WHO DISABILITY-INCLUSIVE HEALTH SERVICES TRAINING PACKAGE

A COMPANION TO THE

DISABILITY-INCLUSIVE HEALTH SERVICES TOOLKIT:

A RESOURCE FOR HEALTH FACILITIES IN THE WESTERN PACIFIC REGION

World Health Organization

WHO disability-inclusive health services training package

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CONTENTS

INTRODUCTION

This Training Package is a companion to the "WHO Disability-Inclusive Health Services Toolkit: A resource of health facilities in the Western Pacific Region". The Disability-inclusive Health Services Toolkit was commissioned by the World Health Organization (WHO) Regional Office for the Western Pacific as a resource to support greater inclusion of people with disability in health-care services across the Region.

A copy of the Toolkit is available at https://apps.who.int/iris/handle/10665/336857.

This Training Package has been designed to guide you through how to implement the tools and information from the Toolkit directly into your health service. The Training Package offers a range of activities and short videos that allow you to develop the foundational skills and understanding required to operationalize the Toolkit.

The Training Package can be used as a self-guided course by either individual health-care workers or by a group of health-care workers in a study group. It can also be used as a resource for facilitators from disabled peoples organizations (DPOs) to support facilitator-led training sessions with groups of health-care workers.

The Training Package and the Toolkit are resources to support greater inclusion of people with disability in health-care services across the Western Pacific Region. Their purpose is to support the achievement of universal health coverage (UHC) by health-care service providers through ensuring access to health information and services, best-quality outcomes, and improved quality of life for all people with disability.

This Training Package has been developed based on current best practices in disability inclusion and the knowledge and skills from experience working in disability in global health contexts. It is designed to guide you to implement disability inclusion in your own health service setting.

By the end of this Training Package, you will be able to:

- Feel confident in applying disability-inclusive principles in your work.
- Understand how to integrate disability inclusion so that it is a core part of your everyday practice.
- Understand how disability-inclusive practices are central to achieving UHC and can improve access and quality to all users of a health service.

WHO IS THIS TRAINING KIT FOR?

The Toolkit and the Training Package have been developed primarily for managers and staff of health-care facilities and services (with a focus on primary health-care facilities, including local-level clinics and district hospitals), health policy-makers, and nongovernmental organizations (NGOs) providing health information and services to people with disability. This includes health-care workers and administrative and programme staff, recognizing that those involved in designing and delivering health services are often in the best position to facilitate and support practical changes to service delivery.

DPOs may also find this Training Package useful in their efforts to strengthen provision of disability-inclusive health information and services for people with disability, by providing support for health facilities in conducting training on disability inclusion in health care.

This training is suitable for a range of learners, from people with little or no prior knowledge of disability and disability inclusion but who wish to develop this knowledge, to those with previous knowledge and experience of disability-inclusive practice who are seeking tools to assist with applying this knowledge in health-care contexts.

The following principles have been used in designing the training package:

Learning through case studies: Many of the activities have been developed using case studies to illustrate how the theory covered in the videos can be implemented within a health-care setting. All case studies are fictional and have been based on the many years of clinical experiences of the authors working in health care and with people with disability.

Integrating disability inclusiveness into your existing practice: Even if you have not had previous training in disability inclusion, many of the practices and principles of disability inclusiveness are extensions of practices and principles that you may already be familiar with, such as patient-centred care. Throughout the Training Package you will be guided to make links between your previous knowledge and experience, to enable you to understand where you can integrate disability inclusiveness into your existing practices.

Training for real-life implementation: Each module contains either an activity or link to a tool from the Toolkit that you can apply immediately to your own health setting.

HOW TO USE THIS TRAINING PACKAGE

This training package can be used by individuals, groups or by facilitators wishing to conduct training sessions.

USING THE TRAINING PACKAGE AS AN INDIVIDUAL LEARNER

If you are using this training package as an individual learner, congratulations on taking the initiative to continue your professional development, and gain the skills and understanding to support your health service to be inclusive of people with disability and achieve UHC and health for all.

Use the resources of the Workbooks, Glossary and Answer Book provided in this Training Package as your own personal "facilitator", to guide and check your understanding of the terminology and correct answers to the activities.

USING THE TRAINING PACKAGE AS A STUDY GROUP

If it is possible, you are encouraged to form a study group with colleagues from your health service or your health-care networks, and work through the modules together. Working in a group is a great way of extending your learning, as you can draw on the knowledge and experience from other group members in understanding the material in the Training Package, and plan together how to apply what you are learning to make changes to your health service.

If completing this Training Package as a group, look out for the "group" activities as you work through the modules for chances to share your knowledge and insights, and to undertake activities specifically designed for groups.

USING THE TRAINING PACKAGE AS A FACILITATOR

You may also choose to use this Training Package to conduct facilitated training by a DPO or by a member of your health service with expertise in disability-inclusive practice.

We have included the PowerPoint slides that we have used for each video so that you can use them to present your own sessions and adapt the presentation to your own context.

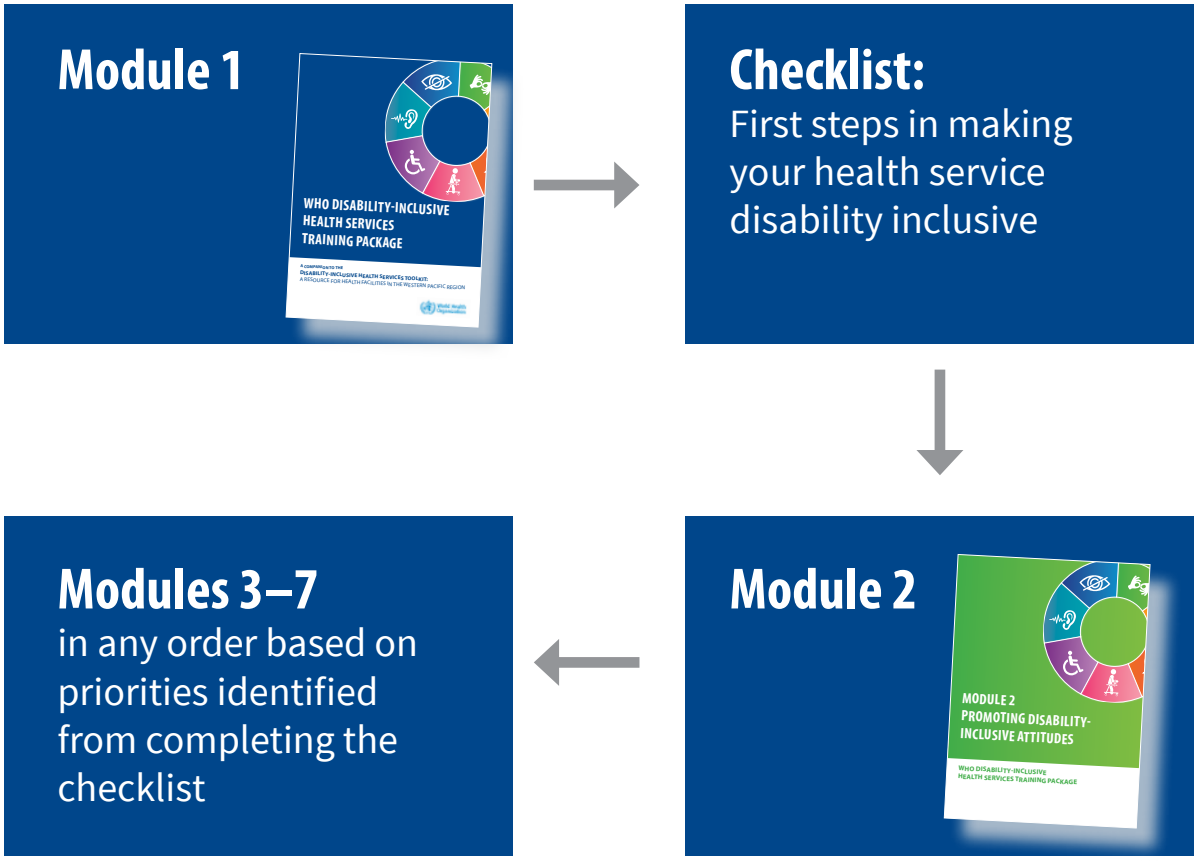
CHOOSING WHICH MODULES TO COMPLETE

The Training Package contains seven modules which align with the seven modules of the Toolkit. Each module is intended to be stand-alone, addressing a specific area of health information and service provision for people with disability. All the modules are central to improving access to health services for people with disability. However, some modules might be more immediately important, or address more pressing issues, than others in your setting.

We recommend that all learners start with **Module 1: Disability-Inclusive Health Services: Getting started**, as this provides the foundation for the rest of the Training Package. It outlines the rationale for including people with disability in health services and introduces key concepts relating to disability and disability inclusion in health. It also includes two tools to get you started.

The checklist at the end of Module 1, **First steps in making your health service disability inclusive**, is designed to help you think through and assess "where your health service is at" in providing disability-inclusive health services and information to people with disability. The checklist will assist you in identifying which areas of disability inclusion are the highest priorities for your health service. You can then begin with the modules that you have the most immediate need for in your health service and work through the remaining modules as you have the time or need for them. In this way, module by module, you can use this Training Package with the Toolkit to introduce disability-inclusive practice in a way that makes the most sense for your health setting.

We also recommend that all learners complete **Module 2: Promoting Disability-Inclusive Attitudes**. We consider this module to be a core module because, in many ways, awareness of attitudinal barriers and their impact on access to health care for people with disability, is key to addressing disability inclusion. By addressing attitudinal barriers, it is possible to identify and remove other barriers.



STRUCTURE OF THE TRAINING PACKAGE

The Training Package is divided into seven modules and contains the following materials. Each module includes:

- **A workbook:** The workbook guides you through each module. It begins with an overview of the topics covered, the learning objectives and the content and time required to complete the module. It also contains the activities for the module and guides you through the order in which to complete the activities and watch the videos.
- **Videos:** Each module contains 2–3 short video presentations that present the main points from the Toolkit that you need to know in order to complete the training activities in the workbook.
- **PowerPoint slides:** The PowerPoint slides for each video are also provided separately. These can be used by facilitators to deliver their own presentations. Each set of PowerPoint slides includes a script for facilitators in the notes section of each slide.

Glossary: This contains explanations of the key terminology in disability-inclusive practice used in the Training Package. The words highlighted in **orange** indicate words that are listed in the glossary.

Answer booklet: This contains the answers to activities from the workbooks. For some activities we have also provided brief explanations for the answers so that you can better understand why these answers are correct.

KEY TO ICONS IN THE WORKBOOKS

Throughout the workbooks you will find the following icons that indicate what you need to do, or a link to other tools or information.

Watch: It is time to watch one of the videos in the module.

Activity: It is time to complete the next activity in the workbook.

Reflect: You are invited to reflect on your own professional experience and how it links to an idea that has been raised in the training kit.

Toolkit: Links to a tool or further information in the WHO Disability-Inclusive Health Services Toolkit.

Group: If you are studying with a group, you are invited to complete this extension activity to share your knowledge, perceptions and experiences with others in your group.

Next steps: These are recommendations for steps that you can take once you have completed the module to apply what you have learned to your work in your health service.

Further resources: These are recommendations for tools and resources that you can use in your health service.

We hope that you will find this Training Package interesting and that it will enhance your practice in health care to become a disability-inclusive health practitioner. By doing so you will be contributing to better access to health care for people with disability and achieving better health for all.

MODULE 1
DISABILITY-INCLUSIVE HEALTH SERVICES – GETTING STARTED

WHO DISABILITY-INCLUSIVE HEALTH SERVICES TRAINING PACKAGE

WELCOME TO THE FIRST MODULE OF THE WHO DISABILITY-INCLUSIVE HEALTH SERVICES TOOLKIT.

In this module we will be guiding you through understanding what disability is, how to identify barriers that people with disability experience, and why disability inclusion is essential in all aspects of health care.

These are the foundations that you will need as you begin to apply **disability inclusion** to your own health service.

After completion of this module you will be able to:

- Feel confident in understanding what is meant by "disability" so you can explain it to others.
- Understand why access to health services for people with disability is needed to achieve **universal health coverage (UHC)**.
- Identify what might prevent people with disability from accessing health services and recognize any barriers that exist in your health service.
- Begin to understand key principles and simple changes you can make to improve access to health for people with disability.

At the end of this module, you will be ready to complete the Checklist: First steps in making your health service more inclusive on page 18 of the WHO Disability-inclusive Health Services Toolkit . This checklist will give you a clear plan for which areas to prioritize to improve disability inclusion in your own health setting.

The checklist will also help you to select the modules in this training to complete next, based on which areas you identify as priorities.

OVERVIEW OF MODULE 1

This module will take you approximately 1 hour to complete.

Remember: you do not have to complete the full module in one sitting and can work through it at your own pace.

STEP 1

Activity: Why is disability inclusion important to you and your health service?
(5 mins)

STEP 2

Video 1: Why is disability inclusion important?

(7 mins)

STEP 3

Activity: Barriers to health care

(5 mins)

STEP 4

Video 2: What is disability?

(7 mins)

STEP 5

Activity: What is disability?

(15 mins)

STEP 6

Activity: Identifying barriers in the patient's journey

(15 mins)

STEP 7

Video 3: Getting started in applying disability-inclusive practice
(7 mins)

STEP 1: ACTIVITY: WHY IS DISABILITY INCLUSION IMPORTANT TO YOU AND YOUR HEALTH SERVICE?

Let's begin with taking a moment to articulate your own reasons for doing this training.

There are many reasons that adopting a disability-inclusive approach is important in health service provision. Identifying why it is important for you as an individual practitioner and for your health service will help you to focus your plan for disability inclusion. It will also help you to communicate the benefits of disability inclusion to others in your health service, so that you can become an advocate for it in your workplace.

1. What are the main reasons that it is important for your health service to become more disability inclusive? You may choose more than one.

    a. We want to bring our health service closer to international standards/best practice to achieve UHC and the United Nations Sustainable Development Goal 3 (Ensure healthy lives and promote well-being for all at all ages)

    b. We are noticing a growing number of patients who have a disability present to our health service and want to be able to understand their health needs

    c. We want to strengthen our human rights approach and make our health service more equitable for vulnerable groups such as women, poor people, people with disability

    d. Other...

2. In addition to the reasons for your health service, we often have our own personal and professional reasons to improve our practice.

    What are your own personal or professional reasons for improving your disability-inclusive practice?

How do you hope this will make your practice stronger or improve outcomes for your patients?

Group study: If you are doing this training in a group, share your responses and your reasons for choosing them with others in the group. You might like to create a poster of all your reasons to put on the wall within your health service to remind you of your goals for becoming more disability inclusive and share these with your other colleagues and patients.

Keep these motivations in mind as you progress through the rest of the training and revisit them at times throughout the training to see how your understanding of disability inclusion has developed.

STEP 2: VIDEO 1: WHY IS DISABILITY INCLUSION IMPORTANT?

Watch this short presentation on how integrating a disability-inclusive approach can improve the health outcomes for people with disability and work towards achieving the goal of universal health coverage.

STEP 3: ACTIVITY: BARRIERS TO HEALTH CARE

Now that you understand the benefits of adopting a disability-inclusive approach, we are going to look at some common challenges that people with disability may have in accessing a level of health care equal to that of patients without disabilities.

Read the statements in Column B. Think about what sort of barriers these are for people with disability in accessing health care. Match these statements to the types of barriers in Column A.

Column A	Column B
1. Attitudinal barriers: Stigma and discrimination; lack of knowledge and training of health workers; lack of inclusive policies; lack of inclusion in planning and decision-making)	a. Vaccination clinic is on the second floor and there is no elevator.
	b. I am deaf. I can't hear what the doctor is telling me.
2. Physical barriers: Location of health services; lack of accessible transport; poor access to buildings, toilets, consulting rooms and furniture	c. My child needs to see a specialist in the city to fix his eyes but it is too expensive.
	d. We have a car but can't afford the petrol to get to the health centre.
3. Communication barriers: Lack of alternative formats of health information; use of jargon; poor signage	e. Our staff don't need to understand about disability. We are not a disability service.
	f. Health promotion activities are promoted only by newspaper advertisements.
4. Financial barriers: Direct and indirect costs of accessing health care can be catastrophic for many people with disability	g. Motorbikes are parked on the ramp to the clinic entrance.
	h. It takes longer to see people with disabilities. We don't have enough staff to give them more time.

STEP 4: VIDEO 2: WHAT IS DISABILITY?

Watch this short presentation where we will talk about what disability is, who may experience disability and how disability is connected to barriers in people accessing health services.

Reflect: As you are watching the video, reflect on how the definition of disability being presented compares to your current understanding of what disability is. Where are there similarities and where are there differences? How does this impact how you interact with patients with disability?

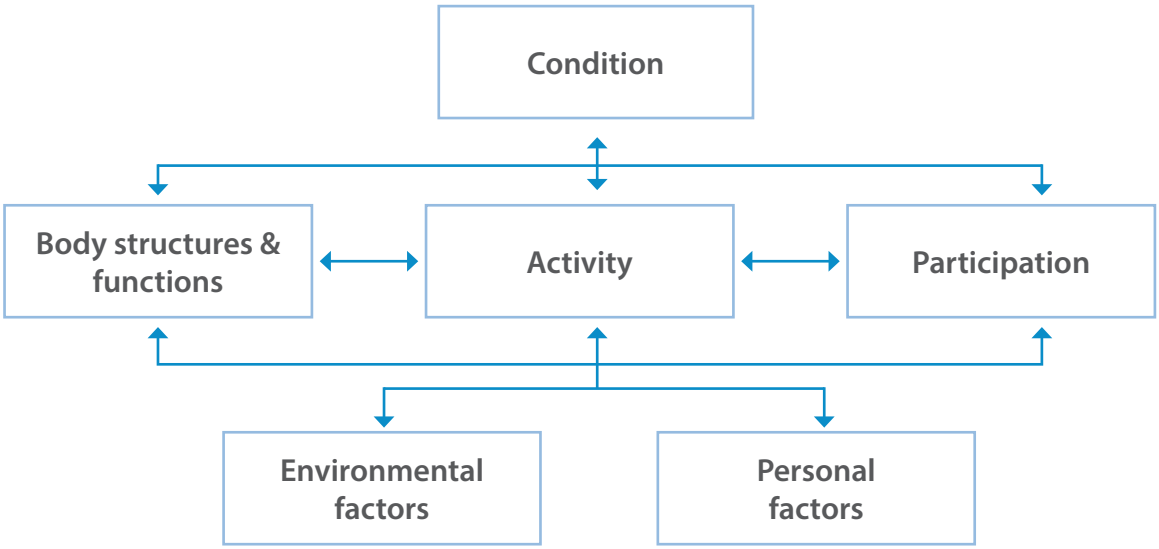
STEP 5: ACTIVITY: WHAT IS DISABILITY?

Disability is an evolving concept but developing a shared understanding of what is meant by "disability" helps us to plan, monitor and evaluate programmes and services that are inclusive of people with disability.

The concept of disability can be difficult to explain and may have different meaning to different people or in different contexts. In the Toolkit and this training we use the definition in the **United Nations Convention on the Rights of Persons with Disability (UNCRPD)** and the WHO **International Classification of Functioning, Disability and Health (ICF)** to understand what is meant by "disability".

Both the UNCRPD and ICF recognize that disability is not a "diagnosis" or a "health condition" but it is the interaction between the impairments a person may have resulting from a **health condition** and their social and physical environment. In this way, a person's **impairments** may be more disabling or less disabling depending on the context in which they live.

This diagram shows the model of disability that the ICF is based on. In the ICF "disability" is a problem, or dysfunction, occurring with one or more of the elements in the middle row of the diagram, as an interaction between a person's condition and their environmental and personal factors.



Read these definitions to assist your understanding of the diagram above.

Condition = disease, disorder or injury

Impairments in body structure & function = problems with anatomical parts of the body or physiological functions of body systems, including psychological functions, resulting from a health condition

Activity limitations = difficulties in completing an everyday task or action (e.g. walking, eating)

Participation restrictions = problems experienced in engaging in everyday life situations (e.g. school, work, community activities)

Environmental factors = the physical, social and attitudinal environment in which the person lives

Personal factors = includes gender, age, coping styles, social background, education, past experience

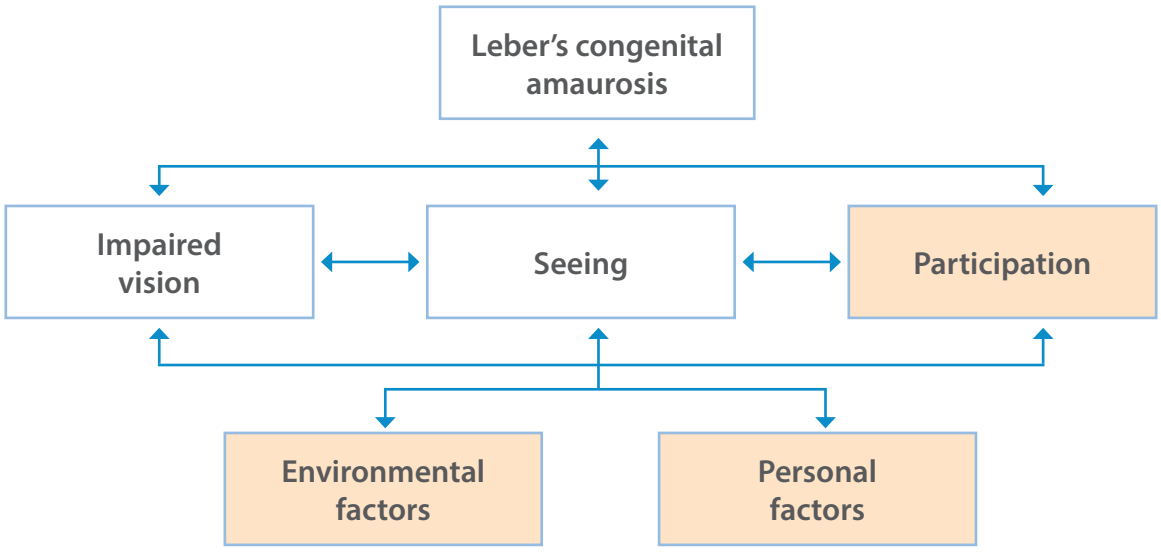
Now let's apply these concepts using some case studies to understand how a person's impairments may be more disabling or less disabling depending on the context in which they live. Read the following two case studies. They are both case studies of men with a vision impairment from the same condition, but with different environmental and personal contexts.

CASE STUDY 1: KHAN

Khan is 28-year-old man who has been blind since birth due to a condition called Leber's congenital amaurosis. Khan lives in an apartment with his wife in a small city where there are footpaths with tactile markers and traffic lights with a sound that indicates when it is safe to cross the road. Khan completed school and now works in an office 5 km from where he lives and travels there every day by public transport. Khan uses a cane to assist his mobility and when he was younger he received training from a vision rehabilitation service which helped him to learn how to safely get around town.

CASE STUDY 2: DAVAA

Davaa is a 28-year-old man who has been blind since birth due to a condition called Leber's congenital amaurosis. Davaa lives in a village where there are paved roads but no footpaths. He lives in a small house with his wife. He attended primary school which was close to his house. His parents were able to take him there each day on their way to work in the plantations; however, the secondary school was too far for them to take him and he could not get there safely on his own so he did not go to secondary school. There are no vision rehabilitation services in the province where Davaa lives and his parents could not afford to take time off work to take him to rehabilitation services in the main city. Although a relative bought him a cane to use, he is too scared to leave the house on his own.



The diagram above uses the ICF framework that we learned about to demonstrate how our two case studies' condition interacts with their environmental and personal factors to influence their participation in everyday life.

QUESTIONS:

1. For each of the case studies, what are some of the environmental factors that might impact on their participation in everyday life, in a positive or negative way?

   a. Khan: _____

   _____

   b. Davaa: _____

   _____

2. For each of the case studies, what are some of the personal factors that might impact on their participation in everyday life?

   a. Khan: _____

   _____

   b. Davaa: _____

   _____

3. For each case, what might be some of the areas where this person might experience participation restrictions?

   a. Khan: _____

   _____

   b. Davaa: _____

   _____

4. What do you notice about the impact of the person's context (environmental and personal factors) on their experience of disability?

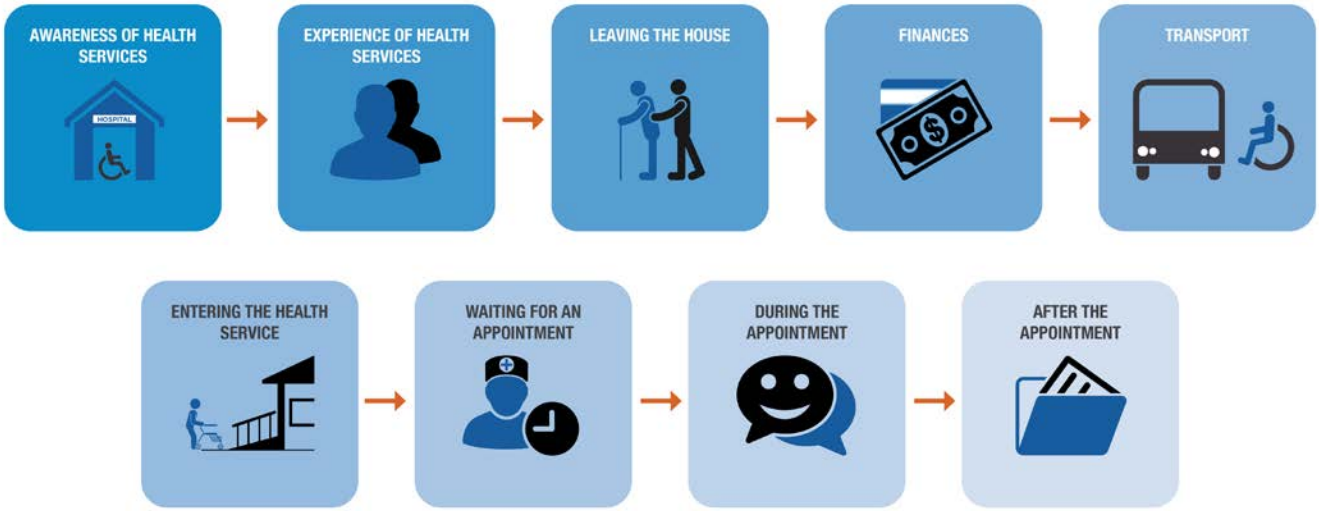
   _____

   _____

STEP 6: ACTIVITY: IDENTIFYING BARRIERS IN THE PATIENT'S JOURNEY

It is essential for health workers to have a good understanding of what the experience of accessing health services is like from the perspective of a person with disability. It is this understanding that will allow us to adapt our practices to become more disability inclusive, and to influence and educate our colleagues to do the same.

The flowchart shows the Person with Disability's Health Care journey as discussed in Video 1. This flowchart can also be found with more details of each stage of the journey on page 11 of the **Toolkit**.



PART 1: YARGUI'S STORY

Read the following case study of Yargui, a Mongolian woman with cerebral palsy, a disorder that affects movement and muscle control, and hear from her about the barriers she encounters trying to get vaccinated for COVID-19. As you read through, follow the instructions to identify which stage of the Person with Disability's Health Care Journey flowchart that she is at.

My name is Yargui and I am 43 years old and live with my husband and two teenage sons on the outskirts of Ulaan Baaatar.

The COVID-19 vaccine is being rolled out in my town but I only found out that it was happening by chance, because my neighbour came to visit and happened to tell me about it.

I have had cerebral palsy since I was born, which affects my ability to move around and my ability to speak clearly. I don't leave the house much as I need to use a wheelchair to get around and my town is not wheelchair accessible. I often am the last to find out about information that others know through being at work or school or seeing advertisements or posters around town.

Stop here and identify which stage Yargui has passed through on the Person with Disability's Health Care Journey and note it below:

_____

_____

I was hesitant to book a time to get vaccinated at first, as I have always had bad experiences at health clinics. My cerebral palsy means that my speech can be slow and difficult for others to understand and health staff often just assume that I am looking for help with my disability and rush me through the appointment. I often leave the clinic without being treated for the other medical needs that I have come to the clinic to get help with. This wastes my time and money in travel fares and I also feel frustrated and ashamed.

Stop here and see if you can identify where Yargui is on the Person with Disability's Health Care Journey and note it below:

_____

_____

Because of the importance of being vaccinated against COVID-19 for the wider community, I decided to go ahead and make an appointment to get vaccinated. My cerebral palsy affects my movement and I need someone to accompany me to any appointment to help me with the travel. My husband works as a taxi driver and often works very long hours and so it is difficult for him to find time to take me, and we would also lose his wages if he took time off work. I have a friend

who can go with me but I have to wait for her to have a day off, so I had to wait several weeks before getting an appointment and almost missed out on the vaccine.

Stop here and see if you can identify which stages Yargui has passed through on the Person with Disability's Health Care Journey and note them below:

I need to get a taxi to visit the clinic as it takes too long to get on and off the buses and the driver is often unwilling to wait for me. The taxi costs 15000MNT which is a significant cost for our family.

Stop here and identify which stages Yargui has passed through on the Person with Disability's Health Care Journey and note them below:

When we get to the clinic, we find that the entrance has three steps up to the front door. As my friend is not strong enough to lift my wheelchair up the steps, I need to sit down on the first step and shuffle up the steps on my bottom. It has been raining and my skirt gets dirty. I feel embarrassed when other patients stare at me as I move slowly towards the door.

Stop here and identify which stage Yargui has passed through on the Person with Disability's Health Care Journey and note it below:

We have to wait for over two hours to get the vaccine. I am thirsty and get up to drink water but I'm unable to reach the water station from my wheelchair.

Stop here and identify which stage Yargui has passed through on the Person with Disability's Health Care Journey and note it below:

Once we get into the appointment the health worker ignores me and speaks only to my friend to provide information about the vaccine and possible side-effects. At the end of the appointment my friend goes to the toilet, and I try and ask the nurse at the reception desk about what to do if I have any concerning side-effects, or how to book an appointment for my second vaccine dose, but she seems to assume that just because my speech is slow due to my cerebral palsy that I also have an intellectual disability, which is just not true!

Stop here and identify which stages Yargui has passed through on the Person with Disability's Health Care Journey and note them below:

_____

_____

PART 2: IDENTIFYING SOLUTIONS TO PATIENTS' BARRIERS ALONG THE PERSON WITH DISABILITY'S HEALTH CARE JOURNEY

Part 1 helps us to understand and empathize with the experience of our patients with disabilities. In Part 2 our work as health workers is to identify what changes we can make in our own practice to remove these barriers to health-care access.

Review the main barriers that Yargui faced in her journey to be vaccinated against COVID-19 – they are listed in the table below.

In the right-hand column, make note of some solutions that Yargui's local health-care clinic could provide at any of the stages to improve her access to health care. There may be many different solutions. We encourage you to draw on your own ideas, and even include practices that you have used yourself or see other people use.

This is just a beginning activity to get us starting to think about how we can provide solutions to barriers. As we move through the rest of the modules in this training package, we will be exploring solutions in much more detail.

(If you are interested in seeing some examples of solutions that we have come up with, we have included them for you in the answer booklet!)

Yargui's barriers to accessing health care	Possible solutions that a health-care service could provide
She did not know about the vaccine roll-out for a long time	
She was hesitant to go due to previous experiences of not having her health needs treated properly	
She could not travel to the health centre without finding someone to accompany her	
The cost of a taxi placed financial stress on her family	
She had difficulty entering the health service due to the stairs	
She could not access the water tap while waiting for the appointment	
The health-care worker did not communicate directly with her during the session	
She was not provided with follow-up information due to incorrect assumptions about her disability	

STEP 7: VIDEO 3: GETTING STARTED IN APPLYING DISABILITY-INCLUSIVE PRACTICE

Now that you have a good understanding of some of the key barriers to health care for people with disability and why it is important for health services to be disability inclusive, we can move onto how you can begin to apply this by assessing the needs and priorities of your own health service.

Watch this short video to learn about:

- Key principles of disability-inclusive health in practice
- What a **disabled peoples organization (DPO)** is and how they can work with your health service to develop disability-inclusive health practices
- The first steps you can take in making your health service more disability inclusive

Key principles of disability inclusion in health service:

- Increase awareness of the rights and needs of people with disability among health service staff (at all levels)
- Participation and active involvement of people with disability
- Comprehensive accessibility
- Twin track approach

Reflect: As you watch or listen to the video, reflect on how these principles are currently being practised in your health service.

NEXT STEPS:

Well done! You have completed Module 1 of this training. You now have a good knowledge of the basics of disability inclusion in health care.

These are your two next steps:

STEP 1: COMPLETE THE CHECKLIST: FIRST STEPS IN MAKING YOUR HEALTH SERVICE MORE INCLUSIVE ON PAGES 18–20 OF THE WHO DISABILITY-INCLUSIVE HEALTH SERVICES TOOLKIT

This checklist will help you to identify which parts of your service and practice are the most important to focus on when implementing disability-inclusive practice and therefore which modules in this training kit you should complete next.

STEP 2: COMPLETE MODULE 2: PROMOTING DISABILITY-INCLUSIVE ATTITUDES

No matter which other modules you have identified as priority areas in your checklist, we strongly recommend that you include Module 2: Promoting Disability-Inclusive Attitudes.

FURTHER RESOURCES

If you are interested in learning about the concepts and practices that we have covered in this module in more detail, have a look at the following resources:

WHO global disability action plan 2014–2021: better health for all people with disability. Geneva: WHO; 2015 (https://www.who.int/publications-detail-redirect/who-global-disability-action-plan-2014-2021).

World report on disability. Geneva: WHO and World Bank; 2011 (https://www.who.int/disabilities/world_report/2011/en/).

Inclusion made easy: a quick program guide to disability in development Part B. Disability inclusion: health. Bensheim: CBM International; 2012 (https://www.cbm.org/fileadmin/user_upload/Publications/cbm_inclusion_made_easy_a_quick_guide_to_disability_in_development.pdf).

MODULE 2
PROMOTING DISABILITY-INCLUSIVE ATTITUDES

WHO DISABILITY-INCLUSIVE HEALTH SERVICES TRAINING PACKAGE

WELCOME TO THE SECOND MODULE OF THE WHO DISABILITY-INCLUSIVE HEALTH SERVICES TOOLKIT.

In this module we will be looking at removing **attitudinal barriers** in your health service.

Attitudinal barriers are one of the most common barriers that people with disability face when accessing health services and promoting disability-inclusive attitudes is key to providing a disability-inclusive health service.

We consider this module as one of the two foundation modules of this training package, as attitudinal barriers often compound other types of barriers, such as physical and communication barriers.

Many attitudinal barriers are the result of a lack of knowledge and awareness about disability, and the rights and needs of people with disability.

While completing this module you may discover that you have areas in which you yourself lack awareness or have had negative attitudes around disability. If this happens do not worry! It is a normal stage of the learning process. Being able to identify our own attitudes and beliefs is an important step towards identifying and taking action to address the attitudinal barriers within our health services.

After completion of this module you will be able to:

- Understand what is meant by "attitudinal barriers" and the impact they can have on health care for people with disability
- Know some common negative attitudes or beliefs faced by people with disability when accessing health services
- Be able to identify attitudinal barriers in your health service
- Be familiar with key strategies to address attitudinal barriers

OVERVIEW OF MODULE 2

We estimate that this module will take you approximately 1 hour to complete.

STEP 1: ACTIVITY: THE IMPACT OF ASSUMPTIONS AND NEGATIVE BELIEFS

We are going to start with an activity to reflect on the way that attitudinal barriers can impact on us as people and affect the way that we communicate and interact with others. Even if you do not have lived experience of disability, most of us have had some experience of a person assuming that we are less capable than we know that we are.

Developing insight into our own experience of attitudinal barriers can assist us to develop greater understanding of the experience of our clients with disability.

Think of a time that you (or someone close to you) had another person assume that you were less capable than you were. You may consider an example of this happening within an institution (e.g. school, work place, health-care service)

Describe the situation: Who was involved? What was the assumption made about you? Why do you think it was made?

_____

_____

_____

What was the impact on you? How did you feel? Did it change your behaviour in any way, for example how you communicated or acted around that person (or in that institution)?

_____

_____

_____

Group study: If you are completing this module in a group, take some time to share your responses with one another.

Do you notice any similarities between your experiences?
Do you notice any differences between your experiences?

_____

_____

STEP 2: VIDEO 1: WHAT ARE ATTITUDINAL BARRIERS AND WHY DO THEY MATTER?

Watch this video to learn what defines an attitudinal barrier and how to identify some of the most common types of negative attitudes and beliefs that create barriers for people with disability when accessing health care.

We will also look at how attitudinal barriers can have a negative impact on the quality of care, both that health workers provide and that people with disability receive.

Reflect: As you watch the video, think about whether you have witnessed any of these attitudinal barriers in your professional life so far, whether in your colleagues or in your own practice.

STEP 3: EXAMPLES OF NEGATIVE ATTITUDES IN HEALTH-CARE CONTEXTS

In this activity you are going to practise identifying different types of negative attitudes and beliefs that contribute to attitudinal barriers and how they might look when you encounter them in a health-care context.

Each of the statements below represents some common attitudes that are expressed by health-care workers when dealing with patients with a disability.

Match each type of negative belief from the left-hand column in the table below with a statement by a health worker from the right-hand column that represents that attitude.

Once you have finished, refer to the answer book for the correct responses.

Types of negative attitude
1. **Stereotyping:** Assuming what patients need or don't need
2. **Pity:** Feeling sorry for people with disability, leading to patronizing behaviour.
3. **Fear and avoidance:** Being afraid of saying or doing the "wrong" thing so avoiding people with disability
4. **Inferiority:** Believing people with disability are inferior because of their impairment
5. **Denial:** Not recognizing the impact of disabling conditions that may not be visible (e.g. intellectual disability, autism) and denying reasonable accommodations where needed

Health worker statements
A. We usually see the people with disability after we have seen all of the other patients because if they miss out on an appointment it doesn't matter as much for them.
B. Why should I spend longer with this patient just because they say they have a disability? They look the same as everyone else to me.
C. Women and girls with disability don't need access to contraception and sexual and reproductive health services because they are not sexually active.
D. When we conduct vaccination clinics at the health centre and I see children with disabilities, I feel sorry for their parents. I talk to them about how hard it must be for them.
E. When one of our deaf patients comes to the health centre, I leave them to be seen by the other staff. I don't know how to use sign language and I am worried I won't be able to communicate with them.

STEP 4: VIDEO 2: ADDRESSING ATTITUDINAL BARRIERS IN YOUR HEALTH SERVICE

In this video we look further into some systemic factors that contribute to attitudinal barriers in health-care settings.

We then examine two key approaches that you can use to address attitudinal barriers: designing in-service training and capacity-building for staff and creating more inclusive policies and procedures.

STEP 5: ACTIVITY: REMOVING ATTITUDINAL BARRIERS BY REPLACING NEGATIVE ATTITUDES WITH DISABILITY-INCLUSIVE ATTITUDES

In this activity we are going to look at approaches that you and your colleagues can take to counter negative attitudes when interacting with clients with disability.

Replacing approaches that are based on negative attitudes with disability-inclusive approaches to practice like the ones in the activity below is a key strategy to addressing attitudinal barriers in your health service.

In the left-hand column of the table below are the types of negative attitudes that we looked at in Step 3.

Match each type of negative attitude in the left-hand column with a more disability-inclusive approach from the right-hand column.

Types of negative attitude	A more disability-inclusive approach
1. **Stereotyping:** Assuming what patients need or don't need	A. Remember that all patients have equal entitlement to health care as all other people under the UNCRPD. *Example:* *"People with disability are entitled to be seen at our health centre on an equal basis with all other people. We will make sure they get the health services they need."*
2. **Pity:** Feeling sorry for people with disability, leading to patronizing behaviour.	B. Try your best to communicate with all patients and find alternative ways of communicating if required. Don't worry too much about saying the wrong thing – it is more important to try to communicate and find out what their needs are than to always "get it right". *Example:* *"When a deaf patient comes into the health centre, although I don't know sign language, I can still find a way to communicate with them."*
3. **Fear and avoidance:** Being afraid of saying or doing the "wrong" thing so avoiding people with disability	C. Ask patients if they need any specific assistance and provide it if requested, but do not insist on helping them or make them feel embarrassed. *Example :* *"When I see a parent with a child with a disability at the vaccination clinic I will ask them if they need any specific assistance but if they say no I just see them for their vaccination the same as all the other children."*
4. **Inferiority:** Believing people with disability are inferior because of their impairment	D. Remember that not all disabilities are visible. Listen to your patients when they communicate what their specific needs are and provide reasonable accommodation when required. *Example:* *"It is important that we accommodate the needs of our different patients. Some patients with an intellectual disability need longer appointment times so that we can take the time to communicate with them in a way they understand, and they have time to process information and ask any questions that they have."*
5. **Denial:** Not recognizing the impact of disabling conditions that may not be visible (e.g. intellectual disability, autism) and denying reasonable accommodations where needed	E. Offer patients the same access to health services as all patients. Let them decide which services they need and don't make assumptions. *Example:* *"Offer women and girls with disability the same access to contraception and SRH services just like all women and girls, to reduce their risk of unwanted pregnancy and sexually transmitted infections."*

STEP 6: ACTIVITY: RESPONDING TO ATTITUDINAL BARRIERS AT THE POLICY LEVEL

As we have seen earlier in this module, attitudinal barriers can occur both at the level of the individual health practitioner and at the level of health service policies and practices.

In this activity, we have selected some common barriers in policy and practices that may result from negative attitudes to people with disability at the organizational level.

For each statement, write down what you could say in response to the statement to encourage a more disability-inclusive approach to the situation.

Once you have written down some ideas, have a look at some suggested responses that we have provided in the answer book.

Examples of attitudinal barriers at the policy level	Possible responses to encourage a disability-inclusive approach
"We don't have the budget to make the clinic accessible for people with disabilities. They are used to managing in other public places so they can manage the same way here."	
"We haven't asked any people with disabilities to be on our board as we don't have time in the meetings to go slowly for them. Also, we wouldn't want to put them under too much pressure."	
"Our staff don't need to understand about disability. We are not a disability service. We should be prioritizing training on improving health practices that apply to everyone."	

NEXT STEPS

Well done on completing the second foundational module in this training course!

Now that you know how to identify and respond to attitudinal barriers in a health-care context, we encourage you to use the tools from the WHO Disability-Inclusive Health Services Toolkit to identify and address attitudinal barriers at both the individual and policy levels in your health service:

Guidelines on how to develop an in-service training plan (pages 32–33)

A checklist you can use to audit the policies and practices of your health service (page 34)

A template for creating a disability-inclusive policy (page 35–36)

FURTHER RESOURCES

Some examples of disability-inclusion training for specific health contexts include:

W-DARE service providers session guide. Disability-inclusive sexual and reproductive health component. Women with Disability taking Action on Reproductive and Sexual Health; 2014 (https://wdare.files.wordpress.com/2018/09/w-dare-service-provider-training-package1.pdf).

MODULE 3
ADDRESSING PHYSICAL BARRIERS – PROMOTING UNIVERSAL DESIGN AND REASONABLE ACCOMMODATIONS

WHO DISABILITY-INCLUSIVE HEALTH SERVICES TRAINING PACKAGE

WELCOME TO THE THIRD MODULE OF THE WHO DISABILITY-INCLUSIVE HEALTH SERVICES TOOLKIT.

In this module we will be looking at how you can make your health facility physically accessible for people with a disability, and indeed for all users of the health service.

You will have the opportunity to practise thinking about **physical accessibility** from various angles. We will be guiding you through removing barriers and improving physical accessibility from the perspective of a range of impairments, including mobility, vision, and hearing impairments. We will also consider how physical accessibility extends beyond the building of the health service itself and includes the types of equipment used in health facilities and transport to and from health services.

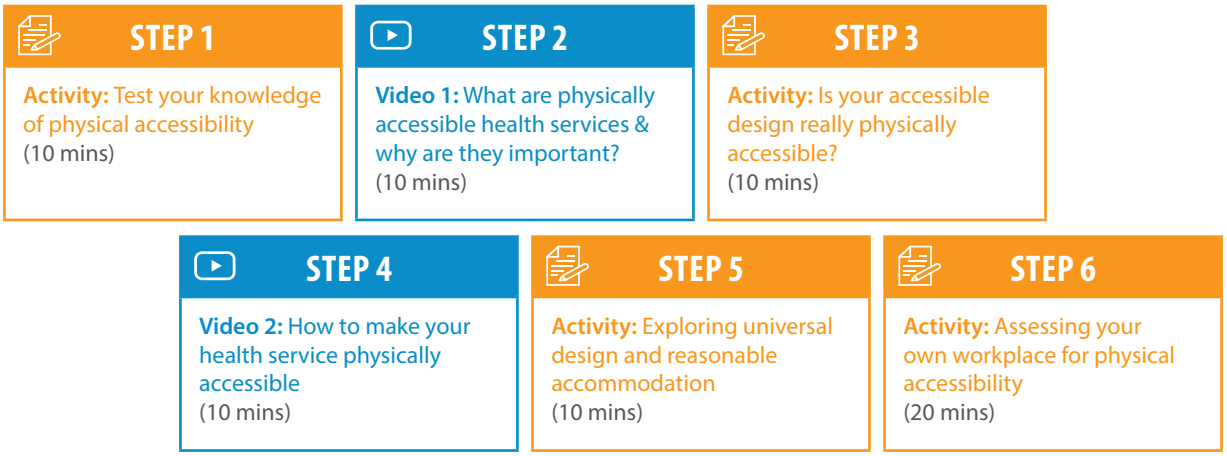
After completion of this module you will be able to:

- Understand what physical barriers are, and some common physical barriers for people with disability when accessing health services.
- Know what is meant by **"universal design"** and **"reasonable accommodation"** and why these are important.
- Be able to identify potential physical barriers in your health service.
- Know some simple, low-cost strategies to remove physical barriers in health services.

OVERVIEW OF MODULE 3

We estimate that this module will take you approximately 1 hour and 10 minutes to complete.

You do not have to complete the full module in one sitting – you can work through it at your own pace.



STEP 1: ACTIVITY: TEST YOUR KNOWLEDGE OF PHYSICAL ACCESSIBILITY

Let us begin with a short quiz to test your knowledge of some key aspects of physical accessibility. Each question below covers an important aspect of why physical accessibility matters and key principles when developing a physically accessible health service. Don't worry if you aren't sure about all the answers. We will be covering each one in more detail in the videos.

For each question below select the answer that you think is most likely to be correct. Once you have completed the activity, refer to the answers in the answer booklet.

1. In addition to patients with disability, what kind of patient will benefit from a physically accessible health service?
    a. Patients with an injury
    b. Patients who are pregnant
    c. Patients who have had surgical interventions
    d. Older patients
    e. All of the above

2. Making a facility physically accessible means that all patients:
    a. Are able to enter and move around inside the building
    b. Are able to use the facilities safely
    c. Are able to use the facilities with dignity
    d. All of the above

3. To conduct an audit of the physical accessibility of a health service the most important people to consult are the health-care providers who work in the facility as they know the facility the best:
    - True
    - False

4. When considering the physical barriers of a health service we only need to look at the infrastructure of health facilities
    - True
    - False

STEP 2: VIDEO 1: WHAT ARE PHYSICALLY ACCESSIBLE HEALTH SERVICES AND WHY ARE THEY IMPORTANT?

In this video you will learn about what characterizes a physically accessible health service and how making a health service physically accessible benefits all patients, including people with disability.

We will also look at examples of common physical barriers that are found in health services.

STEP 3: ACTIVITY: IS YOUR ACCESSIBLE DESIGN REALLY PHYSICALLY ACCESSIBLE?

In the previous video we looked at some of the common physical barriers that can occur in health services.

In practice, introducing accessible features needs to be done correctly and with the end-user in mind to ensure these features are truly accessible to those who need them, when they need them.

In this activity we are going to look at some examples of where the best intentions of improving physical accessibility might still not translate to a physically accessible health service if they have not been considered for how they will work in practice for people with disability.

All of these are based on real-life scenarios and many of them sound quite funny but have a real impact on access to health facilities for people with disability. Reflecting on silly oversights like those below can help us to learn from others' mistakes!

Match each accessibility feature that has been introduced from the list on the left-hand column with what can happen if they are not checked for practical usability.

Once you have completed the activity, refer to the answers in the answer booklet.

Physical accessibility features implemented	……. accessibility oversight!
1. A ramp has been installed at the entrance to the health clinic	A. ...but the reception desk was moved to a new location and the tactile markers not adjusted!
2. Tactile markers to guide people with vision impairment from the entrance to the reception desk were installed	B. ...but it has a chain across it to prevent people parking in it!
3. An accessible toilet has been installed	C. ...but the braille has had another sign taped over the top of it!
4. Flashing lights are provided as part of the emergency evacuations system to alert people who are deaf	D. ...but the globes are broken and have not been replaced!
5. A disabled parking space has been provided at the front of the hospital	E. ...but staff have parked their motorbikes on it, blocking the entrance!
6. Braille has been provided on the hospital directory which informs patients where clinics are located	F. ...but the door into the consulting room is too narrow for wheelchair users to access!
7. A consulting room had a height-adjustable examination table installed	G. ...but the door is always kept locked because staff say they don't have time to clean it!

Reflect on what measures you could have taken to avoid or remove the oversights in the scenarios above, and make sure that the accessibility features were available to the people who needed them when they needed them.

Group activity: If you are studying in a group you might like to challenge each member of the group to conduct an Internet search for images of an "accessibility fail", or when physical accessibility has gone wrong. Select one image to share with the group. The whole group can then vote on what they think the best (or worst!) example is, why it would not work in practice, and what could be done to improve the situation.

STEP 4: VIDEO 2: HOW TO MAKE YOUR HEALTH SERVICE PHYSICALLY ACCESSIBLE

Now that we have looked at examples of what not to do, we are going to guide you through strategies that you can use to make your health service physically accessible.

In this video we will introduce you to two key concepts when addressing physical accessibility:

- **Universal design** principles promote the design of products, environments, programmes and services that are usable by people of all ages and abilities
- For existing facilities, **reasonable accommodations** can be made to overcome physical barriers for people with disabilities.

STEP 5: ACTIVITY: EXPLORING UNIVERSAL DESIGN AND REASONABLE ACCOMMODATION

In this activity we will be looking at some specific examples of how "universal design" and "reasonable accommodation" are applied in a health-care context.

PART 1: UNIVERSAL DESIGN

In this scenario, a health service has conducted a consultation with a local DPO to assist them in re-designing a clinic area and ensure they apply universal design principles to provide an accessible clinic for people with disability.

The DPO has helped them to conduct a physical accessibility audit by walking through the existing facilities, taking the journey that patients would make within the facilities, and looking at the plans for the new clinic design.

In the left-hand column of the table below are three of the recommendations given by the DPO for implementing universal design principles in the clinic re-design.

For each example of universal design, select which groups of patients in the right-hand column would benefit most from this design. There may be multiple groups of patients who can benefit from a single design.

Once you have completed the activity, refer to the answer booklet.

Universal design recommendation	Types of patients that would benefit from this design
1. Change the signage within the facility to light letters on a dark background to increase the contrast to make the signage easier to read	People with mobility impairments Older people Parents with young children in a pram/stroller People with impairment in their arms/upper limbs People with vision impairment People with learning difficulties
2. Replace the steps at the front entrance of a health facility with a gently sloping ramp	
3. Install automatic doors at the entrance to the facility so that patients do not have to physically open the doors	

PART 2: REASONABLE ACCOMMODATIONS

We will now look at how to apply ***reasonable accommodations*** to increase the physical accessibility of health services.

Reasonable accommodations are modifications or adjustments made to ensure equal access and opportunity for all, without placing a large burden on those implementing the accommodation. They may be implemented for an individual or to benefit many people. In health care, these may be simple adjustments to the environment or to the way services are delivered to accommodate the specific needs of a patient or group of patients.

Read through the case studies below.

For each case study, write down a reasonable accommodation that the health-care worker could make to address the patient's need around physical accessibility and ensure that patients with disability can enjoy equal access to the health services being provided.

Once you have completed the activity, refer to the answer book where we have included some suggested reasonable accommodations.

CASE STUDY 1: RONNIE

Ronnie is a 27-year-old Filipino man who is a wheelchair user and lives in Baguio city in the Philippines.

He has made an appointment at the health service for a nurse to inspect a dog bite that he has on his leg.

The nurse needs Ronnie to lie down on the examination table so that she can dress the wound; however, she is not strong enough to lift him up and onto the table. Eventually she gets one of the security guards to come and lift Ronnie on and off the table. The nurse notes that if she had not been able to find a security guard then she would not have been able to complete the examination. At the end of the appointment Ronnie also tells her that he felt embarrassed by relying on the security guard to lift him and invade his privacy by being in the room while he received medical care.

CASE STUDY 2: PAIROJ

Pairoj is a 67-year-old Thai man who has recently had a stroke that has affected the movement in one side of his body. He is no longer able to drive his car and getting on and off public transport is very difficult.

Pairoj has made an appointment at his local health clinic for a check-up and to renew his medication prescriptions. He usually relies on his daughter to drive him to the appointment; however, this morning his daughter has been called into work on an urgent matter. Pairoj calls the clinic to ask if there is an alternative way to renew his prescription if he doesn't have transportation.

CASE STUDY 2: LIA

Lia is a 25-year-old Indonesian woman living in Yogyakarta. She is 6 months pregnant and has multiple sclerosis which affects her mobility.

She arrives at the local maternal and child health centre for prenatal classes and finds out that the classes have been moved from the ground floor to a meeting room on the first floor which is accessible only by stairs.

STEP 6: ACTIVITY: ASSESSING YOUR OWN WORKPLACE FOR PHYSICAL ACCESSIBILITY

In this next activity you will find out how physically accessible your own health facility is.

Using the Physical Accessibility Audit checklist on pages 47–49 of the WHO Disability-Inclusive Health Services Toolkit as a guide, take a tour of your health facility.

We recommend that you complete this exercise in pairs and have one member of your pair take notes in the checklist, and the other member of the pair tell their partner about their experience of using the service as a person with a disability.

Ideally, this member of the pair should be a person with a disability. However, if this is not possible, one member can simulate the experience of using the health service as a person with an impairment. This will help you to get a much deeper understanding of the actual usability of the facilities than if you did the tour just imagining what the experience would be like if you had different impairments.

To simulate different impairments you might try:

- *A blindfold (vision impairment)*
- *Using a wheelchair and/or walker (mobility impairment)*
- *Putting an arm in a sling (arm/upper limb impairment)*
- *Wearing noise-cancelling headphones (hearing impairment)*

In order to get a full sense of the physical accessibility of the service you will need to complete this tour several times, each time simulating a different impairment, or have several people involved, each representing a different type of impairment.

Reflection:

Once you have completed a tour of your health service, take some time to reflect on the following questions:

- What was the experience of the tour like for you? Did you experience any particular emotions at different points of the tour?
- What barriers did you experience? How could these be overcome?
- Did you discover any physical barriers that weren't included in the checklist? If so, what were they?
- Was it helpful to use the checklist? What were the benefits of doing the tour with a simulated impairment?

Group study: If you are studying in a group, try allocating different simulations to different pairs in your group; for example, the first pair uses a blindfold; the second pair uses a wheelchair, etc.

Once you have completed your tours, meet back together to discuss your experiences:

- Were there areas in the health service that different impairments all had issues with?
- What were the areas that only some types of impairments had issues with?

You might also like to take time to share your responses to the reflection questions above.

FURTHER RESOURCES

Accessibility design guide: universal principles for Australia's aid program. Australian Agency for International Development (AusAID); 2013 (https://www.dfat.gov.au/about-us/publications/Pages/accessibility-design-guide-universal-design-principles-for-australia-s-aid-program).

Accessibility for the disabled: a design manual for a barrier free environment. New York: United Nations Enable; 2003–2004 (https://www.un.org/esa/socdev/enable/designm/index.html).

A health handbook for women with disabilities. Berkeley: Hesperian Foundation; 2007 (https://hesperian.org/wp-content/uploads/pdf/en_wwd_2008/en_WWD_2008_fm.pdf).

MODULE 4
COMMUNICATION BARRIERS: PROVIDING DISABILITY-INCLUSIVE HEALTH INFORMATION

WHO DISABILITY-INCLUSIVE HEALTH SERVICES TRAINING PACKAGE

WELCOME TO THE FOURTH MODULE OF THE WHO DISABILITY-INCLUSIVE HEALTH SERVICES TOOLKIT.

In this module we will be looking at common **communication barriers** experienced by people with disability when accessing health care and the impact that these barriers can have. We will then guide you through understanding how to adopt a disability-inclusive approach to communication to improve equal access to health services for people with disability.

Using disability-inclusive communication in health is important for empowering people with disability to have knowledge about their health and the health services available to them, which increases their access to and uptake of the services they need. Knowledge of disability-inclusive communication is also vital to increasing your capacity and confidence as health workers to better address the health needs of people with disability.

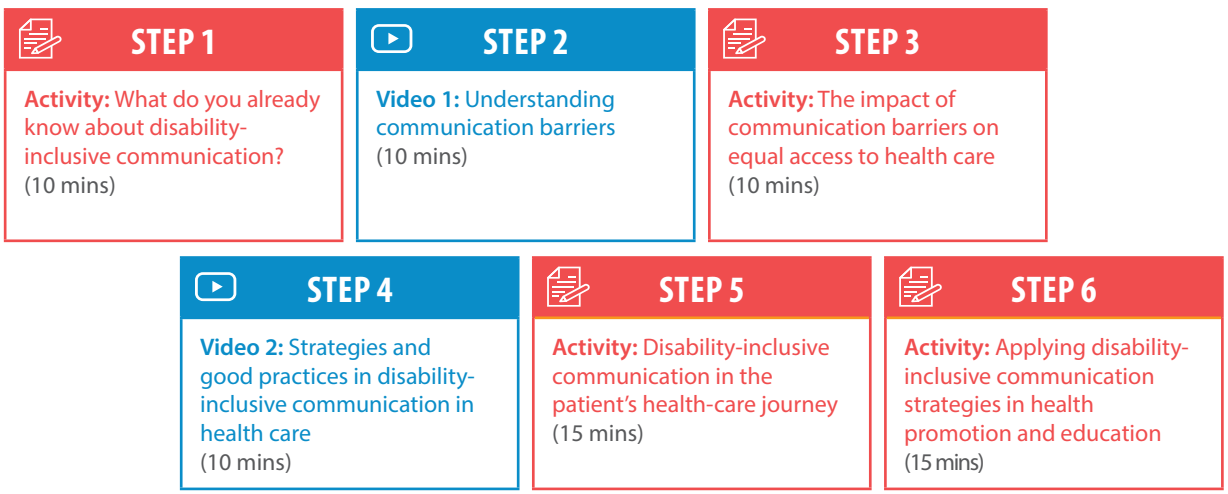
Fortunately, many communication barriers can be addressed at little or no cost, and simply involve adjusting our practices and behaviours.

After completion of this module you will be able to:

- Understand some of the common communication barriers people with disability face when accessing health services or health information.
- Understand the impact of communication barriers in health care for people with disability.
- Apply key strategies to communicate with people with disability and make health information disability inclusive in your health service.

OVERVIEW OF MODULE 4

We estimate that this module will take you approximately 1 hour and 10 minutes to complete. You do not have to complete the full module in one sitting – you can work through it at your own pace.



STEP 1: ACTIVITY: WHAT DO YOU ALREADY KNOW ABOUT DISABILITY-INCLUSIVE COMMUNICATION?

In this first activity, we invite you to reflect on your previous experience of providing patient-centred care.

Using disability-inclusive health communication is an extension of being patient-centred in our practice, so you may discover that you already have skills and experience in this area. In disability-inclusive communication we take the patient-centred care approach and apply it to a specific population of patients.

Through the reflection questions in this activity, we want to encourage you to identify your existing skills that you will be building on as you work through this module.

Think of a time that you have used patient-centred care when treating or interacting with a patient. Respond to as many of the questions below as are relevant to you:

What were the specific needs that you kept in mind as you treated or interacted with this patient? (Tip: Specific needs may relate to many things, for example, their ethnicity or religion, their family context, their gender, their financial situation, where they live, an impairment.)

How did you adapt your practice to suit the patient's needs?

How do you think this impacted the outcome for this patient?

What would have happened if you did not adapt your approach to their individual needs?

STEP 2: VIDEO 1: UNDERSTANDING COMMUNICATION BARRIERS

In this video, we will look at why disability-inclusive communication is key to increasing equitable access to health care for people with disability, and ultimately in improving their health outcomes.

We will also look at some common communication barriers and how they can occur in both health service delivery and health promotion.

Reflect: Can you think of any examples where either you or a colleague have communicated in a way that presented a barrier to a patient with a disability? Were you aware that it was a communication barrier for them at the time?

STEP 3: ACTIVITY: THE IMPACT OF COMMUNICATION BARRIERS ON EQUAL ACCESS TO HEALTH CARE

In the previous video we learned that communication barriers may occur across different aspects of health delivery, particularly:

- When interacting with patients and providing health services.
- In the physical environment of the health service.
- In health promotion materials and activities.

In this activity we are going to look at a range of scenarios that demonstrate how communication barriers can occur and how they impact a patient's equitable access to health care. Each scenario also includes the impact that the barrier could have on the patient's experience of and access to health care.

Read scenarios 1–6 below. For each scenario, select a communication barrier (A–F) from the list that could occur in this situation.

Write the corresponding letter in the space provided in the scenario. Once you have finished the activity, refer to the answer booklet for the answers.

Common communication barriers and examples:

a. **Signage not provided in accessible formats:** The hospital directory that indicates where different clinics and services are located is written in red on a white background and no Braille is provided.

b. **Not enough time provided to use alternative communication methods:** The health worker does not give the patient's support person enough time to translate to the patient.

c. **Inadequate explanations of health conditions or procedures:** The health worker assumes that the patient will not understand the information about the procedure and so they go ahead without explaining what they are doing and why they are doing it.

d. **Being talked down to or patronized by staff:** The receptionist speaks to the patient as if they were a child.

e. **Written information not provided in accessible formats:** The pamphlet contains a large amount of written information, some of it using technical language. The information is only available in this format.

f. **Being ignored or spoken to indirectly through a partner, family member or support person:** The health worker talks only to the patient's support person and does not communicate directly with the patient.

1. Bora, a 34 year-old man with cerebral palsy is attending an appointment to check on a pain in his abdomen. The health worker decides to perform an ultrasound to help him to diagnose the problem.

What communication barrier could occur at this point?_____

Impact: Because Bora doesn't know what is happening, he is unable to give informed consent to the procedure and experiences anxiety while it is being done.

2. Trang, a 32-year-old woman with low vision is attending a maternal and child health centre in the local hospital for her first prenatal check-up. It is her first time at the clinic and she needs to find the location of the clinic where the consultation will take place

What communication barrier could occur at this point?_____

Impact: Trang is unable to find out herself where she needs to go within the hospital and needs to rely on finding somebody who can help her to find out where to go.

3. Arun is a 50-year-old man who has a cognitive impairment due to a brain injury. This affects his ability to take in large amounts of complex information at once. He receives a brochure in his mail from his local health service that outlines the symptoms of COVID-19, what to do if experiencing symptoms, and prevention strategies.

What communication barrier could occur at this point?_____

Impact: Because Arun cannot understand the pamphlet he ignores it and throws it away. He is not aware of what he should do to prevent COVID-19 or if he has symptoms.

4. Hu is a 65-year-old man who has a speech impairment as a result of a stroke, which causes him to speak slowly and slur his words. When he arrives at the clinic for a prostate check he goes to the reception desk to register his arrival and find out directions about where to go.

What communication barrier could occur at this point?_____

Impact: Hu feels embarrassed and stops coming into the clinic for future appointments.

5. Maria is a 20-year-old woman with Down Syndrome who goes to the health clinic to discuss options for contraception. Maria is accompanied by her mother who acts as a support person at Maria's appointments. The health worker provides some information and writes a prescription.

What communication barrier could occur at this point?_____

Impact: Maria does not get the opportunity to ask questions, clarify anything she does not understand, or raise any concerns or needs that she would like addressed that are not raised by her mother.

6. Dong Jin is a 16-year-old boy with a hearing impairment who broke his leg playing football. He attends an appointment to remove the plaster cast with his sister, who will act as his sign language interpreter.

What communication barrier could occur at this point?_____

Impact: Dong Jin does not understand what is being said and does not have the opportunity to ask questions about his recovery or rehabilitation.

STEP 4: VIDEO 2: STRATEGIES AND GOOD PRACTICES IN DISABILITY-INCLUSIVE COMMUNICATION IN HEALTH CARE

In this video we begin by looking at characteristics of disability-inclusive information and communication.

We then look at a range of strategies that you can take to applying disability-inclusive communication in your health service, including:

- Considering the communication needs of different impairments.
- Adopting a patient-centred approach.
- Conducting information accessibility audits.

STEP 5: ACTIVITY: DISABILITY-INCLUSIVE COMMUNICATION IN THE PATIENT'S HEALTH-CARE JOURNEY

This case study presents an example of how a range of disability-inclusive communication strategies can be applied along a patient's health-care journey, in this case for patients with autism and intellectual disability in health responses to the COVID-19 pandemic.

Read through the case study below.

Respond to the questions below to identify the examples of where the health service has applied best practice strategies of disability-inclusive communication.

Once you have finished, refer to the answer booklet for suggested answers.

My name is Erdene and I am 24 years old and live in the province with my parents and maternal grandparents. We live in a small house that shares a common laundry and washing facilities with the other houses in the village.

I have an intellectual disability and autism.

I often get anxious or overwhelmed when my everyday routines are changed or when I need to go to an unfamiliar place. I manage this anxiety by pacing up and down, covering my ears and humming to myself to block out noises – this helps me to focus and calm myself. I can speak,

but it is hard to talk about my emotions and let people know what is upsetting me. I also find it difficult to understand instructions or information if someone gives it to me too quickly or too much at once.

Last week my mother went into hospital for COVID-19. I have heard of COVID but don't really understand much about it. A few days ago, I started to have a dry cough and a slight fever. My auntie said that I should get a COVID test, but I got confused when she told me all the things that I needed to do. My mother usually explains things to me in a way that I will understand, but of course she wasn't there.

Because I didn't understand what the testing process was, I was fearful of doing the wrong thing and I didn't end up doing anything. My auntie arranged for the local DPO to visit, and they helped explain to me what I needed to do. They had a **"social story"** they had written in partnership with the local health-care service. The social story tells the story of a person with a disability, just like me, who needs to get a COVID-19 test. It uses pictures and simple words to explain what happens at the testing centre and precautions to take to protect yourself and others from COVID-19. In the story it said there is a special **"Priority Area"** at the testing centre that is quiet for people like me that don't like crowds and noise. The DPO also had a **communication board** with pictures that helped me communicate that I was fearful of upsetting others or getting into trouble for doing the wrong thing. They reassured me that the health-care workers would look after me and that everything would be okay.

My father took some time off his job at the cashmere factory to take me to get tested. When we arrived at the testing centre, it was very busy and loud and I found it confusing and overwhelming. When I am anxious it is even more difficult for me to communicate. I was so anxious I tried to pull my father towards the door to go home, but he noticed a sign that pointed towards a "Priority Area". I knew from the social story that these were spaces that are calm and quiet, for people with disability or other needs that find busy, noisy areas overwhelming, so we went to wait there and I felt better.

Many times before when I have been to health centres I have been frustrated when the staff have avoided me or have spoken to my parents rather than me, even though I am an adult. So, I was surprised when the nurse came in to give me the test and spoke with me very patiently about what the testing would involve, and the precautions I should take after I get tested. She had a series of pictures in a folder which she used to show me each step of the process. She used everyday language and spoke directly to me instead of my father, but she allowed me time to process what she said and waited for me to respond before she went on to the next step.

Going to the testing centre was not so bad after all.

1. In the spaces below, write examples from the case study of how the health service applied strategies for disability-inclusive communication:

   a. Health information materials and communication strategies are developed with people with disability:

   b. Health workers use patient-centred care to identify and use communication strategies suited to the individual patient's needs:

   c. Health information and communication before, during and after service provision is provided in a range of formats accessible to people with different types of impairment:

   d. Health information includes information specific to people with disability, and uses positive portrayals of people with disability:

2. Consider what could have been the health implications for Erdene and others in his family and community if the health centre had not used these strategies:

STEP 6: APPLYING DISABILITY-INCLUSIVE COMMUNICATION STRATEGIES IN HEALTH PROMOTION

In this activity we are going to look at how you can apply disability-inclusive strategies when you are creating health promotion and education programmemes.

You will have the opportunity to identify practical strategies based on the communication needs of different types of impairments when delivering information both face-to-face and through other formats.

Imagine that you have been asked to develop a disability-inclusive health education programmeme to educate all users of your health-care service about a health issue.

In the spaces below, write some practical strategies that you can use to ensure disability-inclusive communication for people with different impairments.

Refer to the Practice Note: *Look at the practical strategies for communicating inclusive health information to people with different types of impairment on pages 64–67 in the WHO Disability-Inclusive Health Services Toolkit for suggestions. You may also think up your own.*

When selecting strategies, we encourage you to think about your own health service and select strategies that are most relevant to your context.

When you have finished, refer to the answer booklet to see some suggested strategies.

The programme will include a community education session held at the health service.

1. Identify one practical strategy to make the programme disability inclusive for each of the types of impairment below:
   For patients with mobility impairment:_____
   For patients with a cognitive or intellectual impairment:_____
   For patients with hearing impairment: _____
   For patients who are blind or have a vision impairment:_____

2. The programme also includes distributing health promotion information about the health issue to the community through channels such as the local media and mail-outs.
   Identify one practical strategy you could apply to make the health promotion information disability inclusive for each of the types of impairment below:
   For patients with a cognitive or intellectual impairment:_____
   For patients with hearing impairment:_____
   For patients who are blind or vision impaired:_____

Group activity:
If you are doing this training in a group, compare the strategies that you have selected for this activity.

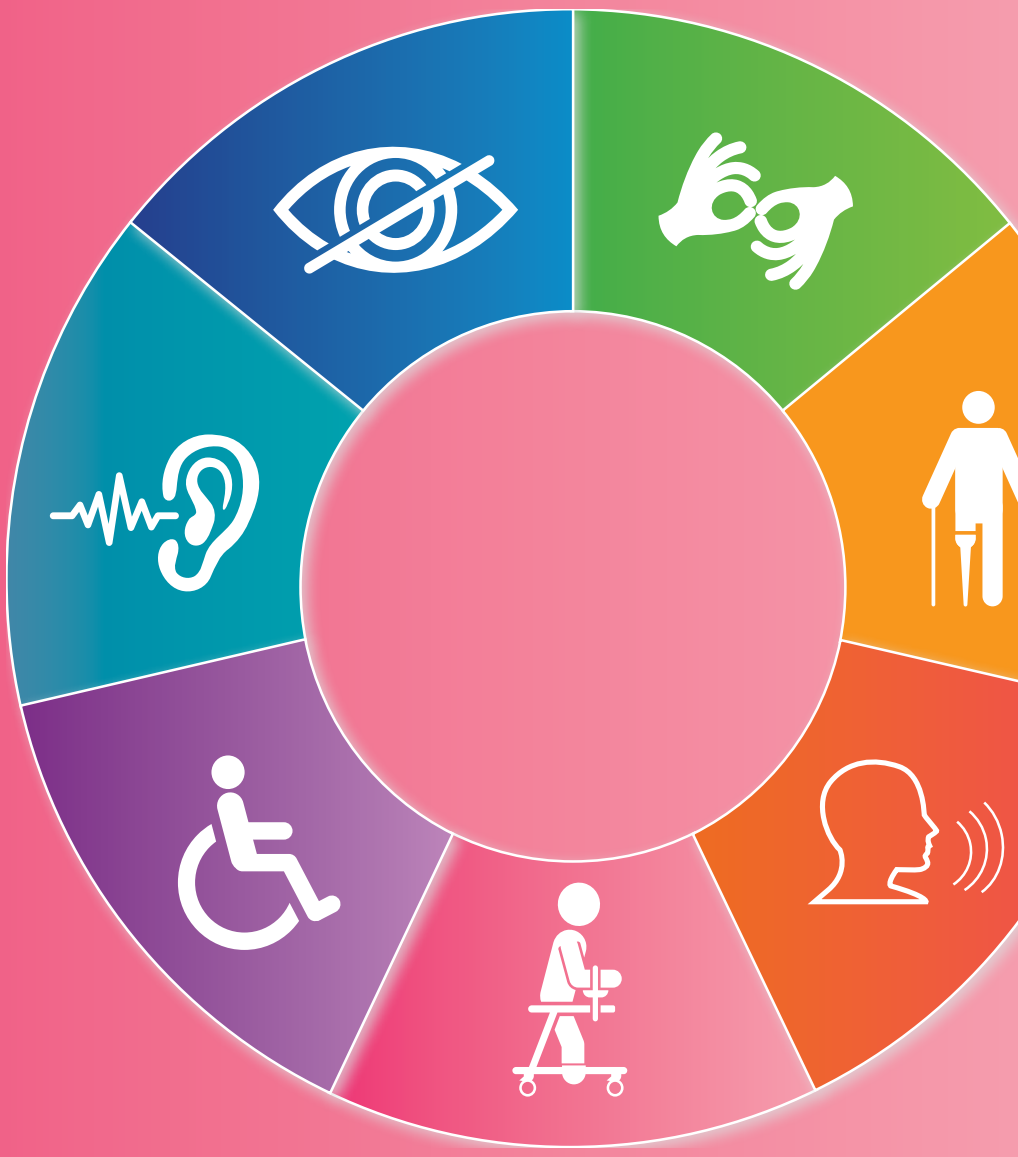
Are there any strategies that you do not currently use that you could adopt for your next health education programme?

What resources would you need in order to apply them?

FURTHER RESOURCES

Inclusion made easy: a quick programme guide to disability in development Part B. Disability inclusion: health. Bensheim: CBM International; 2012 (https://www.cbm.org).

Maxwell J, Belser JW, David D. A health handbook for women with disabilities. Berkeley: Hesperian Foundation; 2007 (https://hesperian.org/wp-content/uploads/pdf/en_wwd_2008/en_WWD_2008_fm.pdf).



MODULE 5
DISABILITY-INCLUSIVE HEALTH INFORMATION SYSTEMS FOR PLANNING, MONITORING AND EVALUATION

WHO DISABILITY-INCLUSIVE HEALTH SERVICES TRAINING PACKAGE

WELCOME TO THE FIFTH MODULE OF THE WHO DISABILITY-INCLUSIVE HEALTH SERVICES TOOLKIT.

In this module we will be looking at how you can collect and use patient data on disability to better understand the health needs of people with disability, and how to use those insights to better target the work that your health service does.

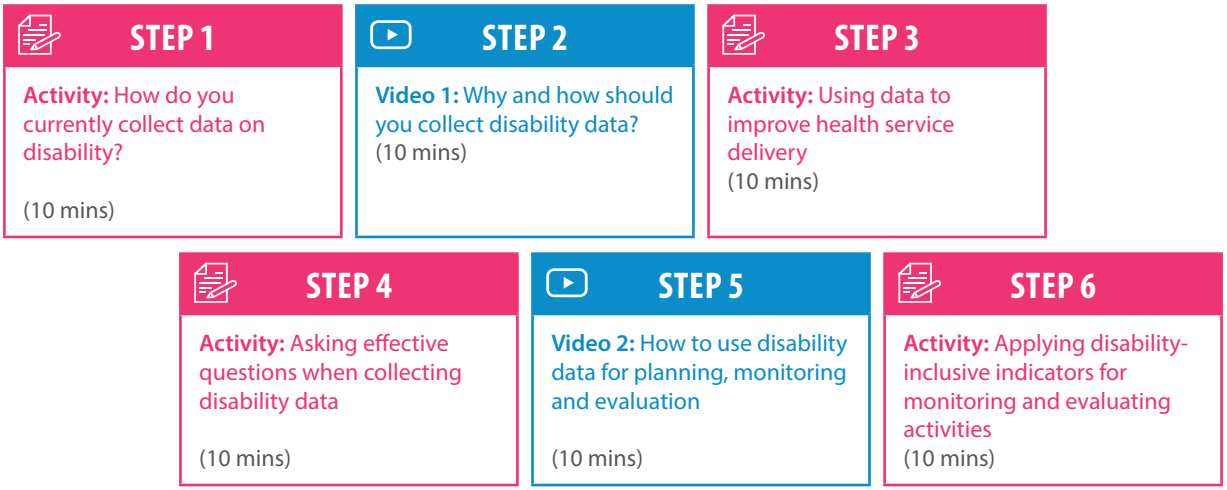
It is very likely that your health service already collects data on many aspects of health service delivery as part of ongoing service monitoring, evaluation and reporting requirements. Data are used every day to guide decisions on planning and resource allocation in health care. In this module we will highlight that by simply including data on disability in those data collection systems, you will have information that you can use to monitor how disability inclusive your health service is, which allows you to make changes where needed.

After completion of this module you will be able to:

- Understand why it is important to include information about disability in health information systems.
- Know the preferred approach to identify disability when collecting data to include in health information systems.
- Know how to use disability data to be disability inclusive in health service planning, monitoring and evaluation.

OVERVIEW OF MODULE 5

We estimate that this module will take you approximately 1 hour to complete. You do not have to complete the full module in one sitting – you can work through it at your own pace.



STEP 1: ACTIVITY: HOW DO YOU CURRENTLY COLLECT DATA ON DISABILITY?

Collecting data on disability in your health service doesn't require you to create new systems of data collection. In fact, it is often a matter of adding or modifying existing questions into the systems that you already use, such as patient registration forms.

In this first activity you will have the opportunity to assess how your health service currently collects data on disability, so that you can identify if there are any changes that you need to make.

Read through the patient registration form that your health service currently uses for new patients. Review the questions in the form to see if there are any questions that ask about the patient's disability, ***function*** *or* ***participation*** *in everyday activities.*

Respond to the questions below that are relevant:

If there are questions: Based on your experience how do you think the information from these questions is useful for your service?

If there are no questions: In your opinion, why do you think questions on disability, function or participation have not been included in this form?

Group: If you are doing this training in a group, share your responses to this activity with the rest of the group.

Do members of the group agree or disagree about whether including this information in patient registration is helpful?

Is there anything that any in the group find challenging about including these types of questions in patient registration forms?

In your experience, have you ever had any challenges with getting patients to respond to these questions? If so, why do you think that is?

STEP 2: VIDEO 1: WHY AND HOW SHOULD YOU COLLECT DISABILITY DATA?

In this video we begin by looking at how data on disability can be used to make your health-care service more inclusive and responsive to patients with disability.

We then move on to look at how you can get started on collecting disability data. We discuss how you can adapt your existing systems for collecting data to be inclusive of disability data, and advise on how to design effective questions to get the most accurate data.

STEP 3: ACTIVITY: USING DATA TO IMPROVE HEALTH SERVICE DELIVERY

As we saw in the previous video, collecting data on disability is the first step in improving health services' ability to plan interventions to respond to the needs of people with disability.

Even if you are not involved directly with planning and designing health interventions in your role, it can be helpful for you to understand how disability data can be used to plan targeted interventions and ensure disability inclusion in your health service. If you are working in a front-line role, you can play an important role in encouraging patients to complete the questions relating to disability and explain to them the way that the information can be used to improve the services they receive in the future.

In this activity we look at some scenarios where data are used to improve health workers' understanding of the health needs of people with disability and of how these needs compare to people without disability.

For each scenario below, reflect on how the insights gained through collecting disability data could be used to take action to improve health services for people with disability.

Once you have written down some ideas, have a look at some suggested responses that we have provided in the answer book.

a. Your health service has included questions on disability on the patient registration forms for COVID-19 vaccinations at its vaccination clinic. After three months of the vaccine programme, you examine the data and notice that very few people with disability have come for a vaccination. You contact the local DPO and find out why this may be and learn that many of their members find it difficult to attend the vaccination clinic.

How could this information be used to improve health services for people with disability?

_____

_____

_____

b. Your service provides a weekly clinic for cervical cancer screening. The patient registration for the clinic includes questions asking about disability. Your data show that the rate of women with disability attending this clinic is far lower than the rate of women without disability. You are worried about how this could impact early detection of cervical cancer in women with disability.

How could this information be used to improve health services for people with disability?

_____

_____

_____

c. You work in a maternal and child health clinic and have been running community education programmes about infant and young child nutrition for new mothers. In your attendance registration form you have included a question about whether their child has a disability. At the end of the year you review your data and note that not one parent of a child with a disability has attended, although you are aware of young children with disability in the community. You are aware of an organization for parents of children with disability in your community.

How could this information be used to improve health services for people with disability?

_____

_____

_____

STEP 4: ACTIVITY: ASKING EFFECTIVE QUESTIONS WHEN COLLECTING DISABILITY DATA

PART 1

In the previous video we learned that the identification of disability is best done by asking questions about function and participation, rather than asking a patient whether or not they have a disability.

In the first part of this activity, we are going to look at a variety of scenarios that highlight some of the most common reasons why a patient with disability might not answer "yes" to the question "Do you have a disability?"

Read the scenarios below.

For each scenario in the left-hand column, select the reason from the right-hand column that they might answer "No" if asked "Do you have a disability?"

Once you have finished, refer to the answer book for the correct responses.

Scenario	Reason for answering "No" to "Do you have a disability?"
1. "I have multiple sclerosis. My condition fluctuates a lot. Some days I feel very tired and weak, have difficulty walking very far and difficulty thinking clearly. Other days I have no symptoms. Whether or not I identify as having a disability depends on when I'm asked."	a. Undiagnosed condition
2. "My son was very slow to learn how to walk and talk compared to other children and is very far behind other children his age and has difficulty with lots of things. I have raised it with my family doctor and other specialists but no one can tell me why he is like this. They all said that my son does not have any particular condition."	b. Fluctuating condition
3. "I have bipolar disorder. This means that I can have difficulty focusing and concentrating because I feel agitated and anxious. It's sometimes difficult for people to understand what I am saying because I speak very fast and my thoughts all come out in a jumble. I don't often tell people about my condition, as I don't want them to think that I am a mad person."	c. Varying outcomes of the same condition
4. "I have had a mild stroke, which resulted only in a mild weakness and lack of dexterity in my left hand. It can make it difficult to do some things like doing up buttons on my shirt and tying my shoelaces, but otherwise I can do everything ok. I usually don't even think of mentioning that I have any problems with anything. I am lucky, some people who have a stroke are very badly affected."	d. Fear of stigma

PART 2

In this second part of the activity you will practise identifying questions that are more likely to elicit reliable data on disability, remembering that it is best to ask questions that are based on a person's function or participation in everyday activities.

Identify which of the questions below are asking about function or participation, and therefore indicate that they have or are at risk of having a disability.

Once you have finished, refer to the answer book for the correct responses.

1. Do you have a disability?
2. Do you regularly need assistance from a person or any equipment (e.g. eyeglasses, hearing aid, mobility device) to complete daily activities?
3. Do you have difficulty walking or moving any part of your body?
4. Have you been diagnosed with a disability?
5. Do you have difficulty completing self-care activities (e.g. showering, toileting, eating) independently?
6. Do you have any difficulty seeing, hearing or communicating with other people?
7. Do you have any difficulty concentrating or remembering?
8. What is your primary disability?

STEP 5: VIDEO 2: HOW TO USE DISABILITY DATA FOR PLANNING, MONITORING AND EVALUATION

In this video we look at how insights drawn from data on disability can be used to assist you in planning and budgeting your health interventions so that they are more disability inclusive.

We also look at how you can include a focus on disability inclusion in your monitoring and evaluation, including through using indicators that include a focus on disability.

STEP 6: ACTIVITY: APPLYING DISABILITY-INCLUSIVE INDICATORS FOR MONITORING AND EVALUATING ACTIVITIES

In this activity we are going to look at how to apply disability-inclusive indicators to monitoring and evaluation processes. Disability-sensitive indicators are used to monitor disability-sensitive targets, using disability-disaggregated data.

To begin with we are going to look at an example of how disability-inclusive indicators can be used to gather insights into the success of an intervention to target better disability inclusion within a health programme. You will then have the opportunity to practise developing your own disability-sensitive indicators for a targeted intervention in your own health service.

In this example, we will revisit the scenario on COVID-19 vaccinations that we looked at in Step 3 of this module and practise applying disability-inclusive indicators for monitoring and evaluation on the programme that was designed to address the health need identified from the data on COVID-19 vaccination rates.

Read the details of the planned intervention to address the issue of low vaccination rates for people with disability and note the examples of the different indicators used.

The national target for COVID-19 vaccinations is 90% vaccination; however, when the health service analysed the data on the levels of vaccination only 60% of patients with a disability had received their vaccination. When the service consulted the DPOs in their area about explanations for these low levels they learned that one factor was physical accessibility – many people with disability have difficulty getting to and from the health clinics to receive their vaccination. From this information, the health service decided to run a targeted intervention programme that involved the delivery of outreach vaccination clinics for patients with disability.

The table below shows the indicators that will be used in the monitoring and evaluation of the outreach vaccination clinics.

Level of indicator*	Example of disability-sensitive indicator
Input	Expenditure on staffing and transport for the outreach clinics
Output	Number of outreach clinics delivered
Outcome	Number of people with disability vaccinated through the outreach clinics
Impact	The vaccination rate for people with disability is the same as for the total population

*Explanation of indicator levels
Input: Resources needed for the implementation of an activity or intervention.
Output: A measure of the intended products or "outputs" of the activity or intervention.
Outcome: Refer to the specific objectives of the intervention.
Impact: Refer to the health status of the target population and indicate progress over the longer term.

Think about an activity that your health service is planning to undertake, or something you would like to do, to make your service more disability inclusive. For example, a new clinic targeting a particular need, a new building or other infrastructure, or a health promotion activity.

Describe the service improvement/development activity using these prompts:

What need is your activity trying to address?

Why is it important?

What activities are you going to undertake?

What are you hoping to achieve?

Using pages 82–84 of the Disability-Inclusive Health Services Toolkit to help you, write in the table below the disability-specific indicators that you could use to monitor and evaluate whether this new aspect of your service is disability inclusive.

Level of indicator	Disability-sensitive indicator
Input	
Output	
Outcome	
Impact	

FURTHER RESOURCES

Jenkin E, Wilson E, Murfitt K, Clarke M, Campain R, Stockman L. Inclusive practice for research with children with disability: a guide. Melbourne: Deakin University; 2015 (https://www.voicesofchildrenwithdisability.com/wp-content/uploads/2015/03/DEA-Inclusive-Practice-Research_ACCESSIBLE.pdf).

Improving data quality: a guide for developing countries. Manila: WHO Regional Office for the Western Pacific; 2003 (https://apps.who.int/iris/handle/10665/206974).

The Washington Group Short Set of Questions can be found at: https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/

MODULE 6
REHABILITATION AND DISABILITY-INCLUSIVE HEALTH SERVICES

WHO DISABILITY-INCLUSIVE HEALTH SERVICES TRAINING PACKAGE

WELCOME TO THE SIXTH MODULE OF THE WHO DISABILITY-INCLUSIVE HEALTH SERVICES TOOLKIT.

In this module we will be looking at the importance of **rehabilitation** in improving health outcomes and quality of life for all patients, including those with disability. We will also consider the essential role that health services can play in early identification of rehabilitation needs, making appropriate referrals, and in delivering some basic advice.

Rehabilitation is an important part of health services that help people to live, work, learn and play to their greatest potential, and is a necessary element in a disability-inclusive health service. There is a growing need for rehabilitation due to increases in noncommunicable diseases and ageing populations. There is also increasing recognition of the benefits of rehabilitation to improve or maintain functioning for people with a wide range of health conditions, thereby improving the health and well-being of the population, and reducing burden on health care systems.

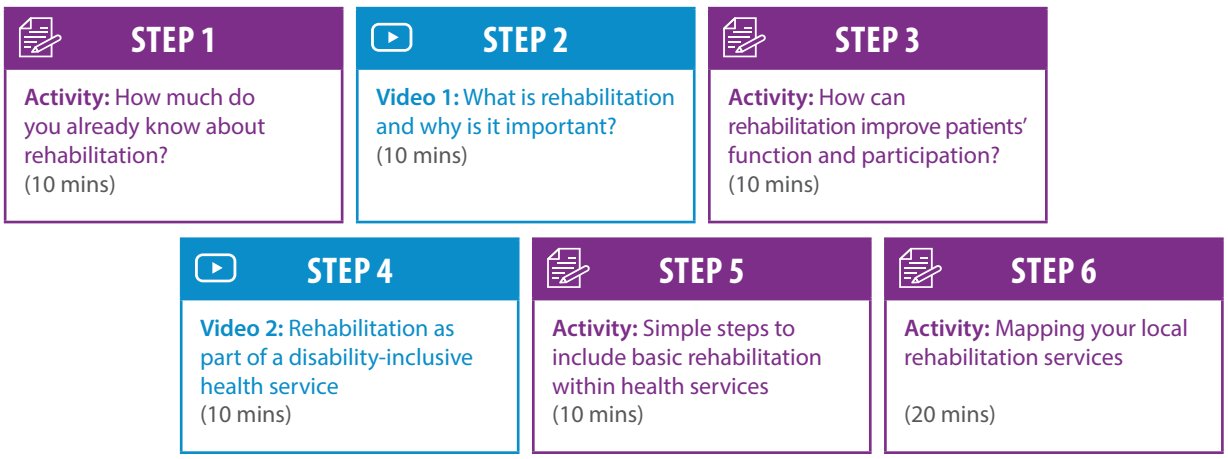
You don't have to be a rehabilitation specialist to play a key role in delivering or promoting rehabilitation services. In this module, our aim is to show you the main areas where you can have a significant impact on your patients' rehabilitation, through identifying your patients' rehabilitation needs and providing basic interventions and referrals.

After completion of this module you will be able to:

- Understand what rehabilitation is, and the important role it plays in health service provision.
- Have learned some simple steps to include basic rehabilitation within health services.
- Have increased knowledge of local rehabilitation services.

OVERVIEW OF MODULE 6

We estimate that this module will take you approximately 1 hour and 10 minutes to complete. You do not have to complete the full module in one sitting – you can work through it at your own pace.



STEP 1: ACTIVITY: HOW MUCH DO YOU ALREADY KNOW ABOUT REHABILITATION?

Let's begin with a short quiz to start thinking about some key aspects of rehabilitation. Each question below covers an important aspect of why rehabilitation matters and who may benefit. Don't worry if you aren't sure about all the answers. We will be covering each one in more detail in the videos.

For each question below select the answer that you think is most likely to be correct.

Once you have completed the activity, refer to the answers in the answer booklet for the answers and explanations.

1. The need for rehabilitation services may arise due to:

    a. Accidents
    b. Noncommunicable diseases
    c. Ageing
    d. Existing disability
    e. Illness
    f. All of the above

2. Rehabilitation services are only provided at specialist rehabilitation centres.
    - True
    - False

3. Rehabilitation is only for short-term impairments
    - True
    - False

4. Rehabilitation helps to achieve universal health coverage because:

    a. Rehabilitation services contribute to healthy, independent populations
    b. Good health is a state of complete physical, mental and social well-being, not just absence of disease
    c. Health care includes the full range of essential health services, including health promotion, prevention, treatment, rehabilitation and palliative care
    d. All people may require rehabilitation services at some point in their lives
    e. All of the above

STEP 2: VIDEO 1: WHAT IS REHABILITATION AND WHY IS IT IMPORTANT?

In this video we are going to look at the basics of rehabilitation, including the broad range of patients who may benefit.

We will also look at the range of rehabilitation interventions, including therapeutic approaches, **assistive technology** and **environmental modifications**.

Reflect: Have you used or witnessed any rehabilitation services or interventions in your work? Has anything in this video surprised you or changed the way that you understand rehabilitation?

STEP 3: ACTIVITY: HOW CAN REHABILITATION IMPROVE PATIENTS' FUNCTION AND PARTICIPATION?

In this activity we are going to look at examples of the different ways that rehabilitation interventions can optimize individuals' functioning and improve their participation in everyday activities.

As we discussed in the previous video, rehabilitation may be needed for patients with a broad range of health conditions. There is also a variety of ways that rehabilitation can be provided, including therapeutic activities and exercises, assistive technology and environmental modifications. In these case studies we have aimed to represent some of this breadth. Hopefully they give you an indication of how far-reaching rehabilitation interventions can be.

Read each case study and respond to the reflection questions for each.

Once you have finished, turn to the answer booklet for some suggested responses to the questions.

CASE A: PREAP

Preap is a 28-year-old man who works as a mechanic in Battambang, Cambodia. Preap injured his right hand in a workplace accident and needs surgery to repair tendons in his hand. Rehabilitation provided exercises to help him regain function in his hand once he had recovered from surgery and provided him with some advice and strategies for managing his self-care activities (e.g. bathing, dressing) one-handed until he was able to use his hand again.

How has rehabilitation benefited Preap? Can you identify 2 areas of function or participation in Preap's everyday life in which rehabilitation has played a role? What might have been the outcome if he could not access rehabilitation?

_____

_____

CASE B: IPUL

Ipul is an 8-year-old girl from Port Moresby in Papua New Guinea who has diplegic cerebral palsy which affects her ability to walk. Rehabilitation provided her with exercises and assistive technology in the form of a walker and orthoses to help her to walk.

Can you think of 2 ways that rehabilitation has improved Ipul's opportunities for education and socialising?

_____

_____

CASE C: SUMANTHI

Sumanthi is a 52-year-old Sri Lankan woman who works as a nurse in Batticaloa. Through her work, she contracted COVID-19 for which she was hospitalized for several weeks and required ventilation. She recovered from COVID-19 but is now experiencing symptoms of long COVID including breathlessness and fatigue. Rehabilitation provided advice and strategies for managing her breathing and energy throughout the day so that she could gradually return to doing things for herself such as taking a shower, preparing food, and going for a walk, and helped her increase her activities over time. They also provided some assistive technology in the form of a shower chair and a walker to assist her in her daily activities in the early stages of her recovery.

What might have been the outcome if Sumanthi had not received rehabilitation? Can you think of some ways that her opportunities for employment and independence have benefited from rehabilitation?

_____

_____

STEP 4: VIDEO 2: REHABILITATION AS PART OF A DISABILITY-INCLUSIVE HEALTH SERVICE

In this video we will look at how rehabilitation is delivered as part of a continuum of health services, that includes primary and tertiary health services and a broader network of specialist providers.

We discuss that while not all health services have the capacity to provide comprehensive rehabilitation, there is still a role for all health services to play in meeting rehabilitation needs by identifying those needs, delivering basic interventions and referring patients on to specialist services.

STEP 5: ACTIVITY: SIMPLE STEPS TO INCLUDE BASIC REHABILITATION WITHIN HEALTH SERVICES

In the previous video we learned that there are three main steps that health-care workers can take in delivering rehabilitation care to patients:

1. Identify rehabilitation needs.
2. Provide basic interventions, including assistive technologies and education.
3. Refer to specialist services.

PART 1

In the first part of this activity, you are going to look at a case study of how a health worker has applied each of these steps and improved the health outcomes for their patient.

Read through the case study below.

Respond to the questions below to identify the examples of where the health worker has applied these three steps in rehabilitation support.

Once you have finished, refer to the answer booklet for suggested answers.

A mother attends a health centre with her 2-year-old daughter who has a bad cough. The health worker noticed that the mother carried the child into the consulting room and that the child sits on the floor but does not attempt to get up and go over to some toys that are in the corner of the room.

The girl's behaviour makes the doctor wonder whether the daughter is experiencing some developmental delays.

She decides to ask the mother about how her daughter is doing with learning to walk, talk and play. The mother tells her that her daughter has not yet started to walk or talk and is not really interested in playing with toys.

As well as addressing the child's cough, the health worker takes some time to talk to the mother about her child's development. The health worker provides a handout on the use of play and stimulation for young children and another handout about the ways to use play to encourage children to move around. The handouts were from the website of a national organization for children with disability and were part of a collection of resources on simple interventions for a range of impairments that the health service had compiled to distribute to their patients. The health worker explains the handouts to the mother and prints out a copy of them to take home.

The health worker also provides the mother with some information about an early intervention programme for children with developmental delays and makes a referral to the programme, with the mother's consent.

Identify the steps that the health worker and the health service have taken to provide rehabilitation support for this patient and her family:

1.
2.
3.

PART 2

In this second part of the activity, you are going to practise identifying some responses that you could make in addressing a patient's rehabilitation needs.

Read through the case study below, imagining that this is one of your patients.

Respond to the questions below to identify how you could provide rehabilitation if you were this patient's health-care worker. Keep in mind that there will not be one "right" answer to this activity – we encourage you to answer based on the approaches you have learned so far in this module and by thinking about what would be possible in your own health service.

Once you have completed the activity, refer to the answer booklet for some suggested responses.

One of your patients is a 62-year-old man who had a stroke two years ago that has affected the movement in his right arm and leg. He has made an appointment with you to review his blood pressure medication. His daughter attends the appointment with him as a support person.

You attend to his blood pressure, but during the consultation you also ask your patient how he is managing at home. He tells you that he lives with his daughter and her husband, but that his daughter has had to give up work because she is worried about leaving him at home alone. He tells you that he is having difficulty with his balance when walking and has had some falls at home.

You can see that it is important to provide rehabilitation to decrease the risk of your patient obtaining a future impairment from a possible fall, and to increase his ability to live independently and reduce the financial strain on his daughter and her husband through her giving up her work.

What could you do to provide him with information about preventing falls?

_____

_____

What kind of assistive technology could you suggest for him to manage his falls?

_____

_____

What referrals could you make to specialist treatment and/or support schemes?

_____

_____

Group Activity: Once you have completed this activity, take some time in your group to: Compare your answers: Were there any of your colleagues' responses that gave you some good ideas about how to address the rehabilitation needs of this patient?

Discuss: What kind of resources or information would you need to deliver the rehabilitation in your responses to the case study? If there are resources that you don't currently have access to, brainstorm how you could develop or procure these.

STEP 6: ACTIVITY: MAPPING YOUR LOCAL REHABILITATION SERVICES

In this activity we are going to guide you through the process of preparing a directory of your local rehabilitation services. This directory will be a tool that you and your colleagues can use in your daily work to facilitate referrals to rehabilitation specialists for patients who need rehabilitation.

Use the "Mapping Rehabilitation Services" template on page 99 in the WHO Disability-Inclusive Health Services Toolkit.

Write down the names of local rehabilitation services, the types of services they provide, contact details and any other information such as cost or how to refer to them.

Follow these steps to find the information to complete the template:

- *Start with any rehabilitation services that you know of – either that are part of your organization or external to your organization.*
- *Ask your colleagues if they know of any other services.*
- *Do an Internet search for rehabilitation services in your district or province.*
- *Include information about any government schemes that patients with rehabilitation needs may be eligible for.*

NEXT STEPS:

Now that you have completed your directory of the local rehabilitation services, we encourage you to share the directory with others in your health service.

- Make the list available to all staff members in your health service who provide clinical care.
- Appoint a staff member to be responsibility for updating the list at regular intervals throughout the year.

FURTHER RESOURCES

Rehabilitation in health systems: guide for action: https://www.who.int/publications/i/item/9789241515986.

Priority Assistive Products list: https://www.who.int/publications/i/item/priority-assistive-products-list.

MODULE 7
DISABILITY-INCLUSIVE HEALTH SERVICES IN EMERGENCIES

WHO DISABILITY-INCLUSIVE HEALTH SERVICES TRAINING PACKAGE

WELCOME TO THE SEVENTH MODULE OF THE WHO DISABILITY-INCLUSIVE HEALTH SERVICES TOOLKIT.

This module introduces you to the knowledge you need to apply a disability-inclusive approach within emergencies. **Emergencies** include things like natural disasters, conflict, transport accidents and pandemics.

Emergencies can disproportionately impact people with disability. They will also impact people with different types of disabilities in different ways. As health workers we need to understand how emergencies can affect the health-care needs of people with disability so that we can adapt and target how we deliver health care during these times. We also have a role in advocating for the rights and needs of people with disability during emergencies.

Emergencies are inherently complex and put extra demands on time and resources of health systems that are often already stretched. As health workers, we need to respond quickly and creatively while drawing on the tools of best practice in disability inclusion.

Our aim with this module is to show you how to apply disability-inclusive practices, in your own contexts based on the resources available to you and the needs of your patients. We have included a specific focus on disability-inclusive practice in the COVID-19 pandemic.

After completion of this module you will be able to:

- Understand how emergencies can impact the health and health-care provision of people with disability.
- Apply key strategies to include people with disability in emergency health responses.
- Understand how the COVID-19 pandemic and related policies, including lockdowns and social distancing, impact people with disability.
- Apply key strategies to include people with disability in COVID-19 health responses.

OVERVIEW OF MODULE 7

We estimate that this module will take you approximately 1 hour to complete. You do not have to complete the full module in one sitting – you can work through it at your own pace.

STEP 1

Activity: Reflecting on your own knowledge and experience
(10 mins)

STEP 2

Video 1: Disability-inclusive health in emergencies

(5 mins)

STEP 3

Activity: The impact of emergencies on the health of people with disability
(5 mins)

STEP 4

Video 2: Disability-inclusive health during the COVID-19 pandemic
(10 mins)

STEP 5

Activity: Quiz: Understanding specific challenges to the health of people with disability in the COVID-19 pandemic
(15 mins)

STEP 6

Activity: Applying disability-inclusive health-care interventions during COVID-19
(5 mins)

STEP 7

Activity: Understanding the importance of consultation with DPOs

(10 mins)

STEP 1: ACTIVITY: REFLECTING ON YOUR OWN KNOWLEDGE AND EXPERIENCE

(10 minutes)

You may have already had experience of providing health services in an emergency situation, such as the COVID-19 pandemic or a natural disaster.

From your own experience as a health-care worker during the COVID-19 pandemic emergency or other emergencies, write down what you have seen to be the **main health-care needs** of clients or patients with disability in this time:

Did people with disability experience any **challenges** to having their health-care needs met during the emergency? If yes, what were these challenges?

Now, what strategies have you used, or that you have seen others use, that have worked well in addressing the health-care needs of people with disability?

Group activity: If you are doing this activity with others, take a few minutes now to share your responses with each other.

What are the similarities in what you have noted?

What are the differences?

STEP 2: VIDEO 1: DISABILITY-INCLUSIVE HEALTH IN EMERGENCIES

(5 minutes)

Watch this first video to hear from the presenter about why and how emergencies can make disability inclusion even more essential.

We will look at the main ways in which emergency and disaster situations can impact people with disabilities and their access to health care.

STEP 3: ACTIVITY: BARRIERS TO HEALTH CARE

(5 minutes)

Emergencies and disasters can impact people with disability in many different ways, and have consequences for their health and well-being in ways that are not related to the emergency.

Match each of the possible scenarios in an emergency or disaster situation with the impact that it might have on the health needs of people with a disability.

Once you have finished, refer to the answer booklet for answers.

Possible scenarios in an emergency or disaster	Impact on people with disability
A) Roads and buildings are damaged due to a cyclone. Health services are moved to a temporary centre.	1) People who are deaf or hard of hearing may not be aware of changes to the emergency response or where to access support, including health care.
B) Curfews and roadblocks are introduced restricting the movement of people around the city or province.	2) People with disability are not seen as a priority for health services and resources and so do not receive equal access to health care.
C) Local authorities are making rapid changes to their responses to the emergency, for example, location of evacuation centres, what services are available, where to access help. This is being communicated on videos shown on TV or social media, with no captioning or sign language interpreters.	3) Ongoing health needs related to the conditions of people with disability are not addressed (e.g. access to epilepsy medications, nutrition supports, wound care), placing the person at risk for poor health outcomes.
D) Health services are under pressure to triage service provision and prioritize patients who are perceived as most likely to survive the emergency or disaster.	4) People with disability may be unable to get to health clinics across cyclone-affected terrain, and may be unaware of the new location of health services.
E) Health services' focus is on treating clients' immediate health concerns, e.g. disease associated with an outbreak.	5) A person with disability may be separated from their usual support people or services that they need for everyday care (e.g. showering, toileting, meal preparation, attending health-care appointments).

STEP 4: VIDEO 2: DISABILITY-INCLUSIVE HEALTH DURING THE COVID-19 PANDEMIC

(10 minutes)

Watch the second video now to learn about the specific challenges for people with disability during the COVID-19 pandemic and what you can do to ensure your health responses to the pandemic are inclusive of people with disability.

STEP 5: ACTIVITY: QUIZ: UNDERSTANDING SPECIFIC CHALLENGES TO THE HEALTH OF PEOPLE WITH DISABILITY IN THE COVID-19 PANDEMIC

(5 minutes)

In the following activity we look at the specific risks that the COVID-19 pandemic poses for people with a disability.

Please answer the questions below to the best of your ability. Once you have finished, refer to the answer booklet for answers and explanations.

1. **People with disability may be at greater risk of contracting COVID-19 and developing severe disease than the general population.**
   - True
   - False

2. **People with disability are at greater risk of contracting COVID-19 due to:**
   a. Being unable to socially distance due to assistance needs with daily living activities
   b. Barriers to accessing basic hygiene measures, such as hand washing
   c. Public health messages not being provided in accessible formats
   d. Barriers to accessing health care, including treatment and preventative measures such as vaccination
   e. All of the above

3. **People with disability are at risk of experiencing a decline in their general health and functioning as a result of the following during the COVID-19 pandemic:**
    a. Lockdowns disrupting access to usual services and supports
    b. Carers becoming ill or having to isolate
    c. Interruptions to supply chains for their medicines and assistive technologies
    d. Interruptions to public transport means they are unable to travel to health care and rehabilitation services
    e. All of the above

4. **Denying people with disability equal access to COVID health care such as vaccines or ventilators is a breach of the right of people with disability to equitable access to health care, as mandated under the United Nations Convention on the Rights of Persons with Disability.**
    - True
    - False

5. **Why is it important to collect data that are disaggregated by disability in health service registers during the COVID-19 response?**
    a. So that we know whether people with disability are equally represented in testing and vaccine roll-outs
    b. To understand if targeted interventions are needed to increase access for people with disability
    c. To assist with planning for disability-inclusive responses for future emergencies
    d. All of the above

STEP 6: ACTIVITY: APPLYING DISABILITY-INCLUSIVE HEALTH-CARE INTERVENTIONS DURING COVID-19

(15 minutes)

The COVID-19 pandemic is presenting new challenges and new ways of working for health workers. The ability to think quickly, creatively and practically, always with people with disability in our minds, is a key skill that we need to use during this pandemic.

In this activity you will be looking at how to apply best practice of disability inclusion during COVID-19 responses, using a case study.

CASE STUDY: ODGEREL

This case study is based on the experience of Odgerel, a 59-year-old woman who lives alone in an apartment in Ulaan Baatar. Odgerel had a stroke several years ago and has slow speech and needs to use a wheelchair to cover long distances, as well as having occasional seizures.

As you read each challenge that Odgerel faces to accessing COVID-19-related health services, select a response from the table below that a health-care provider could take to address Odgerel's health-care needs.

Once you have finished, refer to the answer booklet for the correct answers.

1. One day, Odgerel begins to have COVID-19 symptoms. She knows that she should get tested but cannot travel to the clinic on her own due to her difficulty in walking and need for a wheelchair for traveling longer distances. She does not want to ask her neighbour to take her for fear of passing on the infection to her.

Possible response:

2. After getting tested, Odgerel is not sure what she needs to do next or how she will find out about her test result. She tries to ask the nurse who came to her house to test her, but her speech difficulty meant the nurse did not understand her properly.

Possible response:

3. The vaccine is being rolled out in the area of Ulaan Baatar that Odgerel lives in; however, like many other people with disability in her area, she is not aware of the vaccine roll-out. The DPO in her area consults with the health centre in charge of the vaccine roll-out to find out if there are groups they need to be targeting in their vaccine awareness raising work.

Possible response:

4. Based on the data, the **DPO decides to target communication and outreach campaigns** to their members with sight and physical impairments to increase vaccine uptake amongst these members.

   Odgerel now knows about the vaccine roll-out and tries to make an appointment to get vaccinated. She discovers that people with disabilities are not being prioritized for the vaccine, despite being more at risk of serious effects of COVID-19 than the general population. Odgerel has to join the long waiting list for a vaccine appointment like everyone else.

Possible response:

5. Odgerel is now able to be prioritized and can receive a COVID-19 vaccine. However, she is not sure whether or not she should, as she is worried that it may have an adverse reaction with medications she is taking to manage her epilepsy.

Possible response:

	Possible responses
A	The health centre has included questions in the patient registration for COVID-19 vaccinations to record data based on 1) whether patients have a disability and 2) what type of disability they have. The DPO used this to disaggregate the vaccination data, and identified that very few people with physical and sight disabilities were getting vaccinated. This allowed them to target their vaccine awareness activities for these particular groups.
B	The health workers at the local health centre had received training in searching for information about how a new emergency could affect people with disabilities. They now know that they need to disseminate information about how COVID-19 can affect people with disabilities in a variety of formats and advocate for the increased risks of COVID for people with disability and policies put in place to enable prioritization.
C	The nurse agrees that Odgerel can call her neighbour on the phone, who facilitates communication and helps the nurse understand what Odgerel was asking. She allows extra time in the appointment to allow enough time for the slightly longer conversation that was required due to Odgerel's slow speech. She also shows Odgerel some printed information about the steps for follow-up that is written in a clear, easy-to-read format.
D	The health service works with the local DPO to develop health advice that addresses the most common concerns and questions of people with disability about COVID-19. The DPO consults with their members and finds that concerns about mixing medication with vaccines was of primary importance to them. The health service is able to provide the DPO with specific advice that their members needed to make decisions around COVID-19 vaccination.
E	The health centre provides outreach home-based testing for people who cannot access the testing centres.

STEP 7: ACTIVITY: UNDERSTANDING THE IMPORTANCE OF CONSULTATION WITH DPOs

(10 minutes)

Consultation efforts are key to understanding the needs of people with disability. This last activity aims to highlight the importance of consultation and encourage you to think creatively and to learn and be inspired by real-life solutions from how other health and humanitarian services can provide creative solutions to challenges.

Read through the three scenarios below and note down some possible responses that a health centre could take to be disability inclusive in these situations. There is really no right or wrong answer to these scenarios, as each response will differ based on the context that you are working in and the resources that you have available!

Once you have had a go coming up with a response to the situations, have a look at the answer booklet to see some responses that are based on real-life humanitarian responses to these situations.

Challenge	Solution found through consultation
Aabid is a 35-year-old blind man who has diabetes and lives in New Delhi with his elderly father. When the COVID pandemic hit it was no longer safe for his father to accompany Aabid to the pharmacy to purchase the insulin he needs for his diabetes, as his father was at high risk with COVID-19.	
Ping is a Burmese refugee living in a temporary accommodation in Thailand. Ping has a physical disability and also has post-traumatic stress disorder, which has been exacerbated by the social isolation and stress related to the pandemic. The local community mental health centre has noticed that Ping and many more of their clients' psychological well-being is declining, but their one trained psychologist does not have the capacity to support the growing number of people needing support.	

Challenge	Solution found through consultation
A primary health centre has noticed that a growing number of patients reporting COVID symptoms. are people with cognitive and communication disabilities. They also notice that these patients seem to be unclear about the hygiene and isolation procedures for isolating once they have undergone a COVID test and are waiting for the results. Many appear upset or distressed when told that they must isolate and change their daily routine.	

Group activity: If you are doing this activity with others, take a few minutes now to share your responses with each other.

Discuss what in each other's answers represent best practices and creative problem solving – you could even take a vote on what the group sees as the best responses!

FURTHER RESOURCES

If you are interested in learning about the concepts and practices that we have covered in this module in more detail, have a look at the following resources:

WHO Guidance note on disability and emergency risk management for health: https://www.who.int/publications/i/item/guidance-note-on-disability-and-emergency-risk-management-for-health.

Disability considerations during the COVID-19 outbreak. World Health Organization; 2020 (https://www.who.int/publications/i/item/WHO-2019-nCoV-Disability-2020-1).

Disability considerations for COVID-19 vaccination: WHO and UNICEF policy brief, 19 April 2021. WHO & UNICEF; 2021 (https://www.who.int/publications/i/item/who-2019-ncov-vaccination-and-disability-policy-brief-2021.1).

ADCAP Minimum standards for age and disability inclusion in humanitarian action: https://www.helpage.org/resources/practical-guidelines/emergency-guidelines/.

Support for rehabilitation self-management after COVID-19-related illness. World Health Organization; 2020 (https://www.who.int/publications/m/item/support-for-rehabilitation-self-management-after-covid-19-related-illness).

ANSWER BOOK

MODULE 1: DISABILITY-INCLUSIVE HEALTH SERVICES – GETTING STARTED

Step 3: Barriers to health care

1. E, H
2. A, G
3. B, F
4. C, D

Step 5: What is disability?

These are suggested answers only. Your answers to these questions may be different.

1. a) Khan – lives in the city; accessibility features such as footpaths with tactile markers, auditory signals at pedestrian crossing; accessible public transport
   b) Davaa – lives in a village with poor physical accessibility; lack of transport; supportive family
2. a) Khan – male; completed education; access to assistive technology and services; employed
   b) Davaa – male; primary education only; lack of access to services; poor family
3. a) Khan – no significant participation restrictions
   b) Davaa – school, employment, social activities, accessing the community
4. Two people with the same health condition and impairment can experience very different levels of "disability" in terms of their participation restrictions as a result of their contextual factors.

Step 6: Identifying barriers in the patient's journey

Yargui's barriers to accessing health care	Possible solutions that a health-care service could provide
She did not know about the vaccine roll-out for a long time.	Information about the vaccine roll-out should be made available in a range of formats – TV, radio, social media, newspapers. Health services should provide information to their local DPOs about the vaccine roll-out so that they can distribute it to their members.
She was hesitant to go due to previous experiences of not having her health needs treated properly.	Health services can invite DPOs to hold training for their staff to create better awareness and understanding of the needs and experiences of people with disability when they are accessing health care.

She could not travel to the health centre without finding someone to accompany her.	Health services could provide outreach services to visit people in their home
The cost of a taxi placed financial stress on her family.	The health service could have an accessible vehicle available to bring patients with transport difficulties to the clinic
She had difficulty entering the health service due to the stairs.	Remove the steps and install a ramp at the front entrance. Make sure it is kept clear of hazards.
She could not access the water tap while waiting for the appointment.	Position drinking water where all people will be able to reach it, keeping in mind height and other obstacles
The health-care worker did not communicate directly with her during the session.	See point above regarding awareness training
She was not provided with follow-up information due to incorrect assumptions about her disability.	Consider systems of how future bookings and appointment reminders can be provided in accessible formats, e.g. via SMS, sent to a support person with patient's consent

MODULE 2: PROMOTING DISABILITY-INCLUSIVE ATTITUDES

Step 3: Examples of negative attitudes in health-care contexts

1. C. The health worker is stereotyping people with disability as not being sexually active and therefore not needing SRH services.
2. D. The health worker is pitying the parent for having a child with a disability.
3. E. The health worker is avoiding seeing deaf patients for fear of not knowing how to communicate with them.
4. A. The health worker is giving people with disability lower priority for an appointment due to a belief that their needs are inferior to those of people without disability.
5. B. The health worker is failing to recognize that you cannot visibly see all types of disability, and is denying the patient the extra time they need to ask and receive information relating to their health care.

Step 5: Replacing attitudinal barriers with disability-inclusive approaches

1. E
2. C
3. B
4. A
5. D

Step 6: Responding to attitudinal barriers at the policy level

Examples of some responses to counter the attitudinal barriers in Step 6 are provided below.

1. Improving physical accessibility will benefit many people in our community, including people with disability. For example, it will enable older people, parents with prams, and people who have a mobility impairment to access our health facility more easily. It is important that we include the costs for this in our budget.
2. Including people with disability on the board of our health facility will help us to understand any issues that people with disability face in accessing health care and they can help us to identify solutions. It is important that we hear from people with disability directly. This is important for planning our health services to ensure we are meeting the health needs of the whole community.
3. It is important that our staff understand the needs of people with disability and feel confident in communicating with people with disability. This will help people with disability in our community to feel more comfortable to access the health services they need, which can reduce health-care costs in the long term and contribute to a healthier community.

MODULE 3: ADDRESSING PHYSICAL BARRIERS

Step 1: Test your knowledge of physical accessibility

1. e. All of the above
   Most people experience impairment at some point in their lives; therefore, the need for accessible and inclusive design when accessing health services applies to everyone.
2. d. All of the above
   Physical accessibility is about more than patients being able to enter and exit a room or building; it also requires that facilities and equipment can be used safely, hygienically and with dignity.
3. False
   A study in the United States of America found that 86–90% of physicians believed that their premises and examination rooms were wheelchair accessible. However, many people with disability report that they cannot access their general practitioners' rooms or examination equipment. It is important to consult people with disability when addressing physical accessibility to ensure that facilities and equipment are truly accessible and "usable" by people with a range of impairments.
4. False
   Physical barriers can also exist in the equipment used within health facilities and transportation to and from health facilities.

Step 3: Is your accessible design actually physically accessible?

1. E
2. A
3. G
4. D
5. B
6. C
7. F

Step 5: Exploring universal design and reasonable accommodation

Part 1: Universal design

1. People with vision impairment, people with learning difficulties
2. People with mobility impairments, older people, parents with children in a pram
3. People with mobility impairments, older people, parents with children in a pram, people with arm/upper limb impairment

Part 2: Reasonable accommodations

1. Have a foldable cot available in examination rooms, which can be set up quickly for patients who are unable to climb on to an examination table. Alternatively, you could have height-adjustable examination tables or examination tables of varying heights in different consulting rooms, allocating consulting rooms flexibly depending on the needs of patients.
2. For patients who are unable to travel to the health facility, consider alternative models of service delivery. For example, you can provide outreach visits to patients' homes or telehealth consultations using phone or video calls.
3. Ensure health education/prevention activities are held on the ground floor of buildings or in community spaces that are accessible so that all people can access them.

MODULE 4: COMMUNICATION BARRIERS – PROVIDING DISABILITY-INCLUSIVE HEALTH INFORMATION

Step 3: The impact of communication barriers on equal access to health care

1. C
2. A
3. E
4. D
5. F
6. B

Step 5: Disability-inclusive communication in the patient's health-care journey

1. In the spaces below, write examples from the case study of how the health service applied strategies for disability-inclusive communication:
   a. Health information materials and communication strategies are developed with people with disability.
      - The local DPO and health-care provider had collaborated to produce a social story and communication materials that they used to explain COVID-19 safe behaviours and the testing process to Erdene.
   b. Health workers use patient-centred care to identify and use communication strategies suited to the individual patient's needs:
      - The testing centre provided a "Priority Area" for people with disability or other needs that find busy, noisy areas overwhelming. This allowed Erdene to more easily communicate with the health worker.
      - The health worker took the time for Erdene to process the information and respond in his own time.
      - The health worker spoke to Erdene rather than his father/companion.
      - The health worker explained what was going to happen, using pictures, before she performed the COVID-19 test on Erdene.

c. Health information and communication before, during and after service provision is provided in a range of formats accessible to people with different types of impairment
   - The "Priority Area" was clearly sign-posted.
   - The social story and communication board used by the DPO used pictures and simple language to explain the required behaviours and testing processes.
   - At the testing centre, the health worker had visual communication tools (pictures) to help explain the testing procedure
   - Health information includes information specific to people with disability, and uses positive portrayals of people with disability:
     - The social story featured a person with disability to explain the experience of going to a COVID-19 testing centre, which Erdene could relate to.
     - The story also described some of the specific strategies at the testing centre for people with disability, including the "Priority Area"

2. Consider what could have been the health implications for Erdene and others in his family and community if the health centre had not employed these strategies.

   Some implications might include:
   - Erdene does not get tested and potentially contracts COVID-19.
   - Erdene exposes his immediate family, including his elderly grandparents to the virus.
   - Erdene spreads the virus to others in his community through the shared facilities.
   - Erdene is at higher risk of contracting the disease due to not fully understanding the necessary health precautions to take.
   - The testing experience is very stressful for Erdene and makes him avoid accessing health-care services in the future.

Step 6: Applying disability-inclusive communication strategies in health promotion

Some potential responses to this activity include:

1. Community education sessions:
   - For mobility impairments – Ensure that venues are physically accessible to people with mobility impairments.
   - For cognitive impairments – Supplement spoken communication with visual supports such as pictures and diagrams; present one idea at a time using simple words and short sentences, allowing time for information to be processed before moving to the next point.
   - For hearing impairments – Engage a professional sign language interpreter; if sign language interpreting is not available, use captioning on presentations (e.g. in Powerpoint), written notes of what the speaker is saying, or provide technology with speech-to-text facility enabled (e.g. on a phone or laptop); ensure the presenter's face can be seen to enable lip reading.
   - For vision impairments – Get presenters and participants to say their name before speaking so people with vision impairment know who is speaking; use tactile-oriented approaches in any practical demonstrations; make sure to read out or describe any written materials or diagrams that are not provided in accessible formats.

2. Health promotion materials:
    - For cognitive impairments – Ensure materials are available in an "easy read" format that uses pictures and key words, rather than a lot of text.
    - For hearing impairments – Ensure captioning is available for any materials presented in video format, including on social media; provide written alternatives to audio-only formats (e.g. radio broadcasts).
    - For vision impairments – Make sure that written information is available in accessible formats, including Braille and large print.

MODULE 5: DISABILITY-INCLUSIVE HEALTH INFORMATION SYSTEMS FOR PLANNING, MONITORING AND EVALUATION

Step 3: Using data to improve health service delivery

Some potential responses are below. These are just suggestions; you may have other ideas of how to use the data to improve disability inclusion.

a. You want to improve access to vaccinations for people with disability, so you work with the DPO to arrange a mobile vaccination clinic for people with disability that visits them in their homes.

b. Your health service conducts some targeted awareness activities about cervical cancer for women with disability, in partnership with women from the local DPO.

c. You contact the parent organization and decide to do a small survey of their members to collect some more in-depth data to find out why parents of children with disability are not engaging in the nutrition education programme. These data help you to adapt your programme to more effectively include parents of children with disability.

Step 4: Asking effective questions when collecting disability data

Part 1.

1. B
2. A
3. D
4. C

Part 2.

Questions that asked about function or participation: 2, 3, 5, 6, 7

MODULE 6: REHABILITATION AND DISABILITY-INCLUSIVE HEALTH SERVICES

Step 1: How much do you already know about rehabilitation?

1. F. All of the above
   Rehabilitation is of benefit to people who experience or are at risk of impairment for any reason.
2. False
   Rehabilitation services may be provided by a range of actors and in a variety of settings, for example, hospitals, health clinics, private clinics, NGOs, schools.
3. False
   People with both short-term and long-term, or chronic, impairments may benefit from rehabilitation.
4. E. All of the above
   Rehabilitation is an essential health service, may be needed by most people in their lives, contributes to healthy populations by improving well-being.

Step 3: How can rehabilitation improve patients' function and participation

Case A: Preap
He was able to return to his job and resume his normal duties. He was also able to be independent in his self-care activities while his hand was recovering. If Preap did not receive rehabilitation his hand may not have recovered as well and he may not have been able to do all the things he needs to as a mechanic, which would affect his employment.

Case B: Ipul
Ipul is able to move around her home, school and community without someone helping her. This means that she can do all the usual things that a child her age wants to do like play with friends and join in activities like sports at school.

Case C: Sumanthi
She was able to regain independence in daily activities and progress toward being out in the community and returning to her usual activities. Being able to do things for herself again was important for her mental health and regaining her confidence. Without rehabilitation Sumanthi may not have had the support she needed to recover in an effective way that supported her physical and mental rehabilitation from the effects of COVID-19.

Step 5: Simple steps to include basic rehabilitation within health services

Part 1. Some potential responses are below. These are just suggestions; you may have other ideas.

1. Has identified the need through observing the child and asking about her function in everyday activities like walking, moving and playing.
2. Provided some basic advice and strategies using resources from an appropriate source.
3. Provided a referral to specialist services that can provide further support for the child's developmental delays.

Part 2. Some potential responses are below. These are just suggestions; you may have other ideas based on your own knowledge and what is available in your health service or local area.

To address this patient's rehabilitation needs, you could:

- Find out more information from the patient and his daughter about the falls and the environment at home.
- Provide some advice about reducing falls risk in the home, such as removing tripping hazards and installing handrails where there are steps.
- If your service has a brochure about preventing falls in the home (for example, developed in collaboration with a local rehabilitation provider or DPO), you can give this to the patient and daughter to give them further ideas to use at home.
- Recommend that he use a walking stick and advise where he can get one; for example, a pharmacy.
- Make a referral to a physiotherapy clinic to assess his balance and mobility and provide intervention.
- Provided information about any government social welfare schemes for people with disability that he might be eligible for to assist the family financially.

MODULE 7: DISABILITY-INCLUSIVE HEALTH SERVICES IN EMERGENCIES

Step 3: The impact of emergencies on the health of people with disability

a. 4

b. 5

c. 1

d. 2

e. 3

Step 5: Quiz: Understanding specific challenges to the health of people with disability in the COVID-19 pandemic

1. True
   People with disability may be at greater risk of contracting COVID-19 or developing severe disease because of difficulty implementing prevention measures such as hand hygiene and social distancing, and due to pre-existing health conditions and barriers to health care.
2. E. All of the above
   These are all barriers to receiving and maintaining health that people with disability may experience when trying to reduce the risk of COVID-19.
3. E. All of the above
   Restrictions implemented by many governments to slow or prevent the spread of COVID-19, such as lockdowns, can disrupt the access people with disability have to their usual carers, medicines and even rehabilitation services. This can result in loss of health, hygiene and/or function.

4. True
   Article 25f of the UNCRPD outlines that States Parties shall prevent discriminatory denial of health care or health services on the basis of disability.
5. All of the above
   Being able to disaggregate data by disability allows health services to compare data between people with and without disability to monitor for patterns or discrepancies. This information is useful for planning and adapting responses.

Step 6: Applying disability-inclusive health-care interventions during COVID-19

Case Study 1: Odgerel: Applying strategies to COVID-19 responses

1. E
2. C
3. A
4. B
5. D

Step 7: Understanding the importance of consultation with DPOs

Examples of solution found through consultation – have a read through and compare to the responses that you have created:

1. After consulting with Aabid and others in similar situations, the blind person's association he was connected with helped his local primary health service establish a partnership with local pharmacies, such that after patients had a telehealth consult with their doctor, the clinic reception would organize with the pharmacy for medicines to be delivered to patients' homes.
2. The local community mental health centre partnered with a local primary health centre to organize regular telephone calls for volunteers to provide psychosocial support to Ping through phone calls to refugees with disabilities. It also established WhatsApp groups for families and carers of persons with disabilities to communicate directly with the centre and each other to ask for support and guidance.
3. The nurses and reception staff at the health centre contacted a local DPO. Members of the DPO worked with them to develop communication packs that included visual aids of the places and actions that were permitted during isolation, the ways that the patients could get information, and the reasons that the guidelines were important to follow. The DPO also conducted a training session to train the nurses and other front-line staff in how to use the pack, and sent out the pack to their members and their families so that they were familiar with this information in case they needed to be tested and isolate.

GLOSSARY

ACTIVITY LIMITATIONS	Difficulties in completing an everyday task or action (e.g. walking, eating).
ASSISTIVE TECHNOLOGY	Items or equipment that are designed or adapted to assist a person with an impairment to perform a particular task safely and as independently as possible and improve their participation in everyday activities. May also be called "assistive products", "assistive devices", "assistive equipment", "daily living aides".
ATTITUDINAL BARRIERS	Behaviours, perceptions and assumptions that discriminate against persons with disability.
COMORBID CONDITION	A condition co-occurring with another condition.
COMMUNICATION BARRIERS	Anything that prevents receiving or understanding messages that others use to convey their information, ideas or thoughts.
COMMUNICATION BOARD	A device that displays photos, symbols, or illustrations to help people with limited language skills or other communication difficulties to express themselves.
DISABILITY DISAGGREGATED DATA	Data that have been broken down by sub-categories on the basis of disability.
DISABILITY INCLUSION	Ensuring people with disability have the same opportunities as all other people to participate in every aspect of life.
DISABILITY-INCLUSIVE INDICATORS	Indicators used to monitor disability-sensitive targets, using disability-disaggregated data. May include input, output, process, outcome and impact indicators.
DPO	Disabled peoples organization – community organizations whose members are people with disability and work for the rights of people with disability. May also be known as organizations for people with disability (OPD).
EMERGENCY	An event or incident that requires action, usually urgent and non-routine. May include natural disasters, war and conflict, pandemics and other events.

ENVIRONMENTAL MODIFICATIONS	Changes in the home, school, community, or work environment that are necessary to improve the functional independence and safety of a person, usually with a long-term impairment or disability.
FUNCTION	Refers to body and cognitive functions, as well as activities and participation (ICF definition).
HEALTH CONDITION	A disease (acute or chronic), disorder or injury.
ICF	International Classification of Functioning, Disability and Health.
IMPAIRMENT	Problems in body function or structure (e.g. physical, vision, hearing).
NCD	Noncommunicable disease.
PARTICIPATION	Involvement in a life situation (e.g. school, work, community activity).
PARTICIPATION RESTRICTIONS	Problems experienced in engaging in everyday life situations (e.g. school, work, community activities).
PHYSICAL ACCESSIBILITY (TO HEALTH CARE)	The availability of good health services within reasonable reach of those who need them, and of the opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them.
PRIORITY AREA	An area or room (for example in a health facility) that is allocated for use by people with specific needs or requiring particular attention.
REASONABLE ACCOMMODATION	Modifications or adjustments, where these do not impose disproportionate burden, to ensure people with disability have the opportunity for equal access and participation as all people.
REHABILITATION	A set of interventions designed to optimize functioning and reduce disability in individuals with health conditions.
SECONDARY CONDITIONS	A physical or mental health condition that occurs as a result of a primary condition. For example, pressure sores may be a secondary condition as a result of paralysis.
SOCIAL STORY	Short stories that explain social situations, concepts or skills using simplified language and pictures. Often used with people with autism, anxiety or cognitive impairments to prepare them for new or unfamiliar situations.

TWIN TRACK APPROACH	Specific actions or programmes for people with disability, occurring alongside inclusion in mainstream programming.
UNCRPD	United Nations Convention on the Rights of Persons with Disability.
UNIVERSAL DESIGN	Design of products, environments, programmes and services to be usable by people of all abilities without the need for adaptation.
UNIVERSAL HEALTH COVERAGE	All people have access to the health services they need, when and where they need them, without financial hardship. This includes health promotion and prevention, treatment, rehabilitation and palliative care.
USABILITY	The capacity of a product, system or environment to allow users to perform tasks safely, effectively and efficiently while enjoying the experience.

ANNEX

MODULE 1: DISABILITY-INCLUSIVE HEALTH SERVICES – GETTING STARTED

- **Video 1:** Why is disability inclusion important?
- **Video 2:** What is disability?
- **Video 3:** Getting started in applying disability-inclusive practice

- **PowerPoint slides1:** Why is disability inclusion important?
- **PowerPoint slides2:** What is disability?
- **PowerPoint slides3:** Getting started in applying disability-inclusive practice

MODULE 2: PROMOTING DISABILITY-INCLUSIVE ATTITUDES

- **Video 1:** What are attitudinal barriers and why do they matter?
- **Video 2:** Addressing attitudinal barriers in your health service

- **PowerPoint slides1:** What are attitudinal barriers and why do they matter?
- **PowerPoint slides2:** Addressing attitudinal barriers in your health service

MODULE 3: ADDRESSING PHYSICAL BARRIERS

- **Video 1:** What are physically accessible health services & why are they important?
- **Video 2:** How to make your health service physically accessible

- **PowerPoint slides1:** What are physically accessible health services & why are they important?
- **PowerPoint slides2:** How to make your health service physically accessible

MODULE 4: COMMUNICATION BARRIERS – PROVIDING DISABILITY-INCLUSIVE HEALTH INFORMATION

- **Video 1**: Understanding communication barriers
- **Video 2:** Strategies and good practices in disability-inclusive communication in health care

- **PowerPoint slides1:** Understanding communication barriers
- **PowerPoint slides2:** Strategies and good practices in disability-inclusive communication in health care

MODULE 5: DISABILITY-INCLUSIVE HEALTH INFORMATION SYSTEMS FOR PLANNING, MONITORING AND EVALUATION

- **Video 1:** Why and how should you collect disability data?
- **Video 2:** How to use disability data for planning, monitoring and evaluation

- **PowerPoint slides1:** Why and how should you collect disability data?
- **PowerPoint slides2:** How to use disability data for planning, monitoring and evaluation

MODULE 6: REHABILITATION AND DISABILITY-INCLUSIVE HEALTH SERVICES

- **Video 1:** What is rehabilitation and why is it important?
- **Video 2:** Rehabilitation as part of a disability-inclusive health service

- **PowerPoint slides1:** What is rehabilitation and why is it important?
- **PowerPoint slides2:** Rehabilitation as part of a disability-inclusive health service

MODULE 7: DISABILITY-INCLUSIVE HEALTH SERVICES IN EMERGENCIES

- **Video 1:** Disability-inclusive health in emergencies
- **Video 2:** Disability-inclusive health during the COVID-19 pandemic

- **PowerPoint slides1:** Disability-inclusive health in emergencies
- **PowerPoint slides2:** Disability-inclusive health during the COVID-19 pandemic

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