The impact of the COVID-19 pandemic on disabled people in Low- and Middle-Income Countries: A literature review

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The impact of the COVID-19 pandemic on disabled people in Low- and Middle-Income Countries:
A literature review

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Contents

Acknowledgements

Glossary

- **COVID-19** – A new coronavirus disease caused by the virus SARS-CoV-2 first identified in December 2019 in China
- **DPO** – Disabled People's Organisations
- **EGM** – Evidence and Gap Map
- **LMICs** – Low and Middle-Income Countries (as defined by the Organisation for Economic Co-operation and Development)
- **ICT** – Information and Communication Technologies
- **LGBTQ** – Lesbian, Gay, Bisexual, Transgender, and Queer
- **NGO** – Non-Governmental Organisations
- **OECD** – Organisation for Economic Co-operation and Development
- **PPE** – Personal Protective Equipment
- **PTSD** – Post-Traumatic Stress Disorder
- **SRH** – Sexual and Reproductive Healthcare
- **UN** – United Nations
- **UNCPRD** – United Nations Conventions on the Rights of Persons with Disabilities
- **UNICEF** – United Nations International Children's Emergency Fund
- **WAI** – Web Accessibility Initiative
- **WHO** – World Health Organization

1. Executive Summary

1.1. Overview

This literature review examines the severe impact of the global COVID-19 pandemic on disabled people in Low- and Middle-Income Countries (LMICs), focussing on the sectors of Health, Education, Economy, and Community, as well considering the management of the pandemic generally. It highlights the significant discrimination disabled people have faced across all sectors of society: being deprioritised in healthcare, further excluded from education, facing significant poverty due to unemployment and a lack of social protection, and experiencing significant abuse and violence both in the community and in institutions. For many, these exclusions have been just as life-threatening as the pandemic. The report concludes that there is significant evidence that disabled people have been excluded and deprioritised from international and national government planning.

The literature review examined 113 texts consisting of 67 reports from non-governmental Organisations, UN agencies, governments, and Disabled People's Organisations, and 46 academic research papers, including 14 on the impact of previous disasters and pandemic on disabled people. Most of the literature identified focused on health and economy, while education was the least represented in the literature.

1.2. Findings

1.2.1. Health

- **Setting the scene:** Most LMICs have weak existing health infrastructure, which is often fragmented, disjointed, and not affordable
- Disabled people have been labelled as 'vulnerable' as a group based on their disability status, despite having differing levels of risk
- Disabled people face significant barriers to protection from COVID-19, including lack of access to hygiene and PPE, as a result of inaccessibility, poverty, and lack of guidance
- There has been significant discrimination in access to COVID-19 treatment, including inaccessible facilities and discriminatory triage protocols deprioritising disabled people
- Routine and emergency healthcare have been considerably interrupted, with disability-specific services classed as non-essential
- Health communications are not accessible, due to technology, language, and literacy barriers
- Language used in communications has 'othered' and dehumanised disabled people and added to psychological distress
- Mental health services have been disrupted, alongside a big rise in suicides and PTSD symptoms, exacerbated for disabled people by isolation, poverty, and fear of COVID-19

1.2.2. Education

- **Setting the scene:** Only half of disabled children were in school prior to COVID-19
- School closures in 188 countries disrupted both education and limited access to food programmes, hygiene facilities, safeguarding mechanisms, and healthcare and therapy

- Disabled children and their caregivers faced barriers to learning at home, including lack of knowledge and time among parents
- Access to technology and accessibility of technology were both significant barriers to remote learning
- There is a significant risk of many disabled children not returning to schools, and those who do face attainment gaps and potential further access barriers due to modifications in school

1.2.3. Economy

- **Setting the scene:** There is a strong link between disability and poverty, with only 1% of disabled people in LMICs having access to global protection
- The pandemic has caused a sharp increase in poverty, particularly food poverty, with many perceiving hunger as a bigger threat than COVID-19
- Social assistance measures were often short-term and not targeted at disabled people, sometimes actively excluding them, as well as being difficult to access
- Barriers to accessing relief included including lack of awareness and information, and inaccessibility of the claims process and distribution points
- Disabled people in informal or insecure work were particularly hard hit, due to lack of financial support and high unemployment, with remote working not an accessible option

1.2.4. Community

- **Setting the scene:** A lack of formal care support means support networks are often informal with care provided by family, friends, and the community
- Lockdowns and physical distancing measures led to disruption of care, increased isolation, and sometimes neglect and death
- Interruption of formal and informal care left disabled people unable to meet their essential needs or access assistive devices
- Significant evidence of neglect and human rights violations in institutions with an increased risk of infection and death, highlighting the urgent need for deinstitutionalisation
- Refugee camps, slums, prisons, and homeless people faced similar risks due to overcrowding, lack of hygiene facilities, and inhumane conditions
- Infrastructure barriers were heightened through lack of transport, an inaccessible built environment, and lack of access to information technology
- Access to essentials including food and medicine was interrupted
- A sharp increase in abuse, especially against disabled women and girls, including domestic and caregiver violence, police violence, and increased discrimination and stigma

1.2.5. Pandemic management

- **Setting the scene:** Previous literature has highlighted the importance of both considering and consulting disabled people in emergency and disaster planning
- Disabled people were not considered in most planning processes, and their needs de-prioritised, leading to systematic exclusion and a disproportionate negative impact
- There is considerable lack of data on disability and COVID-19, making it difficult to quantify or take action to mitigate this impact

1.3.   Conclusion

The literature review highlights the common themes emerging across all four sectors, in particular the deprioritisation and exclusion of disabled people, who have not been considered or involved in planning of measures taken to contain the COVID-19 pandemic. As a result, disabled people have faced a considerable increase in access barriers. The review also highlights that there is still a pervasive view of disability as primarily a 'medical' issue and that there is a need for a more holistic approach to disability based in the social model, which recognises the interconnections between different societal systems, as well as the wider geo-political contexts in which disability is produced. Furthermore, there is a worrying lack of data being collected at national and international levels on impacts on disabled people, both in terms of infection and mortality rates, and the impact on poverty, employment, education, and isolation in the community.

This literature has highlighted a number of evidence gaps where further research is required, including on the long-term effects of COVID-19 on health and healthcare systems, the prioritisation of disabled people in vaccination programmes, evidence on school returns and tertiary education, empirical data on poverty and employment, the experience of disabled people in institutions, prisons, and refugee camps, and research in the impact on access to religious worship and practices, leisure, culture, and sport.

This literature review makes the following five key recommendations:

1. Commissioning of further research into the gap areas identified in 9.2., with a particular focus on the long-term effects of COVID-19, vaccination processes, social protection available to disabled people, and collection of empirical data
2. Mapping of data currently being collected at national and international levels on disability COVID-19, who is collecting the data, and how it is used
3. Recognition and further research into the interconnectedness of different societal sectors and systems, and funding approaches aimed building long-term sustainable systems
4. Ongoing campaigns to de-stigmatise and de-medicalise disability and promote a social model, both in countries and in disability studies as a research field
5. Engagement of disabled people in contributing and leading on research, consultancy, and planning processes into a disability-inclusive recovery

2. Introduction

This literature review examines the impact of the global COVID-19 pandemic on disabled people in Low- and Middle-Income Countries (LMICs). The World Health Organization (WHO) declared the outbreak of COVID-19 a pandemic on 11 March 2020. At the time of writing in February 2021, over 2.3 million deaths from COVID-19 had been reported (Dong et al., 2020). Measures taken to contain the spread of the virus including lockdowns, closures of schools and workplaces, and pausing of healthcare services deemed non-essential, caused significant disruptions for people across the globe. This has led to the outbreak being described as a 'triple pandemic', being a health, psychological, and socioeconomic pandemic (UNDRR, 2020). However, for disabled people, this disruption was often heightened and the evidence compiled in this literature review suggests that the pandemic has exacerbated the marginalisation and exclusion of disabled people, including lower socioeconomic status, lower rates of employment, lower overall health status, and higher rates of poverty (Smith et al., 2020). Goggin (2020) highlights that while there were some cultural differences between countries, the majority of issues faced by disabled people were shared across the globe, highlighting in particular medical ableism, the cost of living, and the importance of communication. This literature review will highlight the specific issues faced by disabled people in general management of the pandemic by governments and specifically across the sectors of Health, Education, Economy, and Community, as described in emerging empirical literature, as well as in 'grey literature' including from governments, United Nations (UN) agencies, non-governmental organisations (NGOs), and Disabled People's Organisations (DPOs). It will also provide a critical view of the existing evidence from a critical disability studies perspective, and will indicate current gaps to inform further research and data-gathering.

2.1. Context

2.1.1. Disability in LMICs

It is estimated that 15% or one billion people globally are disabled, and that 80% of these live in developing countries (United Nations, 2020b). The UN Convention on the Rights of Persons with Disabilities (UNCRPD) defines disabled people as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (United Nations). Despite the ratification of the UNCRPD by 182 countries, most disabled people remain disadvantaged with many facing significant barriers around the built environment, health, education, employment, and poverty (Shakespeare, 2019). Persistent stigma against disabled people leads to some unable to identify or describe themselves as disabled (Berghs, 2015b), and for many disabled people, impairment is created or compounded by the endurance of conflict (Berghs, 2015b, Pineda and Corburn, 2020) or disasters (Battle, 2015). However, disasters and emergencies can sometimes act as a catalyst to drive forward progress in the aftermath (Pakjouei et al., 2020) and to 'build back better' (UNDRR, 2020).

2.1.2. Development interventions

Development programmes have often overlooked or ignored disability in initiatives (CBR Africa Network (CAN), 2020, Clugston and Spearing, 2020), with only 5% of direct overseas aid dedicated to disability programmes (Shakespeare, 2019). Some progress has been made since the inclusion of disability in the United Nations (UN) Sustainable Development Goals, after disability was completely absent in the preceding Millennium Development Goals (Shakespeare, 2019, Görgens and Ziervogel, 2018). However, as development funding is often limited, there is often a focus on 'quick fixes' over more complex long-term interventions (Shakespeare, 2019), leading to a fragmented approach with a lack of forward planning (Berghs, 2015a). Berghs (2015b) highlights that development initiatives can perpetuate disabling conditions, and advocates for an 'inside-out' approach to promote emancipation and rethinking of political and economic roles, as well as an 'outside-in' to understand the broader geopolitical influences that contribute to disablement in the Global South. This is replicated in research, where a meta-analysis of studies on development interventions found that research papers are unevenly distributed, with most being focused on health interventions and using a medical model of disability lens, and lack of studies in rights‑based approaches, livelihoods and empowerment (Saran et al., 2020).

2.1.3. Framing of disability

One aspects of disability being regarded as an individual medical problem to be fixed is the uncritical framing of disabled people as inherently 'vulnerable', without recognising the contributing factors that put disabled people more at risk during a disaster or emergency (Abbott and Porter, 2013, Görgens and Ziervogel, 2018). Even in academic literature, disabled people continue to be defined in terms of their deviation from 'normalcy' and their needs described as 'special' (Krishnan et al., 2020). As Abbott & Potter (2013) put it, "in an emergency, being special is not only not a good thing, it can actually be deadly". It is therefore crucial to recognise the factors that put disabled people at higher risk in an emergency or disaster situation, including poverty, accessibility of information, the design of the built environment and prejudicial, structural attitudes towards disabled people (Abbott and Porter, 2013), and particularly in the Global South, the colonial and post-colonial inequalities that lead to the causes of conflict and disablement (Berghs, 2015b).

3. Methods

3.1. Search strategy

The literature review used the principles of a systematic literature review to identify and analyse emerging evidence on disability and COVID-19 and other emergencies and disasters in LMICs, and particularly those countries. This involved mapping out of subthemes and associated search terms across the four sectors of Health, Education, Economy, and Community. Additional search terms related to previous pandemics, epidemics, or disasters. In order to identify relevant peer reviewed published literature, these search terms were combined using Boolean operators and searches were carried out across eight social science databases (Web of science (Core Collection), Ovid – Social Policy & Practice, ProQuest - Social Science Premium Collection, Science Direct – Public Health and The Lancet Public Health, EBSCO Education Databases, SCOPUS, Taylor & Francis Online, SSRN). This included both backwards and forwards citation searching to identify other relevant literature.

Grey literature reports from governments, UN agencies, NGOs, and DPOs were identified through a number of routes. Some were identified through citations in academic literature. In addition, searches were carried out using Google Scholar, the UN official document system, and Google searches by country domain to identify country-specific reports and guidance. In addition, searches were carried out to identify NGO and DPO websites where relevant reports had been published and collated. Searches were carried out between the period of 14 September 2020 to 14 October 2020. Search alerts were set up for the research databases to identify any new relevant reports emerging after the search, and these were added to the sample where they provided new or additional evidence.

3.2. Selection and coding

The initial search process produced 893 potentially relevant results, which were subjected to a light-touch review to select articles using the following criteria:

1) Focus was on disabled people, as defined by the UNCRPD, rather than caregivers/family members, and examining disability from a social science, rather than a medical, viewpoint
2) Disability was a major focus (ie 5 or more mentions of the words "disabled" or "disability")
3) Focus on disability in LMICs, or globally (papers focusing on situations specific to OECD countries were excluded)
4) Academic articles were original research or review articles (exclusion of comment/opinion pieces)
5) 'Grey literature' reported on actual data (rather than guidance or recommendations)

Following this selection process, 113 were selected for close review. Articles were reviewed in detail over a two-month period (October – December 2020). Notes were coded and grouped thematically to identify recurring issues and concerns across the four sections. As a number of articles focussed on the lack of consideration for disabled people in pandemic management generally, a short fifth

section discussing this was added to the existing four sections on Health, Education, Economy, and Community.

3.3. Distribution of literature

Out of the 113 articles reviewed, 99 articles related to COVID-19, with only 14 focussing on other disasters or emergencies. 'Grey' literature represented the majority of the literature reviewed with 67 out of 113 articles. Out of these 67, most were by NGOs (31) or UN-affiliated agencies (19). Other sources included DPOs and government agencies (6 articles each), financial organisations (2), and a not peer-reviewed academic report (1). The 46 academic texts included the 14 texts related to other emergencies, with 32 papers focussing on COVID-19.

Articles covered in the reviewed were published between March and November 2020. Most of the identified literature on COVID-19 emerged early during the pandemic, with almost two thirds (64%) published between March and June 2020. This is particularly the case for grey literature, whereas the publication of academic peer-reviewed literature was more evenly distributed across the 9 months of the review.

As most papers and reports covered multiple topics across the four sectors, up to three of the most prevalent subtopics of each paper were recorded. This indicates that topics are not evenly distributed, with healthcare being by far the most common theme (63 out of 113), followed by 54 on Economy, 38 on Community, and 18 on Education. 28 articles had a general focus, including on pandemic management and data collection.

4. Health

4.1.   Health introduction

This section discusses issues around disabled people's health and access to healthcare in the context of the COVID-19 pandemic, including disabled people's greater risk of infection and death, prevention and hygiene, access to treatment of COVID-19 and rationing protocols, the continuity of essential non-COVID-19 healthcare, the communication of public health messages by government and media, and the impact of the pandemic on mental health.

Existing healthcare infrastructure in the Global South is often poor, and this is particularly the case for countries recovering from conflict (Berghs, 2015a). Even prior to the pandemic, "the systematic misdistribution of power, money, and resources fuels social injustice causing millions of people worldwide to die prematurely" (Xafis, 2020). The financial burden of healthcare pushes many into poverty, with almost 50% of health care financing coming from out-of-pocket in low-income countries (Mills, 2014), particular those with low incomes (Orach, 2009). Due to lack of resources at governmental level, healthcare systems are often supported through private providers (Mills, 2014) or partnerships with voluntary organisations, religious organisations or NGOs (Berghs, 2015a, OECD, 2020). This can lead to a scattered and fragmented approach, with services being built up in silos and a lack of forward planning (Berghs, 2015a, OECD, 2020), in particular with regards to advance planning to ensure adequate provisions for disabled people (Campbell et al., 2009). As a result, there is often a disconnect between global health policy and the way it is implemented in local contexts (Berghs, 2015a). This fragmented approach also leads to healthcare services being considered in isolation rather being connected with initiatives in other sectors, including education, employment, transport, housing, and democracy-building (Berghs, 2015a). Several authors have emphasised the need for a multi-sectoral approach to public health (Qureshi and Scherer, 2020) and the importance of recognising interpendency and unity in the fight for good public health (Xafis, 2020).

The existing lack of infrastructure also leads to significant inequality, with marginalised groups likely to be excluded from access to healthcare, leading to poorer health outcomes (Xafis, 2020, Orach, 2009, Wagstaff et al., 2014, Marmot et al., 2008). While disabled people have more healthcare needs than non-disabled people, both standard needs and links to impairment, they are also more likely to have poor health (United Nations, 2020a). Hashemi et al. have tracked the barriers for disabled people in LMICs to accessing healthcare and found that this can be a very complex process influenced by multiple factors, including type and severity of impairment, as well as prejudice, stigma, and outdated beliefs held by doctors or family members, practical/logistical barriers in physical access to health facilities, and informational barriers with a lack knowledge or poor communicationon either the doctors and the disabled person's side, which can lead to misunderstandings and mistrust (Hashemi et al., 2020). There is still a strong tendency for disability issues to be linked to health (Berghs, 2015b), and international interventions and development programmes have tended to pathologize people and states as 'vulnerable' or 'weak' to justify the need for 'civilizing' control, rather than emancipatory actions (Berghs, 2015b). In addition, several scholars have pointed out that the inequalities experienced by disabled people may intersect with

other areas of oppression; for example mainstream organisations may replicate unequal structures such as racism (Guidry-Grimes et al., 2020). Research into healthcare following disasters also indicates that men are often prioritised and given preferential access to treatment over women (Gartrell et al., 2020, Hines, 2007, Irshad et al., 2012).

Healthcare emergencies and disasters are not only likely to exacerbate the issues of poor infrastructures and health inequalities, but also often create more disabled people with more immediate and long-term health care and rehabilitation needs (Benigno et al., 2015). Berghs discusses the aftermath of the Ebola crisis West Africa, where thousands of Ebola survivors have symptoms with undiagnosed causes of impairment, however the international focus has been on establishing stigma support groups, rather than addressing the long-term medical impact and psycho-social trauma of Ebola (Berghs, 2015a). In policy-focussed literature, Meaney-Davis (2020) also points out that "Disability inclusion appears not to have been prioritised by mainstream actors in the response to previous epidemics", and lessons learned from interventions are still limited.

4.2. Infection and mortality

4.2.1. Increased risk

While the focus of this literature review was on disability as a social phenomenon and articles from the medical field were excluded, there was nevertheless a recognition in both academic and 'grey' literature that disabled people are a greater risk of COVID-19, in terms of rates of infection, more serious complications, and greater risk of death., and that this risk is compounded by both health and social factors. Some impairments or associated health condition increase susceptibility to COVID-19 (Fund et al., 2020, Humanity & Inclusion, 2020c, Humanity & Inclusion, 2020b, Meaney-Davis et al., 2020, Rohwerder, 2020d, World Health Organization, 2020b). Social barriers faced by disabled people also include unequal access to treatment, lack of emergency planning and preparedness for the specific requirements of disabled people, poor health communications, or being unable to afford treatment. (Humanity & Inclusion, 2020b, United Nations ESCWA and World Health Organization, 2020, World Health Organization, 2020b). Some disabled people also face difficulties in taking appropriate protection measures, such as hygiene measures, wearing of personal protective equipment (PPE), or social distancing. (Senjam, 2020, World Health Organization, 2020b, Campbell et al., 2009) (Humanity & Inclusion, 2020b). Disabled people may be at greater risk due to working in high-risk professions, and Singh (2020) particularly highlights the risk faced by disabled healthcare providers. This risk is also gendered with women representing 70% of the global health and social sector workface leaving women, including disabled women, at greater risk (Pearce, 2020, Pregel and Le Fanu, 2020). There is a tendency within the reviewed literature to conflate all disability with a greater risk of COVID-19 without the recognition that not every disabled person will necessarily be more susceptible on grounds of their impairment. Nuance is therefore required to recognise the varying levels of risk faced by different groups of disabled people (United Nations, 2020b) to avoid perpetuating the stereotype of all disabled people as inherently 'vulnerable' or 'weak'. In many countries, efforts have been made to identify those most

at risk of contracting or becoming seriously ill with COVID-19, and asking them to 'shield' by self-isolating in their homes, however this is not always practically possible (McKinney et al., 2020).

4.3. Prevention and hygiene

4.3.1. Barriers to prevention

Following hygiene and advice to prevent infection and spread with COVID-19 presents particular challenges for disabled people, due to the increased need for touching either objects or other people. This presented a particular issue for users of mobility aids, which are frequently handled (Clugston and Spearing, 2020, Fund et al., 2020, Jalali et al., 2020, Qi and Wang, 2020). While the World Health Organization (2020b) recommends that these products are frequently disinfected, this may not always be possible as disabled people either lack the knowledge of how to clean their aids properly (International Disability Alliance, 2020b, International Disability Alliance, 2020s, Senjam, 2020), or do not have funds available to purchase cleaning products (McKinney et al., 2020). Blind people are also at increased risk due to their need to touch tactile surfaces to obtain information on their environment (Clugston and Spearing, 2020, Fund et al., 2020, Jalali et al., 2020, International Disability Alliance, 2020s, McKinney et al., 2020, Senjam, 2020). Disabled people with a variety of impairments may struggle to keep distance from others, due to the need for receiving care or assistance (Emirie et al., 2020, Fund et al., 2020, Guidry-Grimes et al., 2020, International Disability Alliance, 2020s, Nath and Gosling, 2020), or overcrowding in institutional settings and slums (Fund et al., 2020, McKinney et al., 2020, Sakellariou et al., 2020). The widespread of use of masks also presented a particular barrier for many deaf people who rely on lipreading to communicate (Goyal et al., 2020).

4.3.2. Access to PPE and hygiene facilities

Ensuring access to adequate hygiene and personal protective equipment (PPE) is particularly important for disabled people due to their higher susceptibility to the virus. However, due to the sudden increase demand and breakdown of national and international supply chains as a result of the pandemic (Poudel and Subedi, 2020, United Nations ESCAP, 2020), many countries experienced a scarcity of hygiene and PPE products. Several surveys report between 25% to 50% of disabled respondents having difficulty accessing cleaning and PPE equipment of having limited stock, with the majority between the 40-50% mark (Brennan et al., 2020, Humanity & Inclusion, 2020c, Huong, 2020, i2i, 2020, National Federation of the Disabled Nepal, 2020). This was exacerbated by people 'panic buying' and stockpiling resources (Qi and Wang, 2020). Lack of access to hygiene products was a particular issue in institutions (Brennan et al., 2020) and closed off communities (International Disability Alliance, 2020h). One report from a taxi driver working without adequate equipment also suggests that this was a particular issue for those in informal and customer-facing employment (International Disability Alliance, 2020n). In addition, poverty was a major barrier to purchasing adequate equipment where this was not provided by the authorities (Emirie et al., 2020, Gurung and Gahatraj, 2020), with many being forced to choose between economic survival and

protecting themselves adequately (Emirie et al., 2020). Water, sanitation, and hygiene (WASH) infrastructure is often poorly developed in LMICs, such as no running water in many homes or camps (Emirie et al., 2020, International Disability Alliance, 2020j, McKinney et al., 2020), and where these facilities are available, they are often inaccessible (Fund et al., 2020, Rohwerder, 2020c).

4.3.3. Prevention communication

Finally, adequate communications around proper hygiene techniques was a particular issue. As with general public health communications, information on how to prevent infection was often not specifically target at disabled people (International Disability Alliance, 2020b, Zayed et al., 2020) or delivered in different accessible formats and languages (Fund et al., 2020, International Disability Alliance, 2020j)). In Vietnam, only 3% of people in one survey had received relevant training on prevention and infection handwashing (Huong, 2020). Any training will also need to be adapted to address any barriers, for example handwashing and mask wearing techniques for those with limited hand mobility or visual function (McKinney et al., 2020, Senjam, 2020). Effective and targeted communication can also address attitudinal barriers to proper hygiene, for example some young people received bullying as a result of wearing masks in public (Emirie et al., 2020) and many disabled people continue to be stigmatised as 'dirty' and are therefore discriminated in access to WASH facilities.

4.4. Treatment and rationing

Being discriminated against or denied treatment for COVID-19 is a significant concern for many disabled people, both as a result of discriminatory standards of crisis care, and general inaccessibility of testing and treatment facilities. Disabled people are three times more likely to be denied health care (United Nations ESCWA and World Health Organization, 2020), and many may be fearful of hospitals due to past experiences of discrimination and make seek out alternative medicine such as faith-based or spiritual healing (Berghs, 2015a). The Disability Rights Monitor global survey conducted by multiple DPOs received over 550 written testimonies from around the world regarding access to healthcare detailing the barriers to equal access faced by many disabled people. 52% of respondents on a question of access to healthcare stated were denied or deprived of healthcare for COVID-19 during the pandemic (Brennan et al., 2020). This includes a report of an autistic child being denied a COVID-19 test for being "too difficult to assess" (Brennan et al., 2020). Participants in the Disability Rights Monitor as well as a survey by the World Blind Union both expressed high levels of fear of being denied treatment due to disability (Brennan et al., 2020, Zayed et al., 2020).

4.4.1. Triage protocols and healthcare rationing

The first major concern around discrimination in access to healthcare is around the introduction of rationing guidelines and triage protocols for treatment when healthcare providers are at capacity.

As in past pandemics, disabled people have been intentionally or inadvertently de-prioritised by these protocols in many countries, despite the fact that this contravenes both the UNCRPD and the World Medical Association's statement on medical ethics in the event of disasters (Meaney-Davis et al., 2020). This de-prioritisation is often based on assumptions that disabled lives are inherently less valuable and not worth living, which are rooted in the medical model of disability (Women Enabled International, 2020). These assumptions entail that disabled people have a poorer quality of life (Singh, 2020, Scully, 2020), as well as assumptions about the overall health status of disabled people and about their social utility (Scully, 2020). The latter is often equated with economic productivity, meaning disabled people are marginalised as they are assumed to be economically unproductive and therefore a burden to society (Scully, 2020). Due these disablist assumptions, as well as disability being framed as a medical issue rather than a social oppression, there remains a debate within academic and clinical circles around whether it is acceptable to use disability as a consideration factor in triage protocols (McKinney et al., 2020). McKinney et al. (2020) discuss in detail the South African COVID-19 triage policy, which highlights the problem of the conflation between disability and frailty, based on the principles of 'saving the most lives' and 'saving the most life years'. Like policies in other countries, such as the UK, it is based on the Clinical Frailty Scale used in geriatric medicine. This measures frailty based on the day-to-day assistance required by a person to complete everyday tasks. However, it is designed only for use with older people, and therefore does not take into account life expectancy or quality of life. This means a young, physically fit person with average life expectancy, who requires care due to a severe physical impairment or intellectual impairment could be classified as severely frail and therefore denied treatment under the protocol (McKinney et al., 2020). While the South African protocol was later amended to specifically exclude some types of 'stable' impairments from the Clinical Frailty Scale, there is still a concern that people with intellectual impairments, who face particularly high risk of discrimination, are not included, and that the exclusion of disabled people from the Clinical Frailty Scale may not necessarily be clear to those making decisions based on the guidelines (McKinney et al., 2020). Another international survey also found that 81% of respondents had identified either formal or informal healthcare rationing procedures in place in their countries, and fear of deprioritisation and discrimination was deterring many disabled women from seeking out treatment (Women Enabled International, 2020). Further, rationing and discrimination may not necessarily be enshrined in policy, but can occur at individual or hospital level due to negative attitudes, and conscious or unconscious biases held by healthcare workers (Pregel and Le Fanu, 2020). Involving disabled people in the development of crisis standards of care is therefore crucial in ensuring that protocols do not discriminate against disabled people (Guidry-Grimes et al., 2020, UNICEF, 2020a).

4.4.2. Access to treatment facilities

A second area of discrimination is around structural barriers to access both general and COVID-19-specific healthcare facilities. Multiple reports from grassroots DPOs reported about that treatment and quarantine centres built specifically for the care of COVID-19 patients were inaccessible by not providing the required facilities for disabled people (Disability Working Group, 2020, Gurung and

Gahatraj, 2020, National Federation of the Disabled Nepal, 2020), including a lack of accessible toilets and beds (Gurung and Gahatraj, 2020). In addition, disabled people infected with COVID-19 are often separated from their caregivers or personal assistants (Pearce, 2020), which can lead to their care needs not being met, as well as potentially leaving patients with communication impairments unable to communicate effectively healthcare staff (Guidry-Grimes et al., 2020). This is particularly concerning in cases where children are being separated from their parents or caregivers, due to either the child or one or both parents being infected with COVID-19, with reports that in China several children were put in complete isolation (Singh et al., 2020b). There may also be economic barriers to accessing healthcare, particularly for disabled people with no health insurance (International Disability Alliance, 2020q), as payments may be required out of pocket for some treatments (Manderson and Wahlberg, 2020). Some countries, including Argentina and Peru, took measured to ensure all COVID-19-related treatment is free of charge in (Sakellariou et al., 2020). Specific groups of disabled people are at particularly high risk of facing discrimination in healthcare. Children may present COVID-19 symptoms differently from adults and may therefore find it more difficult to access treatment, even though disabled children could fall into the 'high-risk' category isolation (Singh et al., 2020b, Waldman et al., 2020). In addition, in some cultural contexts men may be prioritised over women when becoming ill (Pearce, 2020), and the Arab Organization of Persons with Disabilities highlight that disabled women migrant workers in particular frequently experience barriers to accessing healthcare (2020).

4.5. Essential non-COVID-19 healthcare

4.5.1. Routine and emergency care

As countries around the globe focussed healthcare efforts on treating and containing COVID-19, this had a significant impact on the provision of all other routine and emergency healthcare services, with many services running at reduced capacity or being shut down completely. This mirrors the actions taken in previous pandemics and disasters to divert all available resources to deal with the current emergency, to the detriment of essential general (Berghs, 2015a) and disability-specific healthcare services (Benigno et al., 2015), even though the non-delivery of essential routine services such as vaccinations and screening can contribute to an increase in disability prevalence (Berghs, 2015a, Meaney-Davis et al., 2020). Disability-specific services were often classified as 'non-essential' and therefore ceased (Disability Working Group, 2020, Goyal et al., 2020, International Disability Alliance, 2020g, McKinney et al., 2020) or repurposed into a COVID-19 facility (International Disability Alliance, 2020n). This meant that many disabled people were not able to get their healthcare needs met, with figures of those who had unmet medical needs ranging from 19% to 70% in the literature reviewed (Brennan et al., 2020, CBR Africa Network (CAN), 2020, Starts of Hope Society for the Empowerment of Women with Disabilities, 2020, National Federation of the Disabled Nepal, 2020, Pham, 2020, Women Enabled International, 2020, Huong, 2020). Routine healthcare appointments and check-ups were cancelled or delayed (Gurung and Gahatraj, 2020, International Disability Alliance, 2020q, Jones et al., 2020, Women Enabled International, 2020), which has a disproportionate effect on disabled people (Pham, 2020). Specialist healthcare such as blood testing, physiotherapy, and scanning also became unavailable as resources were allocated to

COVID-19 treatment (Jalali et al., 2020, Jones et al., 2020, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, Starts of Hope Society for the Empowerment of Women with Disabilities, 2020, Women Enabled International, 2020).

4.5.2. Management of conditions

Many disabled people with conditions that require ongoing management face significant barriers to doing their "chronic homework" due to limited access to universal healthcare and access to pharmacies, particularly in rural locations. (Manderson and Wahlberg, 2020) The COVID-19 added to these barriers as many disabled people faced further barriers, including being unable to get to hospital due to a lack of transport (International Disability Alliance, 2020c) and services only being available in major cities, with rural locations closed (International Disability Alliance, 2020k, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, Thompson, 2020, Jalali et al., 2020), and this impacted particularly on indigenous populations (Rohwerder, 2020d) and disabled people living in informal settlements and camps (Thompson, 2020). In one survey of disabled people in Kenya and Bangladesh found that 39% and 44% respectively of those surveyed had experienced disability discrimination, including exclusion from vital services. (i2i, 2020). Examples of exclusion included sign language interpreters not being available or unwilling to attend hospital (Brennan et al., 2020, International Disability Alliance, 2020n), and young disabled people not being supported by family caregivers to access facilities due to stigma related to disability (Emirie et al., 2020). One positive example comes from Chile, where disabled people could obtain a special permit attend a doctor's appointment during lockdown with a companion (Sakellariou et al., 2020). In addition, many disabled people were also unable to access medication and other essential healthcare items, including hygiene materials (diapers, catheters, hand sanitizers, masks) mobility aids, respirators, and special food (ECLAC, 2020, Manderson and Wahlberg, 2020, Goyal et al., 2020, Hillgrove and Pryor, 2020, Human Rights Watch, 2020, Humanity & Inclusion, 2020a, Humanity & Inclusion, 2020c, International Disability Alliance, 2020h, International Disability Alliance, 2020q, International Disability Alliance, 2020r, National Federation of the Disabled Nepal, 2020, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, Women Enabled International, 2020). Being unable access essential care services left some disabled people unable to leave the house (International Disability Alliance, 2020r), relying on self-medication and reliance on home remedies (International Disability Alliance, 2020f, International Disability Alliance, 2020q), as well as putting disabled people at risk of further harm by exacerbating existing health and impairment-related complications (Castres and O'Reilly, 2020, Humanity & Inclusion, 2020a, Senjam, 2020, Thompson, 2020).

4.5.3. Sexual reproductive healthcare

The disruptions to sexual and reproductive healthcare (SRH) service had a negative impact particularly for disabled women, girls, and non-binary people. Disabled women generally face barriers to accessing these services, in part due to the assumption that they are asexual (Emirie et al., 2020). These barriers were exacerbated during the pandemic as SRH services became

inaccessible due to closure or a reduction in services (Emirie et al., 2020, International Disability Alliance, 2020k, Women Enabled International, 2020). Access to sanitary pads was a particular access to many disabled people who menstruate, as these were not included in 'essential' services (Goyal et al., 2020, Panda et al., 2020, Shrestha, 2020). Many were no longer to access these products independently and found it difficult to discuss their requirements with others, particularly male members of the family, due to stigma around menstruation (International Disability Alliance, 2020f). On the other hand, some pregnant people were prevented during labour from having companions present for emotional support, communicating with healthcare staff, and personal assistance (Women Enabled International, 2020). In one survey, non-binary people identified that they were struggling to access hormones; the same survey suggests that some countries across the world were using the pandemic as a cover to permanently scale back access to safe and legal abortion (Women Enabled International, 2020). The disruption to SRH and maternity care are likely to contribute to both an increase in both disability and death, particularly for women and infants (Castres and O'Reilly, 2020, Rohwerder, 2020d).

4.5.4. Remote health services

Some services moved to offering remote services using telecommunications technology, as recommended by the WHO (2020b). While this approach was useful in places with highly developed internet infrastructures such as Iran (Jalali et al., 2020), disabled people are disproportionally more likely to have reduced access to digital technology, as well as facing accessibility barriers in accessing some technologies (Pregel and Le Fanu, 2020, Women Enabled International, 2020). Some were also worries that remote appointments it would not be covered by insurance (Women Enabled International, 2020), or had concerns about privacy (Goyal et al., 2020). Telehealth appointments are not always an appropriate replacement for in-person assessment and treatment (Goyal et al., 2020, Pregel and Le Fanu, 2020), as exemplified by an example from Palestine where a patient felt he did not have to the skills to care for his wounds at home (Humanity & Inclusion, 2020a).There are also some positive examples of services being adapted for home delivery, such as home visits for physiotherapy (National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020), home testing services ((United Nations, 2020b) and the delivery of prescription medicines to local pharmacies (Qi and Wang, 2020).

4.6. Public health communications

4.6.1. Sources of information

Access to reliable, complete and up-to-date public health information is crucial for disabled people in ensuring that they are able to take preventative action to protect themselves from infection, as well as ensure they follow local emergency measures. Governments have a responsibility to ensure communication reaches everyone and is "equally effective to all audiences at all times" (Castres and O'Reilly, 2020). However, the sources from which disabled people receive information on COVID-19 are not homogenous, and may vary by a number of different factors, including by impairment.

Battle (2015) for example notes that persons with hearing and psychosocial impairments are much more likely to rely on family, friends and or neighbours than news organisations for information. This is also reflected in NGO and DPO reporting related to COVID-19, which suggests that there is a high reliance on information through informal networks such as friends and family (Hillgrove and Pryor, 2020, Shrestha, 2020). In addition, Disabled People's Organisation have emerged as major source of information for disabled and have taken on considerable responsibility of relaying COVID-19 to the disabled communities they serve (Ahmed et al., 2020, International Disability Alliance, 2020b) (International Disability Alliance, 2020f, Shrestha, 2020).

4.6.2. Inaccessible communications

Looking more closely at the barriers disabled people faced at explanation, these can be categorised into three main themes: inaccessible formats, technological barriers, and language/literacy-barriers. Accessible formats were described as "non-existent" in one personal account (Meaney-Davis et al., 2020), with a lack of measures to ensure radio, television, and websites where accessible to all, particularly to those with sensory impairments. The need for sign language interpretation was by far the most common requirement identified in reports (Arab Organization of Persons with Disabilities (AOPD), 2020, Castres and O'Reilly, 2020, Cahapay, 2020b, International Disability Alliance, 2020s, Singh, 2020, Disability Working Group, 2020). However, in a review of COVID-19 press conferences and press briefings for 123 LMICs Yap et al. (2020) found that only 64% of LMICs had a sign language interpretation available, and that none out of five major international organizations, including the WHO, provided sign language interpretation available during briefings and conferences. In addition, where sign language interpretation was provided, interpreters were not always adequately trained (International Disability Alliance, 2020b). However, not all deaf people understand sign, therefore captions are also crucial requirement to ensure information is accessible. (Castres and O'Reilly, 2020, International Disability Alliance, 2020g). Other barriers identified included a lack of Braille (CBR Africa Network (CAN), 2020, International Disability Alliance, 2020s), inaccessible helplines (National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, International Disability Alliance, 2020s), inaccessible tracking apps (Goyal et al., 2020), and a lack of recognition that touch is essential to communicate to some people, particular people with deafblindness (CBR Africa Network (CAN), 2020, Meaney-Davis et al., 2020). In addition, two studies examining web accessibility found that the WHO website was less than 50% accessible at double A-level of the Web Content Accessibility Guidelines 2.1 (Fernandez-Diaz et al., 2020), and, that the vast majority of health authority websites for 189 countries had significant accessibility errors, with only 4.7% having fully implemented the WAI accessibility guidelines (Dror et al., 2020).

4.6.3. Technological barriers

A lack of access to technology was another barrier that disproportionally affected disabled people in LMICs. This was a particular issue for people living in rural or remote locations, where people may have limited access to television and radio, and internet connections are unstable and expensive

(Humanity & Inclusion, 2020a, Brennan et al., 2020, Castres and O'Reilly, 2020, International Disability Alliance, 2020c, International Disability Alliance, 2020f, International Disability Alliance, 2020q, Rohwerder, 2020c). According to Singh (2020), around 70% of disabled people in the Global South live in rural areas. Many disabled people rely strongly on family networks, such as relatives from urban areas communicating information to their families in rural locations (Emirie et al., 2020), but where these networks were disrupted or disabled people did not have established networks, they often did not receive the information required (Humanity & Inclusion, 2020a), although in some cases. Further, where there was limited access to technology in households, disabled people as well as girls and women were more likely to be deprioritised in accessing these resources due to cultural and gender norms (Małachowska et al., 2020).

4.6.4. Language and literacy barriers

The third major barrier faced by disabled people accessing information was the issue of language and literacy. Disabled people are more likely to be illiterate or have limited reading ability (CBR Africa Network (CAN), 2020, International Disability Alliance, 2020f, International Disability Alliance, 2020m), which means written information was inaccessible to them, and the language used was problematic as some had issues understanding concepts such as 'quarantine' and 'social distancing' (Gurung and Gahatraj, 2020). In addition, official public health communications were often, and in particular affecting older women (United Nations ESCWA and World Health Organization, 2020). In addition, many public health communications were not translated into local minority languages, meaning it was not accessible to those who had a limited understanding of the main spoken language, and particular affecting indigenous, low caste, and ethnic minority communities (CBR Africa Network (CAN), 2020, Gurung and Gahatraj, 2020, International Disability Alliance, 2020m, International Disability Alliance, 2020k, Gahatraj, 2020).

4.6.5. Messages

Given these barriers, it is not surprising that results from multiple NGO surveys indicated that a considerable amount of disabled people feel they had not received sufficient information about the prevention of COVID-19, or that they did not fully understand the information. The percentage of these people ranged between 22% to 46% depending on the survey (Brennan et al., 2020, Humanity & Inclusion, 2020c, Light for the World, 2020, National Federation of the Disabled Nepal, 2020, Hillgrove and Pryor, 2020, Shrestha, 2020). One survey indicates that the amount of awareness held was inversely proportional to the severity of a person's impairment (National Federation of the Disabled Nepal, 2020).The lack of information was described as a considerable source of concern and anxiety for many people (Zayed et al., 2020, Goyal et al., 2020). Where disabled people were receiving information, this was often not complete, specific enough, or of poor quality. This means that disabled people were not necessarily aware of the full range of symptoms associated with COVID-19 (Shrestha, 2020), of the hygiene and physical distancing measures necessary to prevent infection and spread (Hillgrove and Pryor, 2020, Senjam, 2020, Shrestha, 2020), or of the public measures and programmes taken by their government in response to the pandemic (UNDRR, 2020).

The information provided was often generic and there was no communication specifically targeted at disabled people to address their specific circumstances and needs (Human Rights Watch, 2020, International Disability Alliance, 2020e, International Disability Alliance, 2020n, Pregel and Le Fanu, 2020, Starts of Hope Society for the Empowerment of Women with Disabilities, 2020). In some countries, incorrect or misleading information was spread, both through official government communications (Brennan et al., 2020, Rohwerder, 2020d) and informal channels including social media, text messaging and forums (Light for the World, 2020). (International Disability Alliance, 2020p), giving rise to conspiracy theories, misinformation, and confusion (Light for the World, 2020, Fernandez-Diaz et al., 2020, International Disability Alliance, 2020p, Rohwerder, 2020d). This may particularly affect young people who are more likely to access information through social media rather than official channels (Castres and O'Reilly, 2020). The language used in communications was also frequently problematic, either in general or specifically in how it addressed disabled people. Abrams and Abbott (2020) discuss the language used around 'pre-existing' and 'underlying health conditions' became a way of othering disabled people and normalising their deaths as less noteworthy, to provide reassurance to non-disabled people that it was after all 'only' disabled people who had died (see also Meaney-Davis et al., 2020, Goggin, 2020). In addition, public health and messages were sometimes perceived as 'alarming' and actively adding to mental health distress (Poudel and Subedi, 2020), particularly those with psychosocial impairments (International Disability Alliance, 2020r). Several writers therefore emphasized the need for communications to be considered and emphatic, with positive messages aimed at building mental resilience (Qureshi and Scherer, 2020, Pregel and Le Fanu, 2020, Berghs, 2015a).

4.6.6. Good practice

On a more positive note, many of the articles and reports reviewed cite examples of good practice in ensuring that public health information is accessible to all. Many organisations have created accessible documentation for disabled people, including a daily Iranian newspaper covering COVID-19 news in Braille (Jalali et al., 2020), and multiple examples of Easy-to-read materials being produced for people with intellectual impairments (Brennan et al., 2020, United Nations, 2020b). However, this guidance was most often developed by NGOs or DPOs rather than governments (Human Rights Watch, 2020, Qi and Hu, 2020). Several governments have included sign language interpretation as standard in public health briefings (CBR Africa Network (CAN), 2020, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, Qi and Hu, 2020). However, in many cases, accessibility measures were only put in place after continued lobbying or legal action against government agencies and public broadcasters by local activists and DPOs (Gurung and Gahatraj, 2020, Mhiripiri and Midzi, 2020). Finally, a positive example from a previous emergency, the typhoon Haiyan, was the development of a central Directory of Health, Rehabilitation and Disability Services which signposted disabled people and health and care workers to all available services, thus improving access to available health and social care services (Benigno et al., 2015).

4.7. Mental Health

4.7.1. Impact on disabled people's mental health

Just as previous pandemics have had a negative impact on mental health, evidence is beginning to emerge on the psychological toll taken by COVID-19 on both disabled and non-disabled populations (Meaney-Davis et al., 2020, Poudel and Subedi, 2020, United Nations, 2020d). Like other non-COVID-19 related services, mental healthcare services were significantly disrupted during the pandemic; a striking example comes from Madrid where over 60% of its mental health beds were converted to beds reserved for COVID-19 patients (United Nations, 2020d). A study on young people's mental health following the COVID-19 outbreak in China found that 40.4% of the participants reported having psychological problems and 14.4% youth groups presented with Post-traumatic stress disorder (PTSD) symptoms, with higher rates of distress among those with a lower educational level, and among men (Liang et al., 2020). Another study from Nepal reported a sharp increase in numbers of suicides during lockdown (Poudel and Subedi, 2020). Report and surveys from NGOs and DPOs suggest that many disabled people saw a decline in mental health and need for psychosocial support. (International Disability Alliance, 2020b, National Federation of the Disabled Nepal, 2020, Pham, 2020, Starts of Hope Society for the Empowerment of Women with Disabilities, 2020). In addition, frontline healthcare workers are particularly at risk of psychological distress during a pandemic (Singh, 2020, United Nations, 2020d). In some settings, there is also a high prevalence of existing psychosocial impairments, particularly as a result of conflict, displacement, and poverty (Clugston and Spearing, 2020). A UN report estimates that more than 1 in 5 people living in settings affected by conflict have a mental health condition (United Nations, 2020d). This group is at particular risk of further mental distress, due to barriers in accessing health care, inability to access medication during the pandemic, as well as being at higher risk of violence and abuse (Clugston and Spearing, 2020, Meaney-Davis et al., 2020). People with psychosocial impairments have reported increased stigma and prejudice, including having their capacity to make decisions questioned and having their healthcare needs minimised (International Disability Alliance, 2020m, see also International Disability Alliance, 2020l, Poudel and Subedi, 2020).

4.7.2. Impacting factors

The disruption and social isolation caused by lockdown and quarantine measures is the most commonly referenced cause in the literature reviewed. For many disabled people, this exacerbated the existing isolation and decreased support services reduced their access to community and social life even further (UNICEF, 2020a, Women Enabled International, 2020). The disruption of normal routines was particularly challenging for disabled people who rely on strong routines, such as people with intellectual or development impairments (National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, Singh, 2020). Economic hardship (International Disability Alliance, 2020c) and boredom (Hillgrove and Pryor, 2020) as a result of lockdown were also cited as sources of distress. In addition, some disabled people were worried about contracting coronavirus (Goyal et al., 2020, Light for the World, 2020), some felt anxious due to inaccessible or negative news and public health communications (Goyal et al., 2020, Zayed et al., 2020), and many

were concerned about losing access to treatment or being denied medical assistance (Brennan et al., 2020, International Disability Alliance, 2020q). Data from previous pandemics including SARS, MERS, and Ebola suggests that the mental health effects are likely to be long-term, particularly for healthcare workers and survivors of COVID-19, who may deal with long-term physical symptoms, stigma, or survivor's guilt (Liang et al., 2020, Meaney-Davis et al., 2020, Poudel and Subedi, 2020). The level of long-term impairment is also exacerbated by the presence of environmental barriers, climatic conditions, finances, long-distance transportation, government policies, and adequacy of medical supplies, according to a study into PTSD among survivors of the Wenchuan 2008 earthquake (Reinhardt et al., 2020). Social support is therefore essential to prevent the development of long-term psychological trauma, particularly for those from deprived backgrounds who lack the ability to recover from emergencies (Liang et al., 2020).

4.7.3. Continuity of mental health services

Continuity in mental health care services is crucial in ensuring further exacerbation and long-term detriments in the mental health of both disabled and non-disabled populations. This includes ensuring that services are accessible despite travel restrictions (Qureshi and Scherer, 2020), for example through the use of phone hotlines staffed by trained professionals (Humanity & Inclusion, 2020c). It is crucial that support geared towards the need of its communities, and that it is culturally sensitive, as some mental health interventions based western and bio-medical treatment model may not be appropriate to deliver (Qureshi and Scherer, 2020). Simultaneously, in-person services need to adapted so that they can be delivered in a safe manner, as online services may not be appropriate for all conditions, or may be inaccessible, particularly to poor and older people with limited literacy or telecommunications access (United Nations, 2020d). Effective delivery of mental health services is significantly hindered by the poor lack of investment in these services prior to the pandemic, with countries spending on average 2% of their health budget on mental health, mental health interventions accounting for less than 1% of international development assistance programmes for health (Qureshi and Scherer, 2020, United Nations, 2020d). Services are often funded through time-limited funding programmes run by international organisations, however Qureshi and Scherer (2020) highlight the crucial need for a long-term state-funded system that is sustainable and robust, and for international organisations to take greater accountability for the long-term sustainability of any interventions. Mental health coverage needs to be integrated into universal health coverage (United Nations, 2020d), and, as seen in the Philippines after the typhoon Haiyan, be an essential part of rehabilitation services provided (Benigno et al., 2015). In addition, there is a particular need to invest into specialist and appropriate services for child and adolescent mental health (Jones et al., 2020, UNICEF, 2020a).

5. Education

5.1. Education introduction

This section will focus on the considerable disruption to education as a result of the COVID-19 pandemic, including the effect of school closures, issues and barriers around home and remote learning, and emerging discussions around return to school for disabled children.

Many disabled children in the Global South face considerable barriers in access to education in LMICs, with estimates that around one in two disabled children were not in school prior to the COVID-19 pandemic (Azevedo et al., 2020, UNICEF, 2020b), and in some countries, less than 1% of disabled children are enrolled in primary school (UNICEF, 2020b). Even where students are able to attend school, there is often little awareness of the requirements of disabled students. Due lack of understanding and funding constraints, they therefore receive little to no accommodations, particularly in rural areas or at secondary and tertiary levels (Emirie et al., 2020). Girls in particular are much less likely to attend schools than boys, and this exacerbated for disabled girls, who are much less likely to be enrolled in schools than boys or non-disabled girls (Rohwerder, 2020a, UN Women, 2020).

A lack of funding for education is a major issue in providing inclusive education initiatives, perpetuates the unequal access for disabled people. For example, in Lebanon many special schools are owed substantial amounts of funding by the government, and therefore struggle to deliver quality education (Human Rights Watch, 2020). In Nepal, the lack of data on how on disabled children prevents the effective budget and implementation of inclusive education (Rohwerder, 2020a). There is a need to ensure that development funding initiatives prioritise and target finances towards specific measures to improve access to education for disabled children (McClain-Nhlapo et al., 2020). Education in conflict zones and refugee camps presents a particular challenge due to the lack of infrastructure, including damaged buildings, a lack of appropriately trained teachers (Battle, 2015), and prolonged electricity cuts (Abu Moghli and Shuayb, 2020). All of these existing barriers have been exacerbated as the COVID-19 pandemic disrupted education provision on a global level.

5.2. School closures

As the COVID-19 pandemic spread across the globe, many countries reacted by closing schools to avoid the spread of infection. It is estimated that at least 1.5 billion children and their families were affected by school closures (UNESCO Bangkok, 2020, Waldman et al., 2020), in at least 188 countries (Waldman et al., 2020). This caused significant anxiety and drastic disruption to the lives of many children and their families (Singh, 2020), and particularly for disabled children who found their routines disrupted and faced uncertainty about the future of their education (Cahapay, 2020a, International Disability Alliance, 2020e, Majoko and Dudu, 2020, Małachowska et al., 2020).

5.2.1. Secondary functions of schools

As well as being places of education, schools fulfil several other important social functions and the disruptions had a particular negative impact on disabled children in LMICs. This included the disruption of food programmes, including access to school meals and food parcels distributed through schools (Humanity & Inclusion, 2020b, International Disability Alliance, 2020a, McClain-Nhlapo et al., 2020, UNESCO Bangkok, 2020, United Nations, 2020b, Xafis, 2020). School meals for many children and families may be the main source of nutritious food, however 41 percent of the 129 UNICEF program countries surveyed in May 2020 did not report interventions in nutrition and school feeding as part of their national response to COVID-19 (McClain-Nhlapo et al., 2020).Disabled children are particularly likely to be excluded from feeding programmes, as they are more likely to be excluded from school in the first place (McClain-Nhlapo et al., 2020). Schools are also important as safe spaces for children where safeguarding mechanisms can identify and report abuse (United Nations, 2020b, Waldman et al., 2020). Without these services, girls in particular are at high risk of sexual abuse and exploitation, as reported as a result of the Ebola outbreak, where teenage pregnancies increased in some communities by as much as 65 percent and many girls never returned to school (Azevedo et al., 2020). A recent situational analysis from Tanzania also reports an increase in female genital mutilation (Rohwerder, 2020c) as a result of COVID-19 school closures. Children who are displaced and living in refugee camps, slums, or on the street are also at higher risk of child labour, child marriage and child trafficking. (Waldman et al., 2020). The increased use of online platforms may put children at higher risk of cyberbullying and sexual exploitation (Waldman et al., 2020), and while teachers and social workers can stay in touch through calls and messaging services (Pregel and Le Fanu, 2020), reporting of abuse at home by children may be inhibited through the constant presence of parents and the resulting lack of privacy (Goyal et al., 2020). In addition to routine medical check-ups and services being provided in schools to all children (United Nations, 2020b), schools may also be the setting for delivery of disability-specific therapy services (International Disability Alliance, 2020e, McClain-Nhlapo et al., 2020, Waldman et al., 2020), as well as mental health services (United Nations, 2020d). While some services moved online (Cahapay, 2020a), not all of these were able to provide adequate care using remote methods (United Nations, 2020d). Mental health concerns may be exacerbated by reducing children's opportunities to socialise and play with their friends (UNESCO Bangkok, 2020, Waldman et al., 2020). Schools also frequently act as a primary source of information about the pandemic and disease prevention for children and their families (Senjam, 2020, UNICEF, 2020a, UNICEF, 2020b), and may be the only place where children in LMICs have access to WASH facilities (Senjam, 2020, UNICEF, 2020b).

5.3. Home and remote learning

5.3.1. Impact on parents and caregivers

As a result of school closures, much of the responsibility of educating disabled children fell onto parents and caregivers. In an example from the Philippines, a DPO compiled accessible learning resources for parents (Cahapay, 2020a), however a first-hand report from South Africa and a global survey of blind and visually impaired people both indicate that many households did not receive the

required support to implement effective home education, for example a lack of disability-specific resources, and learning materials in inaccessible formats (International Disability Alliance, 2020a, Zayed et al., 2020). Another major barrier was lack of education among parents and caregivers, particular among children who are first generation learners with parents/caregivers who are illiterate (McClain-Nhlapo et al., 2020, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020). Parents may also not be familiar with Braille or sign language and therefore unable to support children with their learning; McClain-Nhlapo et al. (2020) discuss the example of children in boarding school whose families are not familiar with the formal sign language taught and therefore revert back to informal methods in order to communicate with deaf children.

For many caregivers, the requirement to balance home education with employment and other responsibilities with little notice and no certain end date represented a significant burden and source of anxiety (Light for the World, 2020, McClain-Nhlapo et al., 2020). Two reports indicate that this burden was shared between different members of the household working together to provide home education (Cahapay, 2020a, Majoko and Dudu, 2020), and some parents drew on internet resources for impairment-specific information due to the inaccessibility of usual services (Majoko and Dudu, 2020). In addition, many parents used home education to impart life skills in addition to academic skills, including disease prevention and safety skills, cooking, and cleaning and housework skills (Cahapay, 2020a, Majoko and Dudu, 2020, Pregel and Le Fanu, 2020). However, the gendered nature of household work means that many girls may miss out on study time as they will be expected to complete housework before beginning their schoolwork, while boys do not have any expectations of household tasks (Goyal et al., 2020).

5.3.2. Distance learning

In addition to home learning led by parents, many schools and educational facilities made efforts to provide some education to students through distance learning, through television, radio, messaging services, and online platforms including social media (Majoko and Dudu, 2020, McClain-Nhlapo et al., 2020, Meaney-Davis et al., 2020, Samaila et al., 2020, Toquero, 2020, World Health Organization, 2020b). However, the remote learning provided usually did not include additional time and resources to ensure adequate support for disabled students (Sakellariou et al., 2020, UNESCO Bangkok, 2020), and the engagement of disabled children in remote learning was not necessarily measured or monitored due to a lack of disaggregated data (Samaila et al., 2020). One survey of 942 households that include a disabled person in Jordan, 42% had children not using online education platform during quarantine period (Pham, 2020).

5.3.3. Barriers to remote learning

In addition, teachers require training on the most effective use of technologies to assist remote learning (Samaila et al., 2020, UNICEF, 2020a), however 40% of teachers in OECD countries lack professionals IT skills and knowledge, with no data available teachers' digital skills in LMICs

(UNESCO Bangkok, 2020). In a global survey, A World Bank Group global survey of 1,845 teachers (McClain-Nhlapo et al., 2020) identified the main barriers to effective teaching as:

1) lack of internet/data availability (36 percent)
2) lack of personal assistants for disabled children (35 percent)
3) lack of accessible materials (35 percent)
4) costs (31 percent)
5) lack of assistive devices (30 percent)

The survey also notes that cost was considered a major barrier particularly in Sub-Saharan Africa and Latin America (McClain-Nhlapo et al., 2020) 21% of teachers felt they had not received adequate support to teach disabled children effectively (McClain-Nhlapo et al., 2020). Remote education also disadvantaged disabled teaching staff, particular if online platforms were not fully accessible to them (Goyal et al., 2020).

5.3.4. Access to technology

The two major barriers to remote education for families with disabled children in LMICs were access to technology and accessibility to technology. Many households in LMICs have little or no access to the internet or online devices, and disabled people, poor people, and those living in rural locations are disproportionately affected by a lack of access (Azevedo et al., 2020, Brennan et al., 2020, Castres and O'Reilly, 2020, Goyal et al., 2020, Majoko and Dudu, 2020, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, Rohwerder, 2020a, Starts of Hope Society for the Empowerment of Women with Disabilities, 2020). Results from a global survey suggest that 62% of parents had access to television, while only 25% had access to tablets and 31% percent had access to computers, however only 18% parents felt that television and radio programmes were accessible and useful to support disabled children with their learning (McClain-Nhlapo et al., 2020). The cost of technological equipment and internet access was also a barrier for some (Emirie et al., 2020, Krishnan et al., 2020). In Sierra Leone, radios were distributed by an NGO (Meaney-Davis et al., 2020). Even where technological equipment was present within a household, they may not necessarily have enough devices for both parents and children, particularly in families with multiple children (Azevedo et al., 2020) (Hillgrove and Pryor, 2020). Access to education for girls and disabled children, and particularly disabled girls, was more likely to be seen as less important and therefore deprioritised, compared education than boys and/or non-disabled children (Goyal et al., 2020, Jones et al., 2020, McClain-Nhlapo et al., 2020).

5.3.5. Inaccessibility of technology

The second major barrier for many disabled students was the inaccessibility of remote learning platforms, which lead to them being excluded from remote teaching (Abu Moghli and Shuayb, 2020, Human Rights Watch, 2020). A global survey of 1,628 parents and caregivers found that 58% were concerned learning loss due to inaccessible remote learning modalities and 48% about the lack of accessible educational materials (McClain-Nhlapo et al., 2020). Both teachers and families were

often unfamiliar with the different accessibility features offered by different devices and programmes and how to best employ these to teach disabled students (Goyal et al., 2020) (Toquero, 2020), leading to several reports and research papers calling for greater need for rigorous research into digital technologies and how they are used by children (McClain-Nhlapo et al., 2020, Toquero, 2020), and collaboration with global technology companies to integrate accessibility features into potential learning platforms (Castres and O'Reilly, 2020). Television and radio broadcasts in only one language caused difficulties in multilingual countries (Emirie et al., 2020, McClain-Nhlapo et al., 2020), and particularly for sign language users, in places where sign language was not recognised as an official language (McClain-Nhlapo et al., 2020).Sign language interpretation was also a recurring problem when using online platforms (Arab Organization of Persons with Disabilities (AOPD), 2020), particularly on a small screen where it may be difficult to lip-read, or to view the interpreter and other documents simultaneously (Krishnan et al., 2020, Human Rights Watch, 2020). Other barriers to online lessons included a lack of subtitles (Arab Organization of Persons with Disabilities (AOPD), 2020, McClain-Nhlapo et al., 2020), an absence of Braille provision (Azevedo et al., 2020, Goyal et al., 2020, McClain-Nhlapo et al., 2020), and an insufficient understanding on how to make online documents and images accessible and screenreader-friendly (Goyal et al., 2020, Human Rights Watch, 2020). Online lessons can also requires higher levels of concentration for people with some impairments, for example when lip-reading (Krishnan et al., 2020), as well as affecting motor skills due to the need for typing (Krishnan et al., 2020), and overstimulation for people with sensory issues (Goyal et al., 2020). The prospect or reality of having to drop out of school due to these access barriers added to the anxiety felt by some disabled children and adolescents (Jones et al., 2020, Rohwerder, 2020d).

5.4. Return to school

5.4.1. Drop-out rates

As schools reopen as a result of loosening of lockdown measures, disabled children are at higher risk of not returning to school. This may be because of parents and caregivers' concerns about the safety of return, particularly for disabled children who are at increased risk of severe COVID-19 symptoms (Azevedo et al., 2020, Meaney-Davis, 2020, Pregel and Le Fanu, 2020, UNICEF, 2020b), or because parents hold negative attitudes about the value of education for disabled children. (Meaney-Davis, 2020). Disabled girls in particular are more likely to take on caring responsibilities for family members, and also face increased risk of violence and exploitations, which may prevent them from returning to school (UNICEF, 2020b). During the Ebola epidemic in Sierra Leone, 11,000 girls who were previously in school became pregnant (Mason, 2016), with many not returning to school despite government support measures to increase enrolment (McClain-Nhlapo et al., 2020, Castres and O'Reilly, 2020). The increase poverty caused by the pandemic increases reliance on children's work (McClain-Nhlapo et al., 2020), with boys likely to be pressured to contribute to household income rather than returning to school (Azevedo et al., 2020). Governments will need to take steps to ensure funding is available to support children of all genders, including disabled children to stay in school (McClain-Nhlapo et al., 2020) and put in place monitoring systems to measure the impact on different groups of children through disaggregated data (UNICEF, 2020b).

5.4.2. Attainment gaps

Disabled children who are returning to school are more likely to have fallen behind due to the lack of accessible home and remote learning options (Jones et al., 2020, UNICEF, 2020b). In order to address the widening attainment gap, several reports recommend allowing disabled students to return to schools before non-disabled children (McClain-Nhlapo et al., 2020, Pregel and Le Fanu, 2020). Teachers will need to be equipped to deal with learning recovery through implementation of specific plans for learning recovery for disabled children (UNICEF, 2020b). The timing of exams will need to be considered and adjustments made to ensure disabled students are not disadvantaged (Jones et al., 2020, UNICEF, 2020b). In the Philippines, the Department of Education has developed a Learning Continuity Plan to guarantee continued learning for all children, including disabled children, including curriculum adjustments, alignment of learning materials, various modalities of delivery, and corresponding teacher and parent training for home education. (Cahapay, 2020b). The increase in online learning technologies may also provide an opportunity to offer more flexible education modalities, particularly for disabled children not previously enrolled in school (McClain-Nhlapo et al., 2020).

5.4.3. Discrimination and accessibility

Disabled children are at particular risk of being discriminated against and excluded during schools reopening (McClain-Nhlapo et al., 2020). Schools will need to ensure that any measures taken to make schools safe to return do not impact accessibility for disabled students, for examples physical spaces used to allow for social distancing (UNICEF, 2020b). Accessible WASH facilities are a concern disabled children and disabled teachers (Azevedo et al., 2020, McClain-Nhlapo et al., 2020), including facilities for menstrual hygiene management (McClain-Nhlapo et al., 2020). Changes need to be clearly communicated and alternatives put in place so that learning can be delivered flexibly. Guidance from UNICEF (2020b) suggests the delivery of part-time distance learning, and providing additional resources and extra time for disabled pupils. It also highlights the importance of adequate funding for these measures, as well as ensuring PPE is provided for school staff (UNICEF, 2020b). The importance of contingency measure is highlighted in a first-person account from South Africa where disabled students who failed temperature screening at the door of their boarding school were potentially left without a way to return home due to having nowhere to go and poor availability of public transport (International Disability Alliance, 2020a). Finally, schools need to ensure they are equipped to support students who may have experienced trauma during school closures through adequate psychosocial support and counselling services (Pregel and Le Fanu, 2020, UNICEF, 2020b).

6. Economy

6.1. Economy introduction

This section will summarise emerging evidence regarding the economic impact of the COVID-19 pandemic on disabled people in LMICs, including an increase in poverty, the social protection and relief measures put in place by governments in response, and the impact on employment and work.

The existing link between disability and poverty is well-documented in the literature reviewed (Gahatraj, 2020, Gartrell et al., 2020, Huong, 2020, Light for the World, 2020), with disability both a cause and a consequence of poverty (ECLAC, 2020, Thorpe et al., 2020). People living in poverty are likely to have limited access to basic healthcare, adequate nutrition, secure housing, safe drinking water and sanitation (ECLAC, 2020), all of which increase the risk of acquiring impairments that lead to disability. Disabled people's increased risk of poverty is compounded by a number of factors, including lower income and a lack of savings, weaker social networks, and the "Disability Price Tag", entailing additional costs such as assistive devices, health services, personal assistance, and higher costs for food and accessible transport, which have to be borne by disabled people and their families where there are no support mechanisms in place (Banks et al., 2021, Pineda and Corburn, 2020, Gartrell et al., 2020, ECLAC, 2020). Disabled people are also more likely to be in informal, insecure, and low-waged employment, or, particularly in the case of disabled women, to be unemployed (International Labour Organization, 2020b, Meaney-Davis, 2020, United Nations ESCAP, 2020). An Evidence and Gap Map (EGM) by Saran et al. (2020) found that poverty and disability were linked across impairment types, although the link is likely stronger for people with psychosocial conditions.

Poverty is compounded by a lack of social protection measures for disabled people, with only 28% of disabled people having access to disability benefits globally, and only 1% in low-income countries (United Nations, 2020b). Social security coverage can vary significantly between countries (Banks et al., 2021) and can be fragmented across sectors and regions (Rohwerder, 2020a), making it difficult for the population to navigate the complex administrative and legal landscape to understand and access available schemes. In regions with conflict such as Palestine, social protection systems have been eroded or are completely absent due to decades of occupation and a focus on neoliberal policy development over adequate social security (Starts of Hope Society for the Empowerment of Women with Disabilities, 2020). Social protection is crucial in enabling disabled people's access to rehabilitation, employment, education, travel and recreation (Berghs, 2015b), however in many countries support for disability-related needs are cast as a "family issue" and receive little government support (Gartrell et al., 2020). A scoping review of illness-related income protection in LMICs by Thorpe et al. (2020) found that only 47% of LMICs had policies covering all three areas of sickness, work-related injury, and disability, and that coverage was particularly low across most of Asia, the Pacific, and Africa. Further the study highlighted issues of non-compliance and inadequate enforcement of social insurance regulations, as well as policies not necessarily applying to smaller employers or the informal economy, where many disabled people and migrant workers are employed, and structural barriers including underfunding, corruption, poorly organised administration, and stigma and prejudice against some groups of claimants (Thorpe et al., 2020).

Where there are no social protection measures in place, Low- and Middle-Income countries often rely on development funding in order to provide this infrastructure. However this funding has historically excluded disabled people (Clugston and Spearing, 2020), despite frequently using images of impaired bodies "as a symbol of humanitarian crisis, loss of rights and charitable appeal in a neoliberal humanitarian marketplace" (Berghs, 2015b). The International Labour Organization (2020b) recommend that disability inclusion should be a requirement for funding to ensure donors and recipients are held accountable. However, funding is often tied to conditions and policies that in themselves can perpetuate disabling situations (Berghs, 2015b). Disability is often reduced to economic costs and 'vulnerability', rather than "a focus on social, economic, political, spiritual, cultural and other forms of capital that disabled people use to survive" (Berghs, 2015b). Barriers to economic participation for disabled people are often both institutional and attitudinal (Meaney-Davis, 2020), which cannot be addressed in isolation through funding of economic initiatives, or a focus purely on health and rights (Berghs, 2015b). Saran et al. (2020)'s EGM found that outcome such as control over own money, poverty and out of pocket payments, access to social protection programs, participation in development of inclusive policies were least studied, and studies around assessing stigma and discrimination, safety, participation in mainstream leisure and sports activity, legal rights, access to justice, participation in cultural and religious activities were also limited. Thorpe et al. (2020) on the other hand point out that there has been no WHO publication on income security and health within the last decade. The COVID-19 is a crucial turning point for this, providing an opportunity for 'building back better'. This is exemplified in a study on the positive effects following an earthquake in Iran, which led to new financial and business incentives to improve the financial situation for people with physical impairments (Pakjouei et al., 2020). However, as Meaney-Davis (2020) points out, if this opportunity is missed, evidence from previous economic crises suggests that the pandemic will likely increase inequalities between disabled and non-disabled people recovery will be much longer for disabled people.

6.2. Poverty

6.2.1. Increase in poverty

COVID-19 is likely to be the most significant setback for global poverty reduction efforts in the last few decades, with an estimated additional 88-115 million being pushed into extreme poverty as a result of the pandemic (Lakner et al., 2020). However, there is little large-scale quantitative data available on the economic impact on disabled people specifically, due to a lack of disaggregation of data by disability status (Meaney-Davis, 2020). The first-hand accounts and NGO reports surveyed in this literature review clearly indicate that increased poverty due to the pandemic is an urgent issue for many disabled people in LMICs. Up to 95% of disabled people surveyed were worried about their financial situations (Humanity & Inclusion, 2020a, Huong, 2020), though some surveys reported lower numbers of 57% (National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020) and 39% (Starts of Hope Society for the Empowerment of Women with Disabilities, 2020) respectively. Disabled people reported both increased cost, particularly health-related costs, and reduced income (Meaney-Davis, 2020), leading to the need to borrow and fall back on informal financial support (Ahmed et al., 2020, Meaney-Davis, 2020). For many, this leads to the dilemma of

deciding between economic survival on the one hand, and protecting themselves from the pandemic on the other. (Emirie et al., 2020). The impact of poverty was described particularly stark for multiply marginalised identities, particularly indigenous people, and those from lower classes and castes, as well as ethnic and religious minorities (Gurung and Gahatraj, 2020, Rohwerder, 2020a). Gender disparities in labour force participation also leave women-headed households at particular risk of poverty (Gartrell et al., 2020). The negative effect on global economies is likely to be felt long-term, particular in places where it is compounded by additional factors such as other disasters (Rohwerder, 2020b) or trade sanctions (Jalali et al., 2020), leading to the prospect of "endless austerity" in many countries with a long-term reduction of spending on public services (Manderson and Wahlberg, 2020).

6.2.2. Food poverty

Across the reports and surveys carried out by NGOs and DPOs, food insecurity is cited as the most significant manifestation of poverty due to COVID-19 (Goyal et al., 2020, Humanity & Inclusion, 2020a, Huong, 2020, International Disability Alliance, 2020q, International Disability Alliance, 2020r, Meaney-Davis, 2020, Rohwerder, 2020b). Many disabled people surveyed perceived hunger as a bigger threat to their health than COVID-19 (Gahatraj, 2020, Humanity & Inclusion, 2020a). The percentage of disabled people reporting food insecurity in surveys ranged from 40% (Inclusion 2020) and 45% (Light for the World, 2020) to up to 74% (Humanity & Inclusion, 2020a). The ten countries where the highest percentage of respondents reported no access to food were Uganda, Nigeria, Kenya, Bangladesh, India, Colombia, Côte d'Ivoire, Tanzania, Rwanda, and Peru (Brennan et al., 2020). In Lebanon, Humanity & Inclusion (2020a) reported that the impact on refugees and displaced persons from Palestinian and Syrian backgrounds was much higher than that of Lebanese households. Another survey from Uganda suggests that the impact of food insecurity was more pronounced for those living in urban regions, due to higher cost living and also the option of growing their own food for those living in rural areas (Light for the World, 2020).

6.2.3. Impacts of poverty

An increase in debt was another result of rising poverty among disabled people. In one survey, disabled people reported having no or very little savings (Meaney-Davis, 2020, Pham, 2020) and the need to borrow money led to many taking on debt. (Meaney-Davis, 2020, Pham, 2020). Pressure to use any savings support the family may fall particularly on the eldest child in a household (International Disability Alliance, 2020m). Young disabled people reported the reliance on family members as stressful (Emirie et al., 2020) and the need to rely on others to borrow money also heightens risk of financial abuse (Meaney-Davis, 2020). In some cases, where disabled people needed to resort to begging, they were also left both at higher risk of violence, as well as increased risk of exposure to COVID-19 (Humanity & Inclusion, 2020b). Housing insecurity was another area as a major impact of poverty, with disabled people left at risk of eviction due to being unable to pay rent (International Disability Alliance, 2020q, Meaney-Davis, 2020, Pham, 2020), and struggling to pay utilities (Hillgrove and Pryor, 2020), including internet access to engage in education (Emirie et

al., 2020). Other impacts of poverty included not being able to afford medication or essential treatments (Meaney-Davis, 2020, Starts of Hope Society for the Empowerment of Women with Disabilities, 2020) and masks and sanitation products to protect against COVID-19 (Emirie et al., 2020).

6.3. Social protection and support measures

6.3.1. Mapping of social protection measures

Multiple attempts have been made to map the global social protection response to COVID-19, however the breadth of policies tracked make it difficult to disaggregate which policies either cover or a specifically designed for disabled people. At the time of writing, the International Monetary Fund's policy tracker (International Monetary Fund, 2020) only lists seven countries as specifically covering disabled people. In contract, a mapping by the UNPRPD (2020) identified 60 countries with disability-specific relief measures. A "living paper" by the World Bank (Gentilini et al., 2020) identified that 212 countries or territories have put in place social protection measures in response to COVID-19, including 38 countries which have introduced Pensions / Disability benefits, 14 where disabled people are eligible for home delivery services of food and medical products, 15 countries where disabled people or children have been eligible for additional cash or allowances, and one-off cash transfers in 4 countries (Gentilini et al., 2020). More broadly, Gentilini et al (2020) highlight that social assistance accounts for the majority of social protection measures taken globally, with 61.4%, out which 51% are safety net measures, 31.13% are cash-based transfers, and 22% are in-kind measures (Gentilini et al., 2020).

6.3.2. Types of assistance

However, surveys by NGOs specifically aimed disabled people highlighted that many disabled people reported the need for more assistance (Ahmed et al., 2020).. In the global Disability Rights Monitor survey, only 6.5% of respondents reported that their governments provided cash as a social protection measure to support persons with disabilities, only 10% (205) said that persons with disabilities received financial support, and only 12% (258) said that persons with disabilities had access to benefits (Brennan et al., 2020). Responses varied significantly by country, with some countries including Mexico, taking almost no measures to provide social protection measures (International Disability Alliance, 2020k). The UNPRPD (2020) also note that few measures relate to the expansion of community, and that there is an overreliance on civil societies by governments. A range of different measures have been taken by countries to provide social protection relief. Supporting the World Bank findings (Gentilini et al., 2020), cash assistance (Hillgrove and Pryor, 2020, Humanity & Inclusion, 2020c, Meaney-Davis, 2020, Richardson et al., 2020) and in-kind assistance (Ahmed et al., 2020, Pham, 2020, Humanity & Inclusion, 2020c, Huong, 2020, Meaney-Davis, 2020, Richardson et al., 2020) were most commonly reported in NGO reports. Cash assistance usually took the form of mostly new payments, rather than the expansion of existing programmes, and was usually either one-off or of short duration (Ahmed et al., 2020, Gentilini et

al., 2020, Richardson et al., 2020). In-kind support was also often one-off and include primarily the provision of food, while other needs such as hygiene products for personal care or to ensure prevention of infection were not necessarily considered (Ahmed et al., 2020, Meaney-Davis, 2020, Pham, 2020). A positive example comes from Pakistan, where the government has taken measures to disaggregate data from cash transfer programmes by disability status, thereby allowing for more effective monitoring of the impact on disabled people (Meaney-Davis, 2020). Some countries have taken steps to widen or expand existing social protection systems, including 6-month increase of the Disability Grant value in South Africa (Meaney-Davis, 2020) (UNPRPD, 2020). Several countries have provided advance payments including Argentina, India, Australia, Bahrain, Cook Islands, Tonga, Georgia, Honk Kong, Malta, Mongolia (UNPRPD, 2020), while others including the Kyrgyz Republic and Russia have taken steps to simplify the administrative requirements to access disability benefits (Meaney-Davis, 2020, UNPRPD, 2020). Albania and Armenia have introduced home delivery of cash payments also have introduced home-based services and home delivery of cash to support disabled people (UNPRPD, 2020).

6.3.3. Additional costs

As well as ensuring the inclusion of disabled people in general social protection measures, the "Disability Price Tag" means that specific support targeted at disabled people is crucial in ensuring that the additional barriers disabled people face during the pandemic. Emerging evidence indicates that countries with solid disability allowances and public support services (McClain-Nhlapo et al., 2020) and that a social protection floor as well as universal disability allowance are crucial to address these barriers and build resilience among disabled people to respond to the pandemic crisis (International Labour Organization, 2020b, United Nations, 2020b). As well as a potential need to isolate for longer due to being at higher risk of severe symptoms from COVID-19 (United Nations, 2020b), many disabled people have faced higher costs during the pandemic, (Banks et al., 2021, Goyal et al., 2020, Pregel and Le Fanu, 2020), for example due to the need to buy increased amounts of PPE and hygiene materials, extra costs for home deliveries of items, and the need to pay for additional support due to closure of public services (Sakellariou et al., 2020, United Nations ESCAP, 2020). It is crucial that disability-specific schemes are coordinated with other social protections programmes, (Banks et al., 2021, United Nations, 2020b), as well as ability to work while receiving social assistance (International Labour Organization, 2020b).

6.3.4. Exclusion from support

However, in practice many disabled people were excluded from accessing additional support during the COVID-19 pandemic if they, or someone in their household, were already receiving disability support or other social protection payments (Ahmed et al., 2020, Gahatraj, 2020, Gentilini et al., 2020, Meaney-Davis, 2020, Rohwerder, 2020d, Sakellariou et al., 2020). Employment status also affect the ability to access support, with those in employment excluded from payments in some cases (Meaney-Davis, 2020), while others struggled to access employment-based social protection due to being unemployed (Samaila et al., 2020) or being in informal or self-employment (Xafis,

2020). Where countries are reserving payments for the poorest or most "severely disabled" (International Disability Alliance, 2020s), there is a concern that the majority of people will not be able to access support, leading to the "missing middle" in protection schemes (UNPRPD, 2020). In some countries, eligibility to support was contingent on citizenship (Manderson and Wahlberg, 2020) or the requirement to be registered as a disabled person (Gahatraj, 2020, Meaney-Davis, 2020, International Disability Alliance, 2020q), disadvantaging already marginalised groups who are either rendered ineligible or may struggle to provide proof of eligibility, including indigenous people, single women, and poor people (Gurung and Gahatraj, 2020, Meaney-Davis, 2020). Women in particular may be disadvantaged if payments are made based on family rather than individual income (Women Enabled International, 2020), household funds are controlled by men as heads of the household (Goyal et al., 2020), and men are generally favoured in the provision of monetary assistance (Gartrell et al., 2020), or funding is cont. Access to support also depended on age; while in some countries, measures were limited to disabled children only (Richardson et al., 2020), in other cases children were not eligible for disability allowances (Goyal et al., 2020), and McClain-Nhlapo et al. (2020) highlight that in some cases, schemes for children are tied to school attendance, leaving disabled children at greater risk of exclusion. One report also indicates that type of impairment was a factor in exclusion from social protection, with people with multiple impairments more likely to be excluded, as well as those with psychosocial impairments (Ahmed et al., 2020).

6.3.5. Barriers to social protection

In their analysis of previous studies on disability-inclusive implementation of social protection measures, Banks et al. (2021) highlight the key challenges to ensuring an effective response as restricted eligibility, inaccessible and time-consuming application procedures, inaccessible delivery methods of benefits, and inadequacy of the support provided. These issues seem to have been replicated in the provision of support during COVID-19. As well as restricted eligibility and inadequate provision of support, as discussed in the previous sections, many disabled people were not aware of the social protection support available and how to access it (Banks et al., 2021, Emirie et al., 2020, Gahatraj, 2020, Hillgrove and Pryor, 2020, Humanity & Inclusion, 2020c, Shrestha, 2020). This was exacerbated by helplines and other sources of information about the support available being inaccessible for some impairments (Goyal et al., 2020, Meaney-Davis, 2020). Many disabled people faced administrative barriers in accessing the registration process or in providing the required proof of their status as a disabled person in order to be eligible for support (ECLAC, 2020, Gahatraj, 2020, Giang and Huong, 2020, Goyal et al., 2020, International Disability Alliance, 2020c, Meaney-Davis, 2020, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, Sakellariou et al., 2020). The slow speed of assessing claims for social support also led to payments being delayed, sometimes by several months (Giang and Huong, 2020, Hillgrove and Pryor, 2020, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020).

6.3.6. Distribution and access to relief

Many disabled people reported issues with the distribution and access of both monetary and in-kind relief. DPOs in Nepal reported that less than half (45%) had received relief packages (National Federation of the Disabled Nepal, 2020), while another reported that 67% had not received support (National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020). This is echoed by reports from Uganda (Meaney-Davis, 2020), Bangladesh (Ahmed et al., 2020), and India (Goyal et al., 2020). Disabled people raised concerns reliefs being stolen (Ahmed et al., 2020), echoing a study which reported issues of corruption at local level preventing the effective distribution of relief (Gartrell et al., 2020). Disabled People's Organisation often stepped in to distribute the support measures locally (Brennan et al., 2020, Goyal et al., 2020), however this was often hampered by insufficient food and other relief provided by governments (International Disability Alliance, 2020p, Rohwerder, 2020d, Brennan et al., 2020). In Bangladesh disabled people called on the government and NGOs to take more responsibility in supporting relief efforts (Ahmed et al., 2020). Multiple reports indicate that disabled people faced barriers in physically accessing distribution points, including significant travel times and long queues with no prioritisation for disabled people or their families or personal assistants, and difficulty physically distancing in overcrowded distribution points (Ahmed et al., 2020, Humanity & Inclusion, 2020a, Meaney-Davis, 2020, International Disability Alliance, 2020o). Access to cash in particular was an issue, as disabled people may not have access to formal finance services, due to the inaccessibility of banks with many banks inaccessible (Meaney-Davis, 2020, Panda et al., 2020). Some countries to action to mitigate this through the home delivery of cash transfers in Albania and Armenia, and specific dates for collection of benefits in South Africa to reduce crowds (International Labour Organization, 2020b).

6.4. Employment and work

6.4.1. Informal employment

Disabled people across the globe, and in particularly in LMICs, are more likely to work in the informal sector or be self-employed (Banks et al., 2021, Castres and O'Reilly, 2020, Meaney-Davis, 2020). This is particularly the case for disabled people who are also a member of another minority group, including women (Banks et al., 2021) (International Disability Alliance, 2020r, Pregel and Le Fanu, 2020, Rohwerder, 2020c, UN Women Africa, 2020, Women Enabled International, 2020), young people (Castres and O'Reilly, 2020, Emirie et al., 2020), and indigenous people, ethnic and religious minorities, and low caste communities (Gurung and Gahatraj, 2020). Informal work is characterised by increased insecurity through short-term or part-time contracts, putting disabled people at greater risk of losing some of their income or being made unemployed (Banks et al., 2021, Castres and O'Reilly, 2020, Gurung and Gahatraj, 2020, Meaney-Davis, 2020). Many self-employed disabled people work in small scale trade-based roles, in the food, transport, or tourism sector, which have been particularly affected by pandemic lockdowns (Rohwerder, 2020a), with restrictions impacting those selling goods or services in the street (Emirie et al., 2020, Giang and Huong, 2020, International Disability Alliance, 2020s). One disabled person reports not being able to get permission for a pass to buy items from the market to sell in her grocery shop (International

Disability Alliance, 2020f). Due to the small scale of their businesses, many self-employed disabled people are not eligible for either government support packages (Xafis, 2020) and may find it difficult to access loans with financial institutions less likely to lend during the pandemic (Rohwerder, 2020c). Agriculture-based jobs are an exception as one of the few sectors that was allowed to stay open (Light for the World, 2020). However, there are reports of people with albinism in Uganda feeling forced to accept working in fields without adequate protection from the sun (International Disability Alliance, 2020r, Meaney-Davis, 2020). Many low-paid workers have been recognised as 'essential' during the pandemic and had no choice but to continue working in roles with high exposure risk to the virus (Xafis, 2020). Many disabled people reported being forced to choose between their livelihood and feeding their families, and staying at home to protect themselves from possible infection (International Disability Alliance, 2020o, Rohwerder, 2020c, Xafis, 2020). The impact on informal and self-employed disabled people also particularly affects women (Banks et al., 2021, International Disability Alliance, 2020r, Pregel and Le Fanu, 2020, Rohwerder, 2020c, UN Women Africa, 2020, Women Enabled International, 2020), and this extends to the health sector which is dominated by a female workforce in many countries, leaving women with increased workloads and higher risk of infection (Pearce, 2020).

6.4.2. Unemployment

Disabled people are also likely to be among the first to lose their jobs in a crisis, and the last ones to be hired (Castres and O'Reilly, 2020, International Labour Organization, 2020a). Surveys carried out by NGOs suggest that many households with disabled members lost their employment or were unable to work during the pandemic, with figures ranging from 18% across Africa (CBR Africa Network (CAN), 2020), 30% in Vietnam (Meaney-Davis, 2020), 40% in Paraguay (ECLAC, 2020) and Nepal (National Federation of the Disabled Nepal, 2020), 68% in Kenya (i2i, 2020), 78% in Jordan (Pham, 2020), up to 87% in some regions of Egypt (Meaney-Davis, 2020), and 65% (Ahmed et al., 2020) and 80% (i2i, 2020) for Bangladesh. While non-disabled people were also affected by job losses, the effect on disabled people losing employment was disproportionally higher (Hillgrove and Pryor, 2020, Ministry of Agriculture and Livestock Development, 2020). For others, working hours were reduced or they received pay cuts (Hillgrove and Pryor, 2020, Huong, 2020, Meaney-Davis, 2020). The risk of loss of income was exacerbated by stigma against disabled people, such as the belief that they are carriers of COVID-19 (International Disability Alliance, 2020h), and in one example, an employer used the relaxation of employment laws during COVID-19 to dismiss a disabled employee (Humanity & Inclusion, 2020a). It is therefore crucial for governments to ensure that employment rights and anti-discrimination laws are strengthened to avoid further discrimination (Pineda and Corburn, 2020, Castres and O'Reilly, 2020) (United Nations ESCAP, 2020) against disabled people. In China, courts reduced the costs of litigation and prioritised disabled people's cases against employers to make it easier for disabled people to take action against unfair or discrimination dismissal (Qi and Wang, 2020). The phenomenon of unemployment is also again gendered, with disabled women more likely to be already unemployed (Starts of Hope Society for the Empowerment of Women with Disabilities, 2020) or having their income reduced (Ahmed et al.,

2020), as well as having less financial independence and resilience to recover from crisis (Gartrell et al., 2020).

6.4.3. Telecommuting

The global move towards telecommuting is described as one of the 'silver linings' (Singh, 2020) of the pandemic, enabling more flexible working for many across the globe, including many disabled people who had previously been denied homeworking as a reasonable accommodation (Goggin, 2020). A global International Labour Organization (2020a) survey found that out of 159 companies, 69% provided telework, 56% provided flexible working hours, and 32% provided paid leave. However, disabled people faced additional barriers as they did not necessarily have access to additional furniture equipment or software provided in their workplaces as a reasonable adjustment, or required further adjustments while working from home (Goyal et al., 2020, International Labour Organization, 2020b). The cost and inaccessibility of information technology also presented issues (Meaney-Davis, 2020). With meetings and management supervision taking place online, the inaccessibility of conferencing software, with meetings on small screens without captions or sign language interpretation, led to increased isolation among disabled people (Goyal et al., 2020, International Labour Organization, 2020b). A first-person account from a disabled woman in India who was given more work than her colleagues during homework suggests that disabled people may be subject to discrimination, due to the mistaken belief that they have no other commitments and therefore more time to take on work (International Disability Alliance, 2020c).

6.4.4. Long-term impact

The disproportionate effect on disabled people's employment project is likely to be long-term, with disabled people taking longer to re-enter the workforce (Banks et al., 2021), and many businesses' disability inclusion schemes being negatively affected by the pandemic (International Labour Organization, 2020a). This is likely to be exacerbated by the effect of school closures, as lack of education and training remains a significant barrier to employment for disabled people (Meaney-Davis, 2020). 16% of disabled women interviewed in one survey reported no plans for the future, and several highlighted the need for new employment opportunities (Ahmed et al., 2020). Action on this is led by Business and Disability Networks, who are carrying out training initiatives, as well as advocacy and awareness-raising campaigns (International Labour Organization, 2020a), including job-matching services in Bangladesh and a reskilling initiative to retrain disabled workers in the Philippines (Meaney-Davis, 2020). However, before any return to work, employers need to consult with disabled employees to ensure that workplaces are safe (Castres and O'Reilly, 2020) . (International Labour Organization, 2020a) and that those at higher risk from COVID-19 are not forced to return to work prematurely (Goyal et al., 2020). Employers should be prepared to be flexible to enable disabled employees to work from home for longer (United Nations ESCAP, 2020), recognise other barriers disabled people may face, such as a lack of accessible transport to travel to work (Goyal et al., 2020), and offer support including paid leave (United Nations ESCAP, 2020),

accommodations for caring responsibilities (UNICEF, 2020a, World Health Organization, 2020b), and psychosocial support (International Labour Organization, 2020b, UNICEF, 2020a).

6.4.5. Unpaid and domestic work

There is limited emerging evidence on the impact of the pandemic on disabled people in the context of unpaid work, including domestic and care work. The evidence that exists highlights an exacerbation of the unequal nature of this work, which is often highly gendered with most domestic and care work carried out by women (Arab Organization of Persons with Disabilities (AOPD), 2020, Goyal et al., 2020).The unequal impact is increased through the disruption of formal care provision, meaning informal care arrangements need to be picked up by family members, particularly women (International Disability Alliance, 2020e, United Nations, 2020b). It is important to recognise that women are both receivers and providers of care (Goyal et al., 2020, International Labour Organization, 2020b), leaving many disabled women with little support in carrying out domestic tasks, as well as juggling childcare and working responsibilities (Goyal et al., 2020).

7. Community

7.1. Community introduction

This section will focus on the impact of the COVID-19 pandemic on disabled people's ability to participate in their communities, including the effect of lockdowns and physical distancing measures, the disruption to social care and the ability to live independently, the impact on disabled people in institutions or other confined, crowded spaces, including refugee camps, prisons, and homeless people. It will also discuss the impact on transport and infrastructure, the ability to access essentials including food and medicine, and the increase in violence and abuse against disabled people during the pandemic.

The rapid spread of the COVID-19 pandemic caused considerable disruptions to the lives of many disabled people through the interruption of formal and informal support mechanisms to live independently (i2i, 2020, Women Enabled International, 2020), and access to essential food and medicine (Qi and Hu, 2020), and transport (i2i, 2020). The right to independent living is a key tenet of the global disability rights movement and highlights of the importance of autonomy, dignity, and control over decisions affecting one's life. For many disabled people, this involves access to support from caregivers (Samaila et al., 2020), and the need for assistance is increased through barriers in the built environment, preventing disabled people from accessing public spaces, as well as education, work, suitable housing, and transport (King et al., 2019, Senjam, 2020).

In the Global South, particularly in countries where there is a cultural emphasis on the family unit and community combined with an access of government support, informal care from family, friends, and other community networks are the primary source of care received by disabled people (King et al., 2019, United Nations ESCWA and World Health Organization, 2020). Evidence from previous disasters has shown that disabled people who lack these community networks are therefore at higher risk of isolation and often miss out on support and essential information in an emergency (Gartrell et al., 2020, Castres and O'Reilly, 2020, King et al., 2019). The role of family and community in providing support is reinforced by a lack of home-care services in many countries (King et al., 2019, United Nations ESCWA and World Health Organization, 2020). However, informal caregivers usually do not enjoy the same protections as formal care workers and their lack of recognition means that may struggle to get access to medication or vaccine as a priority (Campbell et al., 2009).

Disabled people also represent the majority of institutionalised people globally (United Nations, 2020b), and are overrepresented in prisons (Sakellariou et al., 2020, United Nations, 2020b). Institutionalisation, imported to many LMICs during colonial times, has historically been used to make disabled people socially invisible and deny access to basic rights including autonomy, education, property, and family life (Choudhury Kaul et al.). Many disabled people therefore regard institutionalisation as a violation of human rights (Brennan et al., 2020).

The lives of disabled people are often devalued, with cultural and religious stigma that view them as 'less than', along with medical and charity models which reinforce the idea of disability being an individual 'problem' to be cured. (Gartrell et al., 2020) These attitudes contribute to increased risk

of violence and abuse of disabled people, including higher levels of sexual violence and abuse (Clugston and Spearing, 2020, Giang and Huong, 2020, UN Women Africa, 2020) and violence from family members (Starts of Hope Society for the Empowerment of Women with Disabilities, 2020, UN Women, 2020). Figures suggest that disabled women are 2-4 times more likely to experience interpersonal violence than non-disabled women (Clugston and Spearing, 2020), and 2019 statistics from Palestine indicate that 37% of married disabled women had experienced violence from their husband in the last 12 months (Starts of Hope Society for the Empowerment of Women with Disabilities, 2020). Disabled people may also be explicitly targeted by military action and deliberately neglected in humanitarian responses (Clugston and Spearing, 2020). Disabled people with psychosocial and/or intellectual impairments are particularly likely to experience violence and abuse (Lund, 2020), and disabled women and girls are at particular risk of abuse, violence, and exploitation following a disaster compared to non-disabled women (Gartrell et al., 2020).

There is little evidence on participation in recreational, leisure, and sports activities, as well as access to cultural and religious events, for disabled people in LMICs (Saran et al., 2020). This lack of evidence is perpetuated in the current body of literature on the impact of COVID-19 pandemic, despite participation in faith, culture, and leisure being an essential human right. Only one report highlights the lack of access to Braille books for blind people isolating at home (Zayed et al., 2020).

7.2. Lockdowns and physical distancing

7.2.1. Lockdowns

As the COVID-19 pandemic spread across the globe, many governments introduced significant social restrictions, with lockdowns affecting at least 4.5 billion, or 58% of the world's population during the first wave of the pandemic in Spring and Summer 2020 (Singh et al., 2020a). Just like other public health communication messages, communications around lockdown were not necessarily accessible to disabled people (International Disability Alliance, 2020s). The short notice at which lockdowns were often introduced meant disabled people had little time to prepare (International Disability Alliance, 2020s). The lack of support for disabled people by governments meant that many felt "abandoned […] and trapped at home", with 45% of participants in a global survey stating that their government had not taken any measures to protect disabled people living in the community (Brennan et al., 2020). This also affected other communities, including indigenous communities (International Disability Alliance, 2020k). In China, a disabled teenager was found dead at home a week after being left alone when his father and brother were forcibly quarantined (Qi and Hu, 2020). Some countries with strict curfews also reported an increase of police harassment and violence against disabled people (Brennan et al., 2020). Prolonged periods of lockdown and bans on household mixing led to isolation for many disabled and older people, as they were cut off from networks of family and friends, communal support, and social and peer support groups (International Disability Alliance, 2020h, Light for the World, 2020, Meaney-Davis et al., 2020, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, United Nations ESCWA and World Health Organization, 2020). Confinement at home has led to additional stress for many, including autistic people and those with psychosocial impairments (United Nations Human

Rights, 2020). While some were able to stay connected through the internet (Zayed et al., 2020), this was not an option for many without online access, particularly those in informal settlements (McKinney et al., 2020). For those living with families, the lockdown highlighted barriers to communication, for example where deaf people lived with family members who had no or limited understanding of sign language (Goyal et al., 2020, Jones et al., 2020, Małachowska et al., 2020). The enforced close proximity with family members has also led to increased risk of conflict (Jones et al., 2020), although some disabled young people reported that having more dedicated time with their family members had been a positive experience for them (Jones et al., 2020, Małachowska et al., 2020). The effect of lockdown was also heavily gendered. In the Arab region, older disabled women are much more likely to live without a partner than older disabled men, leaving them at greater risk of isolation (United Nations ESCWA and World Health Organization, 2020). Girls tended to be much more limited in their mobility during lockdown than boys (Jones et al., 2020, Małachowska et al., 2020), particularly in conservative environments where girls are not allowed to leave the house unaccompanied, and due to additional household responsibilities (International Disability Alliance, 2020f, Małachowska et al., 2020). In countries such as Colombia and Peru, men and women were allocated alternate days on which they could leave the house, which led to an increase in violence against transgender people (Rohwerder, 2020d). A first-hand account from Pakistan also indicates that the transgender community, along with poor and disabled communities, faced particular barriers due to stigma and discrimination (International Disability Alliance, 2020m).

7.2.2. Physical distancing

Another measure taken globally in response to COVID-19 the was the requirement to keep physical distance from others to avoid the spread of infection. This was often termed 'social distancing', although Singh (2020) highlights that this term is potentially problematic as it "has a different connotation in a geographically diverse country like India which has had its share of grappling with untouchability amidst socially outcast Dalit communities and segregated people affected by leprosy in colonies and institutionalized people with intellectual disabilities", and advocates for using 'physical distancing' instead. Keeping physical distance from the others presented a challenge for disabled people receiving personal assistance from others, and those relying on the community for support with personal mobility (Goyal et al., 2020, Gurung and Gahatraj, 2020, Senjam, 2020, McKinney et al., 2020, Rohwerder, 2020b, Waldman et al., 2020). Physical distancing was also particularly challenging for some with intellectual impairments (Goggin, 2020), and for blind people, particularly as new systems such as one-way systems or queueing guidelines rarely took their requirements into account, leading to a counterproductive increase in reliance on touching of surfaces to get around (Zayed et al., 2020). Some disabled people also reported experiencing increased stigma when they were not able to adhere to physical distancing in public (Emirie et al., 2020, Zayed et al., 2020), and to being non-consensually touched or grabbed by strangers who assumed they needed 'help' (Zayed et al., 2020).

7.3. Social care and independent living

7.3.1. Personal assistance

Many disabled people living in the community who used personal assistance found that their access to these services was disrupted as a result of lockdown measures (International Disability Alliance, 2020m, Guidry-Grimes et al., 2020, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, Panda et al., 2020), with 38% of disabled people in a global survey stating that they no longer have access to personal assistance (Brennan et al., 2020). Many were not able to find a replacement for the care provided (International Disability Alliance, 2020m), taking away their independence and dignity (Zayed et al., 2020) and placing them at risk of further harm (Castres and O'Reilly, 2020). Where personal assistants were willing to continue to provide care, they were not always able to do so due to a lack of transport options (National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020) or being prevented by law enforcement (Panda et al., 2020).

To ensure continuity of care and preserve disabled people's independence and dignity, the importance of a number of exemptions for caregivers was identified in the literature. This includes identifying personal assistants and caregivers as 'essential workers' and exempting them from lockdown and curfew restrictions, and ensuring that those enforcing the lockdown were aware of these restrictions (Campbell et al., 2009, Humanity & Inclusion, 2020c, United Nations ESCAP, 2020, World Health Organization, 2020b). This exemption, as well as exemption from physical distancing, was introduced by a number of countries, including Argentina, Peru, and Spain (United Nations, 2020b). In India, this exemption was introduced after a disabled woman's successful campaign on social media (Goyal et al., 2020). Strengthening the labour rights of personal assistants, including the right to paid sick leave, prioritisation for access to PPE, and increased funding for service providers (Guidry-Grimes et al., 2020, Pineda and Corburn, 2020) are among the measures identified to support the continuity of delivery of essential care services.

7.3.2. Informal care

Informal care networks where people received regular assistance from family members, friends, and communal networks and support groups, were also serious disrupted as a result of the pandemic, leaving many disabled people cut off from necessary assistance (International Disability Alliance, 2020h, Manderson and Wahlberg, 2020, United Nations ESCWA and World Health Organization, 2020), including access to food, medicine, and assistance with daily activities such as bathing, cooking, or eating. (United Nations Human Rights, 2020, Zayed et al., 2020). While the World Health Organization (2020b) advised disabled people to increase their 'pool' of informal carers, this was not possible for many. According to a survey from the Americas and Caribbean, 80% of those who required assistance were relying on family members for informal care, and 59% had nobody else to fall back on (UNDRR, 2020). A global survey of disabled people found that 33% had no access to formal care as a result of the pandemic, indicating that a significant amount of people were unable to get their essential needs met (Brennan et al., 2020). Both the growth in demand for assistance during the pandemic and the inaccessibility of formal personal assistance services further

increased the demand for informal care, putting pressure on both disabled people and their caregivers, who are often women (United Nations, 2020b). This increased stress also sometimes negatively impacted the relationship between a disabled person and their informal care provider, with requests for assistance becoming harder to make and heightening the risk of abuse (Women Enabled International, 2020). The lack of both formal and informal care had a significant impact on disabled people's independence and dignity. In one survey of blind people, 49% felt their independence had been impacted (Zayed et al., 2020). While some emphasised the importance of implementing contingency plans for when established care networks fall down (Jalali et al., 2020) (World Health Organization, 2020b), it is crucial that these plans respect the disabled person's dignity and right to choose who provides assistance to them (Pineda and Corburn, 2020).

7.3.3.   Assistive devices

Many users of mobility aids or assistive devices found that lack of access to these during the pandemic caused significant issues (Women Enabled International, 2020). According to one survey, 55% of people using assistive devices said that they did not work well, virtually all of them required replacement (Pham, 2020). However, disabled people came across difficulties when attempting to get their devices repaired or replaced, usually because these services had been closed down due to having been deemed 'non-essential' (International Disability Alliance, 2020p, Smith et al., 2020). A review of assistive technology services by Smith et al. (2020) also found that there was a lack of provider availability as providers of services were reallocated to other healthcare services, and that lockdown both led to an increasing need for assistive devices while at the same time increasing difficulty to accessing it. Other barriers identified where the cost of assistive devices and the lack of skills or appropriate in how to use assistive devices, with the latter posing a particular problem for rural populations who struggled to access services remotely (Smith et al., 2020).

7.4.   Institutionalisation and confinement

7.4.1.   Care and residential institutions

The COVID-19 pandemic had a devastating impact on residential homes and psychiatric facilities (Brennan et al., 2020, Guidry-Grimes et al., 2020), accounting for 42% to 57% of all COVID-19 deaths in some countries (United Nations Human Rights, 2020). Overcrowding, a lack of cleanliness and confined spaces greatly increased the risk of transmission (Campbell et al., 2009, Meaney-Davis et al., 2020), with one first-hand account reporting around 20-30 living in one room in some Indonesian psychiatric institutions, and no handwashing facilities or precautions being taken by staff to stop the spread of infection (International Disability Alliance, 2020d). Two reports indicate that disabled people in institutions had no access to information on the pandemic or how to protect themselves, and were not seen as capable of understanding this information (International Disability Alliance, 2020d, International Disability Alliance, 2020m). Many institutions and governments banned or restricted visitors during the pandemic and prevented residents from leaving, leading to increased isolation and cutting off disabled people from all social support

structures (Brennan et al., 2020), particularly if making contact by telephone was inaccessible to them (McKinney et al., 2020). The limitation of contact with the outside world also led to concerns regarding increased abuse and neglect in institutions, due to a breakdown in established monitoring and reporting mechanisms (Brennan et al., 2020, Castres and O'Reilly, 2020, Meaney-Davis et al., 2020, United Nations ESCWA and World Health Organization, 2020). Disabled children may be particularly vulnerable to abuse or having their basic rights violated and many governments did not take sufficient measures to protect those in institutions (Brennan et al., 2020). In Brazil and Chile, measures to protect care home residents were recommendations rather than mandatory legislation (Sakellariou et al., 2020). Pregel and Le Fanu (2020) highlight the need to prevent increased institutionalisation of disabled people as a way of preventing the spread of COVID-19, and ensuring alternative arrangements are in place. Women, girls, non-binary, and gender non-conforming persons are at particular risk of institutionalisation due lower employment rates and receiving less family support than men (Women Enabled International, 2020). In South Africa, closure of some institutions led to disabled people being sent home to families who were not prepared or able to care for them (McKinney et al., 2020).

7.4.2. Migrants and refugees

The number of international migrants is estimated at almost 272 million globally, or 3.5% of the world's population, with nearly two thirds being labour migrants and 74% of working age (20-64 years) (International Organization for Migration, 2019). While the literature review did not identify any reports specifically covering the impact on disabled migrants, emerging evidence indicates that that the pandemic has had a highly negative impact on the living and working conditions of migrants (World Health Organization, 2020a). An initial analysis in April 2020 suggested migrants are at increased likelihood of contracting COVID-19, not accessing appropriate care, experiencing severe symptoms, suffering psychosocial impacts, and having their livelihood and income security affected (Guadagno, 2020). These factors were exacerbated by migrants' living and working conditions, as well stigmatisation and xenophobia, particularly against Asian migrants, including internal migrants in China (Guadagno, 2020). A survey of 30,000 refugee and migrants across the globe found that more than half of respondents were experiencing greater levels of depression, fear, anxiety and loneliness, and many were less likely to seek medical care if experiencing COVID-19 symptoms, with the most common reasons being financial constraints and fear of deportation (World Health Organization, 2020a).

It is estimated that 79.5 million people are forcibly displaced worldwide, including 26 million refugees (UNHCR, 2020). Out of these, 22 million, or 84%, of all refugees, live in LMICs in Asia and Africa (Khattab and Mahmud, 2019). In 2019 two-thirds of all refugees came from just five countries: Syria, Venezuela, Afghanistan, South Sudan and Myanmar (Amnesty International). In addition, in June 2020, it was estimated that one-third of those internally displaced live in the 10 countries most 'at risk' of COVID-19 (United Nations, 2020c). Data from Lebanon, which hosts the largest percentage of refugees worldwide relative to its national population (UNHCR, 2020), suggests that disabled people and their families who live in refugee camps were particularly

affected by the pandemic, with 93% of Syrian households and 78% of Palestinian households not being able to meet their needs, compared to 69% of Lebanese households (Clugston and Spearing, 2020). Palestinian refugees in Lebanon were also three times more likely to die with COVID-19 (Azhari, 2021). Young people in refugee camps demonstrated less knowledge of the pandemic (Małachowska et al., 2020) and in Ethiopia were excluded from testing initiatives, which focussed on residential housing only (Emirie et al., 2020). Overcrowding, a lack of access to water and sanitation, and absent healthcare infrastructure also increased risk of infection and unmanageable spread in formal and informal refugee camps and slums (Humanity & Inclusion, 2020a, Samaila et al., 2020, Thompson, 2020, Xafis, 2020). Several reports suggest that migrants and refugees were anxious about seeking medical attention due to worry about associated costs or being deported (Pertek et al., 2020, World Health Organization, 2020a). It also highlights the amplified insecurity felt by many women as bureaucratic processes slowed down or came to a stop, adding to uncertainty about their legal status and preventing them from accessing support such as financial assistance or public housing, both in LMICs and in Global North countries (Pertek et al., 2020).

7.4.3. Prisons

Disabled people are also overrepresented in prisons (Jones and Tulloch, 2020, Sakellariou et al., 2020), in particular those with psychosocial and intellectual impairments (United Nations Human Rights, 2020). Conditions in prison, including a lack of nutrition and medical care, can also exacerbate or lead to new health conditions (Jones and Tulloch, 2020, de Oliveira Andrade, 2020). There is little data on the impact of disabled people incarcerated in prisons or immigration detention centres, and general data on rates of infection and death on prison populations are not always trustworthy (de Oliveira Andrade, 2020). The risks faced by prisoners are similar to other incarcerated populations, including overcrowding (Sakellariou et al., 2020), with many prisons operating significantly above capacity (Jones and Tulloch, 2020). Risk is also exacerbated through poor infection control (United Nations Human Rights, 2020), a lack of hygiene facilities (Jones and Tulloch, 2020), and a heightened potential for isolation and abuse (Rohwerder, 2020d). Jones and Tulloch (2020) also highlight the impact of visiting suspension both on prisoners' right of access to courts and legal representation, and on psychosocial wellbeing due to not being to receive family visitors. Many countries have taken measures to reduce numbers of incarcerated people in prisons through early release of prisoners. Release of pre-trial detainees has been widely advocated as an effective measure to reduce numbers, as they outnumber convicted people in at least 46 countries, and their release is likely to be consistent with the Tokyo Rules and the Bangkok Rules to avoid unnecessary imprisonment (Jones and Tulloch, 2020).

7.4.4. Homelessness

Homeless people are more likely to be disabled (Pregel and Le Fanu, 2020), and data suggests that disabled people were at increased risk of becoming homeless as a result of the pandemic (Brennan et al., 2020, Pregel and Le Fanu, 2020), with examples of disabled people being evicted as families could no longer care from them (Brennan et al., 2020), or fleeing domestic abuse (Panda et al.,

2020). Homeless people are at higher risk of infection ((Pregel and Le Fanu, 2020), food insecurity (Xafis, 2020), and particularly for disabled women, exploitation and abuse (Meaney-Davis et al., 2020). A survey of that nearly 40% migrants living on the streets or in insecure accommodations had been affected by perceived discrimination (World Health Organization, 2020a). There are also reports of homeless disabled people being forcibly institutionalised during the pandemic (Brennan et al., 2020, CBR Africa Network (CAN), 2020). While reports highlight the urgent need to provide homeless disabled people with shelter, water, food, and healthcare (CBR Africa Network (CAN), 2020, World Health Organization, 2020b), it is important to note that many existing homeless shelter further increase the risk of infection due to overcrowding and the inability to physically distance (United Nations Human Rights, 2020, Xafis, 2020). As Xafis (2020) points out, some cities have taken measures to providing hotel accommodation for homeless people.

7.4.5. Deinstitutionalisation

The harrowing reports emerging from care homes and other institutionalised settings have caused a group of disability organisations to call for emergency institutionalisation (Brennan et al., 2020). The demand includes the involvement of disabled people in these plans, as well as a ban on new admissions and the reallocation of funding from institutions to community supports (Brennan et al., 2020) This is supported by the United Nations who have recommended the acceleration of deinstitutionalisation with concrete timelines and milestones (United Nations, 2020b). Two OECD countries so far, Switzerland and Spain, have taken steps to move disabled people out of institutions and living with family (United Nations Human Rights, 2020).

7.5. Transport and infrastructure

7.5.1. Public transport

Lack of available transport was highlighted in surveys as a key issue during the pandemic, with 17% of disabled respondents in the Philippines reporting it as a significant unmet need (Hillgrove and Pryor, 2020), as well as 50.1% in a global survey by the World Blind Union (Zayed et al., 2020). For blind people, access barriers to public transports were increased through new regulations, changes in schedules, different levels of street noise, and guide dogs not being trained to ensure physical distancing (Zayed et al., 2020). Disabled people who rely on public transport due to being unable to drive face attitudinal as well as physical barriers, with buses unwilling to stop for disabled people as they are not considered important enough (Humanity & Inclusion, 2020a). Disabled people were significantly impacted by disruption in public transport provision as a result of not being considered during service planning (Humanity & Inclusion, 2020a, International Disability Alliance, 2020i). Many disabled people for whom public transport is inaccessible or who live in rural locations rely on taxis or minibuses, however these are also often inaccessible for wheelchair users and require physical assistance to lift the disabled person, which is no longer possible with physical distancing (International Disability Alliance, 2020h, International Disability Alliance, 2020p, International Disability Alliance, 2020q). One positive example from the Philippines report the establishment of

helplines and a dedicated transport service for disabled people to access education and healthcare services (Cahapay, 2020b).

7.5.2. Built environment

Even prior to the COVID-19, staying at home was the default for many disabled people (Goggin, 2020), due to inaccessibility of the built environment (King et al., 2019, Senjam, 2020). Inaccessible roads and footpaths were identified as a problem in two reports, preventing women in India to go shopping for food independently while public transport was unavailable (Goyal et al., 2020), and leading to blind adolescent girls getting injured due to a lack of assistance in navigating insecure roads (Emirie et al., 2020). Disabled people faced different challenges depending on whether they lived in a city where they may be four times more likely to be injured or die than non-disabled people due to pollution, and poor urban health policy, planning and practice (Pineda and Corburn, 2020), or in rural areas, which were often left out from COVID-19 responses (Rohwerder, 2020d) and put disabled people at increased risk of isolation. Hillgrove and Pryor (2020) also report that in Indonesia, migration was higher for disabled people, and particularly disabled women and those with lower levels of education, with many moving within or between cities.

7.5.3. IT infrastructure

Information and communication technologies (ICT) have been crucial for most people globally to limit the impact of physical distancing and the isolation arising this, but for disabled people, who are most likely to be confined to the home for longer periods, digital participation has been especially crucial (ECLAC, 2020, Goggin, 2020, International Disability Alliance, 2020c, Rohwerder, 2020d). In addition, many services, such as bank services, have moved entirely online (Goyal et al., 2020). However, disabled people are less likely to have access to a mobile phone or internet compared to non-disabled people (Castres and O'Reilly, 2020). This is particularly the case in rural areas, with data from India suggesting that while 69% of the disabled population lives in rural locations, internet penetration is only at 21% in these areas (Goyal et al., 2020). For those who have access to mobile phones, purchasing credit is often another barrier (Gartrell et al., 2020, Małachowska et al., 2020). This has led to calls for the urgent investment by governments in improving access to ICT for all, and particularly disabled people, including children (Castres and O'Reilly, 2020, ECLAC, 2020). This includes improving infrastructure and providing devices, as well as investing in training to improve both general and digital literacy among disabled people (ECLAC, 2020, Goyal et al., 2020). In addition, work is required to ensure that new digital tools are developed with accessibility built in from the start (Castres and O'Reilly, 2020).

7.6. Access to food and medicine

7.6.1. Access to shops

Despite some shops taking measures to implement specific hours for disabled people to shop (World Health Organization, 2020b), the significant disruption to transport, personal assistance, limited opening hours, and the requirement to 'shield' at home to protect themselves from infection, disabled people faced significant barriers to physically accessing shops and markets to purchase essentials, such as food and medicine (Banks et al., 2021, Zayed et al., 2020). A survey from Nepal estimates that 54.1% of disabled people were at risk of scarcity of essential items (National Federation of the Disabled Nepal, 2020), while in a pan-African survey 49% of disability NGOs, respondents indicated that disabled people in their countries had run out of household essentials (CBR Africa Network (CAN), 2020). Some disabled people were forced to break curfew rules in order to access essential supplies due to lack of exceptions made for disabled people (Brennan et al., 2020). While the WHO (2020b) recommended that disabled people buy essentials such as food, cleaning supplies, and medication in bulk, this was in practice not an option for many due to poverty (Gartrell et al., 2020) and a lack preparation time due to the sudden nature of many lockdowns (International Disability Alliance, 2020s).

7.6.2. Online shopping and delivery services

Home delivery has been highlighted as a crucial service to ensure disabled people's access to essential items, including food, medicine, and cleaning and hygiene products (Goyal et al., 2020, United Nations ESCAP, 2020). This is echoed by the WHO's (2020b) advice to disabled people to make purchase online or by phone and have them delivered, where possible. However, delivery services brought with them new sets of barriers (Goyal et al., 2020), including the need to be able to have access to digital technology and to be comfortable with online purchases (Giang and Huong, 2020), the lack of access to credit cards and unavailability of deliveries to informal settlements (McKinney et al., 2020), and the disruption of delivery services as a result of COVID-19 (Banks et al., 2021). Where doorstep deliveries are made, disabled people may also struggle to get additional support, with one woman reporting being injured after having to carry her shopping inside herself despite being unable to do so (Goyal et al., 2020).

7.6.3. Nutrition

The impact of food poverty and inability to access shops meant that several disabled people and families reported only eating a full meal once a day (International Disability Alliance, 2020h) or even once every other day (Ahmed et al., 2020) in order to ration food. The struggle to afford sufficient nutrition also led to poor dietary diversity for many (Goyal et al., 2020), as food relief provided by governments was often limited to large quantities of rice or bread (International Disability Alliance, 2020f, International Disability Alliance, 2020p, Meaney-Davis, 2020, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020). A disabled adolescent girl from Gaza reported no longer having access to vegetables or fruit (Jones et al., 2020). A survey in Nepal found that 23

percent of households had inadequate food consumption and 7 percent of households had poor dietary diversity, including 46 percent of children between 6 and 23 months of age. (Ministry of Agriculture and Livestock Development, 2020). The lack of dietary diversity is likely to increase the risk of further illness due to inadequate nutrients (Gahatraj, 2020) or having to eat certain foods despite to food intolerances (International Disability Alliance, 2020q).

7.6.4. Good practice

Some positive examples reported in literature included the establishment of common kitchens serving cooked food and delivering dry rations in the Indian state of Kerala, alleviating food poverty in the state (National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020). In China, community groups were established via instant messaging apps to coordinate the local delivery of supplies from the government (Qi and Wang, 2020). Some disabled people have also taken the initiative to buy and deliver food, medical supplies, and face masks to those in need who were not receiving government relief (Goyal et al., 2020, International Disability Alliance, 2020k).

7.7. Violence and abuse

7.7.1. Increase in violence

Disabled people were at greater risk of violence and abuse (Humanity & Inclusion, 2020a, Lund, 2020). Emerging data indicates that violence against disabled people increases during the pandemic, in particularly abuse of disabled women and girls. An international survey received 25 testimonies of grave human rights abuses against women (Brennan et al., 2020), while in another 22 women and non-binary people reported feat for their personal safety (Women Enabled International, 2020). In Nepal, 28% of respondents reported abuse based on their disability or gender (Shrestha, 2020). A report from India indicated an almost 100% increase in domestic violence during the beginning of the lockdown (National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020), while in Nigeria, reports from 23 states showed a 56% increase in violence during just two weeks of lockdown (Samaila et al., 2020). In Palestine, 47% surveyed by a women's organisation reported an increased in gender-based violence, with children in 40% of households being maltreated, and older disabled women and women with caring responsibilities being at particular risk (Aisha Association for Woman and Child Protection, 2020). In Togo, Humanity & Inclusion (2020a) report 33 cases of violence against homeless people, who have a high prevalence of disability.

7.7.2. Domestic, caregiver, and sexual violence

As a result of the prolonged isolation in confined spaces, along with economic stresses (Pearce, 2020), many households reported any increase in tensions and conflict in households (Goyal et al., 2020, International Disability Alliance, 2020f, Jones et al., 2020), particularly in households with children (Aisha Association for Woman and Child Protection, 2020). While boys and men were

sometimes allowed to escape family problems by leaving the house, women and girls were more likely to be completely confined to the home (International Disability Alliance, 2020f, Jones et al., 2020, UN Women Africa, 2020). A number of first-hand reports are emerging of disabled women and children being subjected to increased domestic abuse during lockdown, while also having being unable to access family or government support (International Disability Alliance, 2020f, International Disability Alliance, 2020q, Panda et al., 2020). Disabled people may also be at additional risk of caregiver abuse, involving the withholding of assistance with essential daily living activities, such as eating, getting dressed, and access to mobility devices (Lund, 2020). Several disabled women in an international survey reported they found requests for assistance harder to make during the pandemic, with one stating that a family member refused to deliver medication to her (Women Enabled International, 2020). In India, family abandoned a deaf person with suspected COVID-19 at medical centre after giving fake contact details (National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020). Lund (2020) highlight that disabled people are usually advised to have backup caregivers in place in case of abuse by a primary caregiver, but that this is unlikely to be viable during a pandemic. While it is acknowledged in the reviewed literature that disabled girls and women are at particular risk of sexual violence and exploitation (UN Women Africa, 2020), including being forced into survival or transactional sex (Castres and O'Reilly, 2020), there is limited data on this, except for four reports of rape in Nepal, including a 10-year-old disabled girl (Gurung and Gahatraj, 2020).

7.7.3. Police violence

The COVID-19 Disability Rights Monitor survey received 370 testimonies across all continents highlighting the global prevalence of police violence and harassment against disabled people (Brennan et al., 2020). There are multiple reports of excessive forced being used to enforce lockdowns and curfews (Brennan et al., 2020, Goyal et al., 2020, Panda et al., 2020), including deaf people being shot by police after not responding to verbal commands (Brennan et al., 2020, International Disability Alliance, 2020i), others being harassed or beaten while looking for food (Brennan et al., 2020, Meaney-Davis et al., 2020), and being denied a personal assistant while shopping (Zayed et al., 2020). Consequently, disabled people expressed living in fear of the police and being afraid to leave their homes (Brennan et al., 2020, Emirie et al., 2020).

7.7.4. Discrimination and stigma

Despite efforts to destigmatise disability, prejudices and inaccurate beliefs about disabled people continue to be held in many cultures, including disability being viewed as a curse (Emirie et al., 2020, King et al., 2019) or involved in witchcraft (International Disability Alliance, 2020l). This prejudice aggravates the impact of the pandemic by increasing the risk of discrimination when accessing healthcare services, employment, and education, as well as increasing the risk of violence and undermining their capacity and autonomy (Humanity & Inclusion, 2020a). Several reports indicate that disabled people have been discriminated against due to the assumption that they are more likely to be infected with COVID-19 (Humanity & Inclusion, 2020a, International Disability

Alliance, 2020l, Meaney-Davis, 2020, Rohwerder, 2020d, Women Enabled International, 2020) . Rohwerder (2020d) highlights that other marginalised groups have also been stigmatised in similar ways, in particularly the LGBTQ community who have been blamed for the pandemic in a number of countries, as well as racial and ethnic minorities, foreigners, homeless people, sex workers, and people living in poverty. Young disabled people have reported experiencing increased stigma in public spaces, and being verbally abused for wearing masks (Emirie et al., 2020). Other first-hand accounts include a disabled person being given money by strangers who assume he must be a beggar (International Disability Alliance, 2020h) and a disabled person being patronised and treated like a child due to his psychosocial impairment (International Disability Alliance, 2020l). This stigma has led to some disabled people going out less or not using their assistive devices in order to minimise potential abuse (Zayed et al., 2020), while others may not identify as disabled due to the associated stigma, and therefore miss out on support (International Disability Alliance, 2020q).

7.7.5. Access to reporting, support, and justice

The considerable barriers faced by disabled people to reporting violence and abuse, including fear of not being believed, fear of retaliation from the perpetrator or care systems, and inaccessible reporting mechanisms, were increased as a result of the pandemic and its impact on social life (Lund, 2020). As the perpetrators of abuse are often family members or caregivers, disabled people are less likely to report for fear of losing their access to care, which was exacerbated through the lack of care alternatives during the pandemic (Goyal et al., 2020, Humanity & Inclusion, 2020a). Reporting may also put disabled people at higher risk of being institutionalised, and increase their risk of contracting COVID-19 in an institutional setting (Lund, 2020). Lockdowns meant that disabled people often had little privacy, making the reporting of abuse more difficult (Goyal et al., 2020, Lund, 2020, Xafis, 2020). Disabled people in institutions are also more likely to have limited contacts with friends or family, reducing the ability report abuse (Castres and O'Reilly, 2020). Some disabled people cannot access reporting hotlines or websites due to their impairments and shelters are also often inaccessible (Goyal et al., 2020, United Nations Human Rights, 2020). Poverty may also be a barrier for seeking support if disabled people are unable to afford transport to escape an abusive situation (Pearce, 2020). The literature highlights the need for disability-awareness training for police and law enforcement authorities and measures taken to ensure access to justice for disabled people where abuse occurs (Brennan et al., 2020).

8. Pandemic management

This section will focus on the management of and planning of responses to the COVID-19 pandemic by governments and international agencies in relation to the specific requirements and barriers faced by disabled people. Previous literature on management of disasters and emergencies, as well as development and humanitarian programmes, have highlighted the importance of considering the needs of disabled people and involve them in planning processes, and the fact that this has rarely happened in practice (King et al., 2019, Görgens and Ziervogel, 2018, Campbell et al., 2009). The emerging literature suggests that this has yet again been replicated during the COVID-19 pandemic, with most countries neither considering nor consulting with disabled people in the management of the pandemic. In the past, disabled people have sometimes been included with 'vulnerable' groups where their specifc needs were lost (King et al., 2019). Where disabled people were included in planning, their needs were often considered in isolation and plans were not necessarily implemented or enforceable. Adequate planning was also significantly hindered by a lack of data which made it difficult to identify disabled people and assess the impact on them to identify the impact on them.

8.1. Consideration of disabled people's needs

Multiple reports indicate that a number of governments did not take measures to ensure access to food, medication, and other essential supplies specifically for disabled people during the pandemic (Brennan et al., 2020, International Disability Alliance, 2020b, Qi and Hu, 2020). Many countries a adopted a "one-size-fits-all approach" (Goggin, 2020) to pandemic management which put disabled communities at greater risk by neglecting or deprioritising the specific requirements of disabled people (Goyal et al., 2020, International Disability Alliance, 2020c), rather than applying a universal design approach (Gartrell et al., 2020). Where measures were introduced to address the requirements of disabled people, they were not necessarily implemented at local level (Sakellariou et al., 2020), and were often made as recommendations or guidelines rather than enshrined in law, making them difficult to enforce (International Disability Alliance, 2020b, National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, Qi and Hu, 2020, Qi and Wang, 2020, Sakellariou et al., 2020). Measures also frequently failed to recognise that disabled people are a heterogeneous group and did not sufficiently address the needs of different types of impairments or the intersections with other marginalised identities (Gurung and Gahatraj, 2020). This included a lack of consideration for the link between disability and poverty (Sakellariou et al., 2020), and the differing needs of disabled women (Gurung and Gahatraj, 2020), indigenous people (Gurung and Gahatraj, 2020, Sakellariou et al., 2020), those living in rural locations, and children (Brennan et al., 2020). However, a positive example emerge from Peru, where legistation was introduced specifically protecting the rights of disabled people and ensuring equal access to health, employment, education, and social protection, with explicit reference to the UNCRPD (Sakellariou et al., 2020). China also introduced additional mechanisms to facilitate the enforcement of disabled people's rights in the pandemic (Qi and Wang, 2020).

8.1.1. Consultation of disabled people

Existing literature from both disaster planning and management, and development fields highlight the need not only for consideration of disabled people's needs, but for the need of actively involving disabled people in the planning process. Disabled people often have unique insights into their own needs in the event of an emergency (King et al., 2019), as well as experience of making adjustments and accommodations during difficult circumstances, and assessing risks to overcome barriers (Abbott and Porter, 2013, Guidry-Grimes et al., 2020, Pineda and Corburn, 2020). Disabled people should therefore be involved in policymaking through participatory approaches that enable co-production of policy to ensure they are fit for purpose (Gartrell et al., 2020, Görgens and Ziervogel, 2018, Pineda and Corburn, 2020, Pregel and Le Fanu, 2020). This is enshrined in the global disability rights motto "Nothing about us without us". The role of DPOs during the COVID-19 needs to be particularly highlighted, as many challenged the lack of disability-inclusive measures, as well as providing support and coordinating relief efforts (Brennan et al., 2020, Gurung and Gahatraj, 2020, Pregel and Le Fanu, 2020, Zayed et al., 2020), despite encountering resistance from official authorities in some instances (Gartrell et al., 2020, Poudel and Subedi, 2020).

8.2. Data

Accurate data that is segregated by disability is crucial to ensure efficient planning and allocation of resources for disabled people (Campbell et al., 2009, Gartrell et al., 2020), including but not limited to the rate of infection (Qi and Wang, 2020), returns to school (UNICEF, 2020b), and the effects of social isolation (Castres and O'Reilly, 2020). Despite this, the literature reviewed highlights that several countries do not collect data on the disability status of those affected by COVID-19 (ECLAC, 2020, Gurung and Gahatraj, 2020), and disaggregated data is also missing for the population of disabled people in institutions (ECLAC, 2020) and the socio-economic impact of COVID-19 on disabled people (Humanity & Inclusion, 2020a, Meaney-Davis, 2020). Further, the literature highlights a number of challenges regarding the collection of data in LMICs including: a reluctance to identify as disabled due to stigma and discrimination (Berghs, 2015b, Gartrell et al., 2020, Meaney-Davis et al., 2020, Rohwerder, 2020a, Washington Group on Disability Statistics, 2020) and a lack of diagnostics and screening for disabled people, particular children (Cahapay, 2020b, Rohwerder, 2020a). The use of diagnosis as a basis of determining disability is especially challenging when healthcare services are limited, as well as reinforcing a medical model approach (Banks et al., 2021). In addition, where data is collected, quality is variable as methods used to gather data are not consistent (Hillgrove and Pryor, 2020, Rohwerder, 2020a), leading to significant underestimations of prevalence levels of disability (Rohwerder, 2020a). Bias against disabled people can also taint the quality of data, as highlighted by the statistic that 48.5% of death certificates for adults with IDD inaccurately reported their impairment as the cause of death (Sabatello, 2020). The Washington Group questions, which are used to measure the implementation of SDG goals as well as in humanitarian context to gather large-scale data of disability prevalence are recommended by several authors as a way of ensuring that the data gathered on disability and COVID-19 is consistent (Hillgrove and Pryor, 2020, UNICEF, 2020a). Guidance has also been issued by the Washington Group on the application of the Washington Group in a COVID-19 context (Washington Group on

Disability Statistics, 2020). In addition, Bernard et al. (2020) have developed a COV-DIS survey template designed to measure the impact of the pandemic on general and psychological health, instrumental activities of daily living, social isolation, financial strain, and information and transportation access.

9. Discussion

This discussion will provide a critical analysis of the types of evidence that has emerged and seek to identify gaps of where further research and evidence is needed. It will also discuss two of the emerging themes from the literature review; firstly, the de-prioritisation of disabled people during the pandemic and secondly, the tendency for disability to continue to be viewed in narrow medical terms. There will also be a discussion of the limitations of the review and its methods.

9.1. Types of evidence emerging

As highlighted in the methods section, the studies and reports included in this literature review were distributed unevenly across the four sectors of Health, Education, Economy, and Community, with the health and economy being the most heavily populated sectors. This reflects the findings by Saran et al. (2020) in their mapping of studies assessing the effectiveness of interventions for disabled in LMICs, who found that most studies focussed on health interventions, with relatively few focusing on social inclusion and empowerment. This suggests that, despite disability activists advocating for a move away from medical or deficit models, that disability is still often framed as a medical issue. In addition, the heavy focus on economy highlights the strong link between disability and poverty, with most papers in this section focussing on social protection and economic survival during the pandemic. However, it is important to recognise that the distinction between the four sectors is often tenuous and not clear cut, highlighting the interconnectedness of our everyday lives. Food poverty, for example, spans the three sectors of Economy (being able to afford food), Community (physical access to food), and Health (impact on nutrition). While research and funding initiatives may focus on specific issues, it is therefore crucial to consider the bigger picture and understand the interconnectedness of different societal systems in creating structural disadvantage.

The distribution of literature highlights a relative absence of academic research into COVID-19 and disability, with twice as much 'grey' literature as academic texts on COVID-19. This is likely due in part to the longer times required to obtain funding, plan and conduct research, and go through peer review and publishing processes. Most of the 'grey' literature emerged early on in the pandemic, whereas most academic papers were published in July and August 2020. The lack of academic literature means there are considerable gaps in research evidence on several of the topics covered; in particular, return to school, employment and unemployment, and community impacts, including isolation, and access to food and digital infrastructure. This type of evidence is just beginning to emerge in a UK context at the time of writing (February 2021). However, the literature review also found that very little research evidence focussing on the impact on disability as a social phenomenon emerged following disasters and emergencies. It is therefore crucial that for COVID-19 the gathering of evidence on both the immediate and long-term effects of the pandemic in LMICs are prioritised by research funders and other stakeholders, particularly the historical and current lack of data highlighted in 8.2.

59% of the evidence comes from 'grey' literature, in particular NGO reports and guidance from UN agencies (as discussed in 3.3), which often emerged right at the start of the pandemic. Several of the reports therefore discuss potential risks to disabled people rather than presenting empirical

evidence or discussing concrete examples. Where data has been gathered early on in the pandemic, this may not necessarily represent the experience of disabled people as the pandemic progressed, and additional issues may have improved been exacerbated. Governments may have taken different approaches to management in subsequent ways of the pandemic, and it is crucial to recognise the cumulative impact over time on both physical and mental health of disabled people.

9.2. Gaps

This literature has identified a number of gaps in the current evidence across all four sectors of society, where further evidence and research is required to gain a holistic view of the impact of the COVID-19 pandemic.

9.2.1. Health

In Health, the most richly served section in this review, the gaps are around the long-term effects of the pandemic on disabled people and on healthcare systems in LMICs. This includes the impact of "Long COVID", which describes the longer-term lingering of symptoms following the initial infection, with the most frequent symptoms being fatigue, post-exertional malaise, and cognitive dysfunction (Wise, 2021). Long COVID has the potential to increase significantly the number of people of those either temporarily or permanently impaired, and may require multisystemic rehabilitation facilities to be set up (Wise, 2021), in addition to rapidly increasing the number of disabled people across the globe. Other long-term effects to examine include the long-term impact on healthcare systems in LMICs and disabled people's access to them, as well as an increase in both levels and numbers of impairments as a result of cancelled or disrupted services, both due to deterioration of existing impairments, and creation of new chronic impairment due to conditions going untreated. A further crucial area for health is around the access of vaccination for disabled people in LMICs. Currently in February 2021, few LMICs have begun the vaccination process, as many lack both access to vaccines and the infrastructure to carry out mass vaccination of the adult population (Figueroa et al., 2021). While the WHO has recommended the inclusion of disabled people as a priority group in its roadmap for prioritisation of vaccination schemes (World Health Organization), this has not always been applied consistently in Global North countries including the UK, with confusion about which disabled people are included or excluded, and decisions often left to an individual doctor's discretion (Marsh et al., 2021). This literature review has identified a systematic deprioritisation of disabled people's needs in accessing healthcare, so evidence is crucial to identify whether this is replicated in the delivery of vaccination programmes.

9.2.2. Education

In Education, empirical evidence is urgently required on the impact of school closures, including return to school/drop out rates of disabled children, as well as the attainment gaps as a result of disabled pupils' lack of access to remote learning. There is also currently a lack of data on the impact of school closures on disabled teachers and disabled parents, with virtually all research

focussing on the impact of disabled children. This review was unable to identify any literature relating to tertiary and adult education. While there is some evidence emerging from the Global North, primarily focussing on the alternative modes of delivery and access of technology, this cannot be assumed to be transferrable to a Global South context due to the differing availability of information technology access. There is however a wider need for research into disabled people's experience of using accessible technology in different contexts, and from different impairment perspectives, to identify how technology is currently being used, particularly by those with limited access, and what technological advances are needed to ensure technology can truly be accessed by all.

9.2.3. Economy

In the Economy, there is a lack of quantitative data on the impact of the pandemic on disabled people's livelihoods, in particular poverty rates, and both short-term and long-term impacts on disability employment rates. In addition, none of the papers reviewed discussed in detail the impact of the pandemic on unpaid and care work. Disabled people are receivers of care as well as providers (as parents or family members), and often both at the same time. Care work remains a highly gendered issue, with many women's opportunities to take part in paid work being constrained by the burden of unpaid and care work (Chopra and Zambelli, 2017)). The increase in care work required as a result of school closures and disruption of formal care services has the potential to have disproportionately impacted on women, including disabled women. There also wider research challenges around way in which development programmes are inclusive of disability, and support disability-specific initiatives. The current spending on this is low and ongoing data will be needed to identify how post-COVID development funding may affect the funding available for disability-focussed programmes. In addition, this report has identified further data on access to social protection for disabled people, and whether there will be any long-term change to this as a result of the pandemic.

9.2.4. Community

In the community, while there are some evidence of grave human rights abuses taking place against disabled people in institutions, more investigations are required to gain both quantitative and qualitative evidence of the impact of the pandemic on disabled people incarcerated in institutions and prisons, as well as data on the impact on both refugees and disabled people, which needs to included disaggregated data on disability. Some areas of community participation were completely absent in the literature, including religion, such as access to places of worship and religious practices, as well as no discussion of access to leisure, including access to parks, playgrounds, and public spaces, as well as to culture, arts, and sports. Both are crucial to enable to disabled people fully participate in society. However, access to arts and sports in particular are discussed only in a rehabilitation context, highlighting the medicalisation of disability rather than allowing disabled people to participate in these activities for pleasure as humans. Finally, COVID-19 has brought about new infrastructures, including services being delivered remotely. While the literature has

acknowledged the challenges of remote services both in terms of access to and accessibility of technology, this has also brought about opportunities through an increased flexibility which enabled disabled people to engage in work, education, health, and society from their homes. More research is required to identify the longevity of these new forms of access to ensure that disabled people and society as a whole is able to benefit from this increased flexibility, rather than returning 'back to normal'.

9.3.   Emerging theme 1 – deprioritisation of disability

The first major theme emerging from this literature is the de-prioritisation of disability in both planning and service delivery during the pandemic. This literature review has identified a considerable body of existing literature in development studies, disaster and risk management studies, and disability studies, highlighting the importance of consultation and involvement of disabled people in planning and management. However, there is little evidence that this has happened in previous disasters and emergencies or that substantial lessons have been learned in the aftermath, which is underscored by the lack of empirical evidence on the impact of these disasters on disabled people. This review identified only 14 relevant articles focussing in detail on the impact of previous disasters and emergencies on disabled people in countries in the Global South.

While this neglect of considering disabled people is sometimes described as "forgotten" (Goyal et al., 2020) or being "left behind" (National Centre for Promotion of Employment for Disabled People (NCPEDP), 2020, United Nations, 2020b), this suggests that the omission of disabled people in planning processes was accidental. However, it is important to highlight that governments who have signed up to the UNCRPD are aware of the importance of considering disabled people's additional barriers and specific requirements, and the need to involve disabled people has been identified many times in existing literature and policy reports. It is therefore reasonable to conclude that the lack of consideration for disabled people' needs was not an oversight, but that disabled people were not prioritised as they were considered less important. The de-prioritisation of services for disabled people as 'non-essential' perpetuates the continued discrimination and stigma of disabled people as 'less than' human. It is therefore important to address the systemic cultural and attitudinal barriers that leave disabled people an afterthought.

Work is required by governments, and NGOs to centre the needs and concerns of disabled people, as well as adopting universal design practices to ensure any services are accessible from the start to as many people as possible, rather than implementing access retrospectively. In order to achieve this, it is vital that experts on disabled people and accessibility lead in these planning processes – these experts are the disabled people themselves. The evidence on COVID-19 suggests that again disabled people were not consulted in most countries during the planning process, and in most cases their needs were not considered at all. Across all four sectors reviewed, there is a common theme that the barriers that disabled people face to accessing healthcare, education, employment, social protection, and to participate in the community, were not considered in pandemic planning, and that measures to ensure disabled people's access were usually either implemented

retrospectively, or not at all. This review therefore highlights once again the importance of cooperation and communication with disabled people to not only identify and involve them in the process of finding solutions as the default, but to implement mechanisms enabling disabled people to take the lead in voicing their concerns and leading on the pandemic management strategy.

9.4.   Emerging theme 2 – 'medicalisation' of disability

The second theme emerging from this literature review is the continued focus on disability as a medical issue, rather than a social phenomenon of disadvantage. This is highlighted by the uneven distribution of topics in the texts selected for this review, with more than half of texts focussing on health as one of the three primary themes. Rather than the social model or CPRD definitions of disability, some of the papers use problematic definitions of disability based on a medical or deficit model. It is therefore crucial to ensure that any work comes from a perspective that recognises the social factors in the production of disability. In addition, disability is often treated as a monolith both in literature and pandemic planning, for example through a blanket description of disabled people as 'vulnerable' to COVID-19. It is crucial to understand that disability is a heterogenous experience and there will be significant differences in experiences based on types of impairment, cultural context, and intersecting identities or multiple marginalisations. Once again, the involvement of disabled people from a variety of backgrounds in both design and leading research will ensure a more balanced perspective in ensuring that research and reports represent the full breadth of the disabled experience.

More needs to be done to enable disabled people to be centred and leading on disability research. This is underscored by only a small amount of the 'grey' literature emerging from organisations of disabled people, while most of the reporting is carried out by NGOs, who are often international charities, despite the disability movement in the Global North highlighting the historic issue with the 'charity model' approach. In addition, a considerable body of disability research was identified during the initial searches of this literature review as it did not focus on disabled people, but rather centred non-disabled people by examining the impact of the pandemic on carers, parents, family members, and healthcare staff, often using negative narratives around the 'burden' that increased caring responsibilities caused for these groups. Finally, there was a marked absence of positive stories in the reports, with only few good practice examples or discussions of the potential for 'building back better'. There is a danger that purely negative reporting perpetuates stereotypes of disabled lives as 'tragic'. While the pandemic has had devastating consequences, there are also moments of hope, resilience, and survival to be found, not least in the role played by many disabled people's organisations in ensuring access to information and food for disabled people where they were failed by official government processes.

Research needs to take a holistic view of recognising the interconnections of different systems disadvantaging disabled experiences, including recognising that impairment is often created or exacerbated through poverty, a lack of access to education, employment, and healthcare, and wider geo-political contexts, including conflict, neo-colonialism, and capitalism (Berghs, 2015b, Jaffee, 2016). In order, to realise the human rights enshrined in the UNCRPD, it is therefore crucial to

understand the cumulative and interacting effect of these inclusions on disabled people in the Global South. As discussed in the literature review, while most of the text reviewed cover multiple topics across and recognise to some extent the cumulative and interconnected effect of exclusions from different systems, this holistic approach is crucial and needs to be continually emphasised in future research. The need for a holistic approach is made further by the complete absence of any research into access to religious worship, as well as leisure, including access to recreational spaces, culture, and sports. While there is rightly much focus on access to healthcare and economic support to ensure disabled people' survival, it is also important that disabled people's access to a full life with participation in all aspects of society is guaranteed.

9.5.   Limitations

The comprehensiveness of this literature review in mapping out the impact of the COVID-19 pandemic on disabled people in LMICs is constrained by several limitations, Firstly, searches were conducted only in English and all search results were in English. This may have led to evidence in other languages being missed, and particularly risks excluding testimonies from disabled people on the ground, who may not have the knowledge or capital to publish their testimonies in English. As this review focussed on LMICs as a whole, it has also been difficult to consider in enough detail the nuances between different countries, regions, and cultures. Efforts have been made to highlight in texts whenever an experience was highly specific to a context, while also drawing out experiences common across the Global South.

While this literature review was led by researchers with lived experience of disability, the researchers were situated in the United Kingdom. This position of privilege means that researchers do not have first-hand experience of the pandemic in LMICs. To ensure input from disabled people in the Global South, an advisory group was set up to support the and gain feedback on the review as it developed.

Finally, the timeframes for the review have likely contributed to the lack of peer-reviewed academic evidence, as the longer timeframes for this type of research means that much had not yet emerged at the time of the review. While the researchers made efforts to identify and connect with ongoing research into COVID-19 and disabled people in the Global South, it is possible that there will be further research emerging that addresses some of the gaps identified in this literature. The reliance of this review on data from NGO reports, which may not follow established methods and approaches or use representative samples, means that the data the nature and quality of data may vary. However, clear themes and clusters of evidence emerged from across the literature, making it likely that the review has been effective in highlighting the key challenges impacting disabled people during the pandemic.

10.   Conclusion and recommendations

The evidence reviewed and discussed in this literature review clearly indicates an exacerbation of existing barriers faced by disabled people across the world, and particularly in the Global South. It has highlighted that for many disabled people, COVID-19 was yet another additional concern, but that for many, access to healthcare, poverty, and violence, are just as life-threatening as the pandemic.

The review has identified significant discrimination in both access to healthcare and communication of essential public health information, an increase in barriers to education for disabled children, an increase in poverty and a lack of social protection, compounded by a rise in unemployment, and a rise of neglect, abuse, and isolation among disabled people in the community and particularly in institutions, prisons, and refugee camps. Where governments have taken action to limit the impact of the pandemic, disabled people have often been excluded or de-prioritised from any plans, and have not been involved. Furthermore, there is a worrying lack of data being collected at national and international level on impacts on disabled people, both in terms of infection and mortality rates, and the impact on poverty, employment, education, and isolation in the community. This means governments are unable to truly assess the impact and take mitigating action. This review has highlighted that there is an urgent need to both centre disabled people in all future planning, and to involve them in these planning processes. It has also emphasised the need to move away from a medical or deficit perspective on understanding disability, and a more holistic approach that considers the interconnections between different societal systems, as well as the wider geo-political contexts.

In order to address and mitigate the exacerbation of disabled people's oppression under COVID-19 and achieve a disability-inclusive recovery, we make the five following recommendations

1. Commissioning of further research into the gap areas identified in 9.2, with a particular focus on the long-term health and economic effects of COVID-19, vaccination processes, and collection of empirical data
2. Mapping of data currently being collected at national and international levels on disability COVID-19, who is collecting the data, and how it is used
3. Recognition and further research into the interconnectedness of different societal sectors and systems, and funding approaches aimed building long-term sustainable systems
4. Ongoing campaigns to de-stigmatise and de-medicalise disability and promote a social model, both in countries and in disability studies as a research field
5. Engagement of disabled people in contributing and leading on research, consultancy, and planning processes into a disability-inclusive recovery

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