 MODULE 3

RICHARD: Ok, good morning, good afternoon everyone. Welcome to Module 3 of this Commonwealth Disabled People's Forum Online Disability Equality Capacity Building Course. I hope you have enjoyed the material so far. My name is Richard Rieser, I am the General Secretary and today's topic is health, mental health and COVID. To help us today presenting we have Sarah Kamau who is our acting Chair, who you will hear from in a minute from Kenya, Doctor Sruti Mohapatra who is acting Vice‑Chair from Odisha in Eastern India, and is our as I say our acting Vice‑Chair. Michael Njenga we hope will join us from Kenya, and then also myself and we will be splitting up the presentation between us so it gives me great pleasure to ask Sarah Kamau to welcome you and to give us the introduction to this module.

SARAH:    Hello Richard. I want to welcome you to this training, we are keeping strong now, we're to up doing Module 3. I want to welcome you for having been patient and being able to be with us this far, and I want to make an introduction, a short introduction on Module 3 which is on health. This module is going to discuss health issues with regards to how it affects disabled people, and that during the COVID‑19 pandemic the response disproportionately affected disabled people, they were left behind. We will learn the importance of having inclusive basic services, personal assistants and communication being accessible to disabled people in order to have an inclusive society. Food, nutrition and healthcare services are key aspects of general physical wellness for everyone, including disabled people. The need to access healthcare services cannot be over emphasised and disabled people are at risk of contracting diseases more than non‑disabled people. Article 25 of the CRPD on the right to health requires health professionals to provide healthcare to persons with disabilities on an equal basis with others. Including on the basis of free and informed consent. So forced treatment, for example where this occurs on the basis of disability, will not be in compliance with the Convention. We also see Article 12 specifically highlighting the universal legal capacity right which should be accorded to disabled people, regardless of their impairments. For example, disabled people with psychosocial, Down's Syndrome, mental impairment, should be allowed to exercise their will and to enjoy their human rights. During the pandemic, high fatality rates for those in institutions, people with learning difficulties and those with chronic conditions who need support from the government were experienced. Today we shall learn how health impacts the different types of disabilities especially those with cognitive, psychosocial, and mental disabilities. Universal health should be inclusive and responsive to issues of disabled people. What this means to us. We need as Commonwealth Disabled People's Forum and Disabled People's Organisations, to hold our governments to account to provide universal health that is inclusive and responsive to disabled people taking cognisance of their different types of impairment. I will also want to talk about the language that we as the Commonwealth Disabled People's Forum use, with regard to disability. We use the concept 'disabled people', why do we still choose to call ourselves disabled people? In the Commonwealth Disabled People's Forum we call ourselves disabled people because of the development of the social model of disability. In the 19th and 20th century, a disabled person's medical condition was thought to be the root cause of their exclusion from society, an approach now referred to as the medical or individual model of disability. We use the social model of disability where the barriers of environment, attitude and organisations are what disable people with impairments and lead to prejudice and discrimination.

So to call ourselves persons with disabilities, is to accept that we are objects and powerless. We view ourselves as united by a common oppression so as to identify as disabled people, rather than people with disabilities.

When we are talking about the UN Convention on the Rights of Persons with Disabilities, we shall use persons with disabilities. Thank you. I hope now you get the concept about why we choose call ourselves disabled people. Thank you.

RICHARD: Thank you Sarah. Now I am going to ask Sruti Mohapatra to take us through some slides on the impact of the recent pandemic of COVID on disabled people. So if you highlight yourself so you can be a speaker Sruti. If you, yeah, you can cut yourself out Sarah.

SRUTI: 2020 brought in front of us very uncertain times, like everyone in the world people with disabilities are the disabled people, we're also impacted. This impact was more duty to attitudinal, environmental, and institutional barriers that are reproduced in the COVID‑19 response. The concern is that we should understand what is the situation. How are people with disabilities. Next.

These concerns which should have been considered by all the governments across the world, did not happen. The first thing we need to remember is it is a huge population, and a heterogeneous population. The study was done by WHO and World Bank and they found that 15% of the population of this world has some or other kind of disability and this is unique challenges, unique issues, but none of these were discussed. The second concern we must keep in mind while designing any responses, this is the most underprivileged and poorest of all groups and it has been found that 20% of the poorest of the people have a disability. Next.

The other concerns which are very necessary to understand is it's a high‑risk population. Many disabled people, they have pre-existing health conditions that make them more susceptible to contacting the virus, make them to experience more severe symptoms upon infection, and this leads to elevated levels of death. We will be talking about these levels of death very shortly and showing you a lot of statistics for you to understand. Next.

Now what have been the major impacts on disabled people by the Coronavirus, and by the response to Coronavirus? The first area which it impacted was health and wellbeing. Impacted care and support giving, impacted livelihood, vulnerability to the disease, mental ‑ created new mental health issues. There were absolutely no access to information, education was impacted, and there was increased domestic violence for women and girls. Next.

When you come to health and wellbeing, there are a lot of newspaper articles that you can read and there are a lot of surveys that have been done. One thing is that of the 42%, over 2 in 5 of those whose care had been reduced ‑ this was a study done in the UK, this is the National Statistics ‑ it shows that 5 of those whose care had been reduced or cancelled, their condition got worse. And those with physical disabilities that affected the immune system, the lung function, or other related factors, they were at higher risk for serious complications, such as confusion, delirium, stroke, liver failure and seizures. Healthcare workers were also not equipped to deal with disabled people. Those with such condition as diabetes are facing problems even now to get their tests done. Those living in institutions and care homes and under‑represented groups of disabled people such as the deafblind, those with psychosocial issues, and those with learning disabilities were very badly hit. Next please.

Further, we found that there was a lot of impacted health and wellbeing, because access to goods and services was completely marred or barred or completely stuck. Because of the lockdown people could not access many things like rehabilitation facilities, physiotherapy, care therapy, even basic things like medicine, diapers, assistive devices and special nutrition that was needed, access to those food and groceries become particularly difficult for those who have mobility issues. We do know in countries like in India food was distributed. We found that only 22% had access to the delivery of these essentials and 67% had no access. Next please. In care and support as well as the lockdown brought major challenges. We know of people who for 48‑72 hours were locked out of any kind of care because their care givers, their attendants, could not reach them. There were no buses, lack of transport, and the colonies, the gated colonies, the apartments, simply did not allow outsiders to come in. In the UK we have a report that showed only 12% of unpaid carers feel they had enough support, so most of this care provided was by the unpaid carers, that is family members. They were overworked and overwhelmed. Coming to health and wellbeing, this again is a study in the UK. Over three‑quarters of disabled people are very or somewhat worried about the effect that Coronavirus is having on their life. And this study brought the percentage to 75%. People with health conditions that are twice as like to feel lonely than the overall population. 43% of people with health conditions reported higher levels of anxiety as compared to 35% in the general population, and COVID‑19 had a major impact on wellbeing, access to groceries, and their health as compared with general population. Next please.

Livelihood. Livelihood was one of the areas which was severely impacted. Not just in Bangladesh and Kenya, the examples we have presented before you, but across the world people felt the impact of it. People who were surveyed in Kenya and Bangladesh they said they are concerned about finances due to a lack of access to Government benefits, and the impact of unemployment. In Kenya, 68% of people with those disabled people reported not being able to work, 65% felt insecurity in their present jobs. In Bangladesh, 80% reported not being able to work and more than 85% felt insecurity in their current job. This was done by Lennard Cheshire and the UK Aid. Next please.

In India and most Commonwealth countries, in all of our neighbouring countries, most of them, the unorganised ‑ since most disabled people they work in the unorganised sector due to this pandemic there was immediate job loss. Most self‑employed were overnight poor and many of them who did not come under this BPL, below the poverty level, those that did not come under the BPL category did not receive any financial assistance of free rations. Similarly, another survey has also been done by ILO Global Business and Disability Network, GBDN.

RICHARD: You have frozen.

SRUTI: [inaudible] Flexible hours, paid leave. As a result of this many people in these regions could sustain their jobs. Next please.

 RICHARD: I think I am doing this one Sruti, so thank you for the moment. You blank yourself out, then it will come to me. Right. Yeah thanks.

So this is many places around the world there's anecdotal evidence of higher death rates for disabled people, but most countries do not gather data that is sufficiently fine-tuned, and this is one of our key demands. That Government do gather disaggregated data about disabled people. Now in the Census, every 10 years in the UK, they ask questions along the lines of are people limited a lot or limited a little by a range of impairments that they have, or long‑term illness, and they count as disabled. Now remember the statistics they are using here are 10 years old, 9 at the time they made the comparison and therefore more people will have joined the ranks of the disabled, disabled people. At the moment the population is estimated at 17% of the UK England and Wales population. Yet, when they analysed the deaths they found that 28% of the deaths from March to May, and the figure has similar numbers proportion when they have done it through November has shown up, and have a large limits and 28% smaller limits, meaning that 42% of all the deaths were non‑disabled people. And yet disabled people are only 17% of the population. In other words, 60% of the deaths in England were that. Now that may be explained because of the deaths in care homes where a lot of disabled people are, because they can't live independently. It would have been better if they could live independently because it wouldn't have spread so quickly. This is a good idea for getting rid of care homes an institutions and supporting people living in their own homes and families. The effect of that when we look at the, the risk of dying of COVID was higher for women than for men, for every one disabled woman who dies, 11 disabled people died, and for every non‑disabled man who died, 6.5 disabled men died. There's another column that should have been on there because recently there's also been a study done on people with learning disability or learning difficulty which had found for young people in the age range 18‑34, that they died at 30 times of the rate of other people. This can only be explained by the lack of care, lack of support and information that those people got.

Now has Michael joined us yet?

GEMMA: No, not yet.

RICHARD: If we look at mental health then, the social isolation and loneliness have been associated with an increase in heart disease, dementia and other health problems according to the National Academy of Science and Health Engineering and also the emerging research on COVID shows that Coronavirus pandemic has increased psychological distress both in general population and among high‑risk groups. Behaviour such as physical distancing and well as socio‑economic impact has worsened mental health, particularly the isolation of lockdown and the impact on children. 1.6 billion children being locked out of school.

GEMMA: Richard, could you slow down please.

RICHARD: Thank you. 1.6 billion children locked out of school. It's a research on the psychological impact of mass trauma is similar to natural disasters and flu outbreaks suggest the pandemic might be particularly hard on mental health and marginalised people, so those with psychosocial issues already, those with socio‑economic and poor support needs would have been damaged.

There are unique stressors and challenges that could worsen mental health of disabled people during the COVID crisis, and research on past pandemics shows that disabled people find it harder to access critical medical supplies.

Now I hand back to Sruti who will take us on through access to information. Sruti. We can swap over again.

SRUTI: One of the major challenges that people faced during this pandemic, was not having information. Although television after television was busy dispersing, disseminating information and every minute there is a new information coming, but to many who were speech and hearing impaired, with learning disability, they had immense problem in understanding the extent of the impact and the places where they could go for testing and such things.

Apart from this though, a couple of helplines came up in different parts in India also. These helplines were only for those who could speak, but those who had other challenges, those who had cognitive issues, speech and hearing impairment, for them there is no dedicated helpline available. In Odisha, in the eastern state in the country of India the daily bulletin by Government was being given without sign language interpreter. It took a whole lot of advocacy to bring in a sign language interpreter and even larger and stronger advocacy to finally ensure that a sign language interpreter who knew the right things could do it. And we all know the World Health Organisation has said that 61% of Government websites are not accessible in India.

RICHARD: Thank you. I am doing this one, then I think you're coming back on the one after that, if that's all right. So we'll swap over, if you can blank your screen.

So the impact on education for disabled children. Lockdown measure led to school closure for long periods and as we have already said, led to isolation, it led to an increase in abuse, mental health problem and what we also found out is that disabled students often missed out on remote teaching by computer or phone because they did not have IT at home, or it was not adapted for their needs. So for instance, their computer was not adapted in the way that the one they used at school might be.

Many places, particularly in rural areas and poorer communities, didn't have any access to IT at all. A few place such as the Gambia and Namibia and a few other places started using radio which reaches a far wider range of students, but that wasn't the most common thing. In the second and third lockdowns we have had much more use of television which is more of a leveller, everybody can tune into television in most places.

The curriculum and materials that were offered were not differentiated. This is quite important. Belatedly they did, for instance in the UK we had an online curriculum called OAK in the first 6 weeks. It did not have differentiated materials on it. Lack of peer support and isolation led to increased anxiety and depression, existing inequalities of income and social insecurity were multiplied and although various governments said they were going to do catch up and support, the amount that governments have had to spend on prevention of COVID, and now trying to get people vaccinated, means that there's very little money to put into education to catch up. So we really need all of the multilateral aid partners to really do something to bring education back.

Poorer children, disabled children, missed out on feeding programmes. Often their only meal of the day is at school so they weren't getting that. Inclusive education was directly impacted because of staff absences and illnesses. In the UK, surveys show a disproportionate negative impact on disabled children and I think we're picking that up elsewhere round the world. Back to you Sruti. Sruti? Can you put your screen back on again please. Ah there you are.

SRUTI: We all know that women and children with disabilities, they regularly experience different forms of abuse and violence through their lives, and it's 2 to 3 times higher as compared to the general population. And it's well documented, we have lot of survey and research, humanitarian inclusion states that 83% of disabled women are sexually abused in their lifetime. But, the pandemic was a unique and peculiar situation. It was one of stress anxiety, and people remaining having to remain indoors for not just days and weeks, but months. This brought about a lot of aggression against both [*video frozen*] increase in economic, physical, psychological, social and all different kinds of abuse.

RICHARD: I am just catching up, hold on a minute.

SRUTI: In Bangladesh, 39 DPO leaders said that 47% report show that their members are a greater risk of been abused. This kind of abuse did not happen just in Uganda or Bangladesh, it happened in India, Pakistan, happened in everywhere. There were a lot of physical beatings, also a lot of sexual abuse. Next.

RICHARD: There's one more paragraph there. With global monitoring?

SRUTI: COVID‑19 disability rights monitor global report, they received 25 testimonies of grave human rights abuses, which included multiple forms of assault and violence. There were reports of sexual assault, domestic violence, and police brutality against women and girls with disabilities. Next please.

RICHARD: Now I am doing this one but you can stay on. So what did we as Disabled People's Organisation do, and there were varying degrees of success. This is a picture of Cameroon on trying to get better protection. They held seminars and then gave their information to the Government. In Bangladesh there was quite a lot of discussion with the Government. India partially had a national level but it didn't seem to work so well as it's trickled down to the various states. Malaysia did quite well. Maldives had a good impact. New Zealand really have come out of this very well, there was a lot of co‑operation there with their DPOs and Guyana and Gambia, and in the UK not so good, but in Scotland there was a much better rapport between the Scottish disability organisations and the devolved Scottish Government, and in Singapore. But many of the big countries, with large populations like Nigeria, Pakistan, and Bangladesh to some extent and did not really get to grips with this. If they did, it was at a national level and not down at the local level. So a lot more work needs to be done to get our views across. And there should be forward planning because after all, the next article we're going to talk about and Sruti will tell you, Article 11, makes it very clear that governments need to have plans before something like this happens, to make sure that they can actually support disabled people.

SRUTI: UNCRPD has an article, Article 11 and which specifically talks about the situation of risk such as this pandemic. Now the question was raised as to why is this necessary, because we're already talking about all other aspects of safeguarding the right of persons with disabilities. Why it was important, and what is it. Article 11 talks, says that State Parties should take all necessary measures to ensure that protection and safety of persons with disabilities in situations of risk, and they have outlined three risks. The armed conflict, humanitarian emergencies and the occurrence of natural disasters. But what happens when the pandemic arrives? Everybody is in a rush to create a document, their response, how they are going to take care of the people, safeguard. But in this rush from developed countries to the least developed or the poor countries, from the countries in the north to the countries in the south, the CRPD Committee noted that the rights of all disabled people had been violated. Article 11 has been completely flouted because no concerns of the disabled people was concerned by the different governments while planning the responses. A major strong statement I think all of us everyone must understand is people with disabilities, or the disabled people, they are not inherently vulnerable. I had stated this in the beginning. The vulnerability happens because of attitudinal environmental and institutional barriers that impede our activities. So we have underlying health, many people with disabilities have underlying health conditions which makes them susceptible to COVID‑19. But lack of access to the existing facilities, the healthcare institutions, make people more vulnerable, and often leads to death. The current position of only those with profound and multiple learning difficulties and not mild to moderate learning difficulties being denied vaccination in UK is another breach of article 11.

RICHARD: It's an important point here that equality is treating everyone the same, but equity means giving people who are less advantaged more things so they can be treated equally. So what has failed to happen here is positive action to deal with the extra risk that disabled people face. And that's really what these Article 11 situation analysis need to point to. Thank you very much Sruti. I am now going on to ask Sarah back, to talk about the right to health across as a general right. Sarah, are you online?

SARAH:    Yes I am Richard.

RICHARD: Ok thank you. So this Article 25 and you are going to tell us a bit about that and the barriers and then maybe some of the experiences you have in Kenya. Thank you.

SARAH:    Ok maybe you can also put the wordings up. I am going to talk about Article 25 which is the right to equal access to same standards of health and services as others, must take all appropriate measures and also this health rights are included in the Sustainable Development Goals Number 3.

Article 25 of the UNCRPD reinforces the right of persons with disabilities to attain the highest standard of healthcare, without discrimination at all. However, the reality is that few countries provide adequate quality services for disabled people. Also very few countries collect data to enable disaggregation by disability in the health sector. Sustainable development goal with Goal Number 3 aiming to ensure healthy lives and promotion of wellbeing for all at all ages. This is a goal that also emphasises, or puts more emphasis to Article 25 of the CRPD. And disabled people are an important disadvantaged and marginalised group to consider, when it comes to the implementation of the SDG3 and Article 25 as they are a large group, making up estimated 1 billion people world‑wide and they experience a range of exclusion owing to multiple forms of discrimination, and inaccessible environments in many spheres of life, including SDG3 targets.

So this, there are some barriers that have been experienced to adequate health, care for disabled people, and thee barriers include prohibitive costs. Affordability of health services and transportation are two main reasons why disabled people do not receive the much needed healthcare in low‑income countries. Just over half of disabled people are unable to afford healthcare compared to a third of non‑disabled people.

The other barrier includes limited availability of services. There is lack of appropriate services for disabled people. Many reveal high unmet needs for healthcare among disabled people due to unavailability of services, especially in rural and remote areas.

Another barrier is the physical barrier. The uneven access to buildings, to hospital and health centres. Inaccessible medical equipment, poor signage for those who are unable to see clearly, and lack of interpretation for the deaf, narrow doorways for people who are wheelchair users, internal steps for the physically impaired, inadequate bathroom facilities as well as inaccessible parking areas that create barriers to healthcare services.

Another barrier that we also experience as disabled people, is inadequate skills and knowledge of health workers. Disabled people are more than twice as like to [inaudible] inadequate to meet their needs, four times more likely to report being treat the badly and three times more likely to report being denied access. So these barriers are of great challenge to impairments that disabled peoples have, which they need removed or taken care of so they can fit and be well provided for in society. Taking a look at the Kenya situation, I can say that we have a hard challenges when it comes to healthcare provision. Mainly because of the barriers that we have talked about, for example access to information. The information is not in accessible formats for people who have impairments to be able to read and be able to know what to do. In cases like during the pandemic, there was a lot of information on washing of hands, putting on masks, and accessing medical care or there was a line, a free line where people could call so that they could get assistance. But this line was not accessible, especially even for people with, who are deaf because it's, it did not have the messaging services which needed to, which required an interactive approach for them, and even we have spoken about barriers like physical barriers, where persons with disabilities are unable to access hospitals, and even during the pandemic transportation to hospital was a great challenge and this even brought about more stress, and more distress to persons, especially mental and other Down's Syndrome, psychosocial disabilities. It brought a sickness more to the home because of the barriers that were there during the response of the pandemic. So we have a long way to go and the barriers are real.

RICHARD: Thank you Sarah. Now, these slides, these next seven slides were produced by Michael Njenga, who is on our executive from Kenya, representative people with psychosocial issues. I think he has not been able to make it on to this presentation so I am going to put them out for him. Hopefully he will be on the seminars next week, to actually talk about them. So Article 12 is a key article in perhaps with the hardest one to win when we were making the convention. Because a lot of people just couldn't see how people with mental health issues could have legal capacity. So most people take it for granted they can make decisions and have their respected by others. Legal capacity is the ability to hold rights and duties and the ability to exercise those rights and duties. It's about big and small decisions and it's a prerequisite of enjoying all our human rights. Historically many groups have been denied of the right to legal capacity. They have had their freedom taken away, if they have a certain level of intellectual capacity. So IQ tests have led to people being locked away, doctors have decided that people are a danger to themselves and others and lock them away, they have been treatments that have been given to people without their permission such as in the past lobotomy, electrical treatment to the brain and heavy medication and so on, which many people didn't want but they had no say over it. So persons with disabilities remain a group whose legal capacity is being denied globally. Persons with psychosocial and intellectual disability are disproportionately having their legal capacity denied. How is that legal capacity denied? Well other people take responsibility for making the decision, it's called guardianship, and in most countries in the Commonwealth that is still the law. That law has to change, because it is out of kilter with the UNCRPD. Mental health laws that allow for involuntary admission, forced treatment and deprivation of liberty on the basis of disability or impairment, how severe the psychosocial impairment is, are not acceptable under Article 12. Informal guardianship is also a problem. This is an informal regime of substitute decision making where the families and members make the decisions on behalf of the persons with disabilities. This is often to the benefit of those making the decision and there's no‑one outside the family who Is checking whether they are actually taking the decisions in the best interests of the person or against them. Now the paradigm shift which we talked about last week, is very important here. All disabled persons with an impairment are presumed to have legal capacity, and states must take all appropriate measures to ensure this is realised. It must prohibit all involuntary practices, such as taking people into hospitals or homes without their permission. Embrace supported decision making, so we are supporting people to find ways of making decisions about their lives. Nothing about us without us, remember that. Recognise will and preference to be the underlying principles of all decision making. Provide safeguards against abuse and undue influence by the people helping the person make the decision. Recognise the right of the person with disabilities to own property and access all financial services on an equal level with others, though of course they may be getting support in making these decisions, and distinguish between mental capacity and legal capacity. You can still have mental issues which impact on your day‑to‑day about how fit you are to study, to make manage reality decision, but can still have legal capacity. This was an important issue to get across to people when we made the Convention.

Supported decision making ensures that information is provided in an accessible way that persons can understand. That there is an evaluation of all available alternatives and their consequences. Do you want to do this, or do you want to do that. If you do, A, then the following things may happen. You might not want to do that. So it's about talking it through with the person who is making the decision, so they fully understand the consequences of the decision they are going to take. This can be done in a number of ways.

Appropriate safeguards can be provided. We can have peer support circles, where peers talk to each other and give support in making these decision, 'well I did that once and the following things happened so it's not a very good idea to do that.'

Advance directive, so people can write in advance of a particular bout of health problems that this is what they would like. This is there what they want to be treated, in this way. It can have a circle of friends which is focused on the individual who is making the decision. People can be recruited that who are their family, friends, their peers and they can support the person who is the focus of the circle, to make the decisions that are in their own best interests. We can have support agreements, and we can have family support, but the family support needs to be mediated, usually by a facilitator to make sure that the family are not doing things against the interests of the person.

We can have social capital and social workers and facilitators who are employed, who are independent of the consequences of these decisions, and can help the person.

What happens in difficult situations, and nobody says that everyone all the time is going to be able to make decisions. It was made clear in General Comment Number 1, from the CRPD Committee, after significant efforts have been made, and it's not practicable to determine the will and preference of an individual then the best interpretation of will and preferences must replace the best interests determinations.

How do we make this best interpretation or will and preference? Well, we evaluate previously manifested preference and attitude, narrative and action. What the person has preferred before, what they have said to other people is what they want. They could be the verbal or non‑verbal. Provided unconditional and intensive support and use of advance directives. So there are a whole series of options that should be being put in place, rather than the psychiatrist or two psychiatrists signing away the person's liberty, or what medication or invasive treatments they should be on. They should not be doing that. Many mistakes have happened. They should be becoming experts in finding out the best interpretation of will and preference, and that means keeping a lot of records on what the person has said when they are not in their worst phase of their condition.

So overall, the right to legal capacity is critical in restoring voice and power and choices to persons with disabilities.

Ok. Now, who is doing this next ... I think we're going to now reach some concluding points, and the first person is going to talk about this is Sruti, and these come from both the survey that we carried out, and the survey of the Global Monitoring Report. Sruti, are you still with us?

SRUTI: Yes.

RICHARD: Right so you are doing this slide and the next slide, ok?

SRUTI: Ok. So the CDPF has demanded from building back better from Coronavirus, and 'building back better' is a call that has been given back during the December 3rd celebrations which is International Day for Persons with Disabilities, and actually the COVID‑19 pandemic has given us an opportunity. We have seen the gaps that are there in the services being provided for the disabled people and this is an opportunity for the entire world is thinking of innovations, is thinking of new communications, new processes, to keep the world safe. Our needs can also be looked at. So the CDPF has called on governments to take some long‑term steps, that is at the planning level disabled people and their representative organisations must be involved. So this has been a demand by the disability sector since long, that whether it's a natural emergency or a man‑made, the initial process of planning for the same, starting from rescue must involve the disabled people. Second is allocation of adequate financial and human resources. We all know that this is a major concern. The COVID pandemic brought to the fore that healthcare care givers were not being understanding to specific needs of categories of people with disabilities. Debt cancellation in low and middle‑income countries is much needed, many people are already hand to mouth, many are starving. They are living on Government aid, this needs to be done. Ensure resources and vaccines are shared so COVAX, we all, I hope we all know what is COVAX all about. COVAX is a global partnership which has been initiated by World Health Organisation, and an organisation which works for the development and manufacture of vaccines and also sharing and also ensuring that there is equitable distribution. The rich nations should not hog everything and leave the poor nations and the underprivileged there short of medicines and recovery. And the entire world should learn the lessons of global collaborations in implementing the Sustainable Development Goals which is barely 9 years away. Next please.

You see the Global Monitoring Report which is again done by the World Bank and a few other organisations. Many surveys that have been done by CDPF and many other organisations across the world, and there is a very clear way forward. What we can do and the first and most important thing is deinstitutionalisation. The world saw that people in institutions suffered the most, there was no one to take care of them, and they either they suffered serious implications or they never recovered from what happened to them. So what do we need to do for deinstitutionalisation? We must develop an emergency deinstitutionalisation plan in line with Article 19 and what is Article 19? It's independent and community living. Second, is we must implement an immediate no admission policy to large and small scale institutions. We simply cannot take our people and dump them somewhere because we are unable to take care of them. We need to closely monitor the situation institutions, and release data and information. We see one of the major problems that was faced was most institutions did not release data in time as to how people were dying or getting severely infected. We have to guarantee measured, unfettered access to independent national human rights authorities. We have these institutions across the world in almost every country. They must be allowed to go into the institution, see the situation, how people are being taken care of and if their rights are being violated. We have to provide immediate access to food, social distancing resources, and appropriately trained staff and this was a crunch everyone felt as health workers were not conscious, were not aware and because of lack of accessible information about which I talk in the next point, people did not understood where are the test centres, where are the free rations available and as such. We have to provide accessible information in multiple formats. We cannot say that I have given a sign language interpreter, we have to provide Braille format, we have to provide audio format, we have to provide a large print format and such. We have to ensure full access to healthcare on an equal basis with others. The pandemic brought to the fore how unequally we are being treated. We implement immediate measures to ensure that residents can contact law enforcement and complaint mechanisms. Complaint mechanisms was a huge issue because most of helplines and complaint lines were not accessible to people.

We have to ensure that persons within institutions have access to mental health supports and services, and lastly, we have to prevent family separation and institutionalisation of children from parents due to COVID‑19. This happened in many cases. A little girl was speech and hearing impaired was separated from her parents and left in a quarantine centre which led to severe health issues, mental health conditions in her case. Next please.

RICHARD: Thank you Sruti. I think we are now going on to Sarah, are you still there Sarah?

SARAH:    Yes, Richard I am here.

RICHARD: We're running out of time so pick out the key points please.

SARAH:    We will also talk about disabled people living in the community like there is need to guarantee full participation and meaningful involvement for them in their representative organisations at every stage of the response, and we need to put some safeguards within the community‑based services, including personal assistance, home support and assistive technology. Also, it's very important for information to be provided in accessible formats. And we should also strive to enact emergency measures those enduring even after the pandemic, adequate and affordable food and medication distribution throughout the country. Including rural and remote areas which are especially rural are mostly behind. Then we should also provide immediate financial assistance to disabled people to cover the additional cost of living and the rise in the cost of food, medications, as well as essential supplies. Maybe we can go to the next Richard.

RICHARD: There we go.

SARAH:    We also are looking at disproportionate impact of under‑represented groups of disabled people, and it's important for us to guarantee full participation and meaningful involvement of under‑represented disabled people and their representative organisations, in decision and policy making processes and this includes women and girls, homeless, children, and those living in rural and remote areas. Like we're saying, these are people who are disadvantaged in many ways and we should disproportionately look at this impact and make them the same, make it equal for all people to be able to fit and function in the society. We should also ensure that legislation and policies are disability sensitive, and recognise diversity among disabled people and the intersectionality of these rights. Then after legislations are in place we should closely monitor the situation of under‑represented groups and also collect data and information on their needs so that we can be able to put measures in place, or to put activities and put the right things, the right rights for them in place so they are able to function and equally enjoy life like anybody else without disability. To ensure that implementation of policies especially during emergency response are sensitive and the overlapping needs of disabled people are there included. Should also provide access to justice, women's shelters, social workers, trauma counselling and other support for survivors of domestic violence, and sexual abuse which rose so high, especially for persons with disabilities during the pandemic. And also there's needs for provision of justice, women shelters, trauma ‑ I think I have talked about that. And sexual abuse also went up especially for persons with disabilities during the lockdown and the quarantine I think they are most abused [inaudible].

RICHARD: I think we'll have to ‑

SARAH:    I think we should also ensure that disabled children should also have equal access to health education food and medicine and other community services and the rest are in the book, in the workbook, and when you are doing the online course you will find more information about the same. Thank you.

RICHARD: Thank you very much Sarah, I will just finish off. The last two are obviously, we talked a lot about healthcare and the lack of access to it, so this has to be a key thing now for disabled people to get access to healthcare. Particularly those institutions who were so badly dealt, Information needs to be there, raise awareness of disability rights amongst the professions, ensure access to specialist help and rehabilitation, guarantee affordable healthcare, provide health information, ensure it's there for everybody. And provide multiple and accessible formats and lastly but very important as we said, with 1.6 billion children locked out of education it looks already that many disabled children who were being included are less like to be going back to school, which is a lot of girl children are not going back to school. Government needs to make every effort to get all children back to school, to live up to their commitment of SDG4 that everybody has quality education. Develop inclusive and engaging teaching. That may mean raising the level of the amount of the annual budget of the Government that is actually spent on education, over the next 4 or 5 years to actually make up the gaps that have been created here, with actual funding from organisations like the Global Partnership On Education and the UN and so on, and the World Bank. Strengthen the education workforce with teachers leading child‑centred team, drawing together parents and communities. Expanding the ability of teacher trainers to train teachers to work in different situations and ensure that all learners get access to online or radio learning. Protect and enhance fully especially reasonable accommodation and support for disabled learners. Mobilise resources as I said and improve organisation focus on learning achievements. We can see through the journey through health, look through the lens of COVID, disabled people are very unequally treated when it comes to health and Article 25 applies, Article 11 applies, when it comes to things like the pandemic, and overall, the principles of the Convention of equality, and equal treatment must be applied and that requires really us as disabled people and to join organisations and to campaign for these things. So we would like to thank you for listening to this and hope you will tune into the seminar on this on the Friday which is coming up. The seminar on health will be on the 5th of March and make sure you have it in your diary, either morning or afternoon one. Where we will hear much more about this and you can ask your questions. So thank you all very much for tuning in.