Disability Awareness Checklist Facilitator Guide

CDC Centers for Disease Control and Prevention

ARRC

UNFPA

University of KwaZulu-Natal

saMRC advancinglife

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1. ACKNOWLEDGEMENTS

The Disability Awareness Checklist (DAC) is a simple disability sensitization tool that can be used to undertake a basic assessment of a health facility's preparedness to accommodate people with disabilities and support this facility to develop a 'quick and easy' action plan. The original version of the DAC was developed by Prof Dr Jill Hanass-Hancock and Prof Dr Verusia Chetty during the Closing the Gap and Breaking the Silence studies at the University of KwaZulu-Natal. Thereafter the DAC was adjusted, validated and piloted in collaboration with the South African National Department of Health (NDoH) and CDC in a study focusing on the adaptation of a post-Gender Based Violence (post-GBV) Service Quality Assurance tool at the South African Medical Research Council. This project was led by Dr Kristin Dunkle, Prof Jill Hanass-Hancock and Dr Samantha Willan with assistance from Nonkulelekho Tesfey, Thesandree Padayachee and Bradley Carpenter.

Furthermore, the DAC was reviewed by a number of experts in the field of disability, health care and GBV namely: Dr Jacques Lloyed, Thembelishe Zulu, Pam MacLaren, Maryke Bezuidenhout, Natasha McAllister, Thoko Modise, Jacquili Kathleen Kaschula, Thesandree Padayachee, Dr. Adele Marais, Dr. Johan J. Hugo, Sr Mapaseka Mabena, Dr Lukhozi, Anil Padavatan, Sharon Cox, Dr. Erumeda, Dr. Avni Amin, Dr. Ntlotleng Mabena, Constance Noluthando Mathe, Dr Mike Lukhozi, Venice Mbowane, Leora Casey, Minja Milovanovicm, Dr. Jenny Coetzee, Pricilla Monyolo, Sunitha Maharaj, Dr Ellesh Narbharam Soni, Sister Doreen Rose Thandeka Gumede, Nthabiseng Sibisi, Annah Mabuda, Sally-Jean Shackleton, Rainy Radaba, Nozuko Majola, Chris McLachlan, Sinikiwe Biyela, Wendy Mehlomakhulu, Jennifer Drummond, Jacobus Oliver, Nuha Naqvi, Sibongile Dladla, Bettina Schneider, Maria Bakaroudis and Hellen Sever.

2. GLOSSARY OF TERMS

Abbreviations

ARRC	Afrique Research and Rehabilitation Consultants
CDC	Centre for Disease Control and Prevention
DAC	Disability Awareness Checklist
GHS	Global Health Survey
GBV	Gender-based violence
GBV-QA tool	Gender-based violence quality assessment tool
HRBA	Human Rights Based Approach
NDoH	National Department of Health
SLI	Sign Language Interpretation
UNFPA	United Nation Population Fund
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities

Conceptual terms

Disability: is an evolving concept which "results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others"(CRPD)(1)

DAC facilitator: stands for Disability Awareness Checklist facilitator who uses the DAC tool to conduct a facility assessment and develop a facility action plan.

Gender-based violence: describes violence that establishes, maintains or attempts to reassert unequal power relations based on gender. The term was first defined to describe the gendered nature of men's violence against women. Hence, it is often used interchangeably with 'violence against women'. The definition has evolved to include violence perpetrated against some boys, men and transgender persons because they do not conform to or challenge prevailing gender norms and expectations (e.g. may have a feminine appearance) or heterosexual norms" (ALIV[H]E framework) (2).

Key population: are often defined in a particular disease context such as HIV where key population are defined as groups who, due to specific higher-risk behaviors, are at increased risk of HIV, irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviors that increase their vulnerability to HIV (3).

People/Person with disabilities include 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 (CRPD)(1).

Primary health care: is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people's everyday environment (4)"

Organization of Persons with disabilities (OPD): is a representative organization or group of people where persons with disabilities constitute a majority of the overall staff, board, and volunteers in all levels of the organization (5)

Reasonable: "means necessary and appropriate modification and accommodation adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms" (CRPD p4)(1).

Universal design: "means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design. 'Universal design' shall not exclude assistive devices for particular groups of persons with disabilities where these are needed". (CRPD p 4)

Vulnerable populations: "are groups and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability" (6)

3. INTRODUCTION

People with disabilities make up at least 15% of the world's population (7, 8). They are also part of all key and vulnerable populations and experience many health disparities (8, 9). For instance, people with disabilities are two times more likely to be malnourished and die as a child, experience intimate partner violence or be infected with HIV (7, 8, 10-12) and have 2.4 fold higher mortality rates (13). They are 50 times more likely to have catastrophic health expenditures than their peers without disabilities (7, 14). Census and Global Health Surveys (GHS) data in many countries show that people with disabilities are more likely to be poor and earn less than their peers without disabilities, making it very difficult to cover their health care costs themselves (13-15).

In addition, people with disabilities may experience double discrimination based on their disability (type and severity) and its combination with individual characteristics such as age, gender, sexual orientation and/or the experience of environmental barriers which can increase the exclusion and vulnerability of people with disabilities. Hence, people with more severe disabilities, children with disabilities, women with disabilities, LGBTQI+ people with disabilities or those living in extremely inaccessible environments carry additional layers of vulnerability (9, 16-18). Similarly, a person with disability, who also has another stigmatized health condition such as mental illnesses or HIV infection may experience double discrimination. The intersection between disability and additional factors associated with increased risk and vulnerability may create complex and unique healthcare needs and concerns.

People with disabilities often struggle to access health care services, including primary and specialized health care, disease prevention, and post-GBV care (7, 8). Commonly the challenges to access health care are attributed to a lack of knowledge and access to information about health care among people with disabilities, a lack of accessible and affordable transport, challenges when accessing facilities themselves, lack of health care staff's skills to accommodate disability and attitudinal barriers at the health facility level (7, 9, 19-22).

Some health facilities and health care worker-driven factors that lead to the exclusion of people with disabilities can be addressed at health care facility level. This includes the increase of knowledge and attitudes towards disability among staff, the improvements of physical accessibility of the facility and the adjustment of communication and information material to accommodate people with different kinds of disabilities.

Many health facilities in low- and middle-income countries do not have a simple mechanism to identify disability accessibility and service provision gaps. While available 'disability audits' are very comprehensive they are often designed for resource rich countries, require highly trained staff and fail to identify feasible options of change for a facility in a resource poorer setting. It is against this backdrop that the Disability Awareness Checklist (DAC) was developed. This document serves as a companion guide for anyone wishing to use the DAC or facilitate its implementation within health facilities in a low- or middle-income country. The DAC was developed and tested in the South Africa context of public health care settings with diverse resource options and constrains.

4. PURPOSE OF THE DISABILITY AWARENESS CHECKLIST

The developers of the DAC framed the tool within a **human rights-based approach** and aimed to increase awareness of accessibility and service delivery needs for people with disabilities by analyzing barriers, inequalities, discriminatory practices, and unjust power relations that may exists in health care facilities.

Within this approach the DAC sets out to **assist health facility staff** to initiate the process of increasing disability accessibility and service delivery at health facility level and achieve a heightened level of disability awareness within their teams. The DAC is based on the principles and concepts of the UN Convention on the Rights of Persons with Disabilities (UNCRPD) and was informed by existing disability audits. Its design was completed through a comprehensive expert review in 2021 and pilot testing during a study focusing on the adaptation of the WHO post-Gender-based Violence Quality Assurance tool (GBV-QA tool) in 2022 (23).

The DAC is a **disability sensitization tool** that aims to increase awareness for disability accessibility and service delivery for people with disabilities. Unlike a full disability audit the DAC is not a comprehensive tool to assess all aspects of disability accessibility, inclusion and service delivery. The DAC rather sets out to identify basic gaps in accessibility and service delivery, sensitize staff about disability needs as well as help staff to identify areas they can improve.

Hence the DAC is a **developmental and process orientated tool** designed to further strengthen the awareness and realization of rights of people with disabilities. In addition, the DAC is intended to be 'easy to use', hence it aims to be implementable by all health care staff or civil society organization representatives without extensive training. Hence it sets out to be user-friendly and collaborative in its application and enable users to develop a 'quick and easy' action plan based on what actions are in the control of the DAC facilitator and/or health care staff.

5. GUIDANCE ON HOW TO USE THE DISABILITY AWARENESS CHECKLIST

Facilitators/staff implementing the DAC tool need to be literate, take simple measures of width and angles and be familiar with this DAC facilitator guide. In order to ensure a lasting impact, it is important that the DAC is implemented using participatory methods and working in close partnership with health officials and service providers. The guidance provided in this document is meant to provide support to DAC facilitators who wish to use this tool to raise awareness about disability access and service delivery issues within healthcare facilities. There are several steps necessary for preparing, conducting and responding to the findings of the DAC and we unpack these in some detail below. However, users need to be aware of the need to adapt these steps to the context of their provinces, districts and facilities within which they work.

Step 1: Identification of DAC facilitator

The assessment process requires one or more DAC facilitator(s), who can be anyone seeking to improve or assess the accessibility of a health care service. Hence, DAC facilitators can be a community member, a member of the facility staff, a representative from an organization of persons with disabilities or persons with disabilities themselves.

The DAC facilitator(s) need to have acquired the following skills:

- Reading, writing and measuring widths of doors and angles of ramps
- Understanding of how to use a checklist and fill in forms/tables
- Facilitating the development of an action plan with a health facility

While it is not necessary for the facilitator to be fully knowledgeable about UNCRPD and other conventions, it is valuable for the facilitator to have an interest in achieving inclusive health systems and an appreciation for the human rights principles that underlie the DAC.

The UNCRPD can be found under:
https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html .

Step 2: Preparing for a Disability Awareness Visit

In order to prepare for a 'Disability Awareness Visit' DAC facilitator(s) need to:

a) Identify which health care facility/facilities they want to assess and support
b) Become familiar with the DAC tool and its processes
c) Obtain approval to access the chosen health facilities form departments of health if facilitators are not staff members
d) Consult to the chosen health facility's staff in advance to ensure support and buy-in to the process

a) Become familiar with the DAC tool

First time facilitators need to **conduct a pilot assessment or test run with the DAC** to familiarize themselves with the use of the tool. The DAC Facilitator(s) need to be familiar with the DAC and its two-stage process

Facilitator(s) need to ensure they have the following items for the facility visit: t**he DAC paper form to be completed** (or electronic version)**, angles measures** (e.g. on a mobile phone) and a **measuring tapes**. In order to assess angles the facilitator can download simple Apps https://www.slashdigit.com/best-angle-measure-apps/ . For instance, The Angle Meter Pro works for Android and iOS mobile phones. The phone is simply aligned to the angle and reads the angle automatically. Other Apps work similarly.

The DAC facilitator needs to **understand the structure of the DAC**. The DAC is organized into 4 sections:

- Universal Design and Accessibility of facilities for people with disabilities,
- Reasonable accommodation (accommodating disability where universal design is not enough)
- Capacity development of facility staff on disability and
- Linkages of service to disability and rehabilitation services and support.

Each section has sub-categories with a set of questions prompting basic elements of disability accessibility and service delivery. Each element can be answered with "yes", "no" or "not sure".

Stage 1:
Assess service and access gaps through checklist (through answering all questions first)

Stage 2:
Reflect on what can be changed

Assessment sections:

Universal design and accessibility

Reasonable Accommodation

Capacity development of facility staff and

Linkages to disability and rehabilitation services.

UNIVERSAL DESIGN AND ACCESSIBILITY

Does your healthcare facility have the following elements to support universal accessibility?	Yes	No	Not sure	Things I can change/influence
Entrance to services				
Public Transport access for wheelchairs (intact tared pavement) not further than 1 km from the entrance door to clinic/facility				
Clearly signed parking space/s for people with disabilities with access pathway to the front door				
Ramps to access your building/s with 1:12 slope (5-degrees or less and no lip on door) OR building level with the ground (no stair(s) at entrance and no lip on entrance doors)				
Doors in your facility that open easily with one hand and can accommodate a wheelchair (at least 82cm wide at the narrowest point including the security gate)				
Reception desk at a suitable height for wheelchair users (82cm)				

The DAC facilitator needs to **understand the two-stage** process of the DAC.

Stage 1: First assess all checklist questions and their elements (using yes/no/don't know response options)

Stage 2: Thereafter inquire which missing elements can be influenced or changed through the facilitators or facility staff

During the first stage the DAC facilitator(s) assess the presence or absence of a particular element. In the second stage the facilitator(s) discusses with facility staff/management whether identified gaps can be changed through actions of their own or through their advocacy for actions in government departments or other stakeholders.

An action can be making a change to the facility structure or procedures themself or an application for support, resources or training to have facilities and processes adjusted. For the later the DAC facilitator needs to inquire where or who can provide training and support.

b) Obtain permission to conduct the assessment in facilities

The DAC facilitators need to **identify who will provide permission** for the Disability Awareness Visit. In many countries, access to health facilities is carefully managed by the local health authority. Unless the facilitator is a staff member of the facility, any outside party wishing to conduct an assessment within a health facility may require prior approval from local and facility management. The process involved in obtaining the approval may vary across countries and provinces. Linking with the District Health Management Team may be a good place to start as this may be an ideal point of entry into a district and its associated health facilities. They may also be able to introduce you to the relevant sub-district teams that lead other assessments in the facilities you are interested in. However, if this is difficult interested DAC users can also engage directly with the health facility staff and ask them for collaboration and assistance with introduction to the necessary authorities and approval processes.

The DAC facilitator(s) or someone from the health facility can **initiate the introduction** of the DAC process with the district management team telephonically, via email or face-to-face for each health care facility. The DAC facilitator(s) will need a list with contact details. An example of links to the contact details of South African health districts can be found on Appendix A.

The DAC facilitators may also have to **write a formal letter** to health authorities. An example letter is attached as Appendix B and may assist the DAC facilitator with any formal correspondence that is required when engaging with the district management team or other relevant officials. Carefully worded communication allows authorities to fully understand the nature of the DAC assessment, the process, and implications of the findings. During the introduction of an DAC assessment project the facilitator should outline the following details about the intended visit and assessment:

- The purpose of the visit
- The proposed date of the visit
- People in the facility needed for collaboration. If the DAC facilitator is a staff member from the selected facility, then list the staff members needed.
- How the collected information will be used

The facilitator should also share a copy of the DAC.

Step 3: Orientate the DAC Facilitators at the Health Facility

Once permission has been granted the facilitator(s) are able to **prepare for a meeting** and orientation of facility staff with the DAC and its process. An example slide deck (Appendix C) has been prepared, which facilitators can use to provide the background on the DAC and motivate for the need to better understand the disability accessibility and service delivery of a health facility.

In the orientation meeting the facilitator greets the management team and other staff and **explains the DAC purpose and procedures**. The facilitator(s) need to emphasize that the tool can be used to identify service and access gaps and enables facilities to work within their team and in collaboration with other stakeholders in the community to find solutions to improve access to health services for persons with disabilities.

The facilitator must be prepared to discuss how the DAC will feed into routine health facility assessments such as risk assessments and general monitoring and evaluation activities. At the end of the introduction meeting the facilitator(s) need to **set a date for the "Disability Awareness Visit"** and identify which staff members will participate in the DAC visit.

Step 4: Conducting the Disability Awareness Visit

During the Disability Awareness Visit the facilitator(s) **complete the DAC collaboratively with the health facility staff**. Having staff accompany the DAC facilitator on a physical walk through the health facility helps to sensitize staff to the challenges faced by persons with disabilities in accessing health services. Having a member of management join the walk through may prove valuable to the entire process and subsequent discussions about what can be changed / addressed by the staff. Staff in the facility are also a good resource for questions relating to training and linkage to services. If the DAC facilitator is a staff member working at the facility, the facilitator will conduct a facility walk in collaboration with another staff member. In some facilities it may be useful to take all measurements before going formally through the DAC checklist.

Filling in the **DAC is a two-stage process. Firstly**, all DAC questions and their elements are filled in and questions of clarity from the facility staff are encouraged. For each question element the facilitator(s) need to identify if the health facility has a particular element or not ('yes' or 'no' answer). If the existence of an element cannot be determined with the help of the staff members or point person, then the answer to this question element is 'no' (e.g., if staff and management cannot remember if they have been trained on disability or if they have screening tools on disability – the answer will be no). The facilitator(s) need to check themselves if an element can truly be answered with yes (e.g., review existence of training log or screening tools). Only if there are still uncertainties the facilitator(s) can indicate with an 'Not sure' and provide an explanation why they are unsure. At the end of this stage the facilitators can add all points in the DAC together. A 'Yes' is allocated a 1, and a 'no' or 'not sure' a 0. Each section is summed up and can be translated into percentages or presented as is.

Secondly, after the DAC questions have been completed the facilitator(s) and health care staff reflect on which elements on the DAC are amenable to change. This is reflected on the last column of the DAC i.e., "Things that I can change/influence". Here the DAC facilitator(s) identify what they and the facility staff can change or influence. This may include motivations to management to upgrade facilities or may also include alternative steps

to access tools to help improve access for people with disabilities and other resources within the community that may improve linkages to other care and support. Hence the staff within the facility are given the opportunity to assess their own ability to drive change and improve the experience of care for persons with disabilities.

If the DAC facilitator(s) are not staff members, then they identify what they can influence, this could be as simple as sharing the DAC results with the staff and starting to engage with the management about what, by whom and when things can be changed. **It is important for the DAC process that the facilitator(s) themselves take responsibility for driving change.**

At the end of the visit the facilitator and staff member get a copy of the completed DAC and its results.

Step 5: Providing Feedback to the Facility and Developing an Action Plan for Change

The implementation of the DAC will lead to the identification of accessibility, capacity and linkage to care gaps. Based on the results of the assessment, the DAC facilitator(s) and the facility staff members (including management) need to discuss the causes of the gaps and identify measures to implement change and increase accessibility and service delivery. The facilitator(s) need to **agree a follow up and feedback meeting** date with management of each facility in which they present results, lead discussion on which things can be changed in the short/long term and help facilities to develop a feasible implementation or action plan of things that can be changed. For the purpose of developing an 'action plan', the facilitator(s) can use the DAC last column. This column already indicates which opportunities for change were identified during the assessment and can be used to inform the feedback meeting and development of a simple action plan that identifies **'who**, does **what, when'**.

In the feedback meeting the facilitator(s) work with management and staff towards feasible solutions. For many staff, the identification of gaps using the DAC may feel overwhelming as there are intrinsic health system limitations/challenges that they may perceive as insurmountable. This is why careful facilitation and empathy is needed to move the staff from focusing on limitations **towards solutions-based thinking**. It is also vitally important to reiterate the human rights basis for the activity and the fact that staff as bearers of a service are responsible for ensuring that people with disabilities are adequately catered for within their facility. It is important to acknowledge that not everything can be changed immediately but with careful planning it can be changed over time. For instance, some items need very little financial or human resources (e.g., disability desk, collaboration with an OPD), while others require ongoing financial and human support (SLI). For both different approaches and solutions can be found over time.

After completion of the feedback meeting and consultations, the facilitators and facility management need to complete the assessment process with a **written action plan** that will be included in the facilities monitoring and evaluation processes moving forward (see appendix D). Such an action plan should state the findings of the DAC process, identify short-, medium- and long-term actions that the facility wants to take and identify by who, where and when these actions will be driven. Where possible this action plan should set timelines and identify the next follow up meeting. In addition, where outside services are needed for instance for staff training the action plan should identify the service provider (e.g. https://www.knowledgehub.org.za/course/sexual-and-reproductive-health-and-rights-training)

6. ATTACHMENTS

ATTACHMENT A: Example District Health Contact Details in South Africa

KwaZulu-Natal:	http://www.kznhealth.gov.za/districtoffices.htm
Gauteng:	https://www.gauteng.gov.za/Departments/DepartmentDetails/CPM-001006
Free State:	http://www.health.fs.gov.za/
Mpumalanga:	http://www.mpuhealth.gov.za/District_contact_us.html
Northern Cape:	http://www.northern-cape.gov.za/health/index.php/contacts/management
Eastern Cape:	http://www.echealth.gov.za/#
Western Cape:	https://provincialgovernment.co.za/units/view/117/western-cape/heal
Limpopo:	https://provincialgovernment.co.za/units/view/63/limpopo/health
North West:	https://provincialgovernment.co.za/units/view/101/north-west/health

ATTACHMENT B: Example Letter for Health Care Facility

Date: XXX
Address: XXXXX
Date: XX XX XXXX

To: XXXXX
District Manager: (Name of District)
Address: XXXX

Dear Mr/Mrs XXX

Request for permission to implement the Disability Awareness Checklist in health facility(ies) XX in XXXXX District

On behalf of (**NAME OF YOUR ORGANISATION**), we would like to engage with the (**NAME OF DISTRICT**) to implement the Disability Awareness Checklist (DAC), which assesses the extent to which services in the health facility are prepared to accommodate people with disabilities. The Checklist is based on participatory methods to empower health facility staff understand how to accommodate people with disabilities and develop a disability-related action plan. The DAC was developed by Prof Dr Jill Hanass-Hancock, Dr Kristin Dunkle, Nonkulueleko Tesfay, Thesandree Padayachee, Prof. Dr. Verusia Chetty, Bradley Carpenter and Dr Samantha Willan and has been piloted in a larger CDC funded study focusing on the adaptation of a GBV-Quality Assessment tool.

The DAC was developed because people with disabilities experience more health disparities than those without disabilities, yet they often face more barriers to access to health care services. This also includes sexual and reproductive health care (SRH) and gender-based violence (GBV) services, which are particularly relevant to women and girls with disabilities, who are more vulnerable to adverse sexual and reproductive health outcomes than their peers without disabilities.

In many studies conducted in South Africa and internationally, the lack of access to health care services is often related to a lack of universal design, reasonable accommodation, and an effective referral system (for disability and rehabilitation services, assistive devices and disability support and assistance) in public health care facilities. In addition, negative attitudes of healthcare workers towards people with disabilities and the lack of knowledge about disabilities further increases the healthcare access challenges faced by people with disabilities. The challenges affect access to health including GBV and SRH services. We are aware that there are other audit tools that can be used by health facilities, but that these do not provide a simplified approach for disability accessibility assessment, are not change orientated and do not aim to develop a facility action plan. The DAC is a tool that can address this gap with a collaborative and action orientated approach.

We are requesting your permission to implement the Disability Awareness Checklist in facilities in your district. We feel that the tool will serve to empower facility management teams to better understand the needs of persons with disabilities who are also service users of the health system. The DAC can also serve a valuable function for the District Management team in that the finding can be used to promote better planning for

ATTACHMENT B: Example Letter for Health Care Facility (continued)

people with disabilities as it identifies accessibility gaps and opportunities to create more inclusive health care services.

The processes involved in implementing the DAC include a facility visit (approximately 2 hours), scoring with the DAC and feedback meeting to develop an action plan. We would like to engage with one focal person in the facility management.

We have provided you with an attached document which outlines how we envisage the process of implementation, however, we also appreciate the opportunity to present the DAC to you and relevant managers so that you and your team are able to provide additional inputs to the proposed implementation approach. We would be grateful if we could approve the implementation of the DAC or grant an appointment to meet with you and discuss the matter further.

We look forward to engaging with you.

Yours sincerely

_____

Name: XXXX
Designation: XXXXX
Contact number: XXXX
E-mail: XXXXX

ATTACHMENT C: Example Slide Deck for Facility Orientation

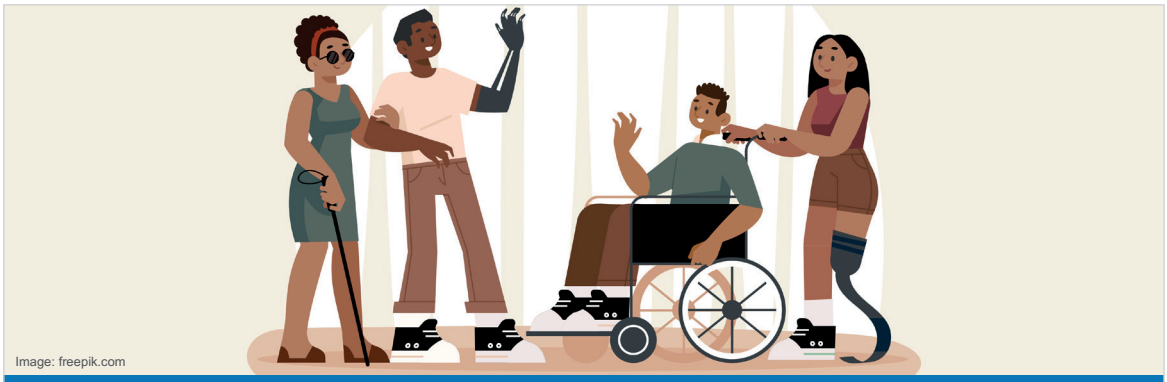

Image: freepik.com

INTRODUCING THE DISABILITY AWARENESS CHECKLIST (DAC)

NEED FOR ACCESSIBLE HEALTH CARE SERVICES

People with disabilities:

- Make approximately 15% of the population
- Are 2 times more likely to be malnourished and die as a child
- Have a 2.4-fold higher mortality rate
- 50 times more likely to have catastrophic health expenditures
- Women with disabilities are two times more likely to experience intimate partner violence or be infected with HIV

YET people with disabilities lack access to:

Health information | Transport | Health facilities | Care and support

ATTACHMENT C: Example Slide Deck for Facility Orientation (continued)

PURPOSE OF THE DAC

The Disability Awareness Checklist (DAC) for health care services is a sensitization tool that aims to increase awareness of disability accessibility and service delivery gaps for people with disabilities in a simple and action orientated way

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DISABILITY AWARENESS CHECKLIST FACILITATOR GUIDE 3

DEVELOPMENT OF THE DAC

Developed draft versions based on CRPD principals (e.g. participation, accessibility) and concepts (universal design and reasonable accommodation) by staff members of UKZN and disability sector in health care worker training in 2014 and ALIGHT project in 2018

Adapted by the South African Medical Research Council (SAMRC) with information from existing disability audits in 2020

Reviewed and adjusted by an expert panel in 2021

Piloted and field-tested in Ekurhuleni and uMgungundlovu district in South Africa in 2022

DISABILITY AWARENESS CHECKLIST FACILITATOR GUIDE 4

ATTACHMENT C: Example Slide Deck for Facility Orientation (continued)

STEP BY STEP USE OF THE DAC

1. Identity a DAC facilitator
2. Prepare for a disability awareness visit
3. Orient DAC facilitators at the facility
4. Conduct the disability awareness checklist in 2-stage process
5. Provide feedback & develop an action plan for change

DISABILITY AWARENESS CHECKLIST FACILITATOR GUIDE 5

APPLICATION OF THE DAC VISIT

WHO WILL CONDUCT THE DAC?

Any healthcare provider

OR

civil society organization representatives

WHERE?

Any primary healthcare facility

WHAT WILL BE USED?

The facilitator will take some measurements before filling in the DAC questionnaire in a **2-stage process**:

1) Answer all DAC questions
2) Identify opportunities for change

DISABILITY AWARENESS CHECKLIST FACILITATOR GUIDE 6

ATTACHMENT C: Example Slide Deck for Facility Orientation (continued)

SECTIONS OF THE DAC QUESTIONNAIRE

Universal Design	• Entrance to services (5 elements) • Reception, corridors, and waiting rooms (9 elements) • Examination rooms (3 elements)
Reasonable Accommodation	• Information and communication (7 elements) • Assistance and support (6 elements)
Capacity of facility staff	• Training on disability (6 elements)
Linkages to disability and rehabilitation services.	• Appropriate linkages to disability and rehabilitation services (11 elements)

DISABILITY AWARENESS CHECKLIST FACILITATOR GUIDE 7

TWO-STAGE PROCESS

Stage 1:
Assessment of service and access gaps through checklist
(answer all questions first)

Stage 2:
Reflection on what can be changed

Assessment sections:

Universal design and accessibility

Reasonable accommodation needs of people with disabilities

Capacity of facility staff and

Linkages to disability and rehabilitation services.

UNIVERSAL DESIGN AND ACCESSIBILITY

Does your healthcare facility have the following elements to support universal accessibility?	Yes	No	Not sure	Things I can change/influence
Entrance to services				
Public Transport access for wheelchairs (intact tared pavement) not further than 1 km from the entrance door to clinic/facility				
Clearly signed parking space/s for people with disabilities with access pathway to the front door				
Ramps to access your building/s with 1:12 slope (5-degrees or less and no lip on door) OR building level with the ground (no stair(s) at entrance and no lip on entrance doors)				
Doors in your facility that open easily with one hand and can accommodate a wheelchair (at least 82cm wide at the narrowest point including the security gate)				
Reception desk at a suitable height for wheelchair users (82cm)				
Reception, corridors and waiting rooms				

DISABILITY AWARENESS CHECKLIST FACILITATOR GUIDE 8

ATTACHMENT C: Example Slide Deck for Facility Orientation (continued)

DEVELOPMENT OF AN ACTION PLAN

Gap on the DAC that facility wants to improve	Which actions can address this gap?	Who can take these actions?	When will these actions be taken?

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DISABILITY AWARENESS CHECKLIST FACILITATOR GUIDE 9

Image: freepik.com

THANK YOU

ATTACHMENT D: Example Simple Action Plan

Gap on the DAC that facility wants to improve	Envisioned outcome	Which actions can address this gap?	Who can take these actions?	When will these actions be taken?

7. REFERENCES

1. United Nations. Convention on the Rights of Persons with Disabilities. UN; 2006.

2. Salamanda Trust, ATHENA, UNAIDS, AIDS Legal Network, Project Empower, HEARD, et al. Actions linking initiatives on violence Against women and HIV Everywhere, ALIV[H]E framework. Geneva: UNAIDS; 2017.

3. World Health Organization. Global health sector strategy on HIV/AIDS 2011-2015. WHO; 2011.

4. World Health Organisation, UNICEF. A vision for primary health care in the 21st century towards universal health coverage and sustainable development goals. Geneva: WHO; 2018.

5. Disability Rights Fund. What is an "OPD"? : DRF; [Available from: https://disabilityrightsfund.org/faq/what-is-a-dpo/.

6. National Collaborating Centre for Determinants of Health. Glossary of essential health equity terms. Vulnerable populations: NCCDH; [Available from: https://nccdh.ca/glossary/entry/vulnerable-populations#:~:text=Vulnerable%20populations%20are%20groups%20and,due%20to%20illness%20or%20disability.

7. Kuper H, Heydt P. The missing billion. Access to Health services for 1 illion people with disabilties. London: London School for Hygine and Tropical Medicine; 2019.

8. World Health Organisation, World Bank. World disability report. Malta: WHO; 2011.

9. Kuper H, Hanass-Hancock J. Framing the debate on how to achieve equitable health care for people with disabilities in South Africa. South African Health Review. 2020:45-52.

10. UNAIDS. Disability and HIV Refernce Report. Geneva: UNAIDS; 2017.

11. De Beaudrap P, Beninguisse G, Pasquier E, Tchoumkeu A, Touko A, Essomba F, et al. Prevalence of HIV infection among people with disabilities: a population-based observational study in Yaoundé, Cameroon (HandiVIH). Lancet-HIV. 2017;4:e161-8.

12. De Beaudrap P, Mac-Seing M, Pasquier E. Disability and HIV: a systematic review and a meta-analysis of the risk of HIV infection among adults with disabilities in Sub-Saharan Africa. AIDS Care. 2014;26(12):1467 - 76.

13. The Missing Billion Initiative, Clinton Health Access Initiative. Reimagining Health Systems that expect, accept and connect 1 Billion people with disabilities. A follow-on to the first missing billion report. London: Missing Billion; 2022.

14. Hanass-Hancock J, Nene S, Nicola D, Pillay S. "These are not luxuries, it is essential for access to life" Disability related out-of pocket costs as a driver of economic vulnerability and exclusion in South Africa. AJOD. 2017;6(0):a280.

15. Banks LM, Polack S. The economic costs of exclusion and gains of inclusion of people with disabilities. London School of Hygiene and Tropical Medicine; 2015.

16. Dunkle K, Van der Heijden I, Stern E, Chirwa E. Disability and violence against women and girls global programme. London: What Works; 2018.

17. UNFPA. Young persons with disabilities: global study on ending gender based violence and realising sexual and reproductive health rights. New York: UNFPA; 2018.

18. UNFPA. The right to access. Regional strategic guidance to increase access to sexual and reproductive health and rights (SRHR) for young persons with disabilities in east and southern Africa. Pretoria: UNFPA; 2018.

19. Eide A, Mannan H, Khogali M, van Rooy G, Swartz L, Munthali A, et al. Perceived Barriers for Accessing Health Services among Individuals with Disability in Four African Countries. Plos 1. 2015;10(5): e0125915.

20. Visagie S, Eide A, Dyrstad K, al. e. Factors related to environmental barriers experienced by persons with and without disabilities in diverse African settings. PloS One. 2017;12(10):e0186342.

21. Vergunst R, Swartz L, Hem K, al. e. Access to health care for persons with disabilities in rural South Africa. BMC Health Serv Res 2017;17(1):741.

22. Hanass-Hancock J, Alli F. Closing the gap: Training for health care workers and people with disability on the interrelationship of HIV and disability. Disability Rehabilitation. 2015;37(21):2012-21.

23. jhpiego, PEPFAR, CDC, WHO. Gender-based violence quality assurance tool - minimum care version. Baltimore: Jhpiego and WHO; 2018.

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