World Health Organization

REGIONAL OFFICE FOR THE Eastern Mediterranean

Disability inclusion in health responses to COVID-19 in the Eastern Mediterranean Region

Results of a rapid assessment

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WHO Library Cataloguing in Publication Data

Names: World Health Organization. Regional Office for the Eastern Mediterranean
Title: Disability inclusion in health responses to COVID-19 in the Eastern Mediterranean Region: results of a rapid assessment / World Health Organization. Regional Office for the Eastern Mediterranean
Description: Cairo: World Health Organization. Regional Office for the Eastern Mediterranean, 2022
Identifier: ISBN 978-92-9274-059-7 (pbk.) | ISBN 978-92-9274-060-3 (online)
Subjects: Disabled Persons | COVID-19 | Betacoronavirus | Disease Outbreaks | Health Services for Persons with Disabilities | Outcome and Process Assessment, Health Care | Eastern Mediterranean Region
Classification: NLM WC 506.41

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Foreword

The COVID-19 pandemic has disproportionately affected persons with disabilities. It has put a spotlight on the inequities and exclusion that they have long faced, pushing them further to the edge of society. Persons with disabilities also have a higher risk of getting infected, enduring severe illness and dying of COVID-19.

Despite this, they have often been overlooked in COVID-19 health response plans. In addition, the essential services that they need most to function were among the first to be disrupted when health systems were overwhelmed early in the pandemic. Even this year, rehabilitation services were still facing disruption, a global survey by the World Health Organization (WHO) found.

Dr Ahmed Al-Mandhari
WHO Regional Director for the Eastern Mediterranean

In recognition of this, the WHO Regional Office for the Eastern Mediterranean proactively undertook a rapid assessment to look into the disability inclusiveness of COVID-19 health responses and understand the impact of the pandemic on health services for persons with disabilities. This is in line with WHO's regional vision of Health for All by All, which emphasizes the need to work for equitable and resilient health systems and universal health coverage. Countries were supportive of the assessment: 18 of the 22 countries and territories of the Region, representing 80% of the regional population, participated in it.

The survey suggested that a key predictor of inclusiveness of disability in a country's COVID-19 health response was the existence of a resilient and inclusive health system *prior* to the pandemic. While there were multiple and varying efforts in support of persons with disabilities across countries, some of the fundamental issues that persons with disabilities face, such as in access and accessibility, need to be further addressed.

The findings show a need to change perspectives and adopt a more systematic approach. For example, governments need to routinely collect and disaggregate data on disabilities in order to identify barriers to accessing services. In general, disability needs to be more purposefully and systematically included in health planning. WHO will endeavour to provide countries with the necessary technical support in this regard.

Persons with disabilities make up a sizeable population in the Region, numbering almost 100 million, based on calculations from an estimate in the *World report on disability* (2011). The invisibility and barriers that they face when seeking care must be addressed not only from a rights perspective, but also in order to achieve global health goals, including the commitment in the 2030 Agenda for Sustainable Development "to leave no one behind". Moreover, ensuring their human rights is an obligation under the United Nations Convention for the Rights of Persons with Disabilities, a legally binding treaty.

This rapid assessment is an important first step towards disability inclusion. It is hoped that it will shed light on the measures needed for progress, provide a basis for further research and encourage countries to take action in this area.

The inclusion of persons with disabilities in the COVID-19 health response will ultimately benefit everyone, by helping transform health systems to become people-centred and inclusive of all, including persons with disabilities. Let us learn from our experience with COVID-19 and seize the opportunity to build back better and fairer.

Dr Ahmed Al-Mandhari
WHO Regional Director for the Eastern Mediterranean

Acknowledgments

WHO would like to thank the following for their contributions to the development and implementation of the rapid assessment survey and the development of this report.

WHO Regional Office for the Eastern Mediterranean: Dr Maha El-Adawy, Director for Healthier Populations; Dr Hala Sakr, Regional Adviser for Violence, Injuries, and Disabilities; Dr Heba Fouad, Regional Surveillance Officer, Noncommunicable Diseases and Mental Health; Dr Abdelrahman Elwishahy, Dr Gamal Ez Elarab and Ms Mangai Balasegaram (consultants).

Country focal persons or entities for the rapid assessment who coordinated data collection at country level: Dr Musa Zia (Afghanistan); Dr Rehab M. Al-Marzooq (Bahrain); Dr Saleh B. Tourab and Mrs Neima Moussa (Djibouti); Dr Heba Hagras, representatives of the Ministry of Health and Population, and representatives of the Ministry of Social Solidarity (Egypt); Dr Mohammad T. Joghataei, Dr Marzieh Shirazikhah, Dr Mahdi Alizadeh, Dr Mohammad Nafariyeh, Dr Afrooz Saffarifard, Dr Fariba Barimani, Dr Khadijeh Gharedaghi, Dr Parisa Arzani, Mr Farideh Baghalishani and Ms Maryam P. Mohammad (Iran, Islamic Republic of); Dr Sabah K. Yas and Dr Ahmed H. Radhi (Iraq); representatives of the Ministry of Health, Jordanian Society of Physical Medicine, Arthritis and Rehabilitation and The Higher Council for Rights of Persons with Disabilities (Jordan); representatives of the Ministry of Public Health and the Arab Organization of Persons with Disabilities (Lebanon); Dr Abubaker Feghia and Dr Mohamed Altriki (Libya); Dr Brahim Bouhmadi (Morocco); Mr Saleh Al-Harbi (Oman); Dr Samra Mazar (Pakistan); Dr Khalid A. Hadi, Dr Nawal K. Al Haddad, Dr Binoi Kuriakose, Dr Lisa Thornton, Dr Noof M. Alsiddiqi, Dr Sarah Al Shaikhly, Ms Fatemah A. Mustafa and Mr Mamoun M. Alkhoub (Qatar); Dr Fatima Elhassan Eisa (Sudan); Dr Asaad Alsaed, Dr Rafif Dahieh and Dr Ali Tourekmani (Syrian Arab Republic); Dr Saida Ouenniche (Tunisia); Dr Sameer Shamasneh, Ms Jihan A. Abdullah, Mr Mohammad Araj and Mr Jamal I. Al Rozzi (West Bank and Gaza Strip); and Dr Mansoor Al-Hubaishi and Dr Raja A. Almasabii (Yemen).

WHO staff from WHO country offices who facilitated the collection of information for the rapid assessment survey.

WHO peer reviewers: Dr Alarcos Cieza and Dr Emma Pearce (Sensory Functions, Disability and Rehabilitation, WHO headquarters); Dr Rania Saad (Healthier Populations Division, WHO Regional Office for the Eastern Mediterranean); Ms Nisreen Abdel Latif (Noncommunicable Diseases and Mental Health, WHO Regional Office for the Eastern Mediterranean); Dr Ahmed Mandil (Science, Information, and Dissemination); Dr Hassan Salah and Dr Saeed Soliman (Universal Health Systems, WHO Regional Office for the Eastern Mediterranean); and Dr Abubaker Abdinaser (WHO Health Emergencies Programme, WHO Regional Office for the Eastern Mediterranean)

Expert peer reviewers: Dr Daniel Mont, Center for Inclusive Policy, United States of America; and Dr Malek Qutteina, independent expert in public health and disability rights.

Executive summary

Persons with disabilities have been among those hardest hit by the COVID-19 pandemic. Not only have they been confronted with higher rates of severe illness and death from COVID-19, but the pandemic has also deepened the inequality, discrimination, social exclusion and low priority – if not invisibility – that they routinely face. A World Health Organization (WHO) survey in 2020 found rehabilitation services were some of the most disrupted services reported by countries.

This report is based on a rapid assessment, a unique endeavour to describe the status of disability inclusion in the COVID-19 health responses of countries in the WHO Eastern Mediterranean Region.

The aims of the rapid assessment were to study the following:

- the inclusion of persons with disability within COVID-19 health responses;
- the impact of COVID-19 on rehabilitation and assistive technology services; and
- country expectations of WHO guidance on a disability-inclusive COVID-19 health response (to inform the development of guidance).

Data was collected from July 2020 to January 2021 through a questionnaire with 13 questions covering: disability inclusion in COVID-19 health responses; rehabilitation and assistive technology (AT) in continuity plans for essential health services (EHS); and actions to reduce the impact and risk of COVID-19 for persons with disabilities. The questionnaire was sent to 18 countries and territories[1] of the Region that had agreed to participate and was followed up with semi-structured discussions. Respondents came primarily from ministries of health in all countries as well as from ministries of social affairs and disability councils and organizations. Countries were requested to share related documents, such as COVID-19 response plans.

The findings are only reflective of the time period of the assessment and the reporting from countries. Other efforts towards a disability-inclusive COVID-19 health response that were not reported or were outside of this time frame have not been included in this report.

Data and information from the 18 countries, which represent 80% of the regional population, were analysed and categorized under four themes. The key findings are as follows.

[1] For convenience, the term "countries" is used in this report to cover countries, territories and areas in the WHO Eastern Mediterranean Region. This does not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Governance and planning

- Only four of the 18 participating countries reported the inclusion of disability-specific sections in their COVID-19 health response plans at the time of the assessment.
- Seven countries reported that their COVID-19 plans followed WHO interim guidance.
- Nine countries included rehabilitation and AT in EHS continuity plans.
- Only five countries reported consultations with persons with disability, or their caregivers or representatives, prior to developing and implementing a COVID-19 disability-inclusive health response.

Information and communication

- Only three countries reported some degree of collecting data on disability within their surveillance and testing strategy for persons with COVID-19. Of these, only one country collected information on the nature of the disability.
- 14 countries reported dissemination of COVID-19 information accessible to persons with disabilities. Of those, 11 shared examples of those materials, which showed sign language was the most dominant accessible format used.

Service delivery

- All 18 countries reported the availability of disability-inclusive COVID-19 services at various health care levels (but actual accessibility of these services was less clear).
- 12 countries reported delivering disability-inclusive remote services for COVID-19 via mobile medical units, telemedicine and community-based rehabilitation (CBR).

Financing

- Over half the participating countries reported availability of earmarked funds for continuity of rehabilitation, AT and personal assistant services during the pandemic.

Respondents also provided suggestions on actions to reduce the impact/risk of COVID-19 on persons with disabilities – most focused on service delivery, underscoring the need for service continuity. The area receiving the least attention was data and research, despite the paucity of material in this field. The most-requested theme for support from WHO was technical guidance, while financial support, data and research received the least requests.

Overall, the survey provides a better picture of the status of disability inclusion in the COVID-19 health response in the Region and indicates how countries can be supported during the pandemic to adopt a greater disability-inclusive approach.

The key conclusions that can be made from the findings are as follows:

- Disability is given neither enough nor explicit consideration in national health responses to COVID-19 in the Region; deliberate and purposeful inclusion of disability is needed.
- Disability data collection within national COVID-19 profiles was exceptional rather than routine – only three countries collected data and only one disaggregated the data.
- Consultation with persons with disability is limited in planning and decision-making in COVID-19 health responses in the Region.
- Rehabilitation and AT services continuation was considered in the essential health planning of only 50% of the countries that participated in the assessment.
- Many countries report availability of disability-inclusive services, but actual accessibility and inclusivity of services to all types of disabilities needs validation and research.

A number of other findings should be noted. Some countries reported that their COVID-19 health response plans were developed, regularly reviewed and updated based on WHO guidance. Thus, including specific considerations for persons with disabilities in WHO guidance is important to promote disability inclusiveness in country response plans.

Several countries also reported multi-stakeholder engagement in the development of their COVID-19 health response. This offers opportunities to broaden the scope and coverage of services with greater resources, but it is important to maintain governmental coordination, oversight and monitoring of services offered by various providers.

The assessment had several limitations, such as a lack of validation for country data aside from some input from stakeholders, the limited time period of data collection and the variation in understanding of certain concepts.

Nevertheless, it has helped build a better picture of disability inclusion in the Region, and it offers a basis for further assessments in countries to inform the development of health systems with disability inclusion at their core. As COVID-19 has shown, we need inclusive health services to control a pandemic and to promote better health and greater equity.

Key insights for the way forward

Insights from the survey point to the following actions for countries to move forward.

- Ensure deliberate and explicit consideration for persons with disabilities in any future COVID-19 health plans, guidelines or protocols.
- Consult with persons with disabilities in planning COVID-19 health responses.
- Collect data on disability, disaggregated by parameters (such as type of difficulty or assistance needed) to assess the COVID-19 impact on persons with disabilities.
- Maintain rehabilitation and AT services in country plans for EHS continuity.
- Build coordination among stakeholders and service providers in the response in order to address service gaps, extend coverage and maximize resources.
- Ensure health services are fully accessible to all persons with disabilities by looking at barriers such as the environment, communications, service delivery mode and so on.
- Assess accessibility by consulting and involving persons with disabilities.
- Sustain development of COVID-19 communications materials in different accessible formats (such as Braille, 'easy read', sign language, large print and soundtrack).
- Make optimal use of innovative alternative strategies such as tele- and digital health to ensure the continued delivery of needed services.
- Ensure disability inclusion is specifically budgeted in health planning.

1. Introduction and rationale

1.1 Background

In May 2020, the United Nations (UN) Secretary-General issued a policy brief on a disability-inclusive response to COVID-19, which underlined that persons with disabilities – one billion people globally – are among the hardest hit in this crisis. COVID-19 has deepened pre-existing inequalities faced by persons with disabilities, exposing the extent of exclusion that they experience. It has highlighted that work on disability inclusion is imperative *(1)*. It is crucial that responses to the pandemic are genuinely inclusive of everyone, including persons with disabilities *(2)* – they must have equal access to all COVID-19 health services and information.

Persons with disabilities are among the most vulnerable populations in the COVID-19 pandemic due to a myriad of health, social and environmental barriers to accessing care, including discriminatory attitudes and inaccessible infrastructure *(3)*. Several factors place them at greater risk of contracting COVID-19, including:

- difficulty in implementing hygiene measures such as handwashing;
- difficulty in social distancing due to assistance needs or institutionalization;
- the need for tactile interaction with their environment; and
- barriers to accessing public health information.

Underlying health conditions may also increase the likelihood of severe COVID-19 illness. Barriers hindering access to care and the disruption of support services providing autonomy and independence also have adverse implications *(4)*.

Even prior to the pandemic, roughly 50% of persons with disability could not afford health care or faced challenges accessing health services, the *World report on disability* (2011) shows *(5)*. COVID-19 has exacerbated this situation, overwhelming even the most resilient health systems globally *(6)* and across the World Health Organization (WHO) Eastern Mediterranean Region, regardless of a country's income level *(7)*. A WHO pulse survey conducted in 2020 found that due to COVID-19 restrictions and lockdowns, rehabilitation services were among the most disrupted services reported by countries. Together with the disruption to all other health services, this further increases the challenges faced by persons with disabilities in accessing needed essential health services *(8)*.

Box 1. Description of disability

Persons with disabilities include those with physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society. This broad description of disability from the Convention on the Rights of Persons with Disabilities (CRPD) is inclusive, reflects the wide range of disabilities and recognizes that disability is an evolving concept. Thus, it is not the impairment that necessarily leads to a disability, but barriers that include personal and environmental factors (such as negative attitudes and inaccessible buildings or transport *(9,10)*.

If not explicitly included in COVID-19 health response planning from the start, there is a risk that persons with disabilities will be excluded from prevention and response measures, despite facing a heightened and disproportionate risk *(11)*. Equally crucial, particularly during pandemics, is the continuity of rehabilitation services and assistive technology (AT) provision (including maintenance and repair). These services enable persons with disabilities to maintain their functioning, interaction with the environment and independence during physical distancing and isolation, thus decreasing their reliance on caregivers, whose numbers have reduced during the pandemic *(12)*. Therefore, rehabilitation and AT services must be considered when prioritizing and adapting health services in COVID-19 planning and response, alongside COVID-19 risk mitigation strategies for services that continue *(13)*.

Box 2. On disability inclusion

Disability inclusion entails the full participation and realization of the human rights of persons with disabilities, as outlined in the UN Disability Inclusion Strategy. In the context of COVID-19, it involves: mainstreaming disability in the response; ensuring access to information, facilities and services; and consultation with stakeholders. The UN affirms that disability inclusion will result in a more effective COVID-19 response that serves everyone *(1,14)*.

Currently, an estimated 97 million persons are living with disabilities in the Eastern Mediterranean Region *(5)*.[1] Including this vast population in the COVID-19 health response and recovery is critical to ensure the goal of leaving no one behind and key for a response that "better serves everyone, more fully suppressing the virus as well as for building back better" *(1)*.

There is currently inadequate data and information on the burden and implications of COVID-19 for persons with disabilities, yet this is crucial for effective and inclusive health responses. Some media reports, especially early on in the pandemic, highlighted challenges faced by persons with disabilities in accessing COVID-19 services in some countries of the Region due to various reasons such as insufficient capacities or even discrimination at the community and system levels *(15)*.

Recent data available on the progress of COVID-19 in the Region points to a need to address the pandemic beyond its direct medical impact, and to consider those indirect implications which increase the vulnerability of certain populations, such as persons with disabilities *(16)*.

Yet disability inclusion in the health sector remains a major gap in countries' health agendas, particularly when health systems are overwhelmed by emergencies such as COVID-19 *(17)*. There is a need to identify this gap and sensitize health authorities in countries to include it in their national health agendas.

Governments and their partners need to rapidly identify and scale up effective health responses and start planning and implementing sound interventions to ensure that vulnerable groups such as persons with disabilities are equally supported against the consequences of COVID-19 *(1,18)*.

[1] This is based on calculations using the *World report on disability* (2011) estimate that 15% of the global population live with some form of disability and that persons with disabilities represent 15% of the total population in Eastern Mediterranean Region of more than 665 million. Source: Global Health Observatory Data Repository (https://apps.who.int/gho/data/view.main-emro.POP2020?lang=en, accessed 23 June 2021).

Box 3. Relevant mandates and commitments

UN Convention for on the Rights of Persons with Disabilities (CRPD)

Almost all Member States of the Region have ratified the CRPD, a legally-binding treaty, which commits them to ensure the human rights and fundamental freedoms of persons with disabilities. Article 25 of the CRPD recognises the right to "the highest attainable standard of health without discrimination on the basis of disability" while Article 26 provides for "habilitation and rehabilitation services" *(9)*.

Sustainable Development Goals (SDGs)

Under the SDGs, Member States have made an commitment to "leave no one behind" with an explicit reference to persons with disabilities. Target 3.8 of SDG 3 (Ensure healthy lives and promote well-being for all at all ages) focuses on universal health coverage and access to essential services *(19)*. Without the inclusion of disability, it will not be possible to achieve this target *(20)*.

UN Disability Inclusion Strategy and WHO Policy on Disability

In June 2019, the UN Disability Inclusion Strategy (UNDIS) was launched to promote "disability inclusion through all pillars of work", requiring all UN agencies to systematically mainstream disability inclusion into all aspects of work. WHO's policy on disability and action plan, launched in 2020, serves as the primary framework to implement UNDIS across the Organization *(10,14)*.

WHA74.8: The highest attainable standard of health for persons with disabilities

In 2021, the World Health Assembly endorsed resolution WHA74.8, which calls upon Member States to make the health sector more disability-inclusive. It calls for involving persons with disabilities in decision-making and designing programmes and taking measures to ensure access to health services for persons with disabilities, particularly during public health emergencies such as COVID-19 *(21)*.

1.2 Objectives

The WHO Regional Office for the Eastern Mediterranean supported Member States to undertake a rapid assessment to gauge the status of disability inclusion in the COVID-19 response and the continuity of rehabilitation services and AT provision during the pandemic.

The objectives of the rapid assessment were to:

- assess the degree to which the national COVID-19 health responses are disability-inclusive;
- explore and understand the continuity of rehabilitation services and AT provision during the pandemic in the Region; and
- obtain a better understanding of country expectations of WHO guidance on a disability-inclusive COVID-19 health response and recovery and beyond.

This report on the findings of the rapid assessment targets different stakeholders concerned with disability inclusion in health systems including policy-makers, academics/researchers, development agencies, health workers and nongovernmental organizations.

It is hoped that the report will inform actions at regional and country levels to improve the disability inclusiveness of health responses. Furthermore, the recommendations on the way forward can support the development of comprehensive country preparedness and response plans, as well as WHO guidance for better health services for persons with disabilities during and beyond the pandemic in line with the aspirations of the CRPD *(9)*.

2. Methods

2.1 Assessment tool and data collection

To conduct a rapid assessment of the disability-inclusiveness of the COVID-19 health response, a questionnaire was developed by the WHO Regional Office, drawing on WHO guidance on disability considerations during the COVID-19 pandemic *(4)*. Additional questions were included seeking country perspectives on improving the disability-inclusiveness of COVID-19 responses, and the expected support needed from WHO in this regard.

The questionnaire consisted of 13 questions organized under these main sections (see Annex 1 for the questionnaire):

- Disability-inclusive COVID-19 response;
- Essential health services (EHS) continuity plan during the COVID-19 pandemic and the extent to which it included rehabilitation and AT services; and
- Reflections on actions to reduce the impact and risk of COVID-19 on persons with disabilities and requests from WHO.

Questions were mainly in a yes/no or multiple-choice format, with more details requested, where applicable. Upon receiving the completed questionnaire, follow-up semi-structured discussions were conducted with each respondent, either directly or through WHO country offices, for further clarification and validation of the responses and information provided. Countries were also requested to support their responses by sharing documentation such as official plans, guidelines or protocols relating to the COVID-19 health response and to the continuity of rehabilitation and AT services during the pandemic, as well as examples of accessible information and communication materials.

The questionnaire was first piloted in three countries in the Eastern Mediterranean Region to check its validity and clarity and was revised accordingly. The assessment was implemented in the 18 countries[1] of the Region that responded to an email from the WHO Regional Office requesting country participation with guidance on the exercise. WHO country offices were requested to share the questionnaire with ministries of health, other key ministries (mainly ministries of social affairs), national disability councils and key nongovernmental organizations, based on the country context. Nominated focal persons in the participating countries were officially assigned to complete the self-administered assessment tool and be part of follow-up discussions for clarifications on country responses as needed.

Data collection took place from July 2020 to January 2021 with WHO support, and the final data sets were sent to respective governments for confirmation. The time frame for data collection allowed for countries being preoccupied with the COVID-19 response and to allow as many countries as possible to share their responses.

All findings in this document are reflective of the information reported by countries and no systematic validation was made aside from some inputs from other stakeholders.

[1] Afghanistan, Bahrain, Djibouti, Egypt, Iran (the Islamic Republic of), Iraq, Jordan, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Sudan, Syrian Arab Republic, Tunisia, West Bank and Gaza Strip, and Yemen.

2.2 Data interpretation and analysis

The data, narrative information and supporting documents received were used to conduct a descriptive aggregate analysis across countries to produce information that would be representative of the Member States that took part in the assessment. Results were categorized under:

- Governance and planning;
- Information and communication;
- Service delivery; and
- Financing.

Responses, which were mostly to yes/no questions, were aggregated into excel sheets to obtain a general picture of the extent of disability inclusiveness in the COVID-19 health response and planning. No grading was used for any of the questions. Additional supporting documents and information provided by respondents were reviewed and a descriptive analysis of their content was undertaken.

Common issues and challenges were also compiled and summarized to contribute to the overall picture of the disability inclusiveness of the COVID-19 health response in the Region. These findings led to a suggested way forward to improve the inclusion of persons with disabilities in pandemic response and recovery efforts and beyond.

Non-responses to some questions/variables were revalidated or checked by communication with focal persons and during follow-up discussions. The non-response rate could be interpreted as an indicator of a lack of knowledge and information to be able to answer the question investigated.

Reflections on actions to reduce the risk for persons with disabilities and requests from WHO received from participating countries were grouped by country respondents and thematic areas, accordingly. Similar suggestions reported from different respondents of the same country were counted as one response.

2.3 Ethical considerations

Officially nominated respondents/focal points were informed that they would be anonymized and that any information shared would be kept confidential and used exclusively for scientific purposes. Summary pages for each country will not be published or disseminated further. Country names have been anonymized in this report, with an aggregate overall regional analysis of the assessment findings. Respondents/focal persons have been acknowledged as contributors here only if they have agreed to their names being included.

2.4 Limitations

Several limitations and constraints affected the implementation of the survey and, as a result, the interpretations of the findings and results. These include the following:

- Responsiveness varied greatly between countries and respondents.
- A standardized protocol was lacking for the selection of responding focal points and entities in countries participating in the rapid assessment.
- Responses from persons with disabilities, their families and representative organizations were not systematically collected in all countries to reflect their perspectives and to validate the findings on accessibility of COVID-19 health facilities, services and information materials. To mitigate this, responses from organizations of persons with disabilities or national disability councils were pursued when possible.
- Variation in understanding of certain concepts might have also impacted the responses in some cases. This was observed for example in relation to the availability of services for the whole population versus accessibility specific to persons with disabilities, or in relation to the differentiation between community and primary health care levels.
- Respondents experienced some difficulty in providing official supporting documents in some countries.
- The lack of reliable information on disability inclusiveness in the participating countries prior to the pandemic makes it difficult to assess to what degree the pandemic has affected disability inclusiveness, or to differentiate between services existing prior to the pandemic in Member States, and those initiated in response to it.

3. Results

The findings below are only reflective of the time period of the study (July 2020–January 2021) and the reporting from countries, without systematic validation, aside from some inputs from other stakeholders. Other efforts towards a disability-inclusive COVID-19 health response that were not reported on or that took place outside of this time frame have not been included in this report.

In total, 18 of the 22 Member States of the Eastern Mediterranean Region – representing 80% of the regional population – took part in the assessment. Responses to the questionnaires were provided by ministries of health in all participating countries either solely or with other stakeholders. Other stakeholders included ministries of social affairs, national disability councils, nongovernmental organizations, organizations of persons with disabilities (OPDs), and UN agencies (see Table 1).

Table 1. Respondent affiliations in participating countries

Respondent affiliations	Number of countries
Ministry of Health	**18**
Ministry of Social Affairs	**3**
National Disability Council	**1**
Disability Committee of the National Women's Council	**1**
Nongovernmental organization or OPD	**4**
UN agency	**1**

3.1 Governance and planning

3.1.1 Disability-inclusive COVID-19 health response

Although all 18 participating countries had a specific plan to respond to COVID-19, only four countries reported the inclusion of disability-specific sections in these plans at the time of the assessment, as seen in Fig. 1.

Seven countries reported that their COVID-19 plans followed WHO interim guidance, (including the four countries that reported the inclusion of disability-specific sections in their plans).

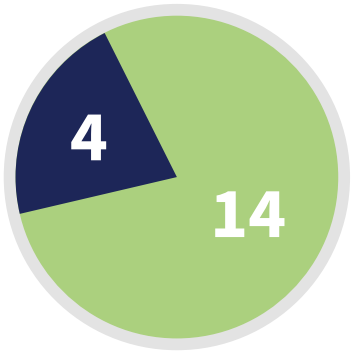


Fig. 1. Number of countries that reported disability considerations in their COVID-19 health response plan

Only three out of the four plans reported to include disability-specific sections in the COVID-19 health response were shared.

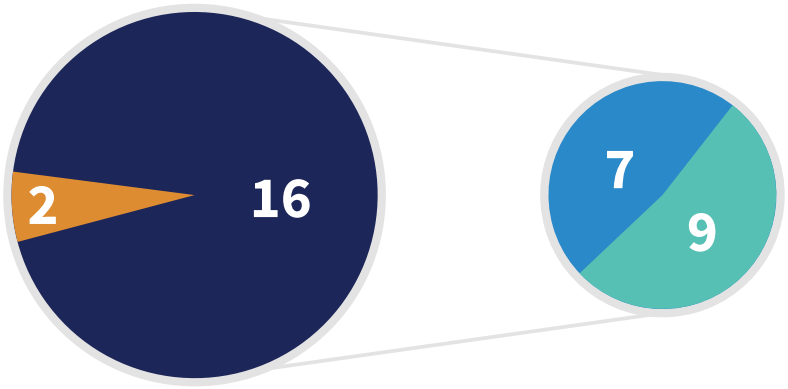
Of these three plans, disability is reflected to varying degrees: One aspect was consideration of children with disabilities among vulnerable groups and addressing their needs through procuring and distributing supplies required for the COVID-19 response – such as personal protective equipment (PPE) and disinfectant – to them and their caregivers. Another aspect was including actions and recommendations for regular and updated collection of disability-disaggregated data to identify gaps and assess the COVID-19 impact on persons with disabilities, as well as highlighting the need to develop accessible information and communication material for persons with disabilities. One plan also reported implementing considerations for persons with disabilities admitted to health facilities due to severe COVID-19 and continuation of their needed rehabilitation services during the period of hospitalization.

One of the three plans provided an account on current challenges for disability inclusion in the COVID-19 health response. These challenges included:

- setting up integrated clinical pathways;
- mainstreaming disability-inclusive clinical planning in line with business planning;
- funding mechanisms in line with clinical needs;
- mainstreaming inclusive access to information and care services;
- ensuring optimal evidence-based data collection; and
- ensuring the quality and operational adaptability of services.

3.1.2 Rehabilitation and AT in EHS continuity plans

The inclusion of rehabilitation and AT services in EHS continuity plans during the COVID-19 pandemic was reported by a total of nine countries as seen in Fig. 2. It is worth noting that regardless of the inclusion of rehabilitation and AT in country EHS plans, all participating countries reported availability of these services at different levels of health care in their responses to other questions of the assessment. A detailed discussion of this issue is included in Section 5 of this report.



- Did report developing a continuity of essential health services plan in the context of COVID-19
- Did not report developing a continuity of essential health services plan in the context of COVID-19
- Countries that did not include rehabilitation and assistive technology as part of their COVID-19 essential health services continuity plan
- Countries that include rehabilitation and assistive technology as part of their COVID-19 essential health services continuity plan

Fig. 2. Number of countries that reported disability considerations in COVID-19 EHS planning

The nine EHS continuity plans that include rehabilitation and AT consider persons with disabilities among the vulnerable groups to COVID-19, in whichever setting they are in, such as at home and in institutions, prisons, public places, informal areas and poor communities, as well as among the homeless. Five of these countries shared copies of their EHS plans or guidance with WHO. The scope of services of these plans varied across the different levels of health care and is further discussed in Section 3.3 of this report.

Of the nine countries reporting inclusion of rehabilitation and AT, three countries reported continuity plans that address different elements of rehabilitation and AT service in terms of the types of service provided, follow up of delivered services, capacity of service providers and the availability of essential assistive products and supplies. Reported alternative modes of service delivery are further discussed in Section 3.3.2 and in the discussion section of this report.

The structure of the nine plans that include rehabilitation and AT range from a group of separate actionable interventions (as reported by most countries) to an integrated structure linked to the country's health system with considerable consideration of rehabilitation and AT (as reported by two countries).

3.1.3 Consultation with persons with disabilities

Only five countries reported that consultations with persons with disability, their caregivers, families, or representatives took place in developing and implementing disability-inclusive plans as part of the COVID-19 health response.

The range and scope of consultation varied among different countries and was reported to be pursued through different modalities, as described below.

In one country, a needs assessment survey was conducted prior to planning the COVID-19 health response. The survey aimed to: identify strategies for inclusion; study the accessibility of information, health services and facilities for persons with disabilities; and, define the role of OPDs in the health response. Respondents comprised persons with different disabilities and relevant stakeholders. Results included current challenges and the impact of COVID-19 on health care services, caregivers and rehabilitation activities, as well as on persons with disabilities, as reflected by them. Based on the findings, a set of recommendations was formulated which included liaising closely with the country health authority on necessary guidelines, arranging accessible handwashing facilities at the residences of persons with disabilities, providing cost-free services for COVID-19 and answering existing medical needs. It is essential to follow up on these recommendations and monitor their implementation, given that they reflect the voice of persons with disabilities.

In another country, persons with disabilities were consulted and engaged in developing the health response to COVID-19, together with their families. The consultations focused on the implementation of restrictive COVID-19 regulations, while OPDs were consulted on developing a disability knowledge centre via an online platform to support persons with disabilities during the pandemic. One country reported consulting with persons with disabilities over the development of ministry of health decrees for continuity of rehabilitation services.

Another country reported having a stakeholder engagement plan for the country health response to COVID-19, under which persons with disabilities were included among targeted vulnerable groups. The plan was reported to be developed in line with environmental and social standards and outlines different ways in which the emergency response plan team should communicate with related stakeholders to engage them in planning and implementation. Although the reported stakeholder engagement plan reflects a disability-inclusive approach, no information was available on the implementation of its recommendations in the health response to COVID-19.

3.1.4 Stakeholders involved in planning

In addition to the ministry of health, multiple national and international bodies participated in the development of country COVID-19 health response and continuity of EHS plans. These included non-health ministries in three countries, national councils for disability in three countries, national nongovernmental organizations in six countries, and international organizations in four countries. In six countries, national taskforces for COVID-19 were reported to be formed and contributed to the development of the country health response to COVID-19. Results show that at least two of the six taskforces included among their members representation of persons with disabilities or organizations overseeing disability issues in the country. One country also reported the presence of a focal person in every ministry to liaise with the national disability body and ensure an immediate response to address any issues or requirements of persons with disabilities, including during the pandemic.

3.2 Information and communication

3.2.1 Data on disability among people with COVID-19

Only three countries reported some degree of collecting data on disability within their surveillance and testing strategy for persons with COVID-19, as seen in Fig. 3.

Two of the three countries indicated that data is collected both inside and outside institutions or care homes. In one of these two countries, data was disaggregated by gender, broad age groups (adult and child) and type of services provided. This country reported that a comprehensive checklist is used when persons with disabilities attend a COVID-19 care service point, which collects information on the type of disability and the degree of severity, assistive devices used, mode of communication with the person and level of independence in daily activities, as well as information on family members or supporting organizations who could be contacted if needed. Nevertheless, the data shared by this country did not define the percentage of persons with disabilities among COVID-19 patients. The second country did not share further information on the data, its sources, or the variables collected.

Disability data in the third country is reported to be collected only by a UN agency involved in health care delivery through phone calls by social workers with persons with disabilities and their families that they serve, with no national representation.

The results also show that five of the 15 participating countries that reported not collecting data also reported that national disability councils and organizations had provided recommendations to ministries of health on the need to collect data on disability among COVID-19 suspected persons. No further details on whether these recommendations were taken up were available.

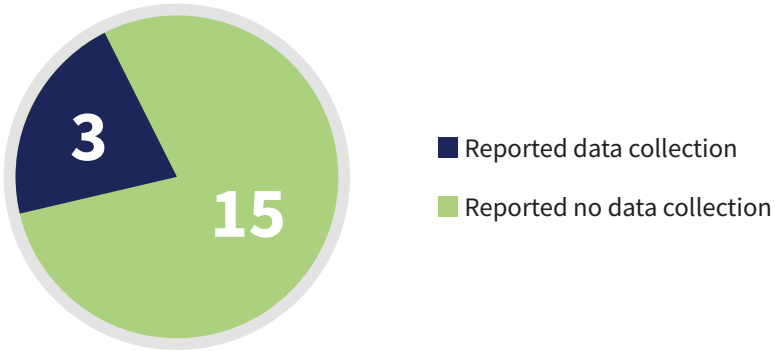


Fig. 3. Number of countries that reported collection of disability-data among COVID-19 cases

3.2.2 Accessibility of COVID-19 information and communication materials

Fourteen countries reported dissemination of COVID-19 information that is accessible to persons with disabilities. Of those, only 12 countries shared examples of the developed materials, as seen in Fig. 4.

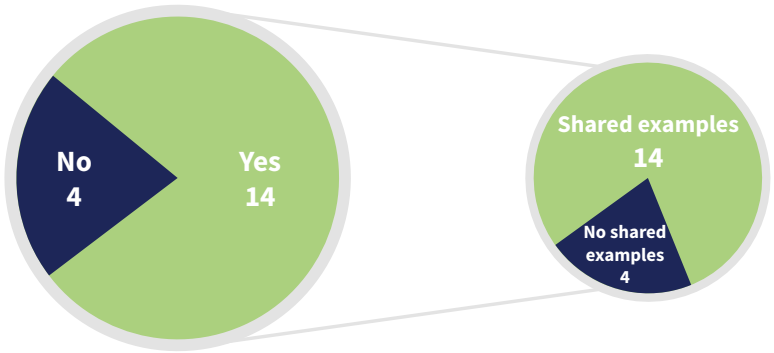


Fig. 4. Number of countries that reported availability of disability-accessible COVID-19 information and communication materials and countries that shared examples of those materials with WHO

The reported communication modes included awareness campaigns through public media (television, radio and newspapers), posters, leaflets, information signs and screens, hotlines, smart phones apps, webpages, videos on social media for persons with different types of disability, and teleconferences, virtual meetings and webinars for disability service providers. Links to a wide range of COVID-19 information targeting persons with different disabilities, in accessible formats and downloadable from platforms, were provided by several participating countries. Also, several countries cited plans for digital dissemination of COVID-19 awareness materials to increase coverage.

As reported by countries, and evident from the shared examples, sign language was the most dominant accessible format used to develop COVID-19 materials, with little consideration given to other formats.

All 12 countries that shared examples included messages on infection control and hygiene precautions in their information and communication materials. Other issues covered were on the nature and modes of spread of the virus; updated statistics on COVID-19; preventive measures such as hand washing and safe and proper mask etiquette; and proper use and disinfection of different assistive products. The materials also provided information on seeking medical advice, psychological support and available social and financial aids for persons with disabilities.

Of the 12 countries, two countries developed and shared materials with instructions on proper AT care; one country developed guidance on self-rehabilitation exercises; and one country developed videos that offered remote guidance for children with autism, cerebral palsy and intellectual difficulties.

The accessible information and communication materials were reported to target persons with disabilities, their families and caregivers, as well as service providers. Among the shared materials were videos developed by two countries in which persons with disabilities themselves presented COVID-19 awareness messages.

Civil society organizations and international partners were reported to have made significant contributions to the development and dissemination of the materials in seven of the 12 countries that shared related examples. In the remaining five countries, materials were reported to have been developed by governmental or official bodies, such as the ministry of health or the ministry of social affairs.

3.3 Service delivery

3.3.1 Disability-inclusive COVID-19 services

All 18 participating countries reported the availability of disability-inclusive COVID-19 services at different levels of health care.

Reported scope of disability-inclusive COVID-19 services

Responses show a diverse scope of disability-inclusive COVID-19 services provided across different levels of health care with variations among participating countries, as seen in Table 2. In some country responses, differentiation between the community and primary levels of care was not easily defined, and thus, no clear differentiation was reported on the services delivered at each of these levels. Moreover, in some cases, it was not clear if the reported services referred to those available to the general population, including persons with disabilities, or whether they specifically refer to services targeting and accessible to persons with disabilities.

Table 2. Collective reported scope of disability-inclusive COVID-19 services across the different health care levels

Health care level	Disability- inclusive COVID-19 services reported
Community level	Health awareness and education, hygiene services, COVID-19 personal protective equipment, home isolation for suspected cases, home visits for home isolated cases, and stress management and psychosocial support
Primary level	Health kits and material for sterilization, triage of COVID-19-suspected cases and case-finding, required medication supply, and isolation of suspected/diagnosed cases at certain health facilities or in refugee camps
Secondary level	COVID-19 PCR testing, other specialized COVID-19 investigations and quarantine services
Tertiary level	Intensive care unit admissions

Three countries indicated the availability of disability-inclusive referral mechanisms operating across the different levels of the health system according to type of care needed.[1] However, no further information was provided on how these referral mechanisms were made accessible to persons with disabilities or adapted to meet their needs.

Stress management and psychosocial support were also reported by six countries as one of the disability-inclusive COVID-19 health services provided to deal with stress posed by the pandemic. The reported scope of such services includes basic support services for persons with disabilities, families, and persons susceptible to violence during the period of lockdown. It also includes specific psychosocial support programmes for people with mental distress offered through home visits and referral services using telephone consultation. Countries that reported these services added that they were part of the COVID-19 information and psychological assistance for the general population, which includes persons with disabilities and have been adapted to their needs. Reported adaptations to these services include information presented in sign language to address challenges related to COVID-19, and guidance on stress management for parents with children with cognitive disorders.

Remote COVID-19 services

Twelve countries reported delivering disability-inclusive remote services for COVID-19 in the form of phone consultations, mobile medical units to deliver services at the community and primary levels and by using telemedicine to cope with the social distancing and lockdown imposed by the pandemic, as shown in Fig. 5.

Providers of disability-inclusive COVID-19 services

While the ministry of health is the only provider of COVID-19 services in six of the participating countries, multiple providers are involved in offering these services in the other 12 countries, as seen in Fig. 6. The reported additional service providers that contribute to delivery of COVID-19 services at all levels of health care include ministries of social affairs and/or other government bodies, national disability councils, nongovernmental organizations (local and international) and the private sector.

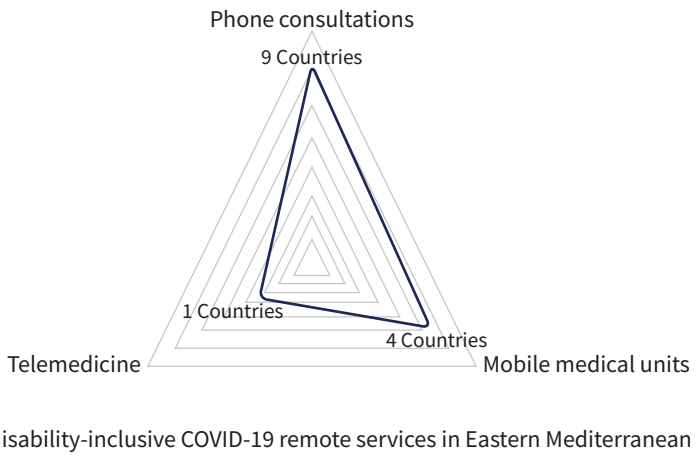


Fig. 5. Reported disability-inclusive COVID-19 remote services in countries of the Eastern Mediterranean Region

[1] It is important to note that other countries might also have their own referral pathways that were not reported in the current assessment.

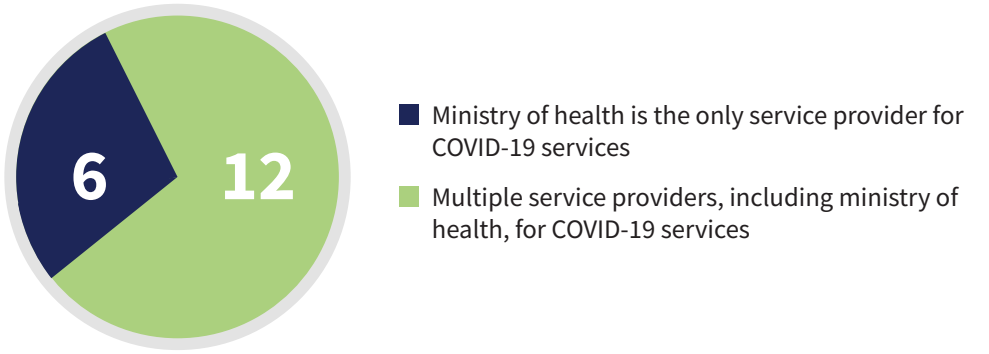


Fig. 6. Disability-inclusive COVID-19 service providers in countries of the Eastern Mediterranean Region

The reported scope of disability-inclusive COVID-19 services provided by non-health service providers includes awareness raising, PPE distribution to institutions and households, home visits for surveillance and material distribution. Public campaigning for disinfection and establishing referral mechanisms with the ministry of health to refer persons with disabilities residing in social care institutions requiring secondary health care were also reported.up were available.

Accessibility of COVID-19 facilities and services

Fourteen countries reported varying degrees of the extent of accessibility of health care facilities managing COVID-19 for persons with disabilities. Fig. 7 shows the number of participating countries that reported accessibility rates for their health facilities managing COVID-19.

Overall, ministries of health in 10 of the 18 participating countries reported that over 50% of health care services and facilities managing COVID-19 are accessible to persons with disabilities. In countries where respondents represented health and non-health sectors, reporting on accessibility of services and facilities was aligned.

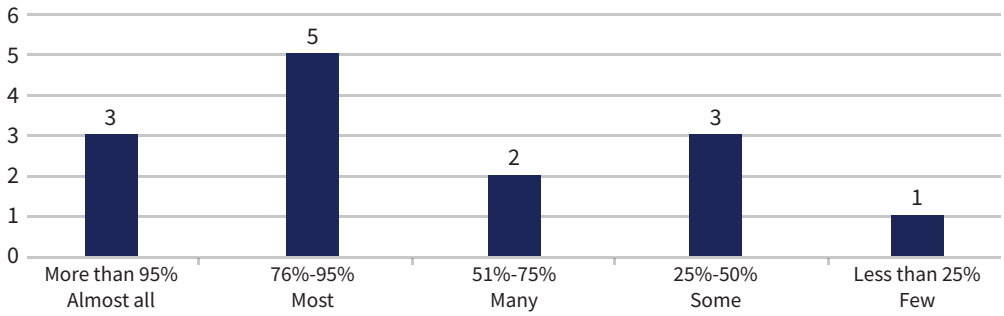


Fig. 7. Number of countries reporting on rates of easily accessible health care facilities managing COVID-19

In terms of adaptation of health facilities, five countries only mentioned the application of accessibility features related to physical/infrastructure barriers that hamper access of persons with physical and mobility impairments to health facilities managing COVID-19. Three of these five countries reported details about interventions to improve accessibility of health facilities, and implementation of construction codes that considered the needs of persons with disabilities in newly-built health facilities before the advent of the COVID-19 pandemic.

Moreover, four countries reported conducting training activities related to disability in the context of the pandemic, such as training for OPDs at district levels to advocate for disability-inclusive responses to COVID-19, trainings on etiquette for communication with persons with disabilities, training healthcare providers on communication with persons with disabilities, and training-of-trainers for medical personnel on sign language planned.

3.3.2 Rehabilitation and AT services

All participating countries reported continuation of rehabilitation and AT despite the challenges posed by the COVID-19 pandemic.

Scope of rehabilitation and AT services

Rehabilitation and AT services were reported to be available at different levels of care – at community, primary, secondary and tertiary levels – as seen in Table 3.

Table 3. Reported collective scope of rehabilitation and AT services across the different health care levels in the Eastern Mediterranean Regions

Health care level	Services reported
Community level	Community awareness, preventive measures at rehabilitation and prostheses centres applicable to service users and service providers, home provision of assistive products
Primary level	Provision of mobility products, individual rehabilitation sessions, basic assessment and referral provided by physiotherapists, home-based services for children, training for OPDs to advocate for disability-inclusive responses to COVID-19, training of health care workers, government officials, service providers and OPDs on the rights of persons with disabilities
Secondary level	Provision of artificial limbs and physical rehabilitation
Tertiary level	Cochlear implant surgeries, physical rehabilitation services at technical orthopaedic centres such as prostheses, orthotic devices, walking aid devices, sticks and wheelchairs

The reported scope of services for rehabilitation and AT provided across different health care levels varied across participating countries.

Nevertheless, all participating countries reported either discontinuation or disruption of in-person and face-to-face rehabilitation services due to COVID-19 lockdown measures in the early phases of the pandemic.

Sixteen of the 18 participating countries reported that rehabilitation and AT services are provided at the community and/or primary levels. Similar to COVID-19 services, some country responses did not reflect a clear differentiation between the community and primary levels in terms of the scope of services delivered at each of them.

Physiotherapy and physical rehabilitation were the most frequently reported rehabilitation services by 15 countries. Only one country reported addressing the key components of rehabilitation services in their delivered services, which included diversity in types of services, follow-up and monitoring of delivered services, capacity of the workforce delivering the services, and availability of essential assistive products.

Adaptations of rehabilitation and AT services

Similar to the approach mentioned for COVID-19 services, eight countries reported adjusting the mode of delivery of rehabilitation services to cope with service restrictions. Alternative modes of service delivery included:

- service follow-up by phone with families and caregivers;
- home delivery of the needed assistive products;
- telemedicine consultations for speech and auditory therapy for children with auditory impairments;
- online rehabilitation programmes;
- establishing an autism e-learning platform; and
- developing instructive videos by specialists and experts to inform families and caregivers of the required care during lockdowns.

Another alternative approach reported by one country was the provision of rehabilitation at the community level through the utilization of committees for community-based rehabilitation (CBR) in partnership with civil society organizations and local committees.

Providers of rehabilitation and AT services

Services for rehabilitation and AT are reported to be provided mainly by the ministry of health in all participating countries. While the ministry of health is the only provider of rehabilitation and AT services in six of the participating countries, multiple providers are involved in offering these services in the other twelve countries, as seen in Fig. 8.

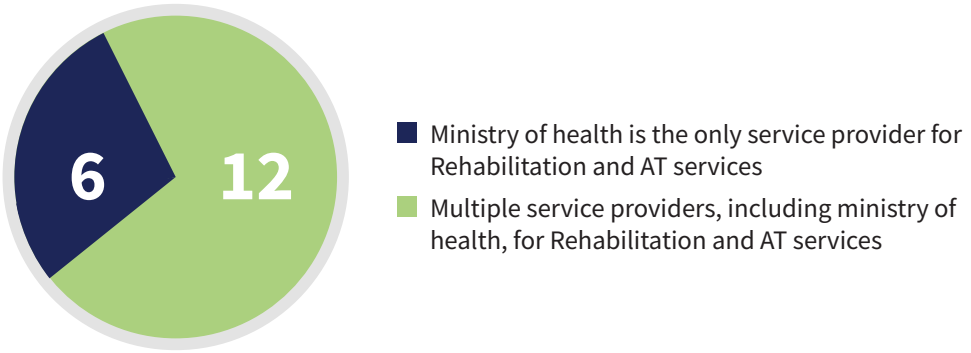


Fig. 8. Reported rehabilitation and AT service providers in countries of the Eastern Mediterranean Region

3.4 Financing

Table 4 shows an overview of the responses received on the availability and sources of earmarked funds to ensure continuity of disability-inclusive health services, especially for rehabilitation, AT and personal assistants, during the pandemic.

Table 4. Number of countries of the Eastern Mediterranean Region that reported financial support for continuity of disability inclusive health services, especially rehabilitation and AT

Financial support for continuity of services	Number of countries (n = 18)
Reported availability of earmarked fund	10
• Source: one government entity	3
• Source: multiple government entities	4
• Source: multiple governmental entity and international bodies	1
• Source: international bodies	2
Undefined responses with discrepancy among responding entities	2
Not available	6

3.4.1 Earmarked funds

More than half of the participating countries reported the availability of earmarked funds to ensure continuity of rehabilitation, AT and personal assistant services during the pandemic. The six participating countries that reported no earmarked funding indicated that rehabilitation and AT service delivery was maintained through budget allocation prior to the pandemic.

3.4.2 Sources of funds

Reported government financing sources included the ministry of health, ministry of social affairs, ministry of labour, disability councils and Islamic Zakat funds. International sources included different entities such as UN agencies, international nongovernmental organizations, and regional and international donor bodies.

3.4.3 Channelling of funds

A total of 10 countries reported having earmarked funding, of which only five reported details on how these funds were allocated and assigned.

The five countries reported using funds for essential medical equipment, PPE and sanitizers for day care and nursing home centres. They also reported using funds for: supporting prosthetic rehabilitation and physiotherapy centres; expanding coverage of rehabilitation and AT services to address the needs of persons with all types of disabilities; and distributing assistive products at home during the pandemic. In some countries, government funds were allocated to support persons who lost their jobs or had to stop working during the pandemic, with prioritization of persons with disabilities, given their higher vulnerability to financial hardship from COVID-19. One country reported using the funds to pay for care offered to persons with disabilities and elderly persons during the pandemic.

4. Country reflections

4.1 Country suggestions to reduce the impact/risk of COVID-19 on persons with disabilities

A total of 81 suggestions were received from respondents from participating countries on possible actions to reduce the impact/risk of COVID-19 on persons with disabilities (see Annex 3 for details). These suggestions were grouped under five thematic areas: planning, governance and financing; data and research; service delivery; awareness and communication; and prevention (see Fig. 9).

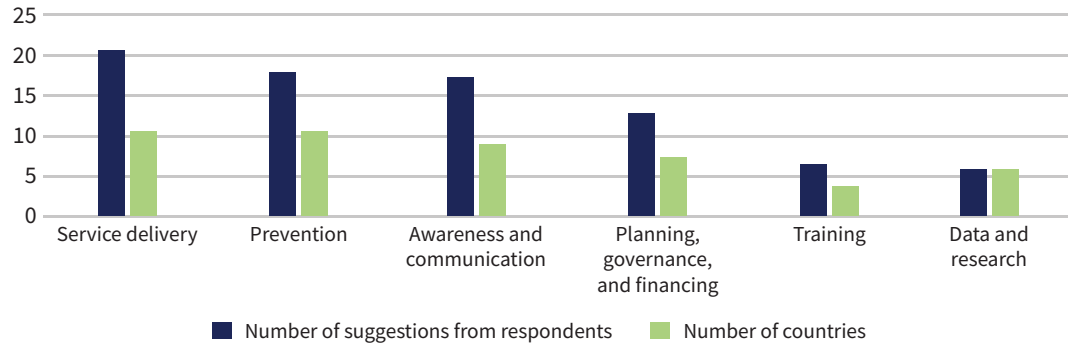


Fig. 9. Number of received suggestions to reduce the impact/risk of COVID-19 on persons with disabilities

Countries recognized the need for improved service delivery and heightened awareness on disability inclusion, as indicated by the number of suggestions made in these areas. However, despite the gap in disability data, few suggestions called for better data collection, reflecting a need for greater advocacy on this issue.

A summary of the suggestions received is as follows.

- Service delivery was the theme of the highest number of suggestions, while training, data and research received the lowest number. This underscores the necessity of continuing COVID-19, rehabilitation and AT services. To overcome service limitations, mobile units and activation of CBR interventions were the modalities specifically mentioned.

- Seventeen suggestions provided by eight countries related to COVID-19 awareness and communication. Of these, five referred to the concept of inclusive (adapted) awareness, while six focused on the need for COVID-19 information in accessible formats.

- Six suggestions provided by five countries underlined the need for further involvement of persons with disabilities in planning and implementation of the COVID-19 health response.

- Three suggestions from three different countries called for research to assess the impact of COVID-19 on persons with disabilities.

4.2 Country requests to WHO

A total of 58 requests pertaining to tools, guidance and needed support from WHO were received from participating countries (details are provided in Annex 4).

The requests addressed nine categories which were later grouped under seven thematic areas for ease of reporting – technical guidelines and protocols, awareness and communication, service delivery for rehabilitation and AT, training of health personnel in disability services, COVID-19 health response planning, data and research, and financial support (Fig. 10).

The most requested area of support was for technical guidelines and protocols, and financial support the least. There were requests for guidance on inclusive health services, AT, accessibility for different types of impairments, adaptation of rehabilitation services, development of inclusive information and communication, accessibility codes for health facilities, adaptation of the International Classification of Diseases (ICD) for disabilities, and service guidelines. The requested protocols include how to reach persons with disabilities in remote and rural areas and prevention of COVID-19 for persons with disabilities.

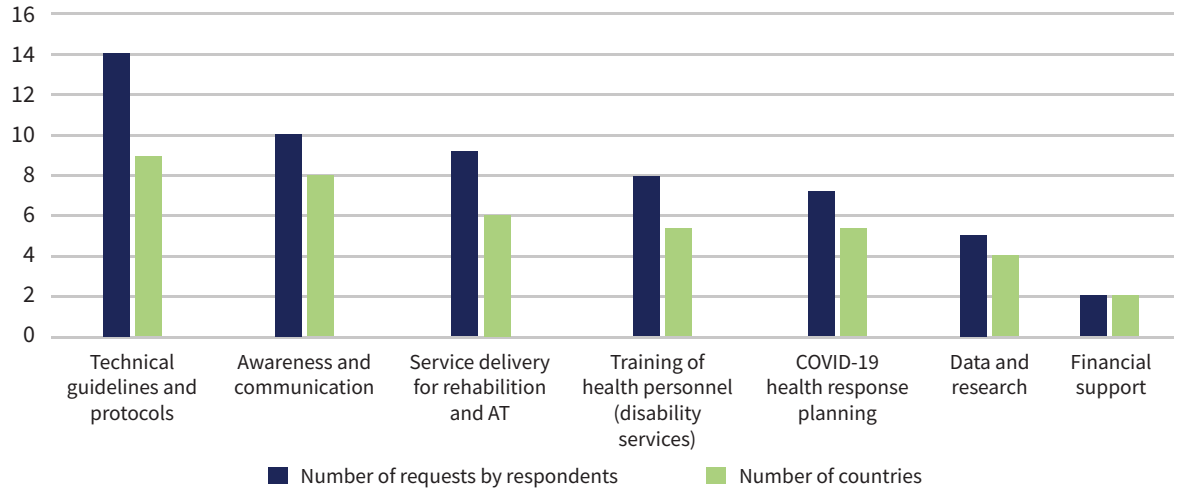


Fig. 10. Number of received country requests to WHO

5. Discussion

The assessment adopted a multifaceted approach to disability inclusion investigating the many different interrelated aspects of the COVID-19 health response. This approach is not only conducive to a more disability-inclusive COVID-19 health response but also to a more equitable and inclusive health system beyond the pandemic.

Governance and planning

Results from the governance and planning section (3.1) underline the inadequate and lack of explicit consideration of disability in the planning and implementation of national health responses to COVID-19 in the Region. Inclusion of persons with disabilities in the COVID-19 response needs to be deliberate and purposeful. If not explicitly included in initial planning, there is a risk that this vulnerable group will be overlooked in prevention and response measures, despite facing disproportionate risks from COVID-19 *(11)*. This would compromise the effectiveness of the overall response and subsequently, control of the pandemic *(1)*.

Many COVID-19 health response plans target vulnerable groups, which persons with disabilities could be included in, being a specific population highly vulnerable to COVID-19. Some of the plans are regularly updated and some were reported to have been developed or regularly reviewed based on the latest WHO guidance. Thus, including specific considerations for persons with disabilities in WHO COVID-19 guidance will be instrumental in promoting and asserting the importance of disability inclusiveness in country responses to the pandemic.

The inclusion of rehabilitation and AT services in EHS continuity plans during the COVID-19 pandemic is particularly important for persons with disabilities – they can compensate for an impairment or intrinsic capacity and improve functional capacity and autonomy, thus reducing the need for caregivers or assistance from others *(22)*. This is in line with WHO recommendations to develop and implement service continuity plans that reflect disability considerations during the COVID-19 outbreak *(4)*.

Multi-stakeholder engagement

Several countries reported having multi-stakeholder engagement in the development of country COVID-19 health response and continuity of EHS plans. Alongside the ministry of health, multiple national and international bodies have contributed to related national efforts. Implementing disability-inclusive health services – which requires careful planning, monitoring and evaluation – could be better achieved through a multisectoral approach and involvement of multiple partners in planning and implementation *(20)*.

Involving multiple partners in developing country plans provides opportunities to benefit from their diverse expertise, maximize existing resources and build on their different complementary roles to strengthen concerted action. This helps ensure that disability-inclusive approaches are adopted across different health-related services provided by various sectors *(20)*. Similarly, involving multiple providers in disability-inclusive COVID-19, rehabilitation or AT service delivery can offer additional resources to broaden the scope and coverage of services.

However, it is important to maintain effective coordination mechanisms among different providers – such as nongovernmental organizations or private health providers – to facilitate the delivery of comprehensive and integrated services. Also essential is governmental oversight and monitoring of services from different providers to avoid duplication of efforts and to ensure all services are of the appropriate standard.

The establishment of a COVID-19 national taskforce, which was reported by a few countries, can help to promote and coordinate disability-inclusive services and health responses to COVID-19 between providers, guided by the health sector, with the participation of persons with disability or their representatives.

Consultations with persons with disability

The findings show that consultation with persons with disability in the planning and implementation of the country health response to COVID-19 is extremely limited in the Region. Such engagement is important for a more disability-inclusive response and has been recognized in international norms and guidelines *(20)*.

Effective policy-making benefits from the consultation and participation of persons with disabilities and their representative organizations in all phases of planning and implementation, which allows for adjustments in planned actions. Yet persons with disabilities continue to be excluded from emergency planning and decision-making *(23)*.

The existence of national disability councils and local disability nongovernmental organizations can support the inclusion of disability perspectives towards a disability-inclusive health response to COVID-19. Engagement of civil society organizations, OPDs and international partners could also contribute to bringing diverse experiences and resources to strengthen the quality of disability-inclusive COVID-19, rehabilitation and AT services and to fill the coverage gap.

Disability data collection

A key finding of the assessment is that disability data collection within national COVID-19 profiles is very limited in the Region. Collecting disaggregated data on disability is vital in order to plan, understand and address the health needs of persons with disabilities, as well as to monitor and evaluate disability inclusion in health services *(4)*. The systematic collection and updating of data on COVID-19 disaggregated by age, sex and type of disability is crucial to assess the impact of the disease on persons with disabilities. Data can also be disaggregated in certain contexts by the person's capacity (degree of difficulty experienced by a health condition), performance (hardship experienced in areas such as mobility or household tasks), need for AT and environmental factors.

Disaggregation can confirm if some types of disability are of higher risk than others or if women or children face more disadvantages. Information on the pandemic's impact on persons with disabilities is also important to be able to monitor the implementation of interventions within the overall health response *(2,13,17,20)*.

Of the countries reporting disability data, gaps were reported in the collected variables or in the systemic collection of the data. Nevertheless, such data collection efforts represent a foundation that could be strengthened – in coverage, quality and reliability – to help inform planning for the COVID-19 health response.

Accessible information and communication materials

Although more than 75% of participating countries reported developing accessible COVID-19 information and communication materials for persons with disabilities, the examples shared of these materials showed that this was predominantly through sign language interpretation, and that the formats used and dissemination modalities were not inclusive of all types of disabilities.

Available literature shows that public information on COVID-19 measures is typically not systematically communicated nor disseminated in accessible formats and means to reach all persons with disabilities *(11)*. At a time when rumours, misconceptions and misinformation disseminated online can negatively impact the health-seeking behaviours of all the population, there is a heightened need for accurate information *(16)*. Otherwise, this could put persons with disabilities at higher risk of COVID-19 infection.

It is thus imperative that communication barriers be addressed and inclusive health information be provided to improve access to health for persons with disabilities *(20)*. Fully inclusive and accessible communication involves:

- converting existing information to incorporate disability considerations;
- a range of formats (Braille, easy-read text, large print and soundtracks) *(24)*; and
- a variety of communication platforms.

Disseminating information through online platforms can be prompt, interactive and cover wider target groups. However, access to online communication may be limited or interrupted in some communities.

Disability-inclusive services

All participating countries reported the availability of disability-inclusive COVID-19, rehabilitation and AT services to varying degrees, regardless of their inclusion in national COVID-19 health response plans or EHS plans. The existence of such services across different health care levels reflects country efforts to widen service coverage to reach the whole population, which includes persons with disabilities.

However, as no participatory audits that validate service accessibility and availability have been reported, the actual inclusivity of provided services to all types of disabilities should be validated through further research that takes into account the experience of persons with different disabilities utilizing these services.

Some of the responses received appeared to be reporting on the availability of COVID-19, rehabilitation and AT services for the whole population rather than the specific accessibility for persons with disabilities. This could be due to the perception of both concepts as synonymous, which they are not.

- *Availability* of services, while important, does not ensure persons with disabilities can easily access and utilize available services.
- *Accessibility* considers identification and elimination of obstacles and barriers to access, in relation to buildings, roads, transportation and indoor and outdoor facilities (including medical facilities), *as well as* information and other services (such as electronic and emergency services) *(1)*.

Barriers significantly challenging persons with disabilities need to be addressed to ensure services are fully accessible. Typical barriers include *(5)*:

- physical barriers – uneven pathways, stairs, hard-to-reach spaces or hard-to-use equipment;
- attitudinal barriers – social stigma and the denial of essential services;
- financial or policy-related barriers – high costs related to treatment or accessing the facility;
- information barriers – poor information dissemination on services to persons with disabilities and caregivers.

While country responses mentioned several efforts to address different barriers, none included information on addressing financial or policy-related barriers.

It is also important to ensure that COVID-19, rehabilitation and AT services are delivered at *all* levels of health care, especially at community and primary levels for persons with disabilities. Such services, provided close to people's homes, enables them to remain independent, reduces the risk of preventable complications and secondary conditions, and can help avoid costly hospitalizations *(25)*. In any well-functioning health system, health services should be *close* to the population, with a routine point of entry to the service network at primary level *(26)*.

Alternative service provision modalities

Alternative service provision modalities for COVID-19, rehabilitation and AT services were reported by several countries. While these alternative modes can compensate for face-to-face services for people with access to online communications, they could be a challenge for persons lacking access to such platforms or the capacity to do so.

One alternative service provision modality reported by countries was utilization of CBR, a strategy to complement and strengthen existing habilitation and rehabilitation service provision, particularly in countries where few services are available *(27)*. CBR could address the lack of trained professionals at community and primary levels, particularly during the pandemic. In many countries, rehabilitation professionals tend to remain located in urban areas *(25)*. To compensate, staff of primary health units and local nongovernmental organizations, health workers, person*s* with disabilities and their families could be provided with appropriate training packages *(27)*.

There is a need to plan context-specific and acceptable alternative modalities of service delivery to persons with disabilities wherever they are. Addressing communication barriers and providing inclusive health information suited to the local context are key to improving access to services for persons with disabilities *(20)*.

Earmarked funds

Government financing and budgetary support for rehabilitation and AT services is instrumental for strengthening the capacity to sustain these services within the national COVID-19 response and recovery plan and mitigate the impact of the pandemic on persons with disabilities *(1)*.

More than 50% of participating countries reported the availability of earmarked funds to ensure continuity of rehabilitation, AT and personal assistant services during the pandemic. The inclusion of persons with disabilities in the response and recovery phases of emergency situations, such as COVID-19, requires securing financing and allocating specific resources for accessibility and inclusion *(1,11,17)*. Removing financial barriers ensures that persons with disability can afford health care without the risk of extreme out-of-pocket and catastrophic expenditures *(28)*.

Several countries reported multiple sources for earmarked funds for continuity of rehabilitation, AT and personal assistant services during the pandemic. Having a bigger pool of resources presents an opportunity to sustain and scale up these services, as well as to expand their coverage to wider groups of persons with disabilities. Coordination among different funding sources and budget contributors through a common platform, taskforce or other mechanism is important in order to maximize the benefits of the available resources and deliver integrated cost-effective interventions *(20)*.

The challenge remains to ensure the allocation of adequate and disability-specific funding within the country response to COVID-19. Evidence shows that over half of all persons with disabilities in low-income countries cannot afford proper health care *(20)*. Inadequate or ill-defined financial support is a significant barrier for health services – it could lead to interruption or total cessation of EHS for rehabilitation and AT that are needed by persons with disabilities. Therefore, disability inclusion must be specifically budgeted for within health service budgets in health planning, especially in times of emergency, such as the COVID-19 pandemic *(20)*.

6. Conclusion

6.1 Key conclusions

This rapid assessment provides a picture of the status of disability inclusion in the COVID-19 health response in the Region during the period studied, identifying existing gaps and areas for priority intervention at both regional and national levels. This information could provide a basis for further and more detailed assessments in individual countries to inform the planning and development of disability-sensitive and inclusive health systems, which should be undertaken in consultation with persons with disabilities or OPDs to ensure those assessments truly reflect actual needs and realities on the ground.

To our knowledge, this rapid assessment was a unique exercise in the Region. It was undertaken as a first step in building a picture of disability inclusion within COVID-19 health responses in the Region at a time when persons with disabilities were facing severe challenges. From the aggregate analysis of data and information, some key conclusions can be made, bearing in mind the limitations of the survey.

- Disability is generally given neither enough nor explicit consideration within the COVID-19 health response in the Region, which has implications for equitable and universal access to COVID-19 health services.

- Data collection on disability within COVID-19 profiles is exceptional rather than routine. Despite the data gap, few suggestions from countries touched on data, reflecting a need for advocacy and guidance on the issue.

- Consultation with persons with disabilities is limited in planning and decision-making in regional COVID-19 health responses.

- Rehabilitation and AT services were considered in the national COVID-19 EHS continuity plans of only half the participating countries. Rehabilitation services were reported to be mostly focusing on physiotherapy and physical rehabilitation, with less consideration of other services that are equally essential for different types of impairment and need.

- Many countries report that disability-inclusive services are available, but the actual accessibility and inclusivity of the services for all types of disabilities needs validation through further research that considers the experiences of persons with disabilities.

- Accessible communication and information materials were reported to be available in more than 50% of respondent countries. However, they did not cover all types of disability nor were they developed systematically. Multiple partners were involved in planning and service delivery in some countries, which helps to broaden the scope of experiences and resources. Governmental coordination, oversight and monitoring of services is essential.

- Several countries reported multiple sources for earmarked funds, which presents an opportunity to scale up services for persons with disabilities. Given WHO's unique mandate as the global agency for setting standards on health, it is imperative to ensure that all WHO normative guidance is disability-sensitive and inclusive. This will encourage countries to adopt such approaches when designing inclusive national health systems and public health interventions to respond to emergencies such as the COVID-19 pandemic, which will help persons with disabilities enjoy the highest attainable standard of health.

6.2 Suggested way forward

Based on the gaps and requests reported and identified by the Member States that undertook the rapid assessment, the provisions of World Health Assembly resolution WHA74.8 on the highest attainable standard of health for persons with disabilities *(21)*, and UN and WHO normative guidance regarding considerations for persons with disabilities amidst the COVID-19 pandemic *(1,3)*, this report suggests the following for a more inclusive COVID-19 health response.

- Deliberately and purposefully include consideration of persons with disabilities in any future COVID-19 health plans, operational guidelines and protocols related to the pandemic response and recovery.

- Consider rehabilitation services and AT provision in country plans for continuity of EHS during emergencies, including appropriate adaptations to mitigate the COVID-19 risk posed by face-to-face service delivery.

- Address the challenges of service discontinuity and unavailability of caregivers, which might hinder persons with disabilities from accessing EHS on an equal basis with others during the COVID-19 pandemic.

- Establish and promote coordination among different stakeholders and service providers involved in the COVID-19 health response, and rehabilitation and AT service delivery, in order to address service gaps, extend service scope and coverage, ensure service sustainability and maximize benefits from available resources towards greater disability inclusiveness within the health response.

- Ensure consultation with persons with disabilities and OPDs in the planning and implementation phases of the COVID-19 health response to understand and consider their actual needs, perspectives and requirements at all stages of developing and/or updating health response plans.

- Collect data on disability disaggregated by parameters (such as age, gender, type and degree of difficulty, degree of dependence, type of assistance and/or services for rehabilitation and AT needed) within national data collected for COVID-19, to refine the profile obtained and assess the impact of the pandemic on persons with disabilities. Such assessments will better inform related disability-inclusive planning and the monitoring of the implementation of planned interventions. Disability data could be added to existing COVID-19 databases in countries, and the registration and surveillance forms could be adjusted to include disability data and variables.

- Ensure that health facilities and services are fully accessible to all persons with disabilities, taking into account the built environment and services, information and communication, modes of service delivery and the capacity of service providers to deliver services to persons with different disabilities. Assessment of the accessibility of health care should be verified through consultation with persons with all types of disabilities. National disability councils and local nongovernmental organizations could support the implementation of participatory audits within health facilities to identify all barriers that impact the accessibility of health services and recommend evidence-based actions to overcome them.

- Sustain and institutionalize the development of COVID-19 information and communication materials in different accessible formats such as Braille, "easy read", sign language, large print and soundtrack to address persons with different types of impairment and consider alternative modalities to deliver health information and communication to persons with disabilities in different settings. Addressing communication barriers and providing inclusive health information through alternative modalities are key to protecting persons with disabilities and improving their access to health services.

- Make optimal use of innovative alternative strategies and solutions (such as the use of tele- and digital health and remote services) to ensure the continued delivery of services for rehabilitation and AT for persons with disabilities during the pandemic and beyond, while taking into account different capacities and the contexts of where they live.

- Ensure that disability inclusion is specifically budgeted as an essential part of health planning and consider financing for sustaining rehabilitation and AT services. To avoid overwhelming available budgets during the pandemic, it may be helpful to consider evidence-based priority and essential interventions for rehabilitation and AT in consultation with persons with disabilities and OPDs.

Given WHO's unique mandate as the global agency for setting standards on health, it is imperative to ensure that all WHO normative guidance is disability-sensitive and inclusive. This will encourage countries to adopt such approaches when designing inclusive national health systems and public health interventions to respond to emergencies such as the COVID-19 pandemic, which will help persons with disabilities enjoy the highest attainable standard of health.

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Annexes

Annex 1. Questionnaire

Rapid assessment of the COVID-19 disability-inclusive health response in Eastern Mediterranean Region countries

Purpose

The purpose of this tool is to facilitate the rapid assessment of implications of COVID-19 pandemic on disability and related services, including rehabilitation and assistive technology (AT), in countries of the Eastern Mediterranean Region. The results of this assessment will inform the development of needed WHO guidance towards a disability-inclusive COVID-19 response and ensuring the continuity of rehabilitation and AT services, as well as identification of the needed disability inclusive measures for subsequent pandemics.

The rapid assessment seeks to:

- Understand the impact of COVID-19 on rehabilitation and AT services provision in a country;
- Identify whether countries are collecting disability data among COVID-19 patients and the inclusion of people with disability (PWD) in COVID-19 response; and
- Understand the country's expectations/tools and guidance from WHO on COVID-19 disability inclusive health response and recovery.

Instructions

This rapid assessment targets the disability focal person in the Ministry of Health (MOH) and National Disability Councils in Eastern Mediterranean Region countries.

The assessment tool consists of three sections as follows:

- Section A – Disability-inclusive COVID-19 response
- Section B – Essential health services continuity plan during COVID-19 pandemic
- Section C – Reflections and requests from the World Health Organization to support country plans.

Questions

INFORMATION PROVIDED BY:
Name:
Position:
Institution:
Country:
Email:
Telephone:

Date of completing this questionnaire: (dd/mm/yyyy)

SECTION A: DISABILITY-INCLUSIVE COVID-19 RESPONSE

1. Does the country have a specific plan to respond to the COVID-19 pandemic?
   - ☐ Yes. *If yes, please share relevant response documents*
   - ☐ No (skip to Question 3)
   - ☐ Do not know (skip to Question 3)

2. Does the plan include disability-specific sections/guidelines/protocols as part of the response to COVID-19?
   - ☐ Yes
   - ☐ No (skip to Question 3)
   - ☐ Do not know (skip to Question 3)

3. Is your country collecting information on disability among patients with COVID-19?
   - ☐ Yes. *If yes, please share resources*
   - ☐ No (skip to Question 4)
   - ☐ Do not know (skip to Question 4)

3.1 What is the percentage of people living with disability out of the total positive COVID-19 patients as reported by MOH?
   - ☐ Answer:
   - ☐ Don't know

3.2 Where were these reported cases:
   - ☐ Inside institutions or care homes
   - ☐ Outside institutions
   - ☐ Don't know

4. Are health services and facilities managing COVID-19 easily accessible for people with a disability?
   - ☐ Yes. *If yes, please share resources*
   - ☐ No (skip to Question 6)
   - ☐ Do not know (skip to Question 6)

5. What is the percentage of the health care facilities managing COVID-19 that are easily accessible to people living with a disability?
   - ☐ More than 95% – Almost all
   - ☐ 76–95% – Most
   - ☐ 51–75% – Many
   - ☐ 25–50% – Some
   - ☐ Less than 25% – Few

6. Are information and communication materials (including awareness campaigns) on COVID-19 measures and response accessible to people with a disability?
   - ☐ Yes. *If yes, please provide examples (share doc)*
   - ☐ No (skip to Question 7)
   - ☐ Do not know (skip to Question 7)

7. Are/were people with a disability, their caregivers, families or representatives consulted in developing and implementing plans in the COVID-19 disability-inclusive health response?
   - ☐ Yes. *If yes, please describe shortly:*
   - ☐ No (skip to Section B)
   - ☐ Do not know (skip to Section B)

SECTION B: ESSENTIAL HEALTH SERVICES CONTINUITY PLAN

8. Does the country have a specific plan/guidance on continuity of essential health services during COVID-19?
   - ☐ Yes. *If yes, please share doc*
   - ☐ No (skip to Question 10)
   - ☐ Do not know (skip to Question 10)

9. Does it include rehabilitation services and/or assistive technology (AT)?
   - ☐ Yes
   - ☐ No (skip to Question 10)
   - ☐ Do not know (skip to Question 10)

10. The following question asks about the disability-inclusive health response and recovery, including rehabilitation and assistive technology services provided during the COVID-19 pandemic by your country?

	Services provided?		By whom?		Further comments	
	COVID care	Rehab & AT	COVID care	Rehab & AT	COVID care	Rehab & AT
Community level						
Primary health care level						
Referral and secondary health facilities						
Tertiary health care level						

11. Is there financial support earmarked to ensure continuity of disability-inclusive health services, especially for rehabilitation, assistive technology and personal assistants during the epidemic?
    - ☐ Yes. *If yes, please specify the sources:*
    - ☐ No
    - ☐ Do not know

SECTION C: REFLECTIONS AND REQUESTS FROM WHO

12. What do you think should be done to reduce the impact/risk of COVID-19 on people with disabilities? To answer this question please consider the specific actions related only to people with disabilities (not the actions that are relevant for all people in the country).

13. What are the suggestions/requests from WHO in terms of tools/guidance and needed support?

Annex 2. Aggregated responses

Questions	Aggregate total	Description
SECTION A: DISABILITY-INCLUSIVE COVID-19 RESPONSE		
1. Does the country have a specific plan to respond to the COVID-19 pandemic?	18/18	Countries reported having a specific plan to respond to COVID-19 pandemic.
2. Does it include disability-specific section/guidelines/ protocols as part of the response to COVID-19?	4/18	Countries reported inclusion of disability-specific sections in the COVID-19 response plan.
3. Is your country collecting information on disability among patients with COVID-19?	3/18	Countries reported collection of information on disability among patients with COVID-19.
4. Are health services and facilities managing COVID-19 easily accessible for people with a disability?	14/18	Countries reported easy accessibility of COVID-19 managing facilities for people living with disabilities.
5. What is the percentage of the health care facilities managing COVID-19 that are easily accessible to people living with a disability?	Above 95%: 3 countries 76–95%: 5 countries 51–75%: 2 countries 25–50%: 3 countries Less than 25%: 1 country	4 countries reported that health facilities are not easily accessible and thus did not provide any definite percentage
6. Are information and communication materials (including awareness campaigns) on COVID-19 measures and response accessible to people with a disability?	14/18	Countries reported development of communication material on COVID-19 targeting and/or accessible to people living with disabilities.
7. Are/were people with a disability, their caregivers, families or representatives consulted in developing and implementing plans in the COVID-19 disability-inclusive health response?	5/18	Countries reported consulting with people with a disability, their caregivers, families or representatives in implementing plans for a COVID-19 disability-inclusive health response.

Questions	Aggregate total	Description
SECTION B: ESSENTIAL HEALTH SERVICES CONTINUITY PLAN		
8. Does the country have a specific plan/guidance on continuity of essential health services during COVID-19?	16/18	Countries reported having a specific plan or guidance on continuity of essential health services during the COVID-19 pandemic.
9. Does it include rehabilitation services and/or assistive technology (AT)?	9/16	Countries reported having an essential health services COVID-19 plan that includes rehabilitation and/or AT services.
10. The following question asks about the disability inclusive health response and recovery including rehabilitation and assistive technology services provided during the COVID-19 pandemic by your country	18/18 18/18	Countries reported availability of COVID-19 services at different levels of health care. Countries reported continuation of rehabilitation and AT services at different levels of health care.
11. Is there financial support earmarked to ensure continuity of disability-inclusive health services, especially for rehabilitation, assistive technology and personal assistants during the pandemic?	10/18	Countries reported financial support earmarked to ensure continuity of disability-inclusive health services.

Annex 3. Details of country suggestions to reduce the impact/risk of COVID-19 on people with disabilities

Field of suggestion	Total number of suggestions	Description and number of respondent suggestions	Number of countries
Service delivery	21	Rehabilitation and AT (10)	7 countries
		COVID-19 (9)	8 countries
		Psychological support (2)	1 country
Prevention	18	COVID-19 prevention, including 5 suggestions explicitly mentioning inclusive COVID-19 preventive measures (16)	12 countries
		Care for AP against spread of infection (2)	2 countries
Awareness	10	COVID-19 including 3 suggestions explicitly mentioned inclusive (adapted) awareness, and one suggestion targets OPDs (8)	6 countries
		Awareness campaign (1)	1 country
		Smart IT use in awareness (1)	1 country
Training	7	COVID-19 for persons with disability, their families and caregivers (4)	2 countries
		For home care (1), volunteers (1) and rehabilitation services (1)	2 countries
Planning	5	Consider disability in national health plans (4)	3 countries
		Include persons with disabilities among vulnerable groups (1)	1 country

Field of suggestion	Total number of suggestions	Description and number of respondent suggestions	Number of countries
Governance	6	Represent persons with disabilities in national councils, consult with OPDs, establish rights-based approach to COVID-19, develop protocols with ministry of social affairs, involve persons with disabilities in COVID-19 communication channels, set up disability-inclusive crisis management unit (6)	5 countries
Communication	7	Accessible formats (6) Special education (1)	6 countries 1 country
Disability data	3	Disability disaggregated data (2) Surveillance of COVID-19 among persons with disabilities (1)	3 countries
Research	3	Impact of COVID-19 on persons with disabilities (3)	3 countries
Financing	1	To support disability interventions in particular for persons with severe disabilities (1)	1 country

Annex 4. Details of country requests to WHO

Field of request	Frequency	Details	Countries
Technical guidelines and support (9 countries)	14	Guidelines and update on COVID-19 prevention	5 countries
		Guideline on covering persons with disabilities in remote areas	1 country
		Accessibility for all types of disability	1 country
		Unified referencing entity fo the assistive technology	1 country
		Inclusive essential health services	1 country
		Protocols to support committee responsible for COVID-19 response among persons with disabilities	1 country
		Protocols to adapt rehabilitation services	1 country
		Development of audio-visual material for persons with visual and hearing impairments	1 country
		Braille and easy to read posters for persons with visual impairment and mental difficulties	1 country
		Procurement of vaccines for people living with disabilities	1 country
Training (5 countries)	8	Approach and prevention of COVID-19 among persons with disabilities	3 countries
		Innovative technology	1 country
		Assistive technology	1 country
		Types of and care for disability	1 country
		Speech and occupational therapy	1 country
		Crisis situations	1 country

Field of request	Frequency	Details	Countries
Service delivery (6 countries)	9	Expansion of rehabilitation services at primary health care	1 country
		Establish tertiary rehabilitation centres	1 country
		Rehabilitation equipment	1 country
		Assistive products	1 country
		Home care service	1 country
		Consumable materials (masks, gloves, etc.)	1 country
		Disability-inclusive services	1 country
		Telemedicine and digital service	1 country
		Vaccination priority for persons with disabilities	1 country
Awareness (5 countries)	7	COVID-19 prevention	4 countries
		Importance of AT	1 country
		Importance of rehabilitation services	1 country
		Criteria for quarantine for persons with disabilities	1 country
Communication (5 countries)	6	COVID-19 materials	2 countries
		Case reports and stories	1 country
		Interregional experience exchange	1 country
		Disability-related update, continuous advice by WHO	1 country
Data on disability (4 countries)	4	Disability data collection	4 countries

Field of request	Frequency	Details	Countries
Planning for COVID-19 health response (5 countries)	7	Disability inclusive COVID-19 health response	2 countries
		Mobilization of resources	1 country
		National guidance, procurement of vaccines, for people living with disabilities	1 country
		System development	1 country
		Revival of community-based rehabilitation (CBR)	1 country
Financial support (2 countries)	2	Financial aid to countries to support disability interventions	2 countries
Research (11 countries)	11	To measure the awareness of the importance of rehabilitation services among medical personnel	11 country

World Health Organization

REGIONAL OFFICE FOR THE Eastern Mediterranean