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**Module 3 Summary: Health-Mental Health and Covid-19**

1. **OBJECTIVES OF MODULE 3;**
2. To discuss health issues with regards to how it affects disabled people.
3. How COVID 19 – pandemic, disproportionately affected disabled people.
4. Importance of having inclusive basic services, personal assistants and communication being accessible to disabled people in order to have an inclusive society.
5. Learn how health impacts the different types of disabilities especially those with cognitive, psychosocial and mental disabilities
6. **THE LANGUAGE CDPF USES**

* ***Disabled people****: We choose to call ourselves ‘disabled people’: In the Commonwealth Disabled People’s Forum (CDPF) because of the development of the ‘social model of disability’. We view ourselves as united by a common oppression so are proud 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 will use ‘people or persons with disabilities’*.

1. **STATISTICS**

* An estimated 1.3 billion people experience significant disability. This represents 16% of the world’s population, or 1 in 6 of us. Some persons with disabilities die up to 20 years earlier than those without disabilities.20% of world’s poorest people have a disability
* Disabled People are impacted more than others, due to attitudinal, environmental and institutional barriers that were reproduced in the COVID-19 response
* Disabled people have twice the risk of developing conditions such as depression, asthma, diabetes, stroke, obesity or poor oral health and face many health inequities.
* Health inequities arise from unfair conditions faced by disabled people including stigma, discrimination, poverty, exclusion from education and employment, and barriers faced in the health system itself. *Source; World Health Organization [Disability (who.int)](https://www.who.int/news-room/fact-sheets/detail/disability-and-health)*

1. **ARTICLE 25 OF THE UNCRPD**

* Article 25 reinforces the right of persons with disabilities to the highest attainable standard of health without discrimination on the basis of disability
* State parties commits to provide persons with disabilities with the same range, quality and standard of free or affordable health care and programs as provided to other persons, including in the area of sexual and reproductive health and population-based public health programs;
* Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;
* Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private health care;
* Forced treatment for example, where this occurs on the basis of disability, would not be in compliance with the Convention. Article 12 specifically highlights the universal legal capacity right which should be accorded to disabled people regardless of their impairments. For example, disabled people with psychosocial, down syndrome and mental impairments, should be allowed to exercise their will and enjoy their human rights.
* SDGs, reemphasizes the need **to ‘ensure healthy lives and promotion of well-being for all at all ages under goal 3.**

1. **COVID 19 PANDEMIC**

* Disabled People were impacted more than others, due to attitudinal, environmental and institutional barriers that are reproduced in the COVID-19 response**.**
* During COVID-19, disable people faced more discrimination, violence and barriers to accessing information, education and services related to gender based violence and sexual and reproductive health**.**
* Many disabled people have pre-existing health conditions that made them more susceptible to contracting the virus made them to experience more severe symptoms upon infection resulting in elevated levels of death
* Coronavirus adversely affected disabled people in many areas of their lives including mental health, vulnerability to diseases, health and wellbeing, livelihood, care and support Education and increased domestic abuse for girls and women.

1. **Health and well-being**; Those with physical disabilities that affect the immune system, lung function or other related factors were at higher risk of serious complications such as confusion, delirium, stroke, liver failure and seizures. Over two in five of those whose care had been reduced or cancelled said their health got worse. Health care workers were not equipped to deal with disabled people. Those with such conditions as diabetes faced problems getting their tests done. Those living in institutions/care homes and underrepresented groups of disabled people such as deaf blind, psychosocial and those with learning difficulty particularly hard hit. *Source Office of National Statistics, UK - Social impact of coronavirus (updated with data from 18-22 Nov 2020)*. In India, Swabhiman and NCPEDP’s surveys revealed that 67 % of persons with disabilities interviewed had no access to doorstep delivery of essentials by the government. Only 22% had the access to delivery of essentials.
2. **Care and Support** - The near total lockdown meant that caregivers were overnight not able to be with PwDs who depended on them. No passes, Lack of transport, Apartments & colonies closed gates.
3. **Domestic abuse** - Before the Pandemic Disabled Women and Girls reported 2-3x level of abuse as non-disabled women. One in three women respondents reported experiencing an increased risk of physical and/or sexual violence. COVID-19 Disability Rights Monitor Global Report received 25 testimonies of grave human rights abuses which included multiple forms of assault and violence.
4. **Livelihood** – Many respondents surveyed in both Kenya and Bangladesh faced employment and job insecurity. They were most concerned about their finances, due to a lack of access to government benefits and the impact of unemployment. In Kenya, **68%** of persons with disabilities reported not being able to work, while **65%** felt insecurity in their current jobs. In Bangladesh, **80%** reported not being able to work and **more than 85%** felt insecurity in their current job. (Leonard Cheshire and UK Aid)
5. **Education –** The pandemic negatively impacted access to education for disabled people. Lockdown measures led to school closure for long periods. Disabled students often missed on remote teaching by computer, phone as did not have IT at home or it was not adapted for their needs. Some countries introduced lessons on radio or TV. The curriculum and materials that were offered was not differentiated. Lack of peer support and isolation led to increased anxiety and depression. Existing inequalities of income and social insecurity were multiplied. Poorer children / disabled children missed out on feeding programs. In UK Surveys show a disproportionate negative impact on disabled children
6. **MENTAL HEALTH**

* Research on COVID-19 shows that the coronavirus pandemic increased psychological distress both in the general population and among high-risk groups. Behaviors such as physical distancing, as well as their social and economic impacts, worsened mental health consequences.
* Research on the psychological impact of mass trauma (e.g., natural disasters, flu outbreaks) suggests that the pandemic might particularly harm the mental health of marginalized populations who have less access to socioeconomic resources and supportive social networks.
* There are unique stressors and challenges that could worsen mental health for disabled people during the COVID-19 crisis.
* Research on past pandemics shows that disabled people find it harder to access critical medical supplies which can become even more challenging as resources become scarce
* Social isolation and loneliness have been associated with increases in heart disease, dementia and other health problems according to the National Academy of Science, Engineering and Health

1. **BARRIERS TO ADQUATE HEALTH CARE FOR DISABLED PEOPLE**

* **Prohibitive costs**; Affordability of health services and transportation are two main reasons why disabled people do not receive much needed healthcare in low-income countries. Just over half of disabled people are unable to afford healthcare compared to about a third of non-disabled people.
* **Limited availability of services;** There is a lack of appropriate services for disabled people. Many studies reveal high unmet needs for healthcare among disabled people due to unavailability of services, especially in rural and remote areas.
* **Physical barriers**; Uneven access to buildings (hospitals, health centers), inaccessible medical equipment, poor signage, lack of interpretation, narrow doorways, internal steps, inadequate bathroom facilities, and inaccessible parking areas create barriers to healthcare facilities.
* **Inadequate skills and knowledge of health workers**; Disabled people were more than twice as likely to report finding healthcare provider skills inadequate to meet their needs, four times more likely to report being treated badly, and nearly three times more likely to report being denied care.

1. **DENIAL OF ACESS TO HEALTHCARE**

* Guarantee full participation and meaningful involvement of disabled people and their representative organizations at every stage of health policy making.
* Prevent denial of health information, health care, or health services, on the basis of disability. Provide access to justice for those who have been denied access to healthcare.
* Disabled people, including persons living in institutions, enjoy the highest attainable standard of health without discrimination, on the basis of disability.
* Require health professionals to provide healthcare and health information to disabled people on an equal basis with other citizens, including persons in institutions.
* Raise awareness of disability rights among health professionals, including the right to access information and give free and informed consent to medical treatment.
* Ensure access to specialized health services including rehabilitation.
* Guarantee free or affordable healthcare, food and medicine, and prohibit discrimination against disabled people in the provision of health insurance.
* Provide health information and services as close as possible to people’s own communities, including in remote and rural areas.
* Ensure that health information and services are age- and gender-sensitive.
* Provide information about healthcare in multiple, accessible formats.
* Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;
* Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability

1. **OUR CALL AS CDPF**

* We need as CDPF and DPOs to hold our governments to account to provide universal health that is inclusive and responsive to issues of disabled people taking cognizance of their different types of impairments.
* The CDPF also calls on governments to take the following longer-term steps to avoid future human rights emergencies:
* Actively involve disabled people and their representative organizations, and civil society, in planning the recovery process and emergency deinstitutionalization plans.
* Allocate adequate financial and human resources to support the transition from institutions to the community, in line with Article 19 of the CRPD.
* Debt Cancellation in Low and Middle Income Countries
* Ensure resources and vaccines are shared top the maximum for global use through COVAX
* Learn the lessons of Global Collaboration in implementing SDs by 2030