to seek health initiatives for people with disabilities. Training health, program staff, and managers is an effective way to increase awareness of disability. Training should cover introductory concepts (a rights-based approach, barriers to participation etc.) as well as content specifically relating to disability inclusion in their program.*	• Has a **training needs assessment** regarding disability knowledge, attitudes, expertise and skills amongst staff been undertaken and a plan developed to address gaps? *For example, disability training incorporated in induction processes; annual training and capacity building activities.* • Is there a plan to **partner with people with disabilities and DPOs** to deliver training on disability inclusion for staff? • Is there opportunity to mainstream disability inclusion into **other training** delivered through the project/program? • Have there been efforts to advocate for training on disability to be integrated into **curriculum and accreditation requirements** for health workers (including doctors, nurses, lab technicians, and community health workers)?
4. Embed disability in health information management and surveillance systems (if and where relevant) *When disability data is collected, data can be disaggregated to understand the health needs for people with disabilities compared to the broader population, and to what extent people with disabilities are accessing health security programs, for example vaccination programs.*	• Where feasible, is **disability data** being collected and analysed using best-practice approaches (such as the Washington Group Questions -WGQs[3]), and is information being used to disaggregate data and inform decision-making? • Is data also able to be **disaggregated by other demographic factors** including sex and age to help understand the needs and access of sub-groups of the populations? • Has qualitative information been collected to strengthen understanding of barriers to access and the needs of people with disabilities?

[3] The **WGQs emphasise functional limitations**, engages the person themselves in reporting their situation, avoids using the term "disability" which can be stigmatising and is understood differently across different context/cultures; and can be asked by any staff (doesn't have to be medical/health staff).

Disability inclusion in practice – applied health research

To ensure people with disabilities are not excluded from participating in research, both as participants and as members of research teams, researchers should consider inclusion across the research cycle:

- During planning, identify and address barriers to participation in planning processes; partner with local DPOs; and budget for reasonable accommodation and accessible communications;
- During research design, identify barriers to inclusion in the research (e.g. sampling approaches, inclusion/exclusion criteria);
- Do the research questions, research design include analysis of the research topic from the perspective of people with a disability?
- During implementation, ensure participant recruitment and data collection methods and information are fully accessible;
- In dissemination, ensure that research findings are shared with partner organisations, local communities, and the wider research community in accessible formats; and that people with disabilities are acknowledged and credited.
- For more information about disability inclusion in research and evaluation, see the Research for Development Impact Network resource Research for all: Making Research Inclusive of People with Disabilities.

Disability-inclusive monitoring, evaluation and learning

Activities to promote disability inclusion in HSI-funded programs need to be monitored and reported as part of regular progress reporting to the Centre for Health Security. While it may not be relevant or possible for all program activities to address disability inclusion, activities where this is possible need to be actively identified and corresponding indicators included in a program's Monitoring, Evaluation and Learning Framework (MELF).

Examples of output and outcome indicators that may be incorporated and adapted are provided in the table below. These come from the HSI's Performance Assessment Framework (PAF) and other sources. Periodic reflection and lessons learnt workshops conducted by programs could consider the results reported against the disability inclusion indicators and how these could be improved.

HSI program activity area	Output indicators		Outcome indicators
Data to inform decision-making / operational research	• Consultations to inform developing national policies and guidelines are inclusive and accessible of persons with disabilities (included targeted consultations where appropriate) • Operational research includes people with disabilities as decision-makers and participants in all relevant the stages of the research cycle • Operational research includes data collection approaches that are inclusive and accessible	→	• Evidence that **national policies** and **guidelines** consider the needs of people with disabilities
Medical products	• Target product profiles include due consideration for end-users with disabilities • Training and mentoring in improvements in national regulatory authority (NRA) business systems and processes includes content on disability inclusion, where relevant	→	• Evidence that **product development** is informed by, and responsive to, the needs of people with disability • Evidence that improvements to **NRA business systems and processes** incorporate the needs of people with disability where relevant
Infection prevention & control	• Program has conducted consultations with people with disabilities during response planning to ensure their needs are considered • Communications for prevention and control are provided in a range of formats to ensure accessibility • Program has shown consideration of accessibility of prevention methods (for example, advocacy for accessible WASH facilities)	→	• Evidence that **infection prevention and control activities** consider the needs of people with disabilities

HSI program activity area	Output indicators		Outcome indicators
Vector control	• Activity planners have engaged with DPOs to identify risks, barriers and strategies for disability inclusion in vector control activities • Information for public participation in vector control available in a range of formats to ensure accessibility • Methods of distribution of vector control products and information involve engaging with DPOs to assist in reaching people with disabilities		• Evidence that strengthening **vector control activities** includes consideration of the exposure, vulnerability and impacts on people with disabilities
Surveillance/ health information systems	• Activities to strengthen disease surveillance and health information systems include incorporating collection of disability data, and analysis that disaggregates data by disability, where feasible • Advocate for the collection, analysis and reporting of disability data as part of activities focused on strengthening health information systems		• Evidence that **disease surveillance and health information systems** collect disability data, where feasible • Evidence that where disability data is collected, programs **use this data to analyse the situation** for women, men, girls and boys with disabilities and inform programs accordingly
Laboratory strengthening	• Activities to strengthen testing to diagnose and monitor diseases is accessible for people with disabilities.		• Evidence that **pathology services are accessible for people with a disability -** this could include the use of mobile pathology • Evidence that where laboratory data is analysed based on demographics that people with a disability are included as a demographic group
Emergency operations centres	• Evidence that table top and other emergency operations simulation exercises include consideration of the needs of people with disabilities • Evidence that community consultations on emergency response plans and processes are inclusive and accessible for people with disabilities • Inclusion of DPOs in national response committees		• Evidence that **emergency response plans and processes** take into account the specific needs of people with disabilities
Workforce development	• Training and other capacity building activities collect participant data disaggregated by disability • Evidence that training in guidelines, standard operating procedures (SOPs) and other workplace systems and processes includes consideration of the needs of people with disabilities, where relevant. • Training in disability inclusion provided to all program staff, ideally in partnership with a DPO.		• Evidence that training and other capacity building activities involving people with disabilities have translated into **improvements in the workplace**