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Lessons learned

Learning from a disability-inclusive sexual reproductive health and rights programme (WISH2ACTION)

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humanity &inclusion

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Acronyms

CHW: Community healthcare workers

DAISY: Digital Accessible Information System

DGFP: Directorate General of Family Planning (Bangladesh)

DMI: Development Media International

HCF: Healthcare facilities

HI: Humanity & Inclusion

INGO: International non-governmental organisation

LCF: Leonard Cheshire Foundation

MoU: Memorandum of understanding

NGO: Non-governmental organisation

OPDs: Organisations of persons with disabilities

SBCC: Social and behavioural change communication

SRH: Sexual and reproductive health

SRHR: Sexual and reproductive health and rights

UN CRPD: UN Convention on the Rights of Persons with Disabilities

WISH2ACTION: Women's Integrated Sexual Health (Lot 2) Access, Choice, Together, Innovation and Ownership, Now

WG-SS: Washington Group Short Set of Questions

Executive summary

This is a compilation of good practices and lessons learnt in disability-inclusive sexual and reproductive health and rights (SRHR) based on experience from the implementation of the WISH2ACTION (Women's Integrated Sexual Health [Lot 2] Access, Choice, Together, Innovation and Ownership, Now) programme.

Firstly, the compilation introduces disability-inclusive SRHR which is critical to address the double discrimination faced by women and girls with disabilities, achieve universal human rights and contribute to the global commitment to leave no one behind. It introduces the WISH2ACTION programme as a comprehensive and integrated approach to deliver equitable access to sexual and reproductive health and rights (SRHR) for under-served women and girls and marginalised populations in low- and middle-income countries.

The methodology explains the approach used to create this compilation, from reviewing existing learning documents, to undertaking stakeholder interviews, to identifying themes and consolidating good practices and lessons learnt.

The main component of this document is sharing 30 good practices and lessons learnt across nine themes: **inclusive culture, quality of care, coordination, data collection and management, referral networks, service integration, social and behavioural change communications (SBCC), partnerships and collaboration** and **policy and advocacy.** Each theme includes case studies from different contexts.

The good practices (23) synthesise examples from six countries that can inform future work in disability-inclusive sexual and reproductive health (SRH). The lessons learnt (7) highlight challenges experienced during implementation and reflect on how these could be addressed in future. A summary of the key points per theme is below:

Inclusive culture

This covers a range of good practices that helped stakeholders build awareness, knowledge, and skills around disability inclusion. It emphasises that inclusive practices are founded in rights-based and social approaches to disability. It discusses awareness building on available SRHR services and shares effective training approaches such as multi-stakeholder events and targeting cross-sector stakeholders to build a disability-inclusive society.

Quality of care

This discusses improving the quality of SRH care for persons with disabilities and the role played by healthcare facilities (HCFs) and service providers. Good practices include undertaking structured assessments of HCFs, creating joint action plans for improvement, training service providers and community healthcare workers and building capacity in sign language interpretation.

Coordination

This focuses on how improved coordination between actors can contribute to more disability-inclusive SRH services. It highlights the important role of including organisations of persons with disabilities (OPDs) in coordination to ensure long term, sustainable and inclusive SRHR services. Key good practices relate to the inclusion of OPD members in local and district health committees and in emergency response committees during Covid-19. This section also notes the importance of considering the SRHR needs of persons with disabilities in humanitarian settings.

Data collection and management

This discusses the importance of collecting disability disaggregated data in health and SRHR using the Washington Group Short Set of Questions (WG-SS) and how this data can improve programming and services. Key learnings relate to building capacity on the application and use of WG-SS through providing tailored training and guidance. This section also reflects on the challenges of embedding the WG-SS into national health information management systems for widespread uptake.

Persons with disabilities attend an event in South Sudan, © Humanity & Inclusion

Referral networks

This looks at identifying those SRH services which are relevant, meaningful, and accessible for persons with disabilities. It also shares good practices around the role of OPDs in supporting more persons with disabilities to access SRH services and on creating integrated referral networks that consider the additional needs and comprehensive care for persons with disabilities (such as rehabilitation, physical therapy, or assistive devices).

Service integration

This considers how to effectively integrate and coordinate different services (including SRH) that are relevant to persons with disabilities. It shares good practice examples of integrating disability inclusion within national health guidelines and existing systems as well as learning about how to link SRH to other services such as vaccination and rehabilitation.

Social and behavioural change communications

This includes key learnings around engaging community members and gatekeepers to identify and shift social norms and how to consider context when designing communication messages. It also shares good practices for making the format and content of communication materials inclusive and accessible for persons with disabilities.

Partnerships and collaboration

This looks at two main areas: firstly, building partnerships and relationships with OPDs and secondly, learnings for effective consortium working. It states that partnerships with OPDs are essential for ensuring sustainable SRHR services for persons with disabilities. Good practices include mapping OPDs, providing training to OPDs on SRH, providing technical support to build the capacity of OPDs and providing the appropriate financial support to strengthen OPDs. Consortium good practices explores the concept of mainstreaming disability inclusion within service provider organisations and the supporting role that technical experts can play.

Policy and advocacy

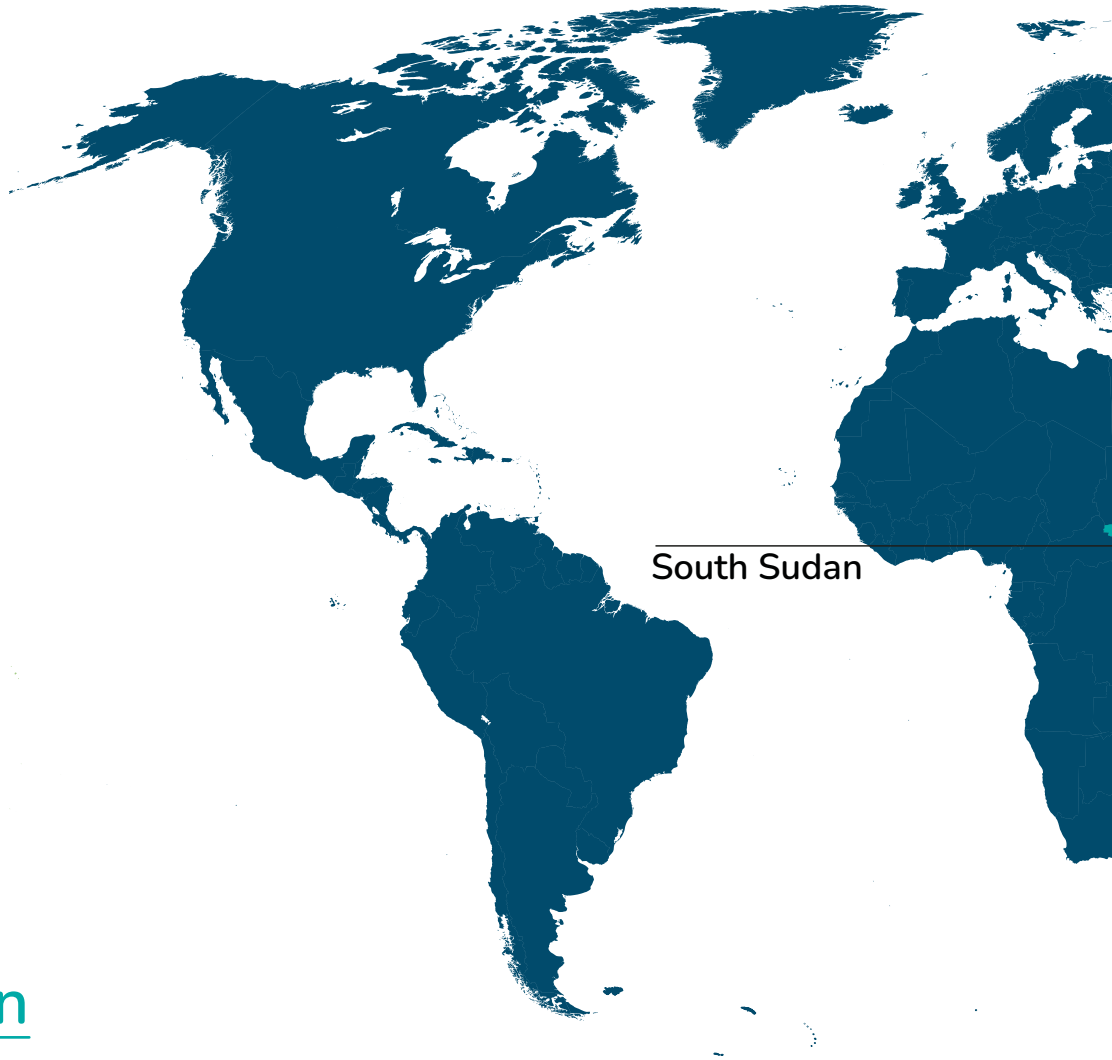
This tackles how to promote the implementation of the UN Convention on the Rights of Persons with Disabilities (UN CRPD) in the field of SRHR at the local and national level. Good practices relate to the important role of OPDs in local and national advocacy and the importance of engaging government stakeholders at different levels to improve inclusion.

The final section of compilation reflects on the learning processes, systems and tools used in WISH2ACTION. It moves from learning to recommendations and summarises key recommendations for three groups: Humanity & Inclusion, SRHR partners (service providers and technical experts), donors and policymakers.

Definitions

Good practice: Examples of good practice in disability-inclusive SRH that were implemented during WISH2ACTION and that could be replicated by others.

Lessons learnt: Lessons learnt from the experience of implementing WISH2ACTION, challenges identified and suggestions for how these challenges could be addressed in the future.



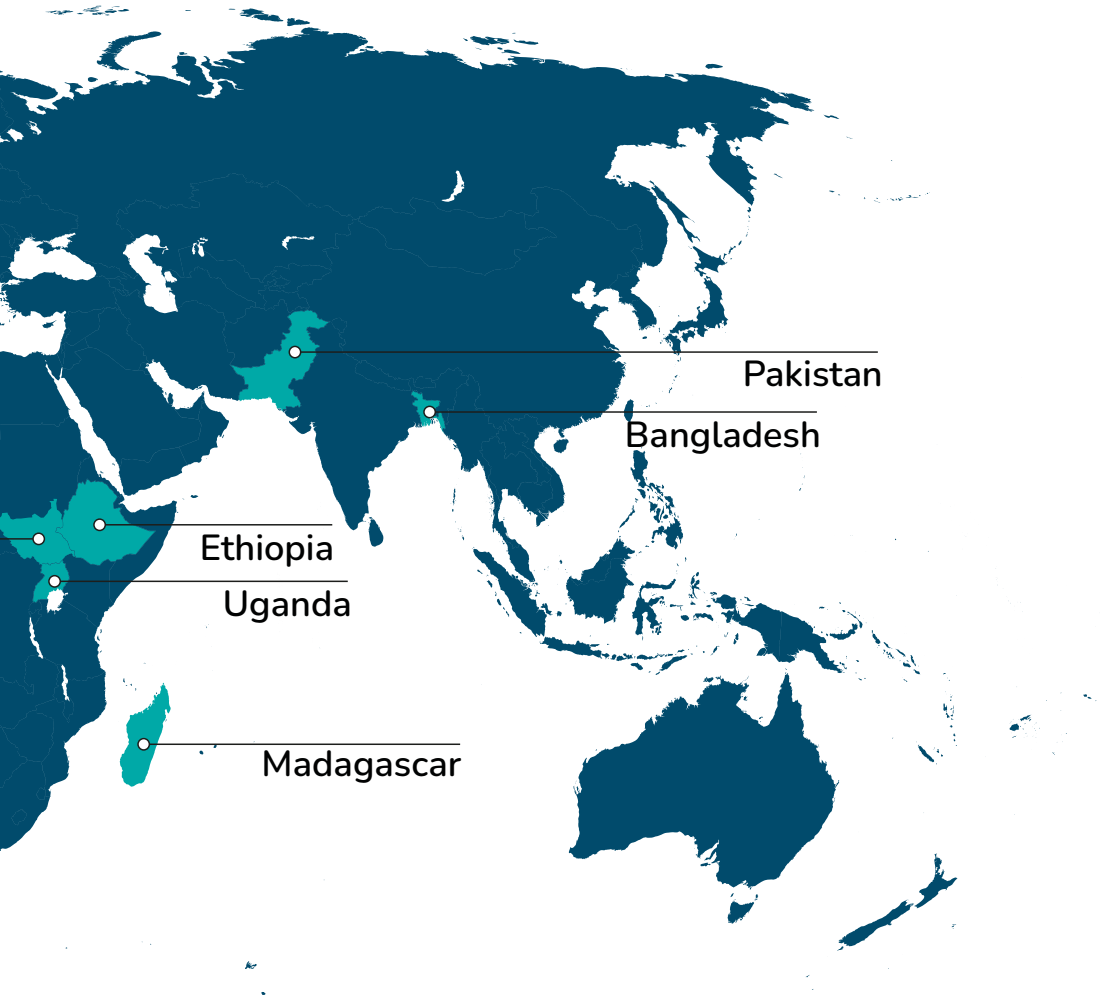
Introduction

Disability-inclusive SRHR links to the global commitment to leave no one behind, to multiple sustainable development goals and importantly to the 2006 UN Convention on the Rights of Persons with Disabilities (UN CRPD). Around 15% of the global population have some form of disability and 80% of persons with disabilities live in low- and middle-income countries (HI 2021a).

While this compilation focuses on disability inclusion, it is important to note that there are strong links and intersections between different aspects of inequality (poverty, gender, age, disability). Persons with disabilities often face negative social attitudes and exclusion from services and healthcare facilities due to discrimination and poor accessibility - despite having the same universal rights to access healthcare as anybody else. Women and girls with disabilities are likely to experience 'double discrimination' due to their gender and disability (HI 2015). This is compounded by the fact that SRH and family planning remain sensitive and taboo topics in many contexts.

Disability-inclusive SRHR is therefore critical to ensure that persons with disabilities have access to healthcare and can realise their rights to SRH services. The World Health Organisation states that SRHR for persons with disabilities requires attention because 'these needs have been so widely and so deeply neglected' (WHO/UNFPA 2009). This area of work is therefore an innovative focus for programme implementation which has received insufficient attention to date.

The Women's Integrated Sexual Health programme, under the banner 'Leave No One Behind', offers quality integrated and inclusive family planning and sexual and reproductive health services to marginalised and hard to reach populations: the poor, youth under 20 and people living with disability. WISH2ACTION is the UK Government's flagship programme to scale up its support to integrated sexual and reproductive health and rights (SRHR) services in a range of countries across Africa and Asia by 2021. It represents 20% of the UK Government's Family Planning 2020 commitments.



The International Planned Parenthood Federation (IPPF) manages the programme through a consortium arrangement (Lot 2) with ten IPPF Member Associations and hand-picked partners chosen for their expertise to maximise access and reach for people in fifteen countries: Development Media International (DMI), Humanity and Inclusion UK (HI), International Rescue Committee (IRC), Marie Stopes International (MSI), and Options Consultancy Services (Options).

This learning compilation focuses on one element of the WISH2ACTION programme - disability-inclusive SRHR, led by HI in six countries: Bangladesh, Ethiopia, Uganda, Madagascar, Pakistan, and South Sudan.

Working as a consortium presented a unique opportunity for implementing, adapting, and learning together and this document aims to share what the consortium has learnt with a wider audience. This compilation captures 30 good practices and lessons learnt that may be relevant globally as well as sharing 18 case studies from six countries.

HI took a strategic approach and focused on six themes to guide their implementation of the project (focusing on two strategic areas each year): **inclusive culture, quality of care, coordination, data, referral networks** and **service integration.** Good practices and lessons learnt related to these areas are further explored in the thematic learning section of this report, as well as three additional themes. The compilation also notes the importance of disability inclusion in humanitarian settings with examples from the Covid-19 pandemic. The recommendations section reflects on learning before making recommendations for HI, service providers and donors and policymakers.

This learning document is complemented by HI's Practical Guide on 'SRHR for all' which aims to move from theory to practice by providing detailed guidance on the implementation of disability-inclusive SRHR (HI 2021b). The Practical Guide aims to support those working on SRHR projects, programmes, or services to design, implement, monitor, and evaluate inclusive SRHR programmes.

Summary of good practices and lessons learnt

Inclusive culture

Good practice 1: Apply rights based and social approaches to disability in order to remove barriers to persons with disabilities accessing sexual and reproductive health services.

Good practice 2: Cooperate with persons with disabilities and build awareness of existing sexual and reproductive health services and rights for persons with disabilities to bridge the knowledge gap about what is available.

Good practice 3: Bring different stakeholders (including persons with disabilities) together for training on disability-inclusive sexual and reproductive health and rights.

Good practice 4: Identify and engage different sectors for training and capacity building to improve disability inclusion across society.

Quality of care

Good practice 5: Work in partnership to undertake a structured healthcare facility assessment and action plan to improve existing healthcare facilities for persons with disabilities.

Good practice 6: Train service providers and community healthcare workers to better support persons with disabilities.

Lesson learnt 1: Sign language interpretation is essential for delivering a high quality SRH service to persons with hearing impairments.

Coordination

Good practice 7: Advocate for the inclusion and representation of persons with disabilities in health committees.

Lesson learnt 2: Continuous capacity building is needed to ensure a disability-inclusive health system.

Data collection and management

Good practice 8: Build capacity through training on the use of Washington Group Short Questions to promote effective use and uptake amongst service providers and government.

Good practice 9: Tailor support and guidance on the Washington Group Short Questions to ensure the applicability of this tool in different contexts and for different purposes.

Lesson learnt 3: Improving national disability-inclusive data collection is a long-term commitment and ongoing challenge.

Referral networks

Good practice 10: Identify where persons with disabilities can access relevant and meaningful sexual and reproductive health services.

Good practice 11: Work with organisations of persons with disabilities to reach and engage persons with disabilities in SRH services.

Good practice 12: Develop an integrated approach to referrals across service providers, OPDs and other actors.

Service integration (programming and humanitarian response)

Good practice 13: Identify the challenges faced by persons with disabilities in emergencies and put measures in place to maintain their access to essential SRH services.

Good practice 14: Integrate disability-inclusive approaches within national guidelines, services and systems for longer term sustainability and mainstreaming of disability inclusion.

Good practice 15: Link sexual and reproductive health services with other health services such as vaccination.

Social and behavioural change communications

Good practice 16: Engage community members and gatekeepers to change social norms about SRH and increase access to SRH for people with disabilities.

Good practice 17: Make the format and content of sexual and reproductive health communication materials inclusive and accessible for persons with disabilities.

Good practice 18: Ensure that communication approaches for providing sexual and reproductive health and rights information are acceptable and appropriate to context.

Partnerships and collaboration

Good practice 19: Service providers (public and private) and NGOs should map, identify, select, and establish relationships with organisations of persons with disabilities (OPDs).

Good practice 20: OPDs need training on SRH which is often a new topic for them.

Good practice 21: Service providers and NGOs should provide technical support to build the capacity of organisations of persons with disabilities as well as forming equitable partnerships.

Lesson learnt 4: OPDs need financial support as well as technical support.

Lesson learnt 5: Organisations of persons with disabilities play an important role in raising awareness, making referrals, generating demand, and conducting effective outreach to persons with disabilities.

Lesson learnt 6: Technical experts should support non-disability organisations to mainstream disability inclusion.

Policy and advocacy

Good practice 22: OPDs should be supported to undertake advocacy towards UNCRPD implementation including the rights of persons with disabilities to access sexual and reproductive health services at the local and national level.

Good practice 23: Engage government stakeholders at multiple levels to improve disability inclusion locally, regionally, and nationally.

Lesson learnt 7: Engage policymakers early on.

Methodology

Reviewing and consolidating good practices and lessons learnt

The foundation of this compilation is learning documentation from HI country teams. Teams regularly captured national-level good practices and lessons learnt. There were also consortium level learning events (and associated documentation) which provided opportunities for group reflection and sharing of good practices.

The consultant conducted a document review of all country-level good practices and lessons learnt as well as supporting documents. The consultant then identified key areas of alignment and similarity between good practices in different countries as well as any unique examples of good practice. The national good practices and lessons learnt were then collated to create programme level good practices and lessons learnt with a shared focus, featuring case studies from different countries.

Key stakeholder interviews

This compilation has also been informed by in-depth interviews with HI country teams and WISH2ACTION coordination staff (7), technical partner staff at the regional and national level (8) and OPD members (5).

Interviews with HI country teams went into depth on existing lessons and good practices and gathered further detail. In the case of technical partners, the interviews focused on capturing their learning on disability-inclusion and on working as a consortium. This helped inform good new practices about the uptake of disability-inclusion by service providers, as well as to add other perspectives or examples to existing good practices from HI.

It was important to engage OPDs directly and to get their perspectives, therefore the consultant spoke with two OPD leaders from South Sudan and three OPD leaders/members from Bangladesh.

Identifying learning themes

HI had identified six themes for programme implementation: **inclusive culture, quality of care, coordination, data, referral networks** and **service integration.** The consultant initiated a participatory process to inform the categorisation of programme good practices into themes using a card sort (Better Evaluation 2016). This process helped sort good practices into the most appropriate theme as well as to identify potential new themes.

The card sort identified that there were multiple ways to interpret themes and that some good practices cross-cuts several themes. For the sake of clarity, each good practice has been categorised into just one learning theme however some good practices are relevant to multiple thematic areas. The input of technical partners through the card sort was particularly relevant to bring new ideas and identify three new categories of learning. Further detail on the learning themes is in the following section of this document.

Learning themes

This section of the compilation introduces each thematic area under which the good practices (23) and lessons learnt (7) included in this report have been categorised.

It builds upon six themes used by HI to implement activities in each of their focus countries: **inclusive culture, quality of care, coordination, data, referral networks** and **service integration.** Three additional emerging themes were also added: **social and behavioural change communication (SBCC), partnerships and collaboration and policy** and **advocacy.** Definitions for all themes are captured below.

Good practices and lessons learnt include case studies giving examples from different countries, quotes, and images to illustrate implementation.

Figure 1 shows the distribution of good practices and lessons learnt across the nine themes, identifying particularly strong learning in the areas of inclusive culture and partnership and collaboration.

Figure 1: Distribution of good practices and lessons learnt across themes

Definitions of learning themes

Inclusive culture: Relevant stakeholders are aware of disability inclusion and their knowledge and skills are enhanced.

Quality of care: The quality of care considering client centeredness, comprehensiveness and accessibility is improved in the provision of SRH services to persons with disabilities.

Coordination: Coordination effectively facilitates a multi-actor and multi-stakeholder approach at the local and national level to ensure for the delivery of disability-inclusive SRHR services.

Data collection and management: Qualitative and quantitative disability disaggregated data are collected and analysed at service provision and community levels for advocacy, SBCC and programming.

Referral networks: People with disabilities seeking SRH services benefit from a clear, accessible, and systematised referral network.

Service integration: SRH services are disability-inclusive and different services are integrated together effectively. This includes programming and humanitarian response.

Social and behavioural change communication: Communication strategies are informed by behaviour science and used to influence knowledge, attitudes, and social norms towards inclusive practices among individuals, institutions, and communities.

Partnerships and collaboration: Organisations work together to build and strengthen effective partnerships that contribute to improving SRH services for persons with disabilities.

Policy and advocacy: Organisations engage in national advocacy efforts to influence and improve disability-inclusive policies and services.

Family planning service providers undertake a role play activity during training, © MSI Bangladesh

1. Inclusive culture

This section looks at good practices and lessons learnt around the theme of creating an inclusive culture in which different stakeholders improve their awareness, knowledge, and skills around disability inclusion.

It covers applying rights-based approaches to introduce the idea of rights to SRH for persons with disabilities, building awareness of available SRH services for persons with disabilities, hosting multi-stakeholder trainings to foster learning and share lived experience from persons with disabilities and engaging different groups to build a disability-inclusive culture across society. It also explores the idea of mainstreaming disability inclusion within organisations and the role that technical experts in disability can play in supporting this.

> ‘Women with disabilities also have children and also have families, there is no way they can be excluded from [sexual and reproductive health] services because they are part and parcel of the community.’
>
> – OPD leader, South Sudan

Key points

- Use the rights-based approach to raise awareness of the universal right to SRH services for communities (including persons with disabilities), service providers and government officials.
- Bring together a range of stakeholders for training and events to foster learning by sharing different perspectives and reflecting on limiting social norms.
- Include organisations of persons with disabilities in training to share their lived experience and build partnerships for improving disability inclusion.
- Consider different groups who could contribute to improving disability inclusion across society such as journalists or architects.
- Service providers and other organisations can work towards a disability-inclusive organisational culture with support from technical experts in disability and OPDs.

Good practice 1: Apply rights based and social approaches to disability in order to remove barriers to persons with disabilities accessing sexual and reproductive health services.

The challenge

The UN Convention on the Rights of Persons with Disabilities (UN CRPD) sets out the rights of persons with disabilities. The UN CRPD was ratified in every context except for South Sudan, making it especially challenging to claim rights in that setting (UN OHCHR 2021). In contexts where the UN CRPD was ratified, this did not however mean that related policies were implemented.

The medical model of disability was dominant in most contexts but not all. Bangladesh differed from other contexts in that disability is the responsibility of the Ministry of Social Welfare and is therefore not seen as an entirely medical topic.

What we did

Several approaches were used to promote rights such as providing training, raising awareness, hosting community dialogues, SBCC materials and focusing on accountability for policymakers to meet their legal requirements. The concept of rights was introduced to service providers, government officials and community members.

Training materials usually included sharing relevant UN declarations as well as national frameworks that translated the UN CRPD into national laws and policies. In Pakistan HI found that some government ministries were initially focused on health and medical issues for persons with disabilities and did not understand why SRH would be a priority – reference of rights, the UN CRPD and local laws helped engage policymakers with the rights-based approach.

Why it worked

The social and human rights-based concept of disability was a successful training approach to explore the concepts of impairments, barriers, and facilitators. Introducing the concept of barriers helped service providers, government staff and community healthcare workers to acknowledge these barriers and think about practical approaches to deliver inclusive services (i.e., physical accessibility to HCFs, sign language translators).

Models of disability[1]

The charity model of disability
The charity model depicts persons with disabilities as victims and as objects of charity or pity whose lives are tragic. It often depicts persons without disabilities as saviours who provide charitable resources to support persons with disabilities.

The medical model of disability
The medical model approaches disability primarily as a problem of the person, directly caused by disease, trauma, or other health conditions. The medical model sees medical professionals as experts in disability, medical care as the main issue, and finding a "cure" as the main aim.

The social model of disability
The social model sees disability as socially created and a relationship between the persons' disabilities and the environment they live in. Adapting the environment by making all the modifications necessary for the meaningful participation and integration of persons with disabilities in all areas of life is considered a collective responsibility of society at large.

Human rights
A rights-based approach to disability is founded in universal human rights and looks at removing different types of barriers so that persons with disabilities can access and claim their rights.

1 Adapted from draft text for HI's Practical Guide on "SRHR for all" (HI: 2021b)

Good practice 2: Cooperate with persons with disabilities and build awareness of existing sexual and reproductive health services and rights for persons with disabilities to bridge the knowledge gap about what is available.

The challenge

The WISH2ACTION programme generally found that persons with disabilities were very willing to use SRH services but often did not know what was available to them. Some persons with disabilities had received misinformation from community members or were not aware of the full range of SRH services available.

There were also negative community perceptions and sensitivity about some SRH services, particularly family planning. For example, one perception was that family planning was about taking drugs to stop having children rather than a way to plan and space births (South Sudan). SRH was sometimes seen as only covering family planning and people did not realise that other services were available such as general counselling, antenatal support, cervical cancer screening, breast screening and prevention of HIV, and prevention and response to gender-based violence.

What we did

HI and partners carried out community meetings and dialogues on the topic as well as door to door visits for persons with disabilities and their carers or families – more is covered on community engagement approaches in Good practice 16.

Why it worked

Engaging communities directly with SRHR helped persons with disabilities and their families understand the range of services available and where they could access them. This also helped to address any negative perceptions about SRHR services and broaden the understanding of what SRHR services covered.

‘My first child was born at home in enormous difficulties, however this time with me knowing about the safe institutional delivery as well as other information on safe motherhood, I intended to follow the advice of the community healthcare workers and health care providers of the family planning department... I went there and delivered a baby boy through caesarean section in 2020. During my first childbirth, I did not get any of this support, information, and emotional support but this time around, I received all the things I need.’

– Woman with disabilities from Bangladesh

Good practice 3: Bring different stakeholders (including persons with disabilities) together for training on disability-inclusive sexual and reproductive health and rights.

The challenge

Several country teams noted that trainings were less effective without persons with disabilities present.

What we did

HI and partners organised mixed, multi-stakeholder group trainings including community healthcare workers, service providers, partner organisations, government representatives and OPDs. A key learning was the importance of having persons with disabilities attending trainings, both to share lived experience, explain existing barriers and so that OPDs attending could build relationships, work with service providers, and ensure inclusion. Providing transport and support for carers to accompany persons with disabilities if needed was important in enabling their participation in trainings.

Why it worked

HI teams found that learning happened because of the mixed group and that having persons with disabilities present helped service providers realise that persons with disabilities have SRH needs just as persons without disabilities do. It also improved their confidence through experience interacting with persons with disabilities.

Health workers and OPD members from Mbale district, Uganda after attending a disability inclusive training, © Humanity & Inclusion

CASE STUDY

OPD members sharing lived experience in training in Uganda

In Uganda, OPDs played the role of 'experts on disability' and shared their real experiences of facing barriers to access healthcare. OPD members gave examples of challenges they had experienced in maternity services such as being asked embarrassing questions about how they got pregnant.

The HI team in Uganda reflected that training a mixed group of service providers and persons with disabilities (from OPDs) present can correct misinformation and myths and can facilitate constructive dialogue around barriers.

'Persons with disabilities are like everybody else, we do not have to treat them according to their disability, or to shout at them.'

– Call operator of Marie Stopes Madagascar's toll-free helpline

Good practice 4: Identify and engage different sectors for training and capacity building to improve disability inclusion across society.

The challenge

Disability inclusion goes beyond the health sector and is a broader societal issue, which needs engagement from other actors and sectors.

What we did

Several HI country teams had an innovative approach to engaging new actors for training on disability inclusion such as journalists (Madagascar) and architects (Pakistan). This engagement went beyond engaging healthcare actors and considered other sectors which could play a role in supporting disability-inclusive SRHR, and inclusion more broadly.

Why it worked

A comprehensive and multi-stakeholder approach considered and included different cross-sector actors who could play an important role in improving national coordination. This can contribute towards building a more inclusive culture and creating disability-friendly environments.

CASE STUDY

Training journalists in Madagascar

In Madagascar, a selection of journalists who had already worked with WISH consortium partners on SRH were invited to attend training. They were invited to attend an awareness raising session explaining the rights of persons with disabilities, how to portray persons with disabilities, appropriate language to use and how to interact with persons with disabilities. This helped increase news coverage of SRH in relation to persons with disabilities.

CASE STUDY

Training architects in Pakistan

In Pakistan, HI identified that despite laws on accessibility of buildings being in place, many public buildings such as hospitals and schools did not comply with these laws. Accessibility is a key barrier for persons with disabilities to physically access healthcare facilities.

HI realised that architects and planners may not be aware of accessibility issues and therefore organised a training session to share information about accessibility of infrastructure for persons with disabilities. Attendees were surprised to learn about this and welcomed learning about national and international standards on accessibility and disability.

A major achievement was that some of the architects and planners formed a national task force to audit accessibility in public places. This has improved coordination on the important issue of making public buildings accessible to persons with disabilities.

2. Quality of care

This section looks at good practices and lessons learnt around the theme of improving the quality of SRH care for persons with disabilities.

It has a particular focus on the role of healthcare facilities and healthcare staff. It is important here to differentiate between service providers who are trained professionally and work in facilities in comparison to community healthcare workers (CHWs) who are generally volunteers working at the community level.

Both groups were engaged in WISH2ACTION at different levels – CHWs helped with demand creation, initial counselling of persons with disabilities and referrals to services. Service providers participated in training and delivered healthcare services.

This section includes good practices around undertaking assessments of HCFs in partnership with service providers and OPDs and then creating and delivering joint action plans for improving HCFs. It also discusses training for both service providers and community healthcare workers.

‘Hospital nurses and doctors are now able to receive couples with disabilities with dignity. They see there are some couples with disabilities coming to the hospital and they give them priority.’

– OPD member in Bangladesh

Key points

- Healthcare facility assessments are an important tool to map barriers to disability inclusion including physical accessibility, communication, and attitudinal barriers.
- Inclusion does not always cost money and small changes can make a big difference to the quality of care for persons with disabilities.
- Assessments can help to conduct better planning and budgeting towards accessible facilities and services.
- Service providers, HCF management, non-governmental organisations (NGOs) and OPDs should work jointly to make, develop, and deliver HCF improvement plans.
- HCFs should engage policymakers at the local and national level to advocate for larger scale improvements to facilities.
- Service providers and CHWs may not understand the SRH needs of persons with disabilities and may be concerned about how to communicate with persons with disabilities.
- Sign language interpretation was identified as a key challenge in several countries where HI implemented WISH2ACTION.
- Training for service providers and community healthcare workers is essential to address misconceptions held about persons with disabilities and SRH.

Good practice 5: Work in partnership to undertake a structured healthcare facility assessment and action plan to improve existing healthcare facilities for persons with disabilities.

The challenge

Healthcare facilities are not always accessible for persons with disabilities, both in terms of physical accessibility but also service provision. Additionally, persons with disabilities are not always included in planning for healthcare facility improvements.

What we did

HI teams in Bangladesh and Ethiopia worked jointly with OPD members and service providers to undertake HCF assessments covering physical accessibility for persons with disabilities as well as challenges with service provision such as communication and attitudinal barriers[2]. The tool also looked at areas such as coordination, referrals, and policies on disability inclusion.

After conducting assessments, some service providers realised that inclusion did not always cost a lot of money and that there were issues that could be resolved with few resources. They were able to make some important changes such as changing the height that posters were hung at to make them more accessible (Bangladesh), adjusting the size of posters (Bangladesh) and purchasing wheelchairs (Uganda).

In Bangladesh, joint assessments led to a shared understanding of what accessibility is and a commitment to undertake building works to improve accessibility at eight HCFs. Issues that could not be addressed with existing resources were passed to the government to request support - OPDs were able to successfully advocate for the government to fund a ramp at a local facility with stairs which was difficult for persons with disabilities to access.

Why it worked

HCF assessments are a useful tool that can identify barriers in place at HCFs and can encourage joint working between stakeholders to reduce these barriers and provide opportunities for advocacy.

Undertaking joint assessments and making joint workplans between NGOs like HI, private service providers, OPDs and public service providers was a successful practice to ensure action and follow up on disability inclusion. A service provider consortium partner reflected that joint working was a good practice for service delivery especially in areas such as quality assurance

CASE STUDY

Designating a disability focal person at healthcare facilities in Bangladesh to mainstream disability inclusion

After conducting HCF assessments, a disability focal person was identified for each HCF involved in Bangladesh. These persons are government staff from the HCFs, nurses and medical officers who received a three-day training on inclusive SRH. This person's role is to oversee and coordinate all disability inclusion, working through committees to coordinate and collaborate with service providers and community healthcare workers. They are also responsible for capacity building and organising ongoing training. This approach helps build longer term sustainability and improve coordination of disability inclusion within individual HCFs.

CASE STUDY

Improving communication in Ethiopia

In Ethiopia, a joint HCF assessment led to an action plan being put in place. HI provided technical support on disability inclusion which helped the service provider to deliver the action plan. Communications between service providers and persons with disabilities emerged as a particular challenge, especially for those persons who speak sign language – HI used this finding to collaborate with 56 government run HCFs and provide sign language training for their staff.

2 Please contact Humanity & Inclusion at j.newnham@hi.org or info@hi.org to see this tool.

Good practice 6: Train service providers and community healthcare workers to better support persons with disabilities

The challenge

Based on the findings of barriers assessments[3], the WISH2ACTION programme found that service providers and community healthcare workers often had misconceptions about persons with disabilities as well as low confidence in themselves about how to deliver services to persons with disabilities.

A common misconception was the idea that persons with disabilities did not have a sexual life, would not become pregnant and therefore did not need to access any SRH services (Bangladesh, Pakistan, South Sudan). While this is a broader societal misconception, training service providers is a key strategy to address attitudinal barriers and improve frontline services for persons with disabilities.

What we did

WISH2ACTION provided training for community healthcare workers, service providers and SRHR telephone operators on the rights of persons with disabilities as well as their SRH needs.

In South Sudan, consortium partners recruited persons with disabilities as community health mobilisers. In Bangladesh, three OPD members with disabilities were recruited and trained by local organisations as community healthcare workers (following advocacy by HI).

Why it worked

The training helped change perspectives of service providers and community healthcare workers. Some participants said that after training that they now prioritised persons with disabilities and aimed to serve them first. Others affirmed that everyone needs access and has the right to SRH services. Furthermore, including persons with disabilities in community health worker recruitment is an important approach for sustainability and for improved quality of care for persons with disabilities.

> 'I have realized that it is fundamental for the rights and wellbeing of women, girls, boys and men with disabilities to have effective ISRH services. This is to ensure that our adolescent girls and adults with disabilities can avoid adverse health and socioeconomic consequences of unintended pregnancy and have a satisfying sexual life like any other person whereas I used to think that the disabled were not sexually active.'
>
> Nurse from South Sudan

CASE STUDY

Training teleoperators in Madagascar on a SRH helpline

In Madagascar, the team worked with OPDs to train telephone operators from Marie Stopes International Reproductive Choices who answer the tollfree helpline to give SRH information and advice and how to access MSM services. OPD members explained how to speak with someone who may have difficulty with communication or comprehension. Previously, teleoperators sometimes thought it was a prank call if someone was slow to respond or had difficulty communicating.

After the training, teleoperators were aware that it might be a person with disabilities and were equipped with the skills to communicate with them. Call operators have been trained on different types of disability and this has informed the advice they give to clients.

3 In 2021 HI conducted extensive Barriers Assessments to identify the barriers that prevent persons with disabilities from accessing SRH information and services. Assessments were conducted in Ethiopia, Madagascar, South Sudan, and Uganda.
For further information please contact j.newnham@hi.org or info@hi.org.

One to one discussion in Bangladesh, © Humanity & Inclusion

Lesson learnt 1: Sign language interpretation is essential for delivering a high quality SRH service to persons with hearing impairments.

Many service providers and community healthcare workers felt ill equipped and unsure about communicating effectively with persons with disabilities. Sign language communication was a particular area of challenge noted for reaching persons with hearing impairments, and in some cases specialised training was offered by HI or other actors:

- Government run HCFs requested sign language training from HI in Ethiopia, and this was delivered to service providers from 56 different facilities. The Ethiopia HI team reflected that this increased government ownership and commitment to disability inclusion at the federal level.
- The Uganda team reflected positively that in some districts they had seen government efforts to train all community development officers and community healthcare workers in sign language.
- In Bangladesh, OPD sign language interpreters attended hospitals with persons with disabilities, however the team noted this is not a sustainable solution.
- Sign language interpretation is particularly important in humanitarian settings such as refugee camps where people speak different languages, IRC noted this was essential in Uganda to ensure persons with disabilities got the right information about SRH services.
- One HI staff member reflected that even if service providers are not fluent in sign language, knowing basic greetings or signs helped persons with hearing impairments to feel welcome and accepted.
- One service provider noted that sign language training is helpful, but time is needed to train people properly and it should be done alongside improving communication for less visible impairments.

3. Coordination

This section looks at good practices and lessons learnt around the theme of coordination between actors and gives examples of how improved coordination can contribute to more disability-inclusive SRH services. OPDs can play an important role in national coordination to bring about longer-term improvements in disability-inclusive SRHR, going beyond programmes such as WISH2ACTION.

Key learnings relate to embedding OPD members in health committees for better coordination and ensuring that disability inclusion is on the agenda. This section also reflects on coordination for the training of community healthcare workers and service providers and how this could be improved at the national level to embed disability inclusion beyond projects.

Key points

- Persons with disabilities should be included in the planning and implementation of SRH services through membership of government-run committees at the village and district level.
- In the longer term, disability inclusion should be embedded in national health care worker training programmes to ensure a coordinated approach to inclusion across the health care system.

Good practice 7: Advocate for the inclusion and representation of persons with disabilities in health committees

The challenge

Cluster or district health committees are permanent structures who are responsible for the planning, implementation, and monitoring of SRHR, and they should engage the local community to create cooperation, ownership, and accountability. There are also new structures created in response to health emergencies such as Covid-19 who must engage communities in emergency response/communication to ensure effective public health programming. However, persons with disabilities are often not represented on these committees which means they may not consider the needs of persons with disabilities.

What we did

HI and partners worked to improve disability inclusion by advocating for the representation of persons with disabilities on health committees. The type of committee ranged from village to district to emergency response committees.

Ongoing engagement and discussions were required with government officials to get OPD members included on committees in Pakistan, Uganda, and South Sudan. In Uganda, the team built on existing guidelines for Health Management Committees to clarify what these committees are responsible for and share how inclusion of persons with disabilities is part of those responsibilities. In South Sudan, after two years of engagement, training and linking with OPDs, 24 village health committees now have OPD members integrated within them.

Why it worked

IPPF Member Association in Pakistan, FPAP (Family Planning Association of Pakistan, WISH Consortium lead), reflected that an important learning had been mainstreaming OPD members into cluster health committees in Pakistan, rather than establishing separate disability inclusion committees as this approach was more sustainable and better integrated inclusion. Sustainability was identified as a challenge. In Uganda, the teams were successful in agreeing that the cost of supporting persons with disabilities to attend meetings must be included and planned for in the next financial budget for health committees.

Lesson learnt 2: Continuous capacity building is needed to ensure a disability-inclusive health system.

A key reflection from several HI country teams, and technical partners was around the challenge of sustainability. As covered in Good practice 6, capacity building and sensitisation of service providers and community healthcare workers on disability inclusion has been an important element of the WISH2ACTION programme with positive outcomes and should be an ongoing component in SRHR programmes.

However, disability inclusion is not often covered in national training of service providers or CHWs. Staff may change roles or move location, presenting a challenge for sustainability. Positive progress is being made in this area in Madagascar and Bangladesh where HI is working with governments to develop a module on disability inclusion in the national training curriculum for community healthcare workers and for service providers in SRH and in family planning. Both versions were being reviewed by government at the time of writing this report. This approach could help build capacity and sustainability for disability-inclusive SRH in national health systems.

> 'Working with training institutions is a more sustainable approach to ensure that inclusive models become part of the curriculum.'
> – HI staff member in South Sudan

District cluster management committee meeting in Pakistan, © Shuja, Humanity & Inclusion

4. Data collection and management

This section looks at good practices and lessons learnt around the theme of data collection and management. It has a particular focus on the internationally recommended use of the Washington Group Short Set of Questions (WG-SS) and how this can be adopted to improve advocacy, planning, programming, and monitoring to measure how SRHR programmes include persons with disabilities and hold duty bearers to account.

The Washington Group Short Set of Questions are a tool designed to be rapidly and easily used for disability data collection in any setting including humanitarian contexts (Washington Group 2021). They aim to contribute towards streamlining global statistics on disability by providing a tool that can collect the same basic information in censuses, surveys, and healthcare systems.

Research shows that asking people directly whether they have a disability is not an effective mode of data collection as people may be hesitant due to stigma or might disclose only severe impairments despite more moderate impairments also being linked to risks of exclusion (HI and Leonard Cheshire Foundation [LCF] 2016). The WG-SS has been developed to avoid using the term 'disability' for these reasons.

The WG-SS are not a diagnostic or assessment tool but are designed to identify the prevalence of disability to address areas such as the level of access persons with disabilities have to healthcare facilities or how inclusive programmes are (HI and LCF 2016). The successful use of the WG-SS requires an understanding of the concepts behind this tool and training to build a basic competency in how to administer this tool[4] (Washington Group 2015).

Key learnings from WISH2ACTION relate to the need to build capacity on the WG-SS through training for governments, service delivery partner and service providers. This section also discusses the importance of tailoring training to context through language and translation in line with recommended protocols (Washington Group 2003). This section closes by reflecting on the challenge of building the WG-SS into national health information management systems for greater disability inclusion.

Key points

- Collection of disability disaggregated data (as started in the UN CRPD) should become routine in all data collection system and practices of SRHR service providers and partners.
- Relevant health stakeholders such as government staff and service providers should be sensitised and trained on the importance of disability disaggregated data collection and the relevance of the WG-SS.
- All data collectors should receive training to ensure consistency and effective integration of the WG-SS into systems and services.
- Training should be tailored to context and should address any concerns that participants have about using WG-SS.
- WG-SS should be provided in the local language following translation guidance from WG to ensure appropriate terminology and to allow training participants to practice use (Washington Group 2003).
- Ongoing support and repeat trainings may be needed to embed use of WG-SS and ensure data collected can be analysed effectively.
- Data collected from the WG-SS can and should be properly analysed and used to improve programmes, influence budgeting, map challenges and inform practice.
- Mainstreaming WG-SS into national health information management and monitoring systems is a long-term challenge that needs engagement from national policymakers.

4 HI and the Washington Group have collaborated to develop online training on using the WG-SS available at this link: https://www.washingtongroup-disability.com/resources/online-trainings-and-webinars/

‘The WG-SQ are instrumental in defining if we are really seeing persons living with disabilities, what disabilities are presenting, how we can modify and deliberately adapt our service delivery infrastructure or information education communication materials based on these results.’

– IRC staff member

Training on the WG-SS in Uganda, © Humanity & Inclusion

Good practice 8: Build capacity through training on the use of Washington Group Short Questions to promote effective use and uptake amongst service providers and government.

The challenge

The WG-SS are often not well integrated in service provider and government systems and training and support is needed to use them effectively.

What we did

Several HI country teams delivered training on the WG-SSs to a range of stakeholders and there were several examples of positive uptake by government and service providers.

Engaging government

- In Ethiopia, a high-level government advocacy workshop was organised using the WG-SS to collect data about persons with disabilities – this was attended by the Director of Gender and Disability who reflected that it was important to collect disability data and instructed staff to improve their work in this area.
- In Pakistan, the WG questions were tested in one district by HI in partnership with the district health team, this is a positive example of a pilot exercise which demonstrates engagement from government.

Engaging service providers

- The Ethiopia team delivered training to nine government HCFs on the WG-SS and these HCFs are now using notebooks to collect WG-SS data from service users.
- The Uganda team targeted service provider organisations and provided training to encourage these stakeholders to integrate WG-SS. Positively, Reproductive Health Uganda (RHU)[5] has now integrated these questions into their electronic routine data system and is using them for data collection for every client as well as reporting. RHU have also continued training staff elsewhere in Uganda.
- IPPF and IRC integrated the WG-SS into their client exit interviews[6] in the following countries: South Sudan, Malawi, Zambia, Mozambique, Sudan, Somalia, Ethiopia, Uganda, Burundi, Tanzania and Pakistan. Client exit interviews are a quality monitoring tool that is used annually to monitor quality of service and client satisfaction. Interviews are extensive, asking clients up to 50 questions. IPPF then took this work one step further by adding several additional disability specific questions into client exit interviews.

5 Reproductive Health Uganda provides services in 29 of the country’s districts through 768 service points: 17 static clinics, 74 mobile facilities, 35 associated clinics and a network of hundreds of community-based distributors/community-based services (IPPF 2021).

6 MSI and the IRC also use the WG-SS questions in their client exit interviews and had done so prior to WISH2ACTION.

Why it worked

HI developed tailored training to support the needs of and build the capacity of different stakeholders on the WG-SS. In the case of RHU, ongoing support was needed to help integrate the WG-SS into their routine data collection - HI met with them regularly as well as providing one on one training for RHU monitoring and evaluation staff.

> ‘Initially the thinking was that HI is totally responsible for disability data but now service providers understand that they need to consider this too.’
>
> – HI Uganda staff member

CASE STUDY

Learning from the WG-SS at the IRC

IRC are using the WG-SS to understand if they are serving the needs of persons with disabilities, adapt their services to better meet these needs and map where more support is needed.

IRC have found the questions useful to understand the types of disability that are predominant in different settings and have been using this information to modify services - in one setting they found that 7% of clients are living with a disability and that most disabilities were intellectual. They have also noted the importance of ensuring the questions are used in a standardised way, are translated appropriately so clients understand them and that all data enumerators are trained in use.

Good practice 9: Tailor support and guidance on the Washington Group Short Questions to ensure the applicability of this tool in different contexts and for different purposes.

The challenge

HI country teams and service provider partners identified several challenges about applying the WG-SS to their setting and work.

In some settings, it was felt that it was uncomfortable to ask these questions if the service user had a visible impairment. There were particular concerns about questions on self-care and communication causing embarrassment. Feedback about the length of the questions was also common, noting that it took a long time to go through all six questions or provide all the response options.

What we did

These challenges were mitigated through HI trainers explaining that the purpose of the WG-SS is to understand the levels of difficulty that persons with disabilities experience, identify those most at risk and use this data to improve services. In Madagascar, support was given to ensure appropriate language use and translation (see case study). Service provider organisations identified that it was best to include these questions in client exit interviews, to have sufficient time to ask them properly.

Why it worked

A tailored approach helped different actors apply the WG-SS effectively in their work. Service provider partners reflected that the WG-SS are useful not only for data collection but for other purposes, i.e., telephone operators in Madagascar could discreetly find out if someone has an impairment and adapt their service accordingly.

CASE STUDY

Translating the Washington Group Short Set of Questions in Madagascar

Language was an important factor in Madagascar, where service providers gave feedback that the Malagasy version of questions was more relevant and practical than the French version. Translation should be done in line with the recommended Washington Group translation protocols (Washington Group 2003).

Malagasy questions were used for a role play scenario so service providers could practice, and the Malagasy questions were integrated fully into training materials. It was useful to provide both the French and the Malagasy version, so the participants were able to compare the meaning of the questions in both languages.

Lesson learnt 3: Improving national disability-inclusive data collection is a long-term commitment and ongoing challenge.

This was identified as a key challenge across all six countries. The WG-SS were not integrated in any government system and some systems had no national indicator for disability in place.

Generally, governments use a national health management information system which is updated every five years or so. This timeframe creates challenges for influencing government to add disability-inclusive data collection questions. It is also challenging to influence national government and can be competitive with other actors aiming to get new health priorities on the agenda.

One challenge identified was the poor quality of data on persons with disabilities in national health systems (i.e., no data collected or missing data). In Bangladesh, persons with disabilities can access financial support from the Ministry of Social Welfare and OPDs supported persons with disabilities to register with government officials to access this support (and this meant they would also be included in national data on persons with disabilities).

There are a range of challenges for rolling out WG-SS nationally including training all data collectors so the questions can be used correctly and consistently, investment in training and systems, and logistical challenges such as sending out hard copy materials. An additional challenge is aligning WG-SS with other disaggregated data on factors such as age, sex, gender, and sexual orientation- these can intersect with disability to create additional barriers to accessing SRHR (HI 2021b). WISH2ACTION found that while the WG-SS are international good practice, it remains challenging to implement them nationally.

> ‘There is no data or statistics showing the rate of gender-based violence on women with disabilities – if people are suffering in Juba, what about rural areas? We want to go deeper and explore this in rural areas. Data is a big challenge, we don’t have the exact number of persons with disabilities.’
>
> - OPD leader, South Sudan.

5. Referral networks

This section looks at good practices and lessons learnt around the theme of improving referral networks for persons with disabilities. Referrals can include both referrals from the community onto SRH services as well as referrals from SRH services to other types of support (such as rehabilitation, physical therapy, or assistive devices).

This section includes identifying where persons with disabilities can access relevant and meaningful SRH services as well as highlighting the important role OPDs can play in improving referral networks and sharing examples of strong referral networks in the WISH2ACTION programme.

Ada (in wheelchair), chairperson of union and a family member during an interview on experience of referrals to health facility for SRHR services (Uganda), © Humanity & Inclusion

Key points

- Persons with disabilities often have accessibility requirements as well as preferences (See Good practice 10) that determine where they can access relevant and supportive SRH services.
- Service providers should understand and consider these requirements and preferences to identify where persons with disabilities can best be referred to and access relevant SRHR services.
- OPDs have built trust with persons with disabilities in their area and have a strong network of contacts who they can engage on SRHR.
- Service providers should engage and work with OPDs to improve referrals to SRH services.
- An integrated approach to referrals involves different actors referring persons with disabilities to appropriate services at accessible facilities.

Good practice 10: Identify where persons with disabilities can access relevant and meaningful sexual and reproductive health services.

The challenge

Preferences varied as to where persons with disabilities preferred to and were able to access SRH services.

What we did

HI and partners provided SRH services at a range of settings including individual door to door visits, attending the offices of OPDs, and attending healthcare facilities.

- Door to door visits were an essential first step in Bangladesh to explain SRH services in a safe environment and then refer women with disabilities to access HCFs.
- In Madagascar, hosting service providers at the offices of OPDs was preferred by persons with disabilities.
- Another effective strategy was having OPDs and CHWs provide community information sessions on SRHR together to raise demand for later attending HCFs.
- Another approach was for OPD members to support service providers at HCF to communicate with clients with disabilities.

Given the inter-section between disability and poverty, some persons with disabilities cannot afford to cover transport costs to HCFs and therefore OPDs supported this by providing transport directly or providing funds for travel.

Why it worked

This tailored approach helped identify the needs, preferences, and access requirements of persons with disabilities in different contexts and increase their access to SRHR services. In some settings, persons with disabilities had an initial preference to attend locations other than HCF but were willing to attend HCFs once they had an increased understanding of the services available there. FPAP reflected that as a result of learning from WISH2ACTION they had introduced more outreach in Pakistan, including service provision days targeted specifically at persons with disabilities (with OPDs identifying and signposting individuals to these outreach events).

CASE STUDY

Delivering SRH services at the offices of OPDs in Madagascar

In Madagascar, it was effective to host service providers at the offices of OPDs and provide SRHR services in that familiar setting. One person attending said this was preferrable to health centres as it was a familiar, comfortable, and welcoming environment. It also meant that while waiting for services, they could connect with other persons with disabilities and provide peer support (i.e., for any anxieties about having a SRH consultation).

Service providers in Madagascar noted that they had more time to deliver a higher quality service to persons with disabilities when using offices of OPDs and it provided an opportunity to talk about and provide other services such as cervical cancer screening.

Project manager talking to participants on the challenges of referrals for persons with disabilities in Bidi Bidi Refugee settlement camp, Yumbe District, Uganda, © Humanity & Inclusion

Good practice 11: Work with organisations of persons with disabilities to reach and engage persons with disabilities in SRH services.

The challenge

OPDs are often well placed to raise awareness, generate demand, make referrals, and reach out to persons with disabilities in their networks. They can play a key role in referrals by signposting persons with disabilities in their networks or groups towards healthcare and other support services. However, they are not always connected or involved with SRHR services.

What we did

HI and service provider partners worked closely with OPDs to improve referrals. OPDs in Uganda created demand through community dialogues that encouraged and referred persons with disabilities to attend SRH services. OPDs in Bangladesh referred persons with disabilities to health facilities for SRH services and to the Ministry of Social Welfare for registration for support (further detail in Good practice 12).

Why it worked

OPDs have extensive experience in mobilising persons with disabilities and maintain lists of persons with disabilities in their area who could benefit from programmes or referrals to services. Importantly, they have a good relationship with persons with disabilities and have built trust within their network.

> ‘Through OPDs, we have identified persons with disabilities, and we work collectively. We now have a budget to provide travel allowances to come to trainings and provide refreshments. They realise HI is working for their rights and families support them to come.’
>
> – HI staff member in Pakistan

CASE STUDY

Working with OPDs to engage persons with disabilities in Pakistan

The Pakistan HI team reflected that initially it was difficult to find and engage persons with disabilities to attend events. There was also a lack of understanding about why it would be beneficial to attend events given that it was often complicated to organise transport and accompaniment was needed from a family member.

OPDs played an important role in bringing people from their homes and encouraging their participation. Persons with disabilities and their family members were eager to attend when they realised that the events would increase their knowledge about the rights of persons with disabilities, knowledge about SRH, family planning, accessibility, and facilities. Participation in community events led to them accessing SRH services.

Good practice 12: Develop an integrated approach to referrals across service providers, OPDs and other actors.

The challenge

It is a challenge to build strong and integrated referral networks for persons with disabilities to improve SRHR and other support services. Multiple actors need to be involved for successful referral networks.

What we did

In Bangladesh, OPDs provided counselling and support to couples, women and girls in communities and referred these people to family planning facilities to address their SRH needs. Generally sufficient support was available at community health facilities, but it was possible to refer them to district hospitals if needed. OPDs also encouraged persons with disabilities to register with the Ministry of Social Welfare for support.

Community healthcare workers also played an important role in referrals and referred persons with disabilities from the community to HCFs to receive family planning services. This was done through regular coordination with government service providers to ensure that persons with disabilities received high quality care once at the HCFs.

HI also delivered training to government and private service providers on referrals – this meant they could make referrals from SRH services onto other support services for persons with disabilities (such as rehabilitation workers for physical therapy or assistive devices).

Why it worked

Referrals worked well in Bangladesh because OPDs knew what services were available at different facilities and understood the access and support needs of persons with disabilities. OPDs and CHWs established a good relationship and worked together effectively. Developing an integrated approach helps create a strong referral network in which different actors can refer persons with disabilities to appropriate services at accessible facilities. Referrals can include referrals from the community to SRH services as well as referrals from SRH services to other types of support (such as rehabilitation, physical therapy, or assistive devices).

6. Service integration (programmes and humanitarian response)

This section looks at good practices and lessons learnt around the theme of service integration and how to effectively integrate different services (including SRH) for persons with disabilities. It covers both programming and humanitarian response.

It includes good practice examples about using national health guidelines to better integrate disability inclusion and building upon existing systems to increase uptake of SRH for persons with disabilities. It also shares new approaches such as linking SRH to other services such as vaccination.

Inclusion in humanitarian response

Barriers to accessing SRH services are heightened in humanitarian contexts such as areas experiencing protracted conflict and refugee camps. This is even more of a challenge for people living with disabilities who face disproportionate risks and barriers (HI 2020).

Language barriers, accessibility requirements, stigma and changing security situations can make it especially challenging for persons with disabilities to access SRH services in humanitarian contexts. Additionally, persons with disabilities have a heightened exposure to risks such as gender-based violence and unintended pregnancy – it is essential to consider these factors and build disability inclusion into humanitarian responses.

Key points

- Build on government guidelines and services to integrate disability-inclusive SRH approaches into existing approaches.
- Think outside of the box and consider other related areas of exclusion for persons with disabilities such as vaccination and rehabilitation.
- SRH could act as an entry point for broader disability inclusion in the health system or be linked effectively with different services for an improved referral network.
- During emergencies, it is important to advocate for the inclusion of persons with disabilities in coordination and planning groups, to tailor telephone support and to use referral networks effectively.
- During the Covid-19 pandemic and in humanitarian response more generally, it is important to consider inclusion and ensure continued access to SRH services for persons with disabilities.

Family welfare corner in Bangladesh, © Humanity & Inclusion

Good practice 13: Identify the challenges faced by persons with disabilities in emergencies and put measures in place to maintain their access to essential SRH services.

The challenge

WISH2ACTION found that there was an urgent need for inclusion of persons with disabilities and the provision of continued access to SRH services during the Covid-19 pandemic. There was also a lack of understanding in some contexts about the additional support that might be required by persons with disabilities during crises.

What we did

Service provider partners worked to increase telephone support during Covid-19 so persons with disabilities had access to a consistent SRHR service. In Madagascar, the team broadcast a video on national television about reproductive health laws and the right to access SRH with a focus on supporting those with disabilities to access services during the pandemic. Trained health providers in Madagascar offered tailored telephone support to persons with disabilities. If referred on to a healthcare facility, they identified the most accessible HCF for that individual.

In Bangladesh, CHWs maintained regular communication with persons with disabilities in their area by phone (reaching approximately 4000 people) and gave them information on both SRH and Covid-19 awareness during the pandemic.

Referrals were also used to increase support. In Bangladesh, OPDs and HI referred persons with disabilities to the local government so they could be included as priority recipients of additional emergency support for Covid-19 and future emergencies – this led to additional support being provided for pregnant women with disabilities to give birth safely.

Why it worked

Support was tailored to meet the needs of persons with disabilities and identify and provide any additional support needed. It was also important to use inclusive approaches to communicate about access to SRH services and Covid-19 protection for persons with disabilities, further information is covered in Good practice 17.

CASE STUDY

Including persons with disabilities directly in emergency response planning in Uganda

In Uganda, HI and OPDs worked together to successfully advocate for the inclusion of persons with disabilities on district level Covid-19 taskforces. This was achieved through ongoing engagement with district government officials.

Inclusion of persons with disabilities led to the increased provision of relief items for persons with disabilities as well as improved communications. Through inclusion on the taskforces, there were new opportunities for OPDs to speak on radio talk-shows and highlight issues such as increasing gender-based violence (GBV) against women and girls with disabilities during the pandemic.

An additional positive outcome of this work was that the HI teams later used this to facilitate longer term engagement of persons with disabilities in Health Unit Management Committees (see Good practice 7).

CASE STUDY

Integrating disability-inclusive SRHR into emergency responses in Bangladesh

In Bangladesh, IPPF, MSI, HI, the United Nations Population Fund and other partners collaborated on a training manual on SRHR in emergency response, this included a module on inclusive services with technical input from HI. The manual was developed for Covid-19 but applies to other humanitarian emergencies too. This training manual will be used for all public and private service providers in Bangladesh and supports disability inclusion beyond WISH2ACTION.

Good practice 14: Integrate disability-inclusive approaches within national guidelines, services and systems for longer term sustainability and mainstreaming of disability inclusion.

The challenge

Mainstreaming disability inclusion requires engagement with existing approaches such as government guidelines, services, and systems. This is especially challenging in a relatively new area of focus such as disability-inclusive SRH.

What we did

In Bangladesh, the HI team used the idea of family welfare corners in HCFs (part of a national strategy on adolescents) to better integrate persons with disabilities. These family welfare corners are intended to reach people who might find it hard to reach conventional services and are therefore well suited to persons with disabilities. HI trained HCWs to make the corners disability-inclusive by engaging disability focal persons (see Good practice 5) and as a result, saw an increase in young persons with disabilities coming to access SRH services.

An effective example from Uganda was using existing guidelines for Health Management Committees to hold HCF accountable to these national guidelines and advocate for integration of persons with disabilities within committees (see Good practice 7).

Why it worked

National guidelines, service and systems provided an important foundation for WISH2ACTION to integrate disability-inclusive approaches to SRH. They also provide a platform for sustainability and mainstreaming of disability inclusion beyond projects.

Good practice 15: Link sexual and reproductive health services with other health services such as vaccination

The challenge

Linking persons with disabilities with vaccination campaigns in Bangladesh had not been part of the programme plan but emerged as an entry point for linking them to SRH services. HI and partners found that many young women with disabilities were unaware of the tetanus vaccine and its relevance to SRH. Most girls receive it in school but many persons with disabilities had not had access previously or had not attended school to access it. Therefore, it was relevant to inform young women and girls with disabilities about the importance of getting protection from tetanus and to facilitate the vaccination.

What we did

In Bangladesh, a targeted approach used one to one counselling to educate and encourage uptake of the tetanus vaccine for young women with disabilities. This resulted in greater uptake of this vaccine.

Why it worked

Community healthcare workers developed a good relationship with service providers and referred young women with disabilities to health facilities, in some cases supporting them by travelling together to receive the vaccine at HCFs. The HI team reflected that receiving direct services from health facilities has helped reduce stigma about women with disabilities.

While this example of linking SRH with other health services only happened in one WISH2ACTION country, it offers a useful example of how SRH can be linked with the broader health system to improve disability inclusion for other services such as vaccinations. This also links to the work done on referral networks in Bangladesh (captured in Good practice 12).

7. Social and behavioural change communications

This section looks at good practices and lessons learnt around the theme of using social and behavioural change communications (SBCC) to influence knowledge, attitudes, and social norms. It focuses specifically around SBCC in relation to persons with disabilities and disability-inclusive SRH. Areas of SBCC covered include interpersonal, media and community mobilisation.

Key learnings covered here include the key role of community gatekeepers in changing social norms, making communication materials inclusive for persons with disabilities and considering context when designing communications.

> ‘It is not easy to break deep rooted stigmas and norms, but we have started. Once there are set norms, rules, and laws, this will help us to slowly make a change.’
> – Service provider partner.

Focus group discussion with young boys with disabilities in Uganda, © Humanity & Inclusion

Key points

- Identify and engage influential community gatekeepers and decision makers on SRH.
- Use appropriate community engagement approaches to reach target groups in the community and to understand widely held myths and misconceptions.
- Effective community engagement approaches will vary according to context but include focus group discussions with youth, door-to-door visits to families of persons with disabilities and community dialogue meetings that include persons with disabilities.
- Consider how best to include and engage men and youth in SRHR projects, programmes, and services.
- Adapt the format of communications to improve accessibility for persons with different impairments, i.e., adapting materials for persons with visual impairments (colour contrast and large print, DAISY[7] [Digital Accessible Information System]), persons with intellectual impairments (simple images and languages) and persons with hearing impairments (providing sign language interpretation). See Table 1 for some examples.
- Community dialogue meetings and FGDs were an important tool to raise awareness of SRH services and rights of persons with disabilities. This was done in partnership with OPD members, sign language interpreters and translators to ensure inclusivity of communications.
- SRH can be a sensitive topic so consider the most acceptable way to introduce SRH messaging at the community level.
- Use myths and misconceptions to inform community awareness sessions, trainings, posters, regular mass media activities such as radio and tv messages/features/talk shows, and other SBCC communications.

7 DAISY Digital accessible information system (DAISY) is a technical standard for digital audiobooks, periodicals, and computerized text. DAISY is designed to be a complete audio substitute for print material and is specifically designed for use by people with “print disabilities”, including blindness, impaired vision, and dyslexia. See https://en.wikipedia.org/wiki/Digital_Accessible_Information_System

Good practice 16: Engage community members and gatekeepers to change social norms about SRH and increase access to SRH for people with disabilities.

The challenge

Acceptability of SRHR services was noted as a key challenge by multiple HI staff and service providers. Engaging those people who have a strong influence on decision-making around SRH is important to address this challenge – such as carers, husbands, mothers in law and grandparents (depending on the setting). It was noted in several settings that men sometimes thought SRH was largely a woman's responsibility and that they did not need to attend information sessions themselves.

What we did

In each setting, HI and partners directly engaged relevant community members such as religious and community leaders, carers, family members from all generations, men, women, youth, and persons with disabilities themselves. In South Sudan it was important to include chiefs and religious leaders in community dialogue meetings. Similarly in Uganda, the team engaged local councils and community leaders from village to district level to build community support.

Some HI teams aimed to specifically engage men given that they often play a key role in decision making about SRH. In Bangladesh, specific courtyard sessions were held for men as well as home visits and discussions in public settings like marketplaces.

Why it worked

Community and in-person outreach was the most appropriate and effective way to reach community members, leaders, and gatekeepers. Given that SRH can be a taboo topic, identifying and engaging those who are influential is essential to increase acceptability of SRHR in communities. Some teams reflected that there were key groups they could have considered and engaged earlier on – such as religious leaders, teachers, and men.

CASE STUDY

Engaging family members in Bangladesh

In Bangladesh, door-to-door visits were an effective approach for engaging the wider family and it was noted that spouses and mothers-in-law was especially important, especially in rural areas where there was more stigma about persons with disabilities.

Family members of persons with disabilities were not always receptive to the idea of them accessing SRH services so it was important to counsel them directly on this sensitive issue as well as explaining rights of persons with disabilities. The Bangladesh team noted a higher rate of persons with disabilities receiving SRH services after awareness raising activities.

> "The main challenge was that caregivers were not aware of the rights of persons with disabilities regarding SRHR and did not want to discuss it due to the taboo around this issue. To mitigate this, we trained OPD members to understand this and built their capacity to conduct counselling at the community level"
>
> - Bangladesh OPD leader

Good practice 17: Make the format and content of sexual and reproductive health communication materials inclusive and accessible for persons with disabilities.

The challenge

Communications materials on SRH are not always in an accessible format which means persons with disabilities can be excluded from engaging with SRH services and information.

What we did

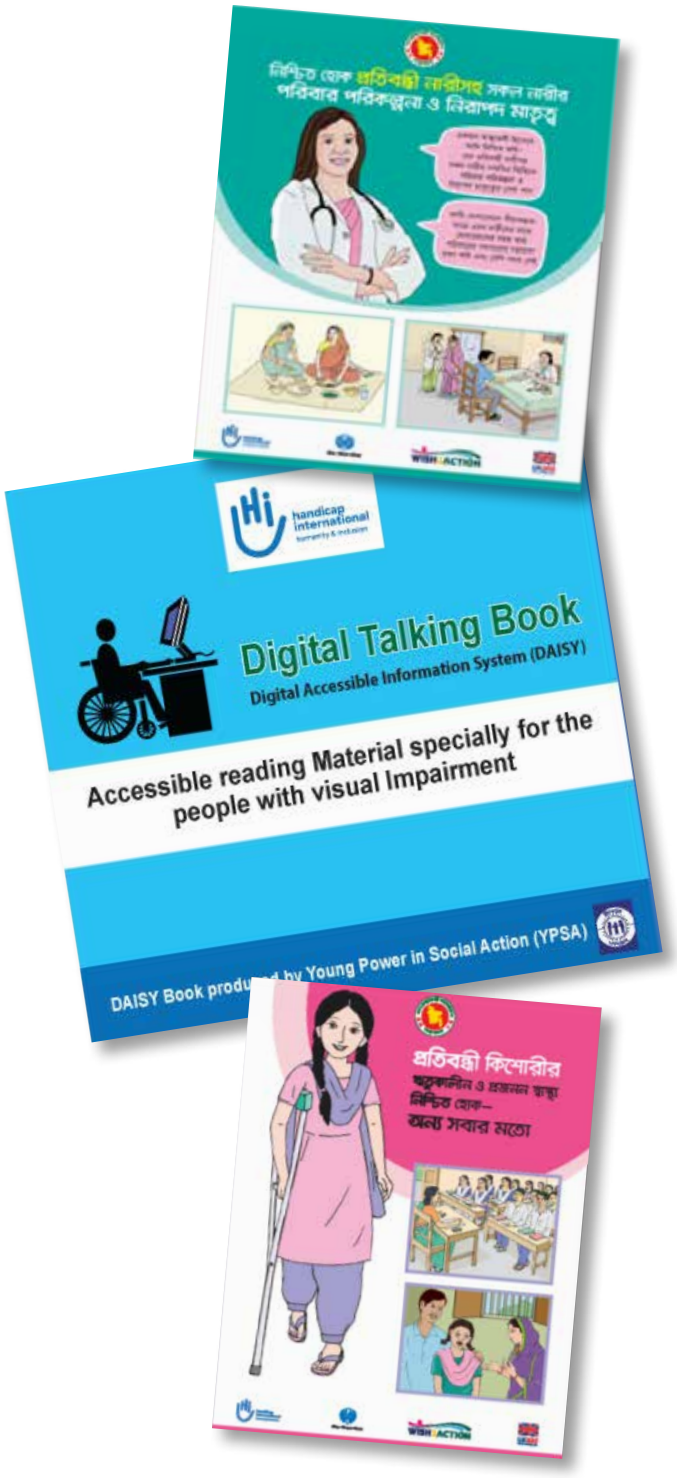
Community engagement

HI and partners used community dialogue meetings to raise awareness of SRH services and rights of persons with disabilities. It was important to work with OPD members, sign language interpreters and translators. An OPD member said that messages should be shared in the local language, but that many persons with disabilities do not have the opportunity to access formal education so using simple, non-technical terminology is important too.

Informing the development of SBCC materials

OPDs and HI held focus groups with people with different impairments to provide input to SBCC experts as to how the format of messages could be made inclusive. Messages were adapted to meet the needs of persons with disabilities and pre-tested by OPDs. This included developing audio messages for persons with hearing impairments (sign language interpretation) and adapting audio-visual materials to reach people with visual impairments (i.e., colour contrast, large print) and persons with intellectual impairments (pictorial, clear and easy language).

The Bangladesh team developed inclusive leaflets, flipcharts, and brochures on SRH topics for community courtyard sessions – they were inclusive because the format was designed to meet the needs of persons with different impairments. In Bangladesh, HI is also developing digital materials which use Braille to support people with visual impairments. Table 1 shares some findings from HI about which formats are effective for people with different impairments.



SBCC materials produced during WISH2ACTION,
© Humanity & Inclusion

Mass media

In South Sudan, HI and the OPD task team used regular slots in radio talk shows to address challenges related to disability-inclusive SRH, raise awareness and link listeners to SRH services. Community radio was also used in Ethiopia to share messages and in Uganda, sign language was included on TV messages during the Covid-19 outbreak. TV was also used effectively in Madagascar (See Good practice 9).

Why it worked

This approach was successful because HI and OPDs were engaged in adapting and testing messages to ensure they were accessible and inclusive for persons with different impairments. Combining interpersonal approaches, community mobilisation and mass media approaches was effective as well as ensuring messages were tailored to the cultural context (see Good practice 18). **Table 1** shares some simple ideas about communications for persons with different impairments.

CASE STUDY

Making flipcharts accessible in Bangladesh

HI developed a flipchart on inclusive SRH, and this was approved to use in counselling and courtyard sessions by government service providers. To make this information accessible for persons with visual impairments, HI developed a DAISY (Digital Accessible Information System) version of the flipchart. DAISY is the technical standard for talking books and is designed to be an audio substitute for printed material that is fully accessible to persons with visual impairments.

The new accessible flipchart was created in partnership with Young Power in Social Action. Government service providers will receive a short training and orientation session on the DAISY version so they can use it effectively in counselling sessions at healthcare facilities for persons with visual impairments.

Table 1: Basic ideas for communication methods for persons with impairments
This is a collection of suggestions from OPDs on communication methods for persons with impairments.

	Persons with a visual impairment	Persons with a hearing impairment	Persons with intellectual impairments	Persons with physical impairments
Radio	Yes	–	Yes, easy language	Yes
Television	For audio content	For visual content	Yes, easy language and pictures	Yes
Printed materials: Posters, billboards, and flyers (dependent upon literacy)	In Braille	Yes	Simplified picture-based messages	Yes
Drama	For spoken content	For visual content	Yes, easy language	Yes
Discussion groups	Yes	With appropriate sign interpretation	If simplified and accepted by group members	Yes

Good practice 18: Ensure that communication approaches for providing sexual and reproductive health and rights information are acceptable and appropriate to context.

The challenge

SRH remains a sensitive and taboo topic in many contexts in general and particularly for persons with disabilities.

What we did

HI and partners organised focus groups and community dialogues to identify myths and misconceptions. These informed trainings, posters, radio messages, community awareness sessions and TV features. Training community healthcare workers was an important approach to address their views as well as to equip them to raise awareness and change negative attitudes in communities (as noted in Good practice 6).

In Pakistan and Bangladesh, it was difficult for HI to raise this topic directly and better to integrate it as one of the topics included in life skills sessions for communities or use a topic like menstrual hygiene management to introduce SRH. In South Sudan, youth focus group discussions were a helpful approach to discuss barriers and identify appropriate messaging to inform community awareness sessions.

Why it worked

Communication approaches were informed by contextual analysis such as the barriers and facilitators assessments undertaken by HI as well as formative research undertaken by DMI. This ensured they were relevant and appropriate to each context, as SBCC is more effective when it is tailored to context.

> ‘Marginalisation is exacerbated for women with disabilities. The impacts of war, discrimination and negative cultures are hindering the participation of women with disabilities. Girls especially suffer a lot of discrimination.
>
> Because of the negative culture and lack of understanding, they don’t know about sexual education or how to access services for family planning. There is an assumption that women with disabilities stay at home, don’t need to go to school or be trained and are treated as idle.’
>
> – OPD women’s leader, South Sudan.

8. Partnerships and collaboration

This section looks at good practices and lessons learnt around the theme of building partnerships and facilitating effective collaboration between organisations to improve SRH services and rights for persons with disabilities. Related lessons on coordination between actors are covered in the section on Coordination.

It covers building relationships between service providers and organisations of persons with disabilities and providing the appropriate technical and financial support to strengthen and empower OPDs. This section also reflects on the critical role that OPDs play, noting that service providers and governments should build partnerships with OPDs to ensure sustainable SRHR services for persons with disabilities and accountability.

This section also examines challenges and successes of partnerships within the WISH2ACTION consortium including open working relationships, communication, and collaboration on mainstreaming disability inclusion at the organisational level.

> ‘It is only through this project we are teaching ourselves on family planning and being trained on how to train and reach other persons with disabilities. We believe nothing will be done for us without us. If you want us to be part of your project, teach us and give us a chance to see the work we are achieving.’
>
> – OPD leader in South Sudan

Key points

- Organisations of persons with disabilities are essential partners for service providers to ensure disability inclusion in projects and in the longer term.
- OPDs play an important role in raising awareness, generating demand, making referrals, and conducting effective outreach to persons with disabilities.
- SRH is often a new topic for OPDs, and training and support is needed. OPDs are eager to work in this area and recognise its importance for persons with disabilities.
- Capacity building and technical support should be provided so that OPDs can better establish themselves as independent organisations.
- OPDs also need financial support and investment to scale up, access their own funding and expand their reach.
- OPDs may need logistics and travel support to implement SRHR related activities.
- Consortium partners should work in partnership to integrate the different components of disability-inclusive programming into programme design and implementation.

Working in partnership in South Sudan, © Humanity & Inclusion

Good practice 19: Service providers (public and private) and NGOs should map, identify, select, and establish relationships with organisations of persons with disabilities (OPDs)

The challenge

OPDs are well-connected with persons with disabilities in their geographical area but relationships need to be built between service providers and NGOs to find and collaborate with OPDs.

What we did

HI used a range of approaches to identify, select and build relationships with OPDs. Most country teams began by undertaking a mapping exercise to find out which OPDs were present nationally and locally, their capacities and their focus of work.

Some countries had national unions of persons with disabilities or umbrella organisations with district level branches. Often, OPDs were organised by type of impairment with a different OPD to represent persons with different impairments. There were often OPDs specifically for women with disabilities or youth with disabilities - these OPDs played an important role.

Some HI country teams had a long-standing relationship with OPDs and were able to build on those relationships. Country teams analysed gaps in OPD experience around disability-inclusive knowledge on SRHR and then developed relevant training and technical support. Some countries used selection criteria to select OPDs with previous experience working with SRHR, delivering community outreach or with women's leadership. HI teams and technical partners found memorandums of understanding (MoU) a useful tool for clarifying the roles and responsibilities of OPDs and establishing good working relationships.

Why it worked

Working with OPDs helped service providers realise the gaps in service provision for persons with disabilities and to understand the important role of OPDs in engaging persons with disabilities. The mapping process was important to understand capacities and experience. IPPF reflected that working with OPDs was an important change in their way of working, facilitated by HI support and networks. They plan to continue working with OPDs using the MoUs and relationships established during WISH2ACTION.

OPD mapping workshop in Pakistan, © Humanity & Inclusion

CASE STUDY

Setting up a multi-OPD task force in South Sudan

The South Sudan team set up a multi-OPD task team per geographical area, bringing together multiple OPDs to run community activities and work with service providers. The task teams were selected from different OPDs covering different impairments and they were trained in inclusive SRHR, SBCC and advocacy.

They reflected that this approach was successful as each member had a different background, there was broad representation across different impairments, responsibilities were divided effectively, task team representatives felt a sense of ownership and each OPD representative could pass information directly to its members. Challenges included managing communication within the group due to different types of auditory and visual impairments.

Good practice 20: OPDs need training on SRH which is often a new topic for them.

The challenge

OPDs were generally very familiar with the rights of persons with disabilities and other issues pertaining to persons with disabilities. Many OPDs had a long history of ensuring the rights of and supporting persons with disabilities. However, SRH was a new topic for many OPDs involved in WISH2ACTION.

What we did

HI, in cooperation with service delivery partners provided training on inclusive SRHR for OPDs in all six countries. OPDs in Bangladesh reflected on the importance of receiving training on SRHR, learning how to counsel families, and improving their understanding of family planning available to persons with disabilities. One OPD in Bangladesh reflected that previously they had never worked in SRH, and this meant that persons with disabilities in their area were also being deprived of SRH services.

Why it worked

OPDs gained new knowledge and realised the importance of SRH services for their members. Some OPDs in Bangladesh said that they will continue disseminating SRH information and making referrals to SRH services beyond WISH2ACTION. A leader from a women's OPD in South Sudan reflected that 'part of our work is for healthcare workers, part of it is for us' and noted the importance of learning about SRH for themselves and their members as women with disabilities.

Good practice 21: Service providers and NGOs should provide technical support to build the capacity of organisations of persons with disabilities as well as forming equitable partnerships.

The challenge

Capacity building was a key challenge and opportunity identified by both HI teams, service providers and OPDs themselves. OPDs often have limited resources and funding but are engaged, enthusiastic and skilled at awareness raising.

What we did

Technical support to OPDs was an important element of WISH2ACTION and training was delivered on various topics. OPDs in Bangladesh said that receiving training on leadership, finances and organisational management from HI was beneficial in developing their organisations and building capacity. One OPD leader noted that many OPD staff have been excluded from formal education and therefore need support and capacity building to develop their skills and better support persons with disabilities in their area. A service provider reflected that OPDs themselves know what their needs are so they should always be consulted around capacity building processes. Another role that HI and partners played was providing exposure and introduction to networks for OPDs.

Why it worked

This approach was important to build OPD capacity, but challenges remain in supporting OPDs in the longer term. OPDs did not always have a strategy of their own in place as activities can be driven by short-term projects led by other organisations – the South Sudan HI team reflected that NGOs should support OPDs to develop capacity to become established organisations who can set their own agendas. This was echoed by South Sudan OPDs themselves who said they wanted to participate fully in projects, to be involved from design to evaluation and to become equal partners.

Lesson learnt 4: OPDs need financial support as well as technical support.

There was sometimes a mismatch in expectations, with HI providing technical support whereas OPDs were looking for financial support. WISH2ACTION focused on capacity building and advocacy but financial support was a challenge for OPDs.

Travel and logistics

OPDs noted the challenge of getting to rural areas with limited resources, budget, and transport – but also the need given that persons with disabilities in rural areas often face more discrimination than those in urban areas. Logistics is a key challenge as OPDs often rely on NGOs for their vehicles or travel allowances. Many OPDs want to expand to rural areas but lack the financial resources or logistical support to do so.

Finance and funding

Receiving funding from international non-governmental organisation (INGO) projects presents challenges for OPDs. The Uganda team reflected that future projects could consider providing more funds and sub-contracting OPDs to deliver activities as OPDs often struggle with resources. OPDs said that while they received travel allowances, their time in communicating and coordinating often was not accounted for. OPDs in Bangladesh reflected that lack of financial security or long-term funding made it challenging to find and retain skilled staff. OPDs also noted it was hard to apply for or receive international funding and this limited potential to expand their work. An OPD leader in South Sudan said sustainability should be considered so OPDs can continue working with persons with disabilities beyond project timeframes.

Lesson learnt 5: Organisations of persons with disabilities play an important role in raising awareness, making referrals, generating demand, and conducting effective outreach to persons with disabilities.

WISH2ACTION trained OPDs in demand generation, SBCC and awareness raising, building capacity in these areas. OPDs then engaged directly with persons with disabilities and the broader community to share messages about SRH services and reproductive health rights as well as making referrals to SRH service providers.

HI teams and service providers found that OPDs were very willing to engage in this work. Given the strengths and networks they bring, it is essential to engage OPDs as well as to provide appropriate training and support. This lesson applies not only in SRHR projects and programmes but in the longer term to ensure sustainable access to SRHR services for persons with disabilities. Several service providers reflected that it was especially important to map and partner with OPDs in future work, including at the design stage rather than only in implementation.

> ‘The inputs they made to the initial programme design were so important… we can’t leave behind persons with disabilities, they need to be part of the decision-making process. We need to engage OPDs when we’re thinking of project design, rights, service delivery, advocacy…’
>
> – Service provider

Lesson learnt 6: Technical experts should support non-disability organisations to mainstream disability inclusion.

HI teams reflected that their priority was disability inclusion, and their role was to provide technical support in this area, but that other partners had their own objectives and areas of focus. This sometimes made it challenging to mainstream inclusion if it was seen as an additional issue for busy organisations to consider. There were also different paces of uptake of disability inclusion depending on when national partnerships started with HI and sometimes slowed down by staff turnover.

Delivering trainings and building capacity in partnership with OPDs helped disability inclusion become more tangible for service providers. Other examples of good practice to integrate disability inclusion were technical partners consulting HI to ensure that disability inclusion was built into work such as national advocacy campaigns (Options).

Reflections for future programmes

- Some partners reflected on how disability inclusion could be mainstreamed in their organisation in the longer term. This raises questions about how service providers can best integrate disability inclusion across their work, explored further in the recommendations section of this document.
- A technical partner reflected that the challenge could have been mitigated by ensuring inclusion was embedded in all service delivery and technical partner workplans rather than seen as a technical area. Another reflected that disability inclusion as a cross-cutting theme could have been emphasised more at the project design phase, requiring all consortium partners to build disability inclusion into programming and budgets.
- One service provider suggested that disability inclusion could be a key performance indicator for future projects to ensure it is prioritised.
- Another suggested that future consortium should ensure that all staff in the consortium get an induction to disability inclusion (through webinar) to ensure everyone is comfortable talking about, managing, and delivering inclusion.

CASE STUDY

Improving disability inclusion at the IRC

IRC said that WISH2ACTION provided a framework to better implement disability inclusion. At the global level, their new global strategy has a focus on inclusion and leaving no one behind and they are developing programme quality indicators to include disability.

At the country level the IRC are working to get better feedback from clients using tools like the WG-SS and building in stronger feedback mechanisms to health centres to ensure feedback is actioned. They are also ensuring inclusion is part of new funding proposals so that future service delivery and facilities are accessible, positive, and inclusive for persons with disabilities.

CASE STUDY

Expanding disability-inclusive SRHR in IPPF

IPPF reflected that they have taken the learnings from WISH2ACTION and are now considering how these apply to their work more broadly, such as reviewing policies for inclusivity in all service delivery and technical partner workplans. IPPF member associations have learnt from the project, and some are now doing outreach to persons with disabilities as well as training for staff outside the project areas.

HI offered webinars for all members across the broader consortium including outside the six focus countries – these were attended by IPPF staff in Malawi who learnt about using community discussions to begin shifting social norms around persons with disabilities and SRHR services. IPPF then piloted some dialogues with community leaders in partnership with a Malawi OPD and are aiming to start shifting attitudes and opening the conversation about disability-inclusive SRHR in this new context.

9. Policy and advocacy

This section looks at good practices and lessons learnt around the theme of undertaking policy and advocacy work to influence uptake of disability-inclusive SRH at the local and national level. Options have also worked on policy and advocacy as part of both Lot 1 and Lot 2 of WISH2ACTION which is likely to produce additional learning around this theme.

This section of the report therefore focuses on emerging learning and good practices from HI's policy and advocacy work on disability-inclusive SRHR. It covers two main areas: the role of OPDs in advocacy work and how NGOs can effectively engage government stakeholders at different levels.

> 'We need to do advocacy to government to understand about disability. There is a negative culture about persons with disabilities and a view they can't contribute to building the nation. Give them education, provide support and they can contribute. Remove barriers to facilitate their participation, facilitate their access to information and services, they can learn skills and contribute.'
>
> – OPD leader in South Sudan

Key points

- OPDs are well placed to carry out advocacy work as they can work effectively at the local, district and national level and are motivated to claim their rights to access SRH.
- Training OPDs on SRHR rights, laws and declarations builds their confidence to claim and advocate for the SRHR rights of persons with disabilities.
- To influence and move towards a more disability-inclusive society, it is important to engage government stakeholders at multiple levels.
- Partnering with other SRH actors and stakeholders on advocacy through working groups or other partnerships helps to increase effectiveness and improve reach.
- It is effective to work with government to embed disability-inclusive approaches into their policies, guidelines, and strategies and to send the message that disability-inclusive SRH comes from government commitments.
- The scale and timeframe of projects and programmes is always limited, and it is therefore important to engage influential stakeholders such as governments, development partners and donors to build partnerships.

Meeting of inclusion committee in Karachi, Pakistan, © Sami, Humanity & Inclusion

Good practice 22: OPDs should be supported to undertake advocacy towards UNCRPD implementation including the rights of persons with disabilities to access sexual and reproductive health services at the local and national level.

The challenge

OPDs are well placed to engage in advocacy work and advocate for the rights of persons with disabilities but may need support to build capacity or connections in this area.

What we did

Advocacy was a key area that OPDs worked on as part of WISH2ACTION, with support from HI and other partners. Training OPDs on rights and SRH rights, the UN CRPD and relevant national laws contributed to their ability to advocate for greater disability inclusion (See Good practice 20). Being part of health committees was also a useful platform for the sustainable inclusion of persons with disabilities in health and SRHR programmes (See Good practice 7).

The structure of OPDs affected how they engaged in advocacy – in some contexts there were national level OPDs who focused more on policy and advocacy with the government and community level OPDs who engaged more in community outreach. Other contexts had umbrella OPD structures where district level branches fed back to the national level organisation.

In Bangladesh, OPDs were involved in advocating for disability-inclusive services at the community level as well as at health facilities. One OPD in Bangladesh said that they had been able to build a close working relationship with relevant local government departments through WISH2ACTION, despite never having worked with them before. Another OPD noted that they had improved their political participation through WISH2ACTION.

Why it worked

Understanding the structure of OPDs in each context (through the mapping mentioned in Good practice 20) allowed HI teams to support OPDs with advocacy work. The HI team in Uganda noted their initial work had mainly been through partners, but they then realised it was important to engage OPDs as they could work effectively at the local level to advocate for the needs of persons with disabilities.

> ‘We are now in a position to conduct demand generation activities, advocate with government and raise the SRH needs of persons with disabilities to a higher level.’
>
> – OPD leader in Bangladesh

Good practice 23: Engage government stakeholders at multiple levels to improve disability inclusion locally, regionally, and nationally.

The challenge

Engaging government stakeholders at all levels is important to influence longer term change and integration of services for improved disability-inclusion.

What we did

WISH2ACTION engaged at the **national level** in several ways including dissemination of information, participating in forums and groups, bi-lateral engagement with relevant government ministries and hosting training and advocacy events. In Ethiopia and Bangladesh, HI oriented and sensitised national government ministry staff on disability-inclusive SRHR as these people could direct service providers to act.

WISH2ACTION also engaged government service providers and local ministry teams at the **district level**, as well as partnering with other organisations who could influence government (such as national OPD unions and UN agencies).

HI teams noted that it was important to **work with government** to embed disability-inclusive approaches into their policies, guidelines, and strategies and importantly, to send the message that disability-inclusive SRH comes from government commitments. An example of this is aligning work with the South Sudan Family Planning 2020 Committee, which commits to increasing access to reproductive health information for persons with disabilities. In Madagascar, the 2017 national law on reproductive health was an essential tool used by HI and the government to raise awareness of rights.

Why it worked

A multi-level approach helped to engage different levels of government on disability-inclusive SRHR as well as to establish longer term relationships with government bodies for future work. Some HI teams reflected that they built strong relationships at the district level but could have done more at the national level in parallel to this. One service provider reflected that a key challenge is taking government engagement beyond healthcare to other government sectors such as education and social protection to ensure there is an integrated approach to inclusion.

CASE STUDY

Collaborating with government in Bangladesh

In Bangladesh, the team signed a MoU with the Directorate General of Family Planning (DGFP) and organised a workshop for government officials on disability inclusion as well as sharing research.

Through WISH2ACTION, a disability-inclusive SRHR working group has been established in partnership with the DGFP. This group includes HI, IPPF, UN agencies, NGOs, OPDs and other interested actors. This approach is bearing fruit as disability inclusion is now included in DGFP operational plan – meaning budget will be allocated and this work can scale up.

Additionally, the working group is developing an inclusive Standard Operating Procedure for family planning service providers, this will apply to all service providers in Bangladesh (government and private).

Lesson learnt 7: Engage policymakers early on.

Several consortium partners reflected that only governments had the reach and power to effectively scale up disability-inclusive SRHR at the national level. Programmes such as WISH2ACTION can test and develop good practices for disability inclusion however the scale and timeframe is always limited - for example WISH2ACTION has worked comprehensively in 2 of 450 sub-districts in Bangladesh.

Key stakeholders (such as governments, development partners, donors, and other influential actors) could be engaged at the beginning of programmes to build better partnerships and the foundation for scale up of community level work. While community level engagement and expanding service delivery is essential, policy engagement could happen at the same time. This could be through advocacy work to influence laws and policies on disability inclusion or through better joint working with governments and other actors.

Alternatively, adopting a transversal approach, with all the different stakeholders, to implementation could create learning opportunities. Other districts or national actors could learn from successful pilots or centres of excellence in specific districts, facilitating training, learning exchanges, and mentoring between districts.

> 'We've been working a lot on disability inclusivity on the ground and on grassroots and at community level. We haven't done so much at the national level, and this is a lesson learnt. Disability inclusivity needs buy in from the top. As a consortium, we could have engaged better and more consistently with policymakers.'
>
> – Service provider.

From learning to recommendations

WISH2ACTION had a strong learning component, providing learning tools, strategies, documentation, contribution to Technical Working Groups, dissemination of learnings and events built into the programme on internal and international consortium level . These included tools for capturing and reviewing learning at the country level as well as global learning events, webinars to facilitate conversation and dialogue. Useful approaches included lessons learnt, case studies, success stories, good practices and After Action Reviews.[8]

Some examples of successful learning practices are detailed below:

- The Pakistan HI team reflected that After Action Reviews (introduced during WISH2ACTION) were a valuable tool for accountability and encouraged them to take action to improve activities. They have begun using this tool for other projects.
- HI hosted regular capacity building technical sessions led by the technical team. These were for all country staff which ensured technical quality of programming and importantly refreshed and improved staff skills on disability-inclusive SRHR, which was a relatively new area for HI.
- Several consortium partners reflected that regular technical webinars hosted by HI were valuable to share good practices and facilitate learning on disability inclusion. These were often shared with colleagues working in countries where HI was not present or colleagues outside the consortium to build organisational capacity.
- Working online (initially a challenge presented by Covid-19 restrictions) presented an opportunity to host more inclusive events with grassroots level representation from OPDs as well as diverse attendance from participants like national Ministries of Health. One partner reflected that online events were well planned and organised to facilitate discussion, interaction, and reflection.

Prioritising learning ensured it was embedded in consortium working and created regular opportunities for reflection, adaptation, and improvement. Emphasising learning within HI and within the broader consortium was particularly important given that WISH2ACTION addressed an innovative new focus and focused on changing mindsets and social norms.

This section of the compilation moves from learning to recommendations. It summarises recommendations arising from the good practices and lessons learnt shared in this compilation. These recommendations are targeted at three different groups of stakeholders:

- **Humanity & Inclusion** – nine recommendations.
- **SRHR partners** (service providers and technical experts) – six recommendations.
- **Donors and policymakers** – seven recommendations.

8 An After Action Review is an internal tool used to collect learnings at HI. It involves teams who implemented activities answering a series of questions in order to better understand the strengths and weaknesses of the activities.

1 Recommendations for Humanity & Inclusion (or other disability-focused organisations)

1. Build OPD partnerships to increase capacity through financial and technical support:

WISH2ACTION has demonstrated that OPDs and other civil society organisations are the key actors to ensure progress and accountability towards the realisation of inclusive human rights in health. Organisations such as HI can play an important role in supporting OPDs to carry out this role through providing knowledge and capacity building on SRHR, facilitating access to networks, and ensuring support and long-term cooperation with SRHR actors.

OPDs have enormous potential to engage persons with disabilities not only on SRHR but any other issues affecting persons with disabilities. Projects must strike a balance between meeting the practical needs of OPDs such as logistics and financial as well as technical support and training. Recruitment of OPD members as actors in national health systems (i.e., as community healthcare workers) can further support the access of persons with disabilities to health services.

2. Offer technical support to integrate disability inclusion for service providers:

In the longer term, mainstreaming disability inclusion in service provider organisations would help to build sustainability. INGOs and NGOs who are technical experts on disability can play an important role in building skills, providing technical and organisational support and empowering other organisations to mainstream disability inclusion into SRH programmes and services.

This could include training of trainer programmes (if combined with mentorship and disability expert guidance), technical support and MEL support for an integrated organisational approach. It may involve giving more ownership to service providers of disability inclusion and supporting them to develop their own tailored training modules or tools.

3. Build service provider and government capacity for disability-inclusive data collection:

WISH2ACTION built the capacity of service providers and governments to use the WG-SS but identified that there is a long way to go towards mainstreaming disability-inclusive data. HI should continue to build capacity of governments, service providers and other NGOs to effectively use the WG-SS for data collection, management, and analysis. This can be done by supporting the development of WG-SS in local languages, supporting the creation of national training modules, provision of tailored training, refresher training and ongoing technical support. HI should also consider how disability data intersects with other areas of vulnerability such as poverty, gender, youth, and older people.

4. Partner with service providers to assess and improve healthcare facilities:

WISH2ACTION pioneered HCF assessments in Bangladesh and Ethiopia and this approach led to action plans to improve disability inclusion in HCFs. HI could play an important role in offering technical support to OPDs and service providers in other countries to assess and improve HCFs. Providing simple assessment tools* can support HCF committees or other governance bodies to put action plans in place that improve disability inclusion in HCF.

5. Support the development of comprehensive and client-centred services as quality criteria for SRHR:

HI should support service providers and government actors to develop an understanding of the WHO quality criteria and its translation into disability-inclusive practices (WHO 2010).

* Please contact Humanity & Inclusion at j.newnham@hi.org or info@hi.org to see the HI HCF assessment tool.

Accessibility, comprehensive care, and robust referral services should be established to ensure persons with disabilities can access all mainstream services as well as considering disability specific needs such as early identification of disabilities, accessible and disability friendly mental health and psycho-social support services, rehabilitation services, the provision of assistive devices, access to livelihood activities and social support schemes.

6. Engage innovative cross-sector stakeholders to improve disability inclusion across society:

WISH2ACTION had strong examples of this through engaging architects in Pakistan and journalists in Madagascar. Thinking innovatively on which cross-sector stakeholders to engage can help improve disability inclusion across society. This could involve going beyond healthcare and engaging actors from sectors such as education, social protection, construction, or media as well as linking with relevant CSOs (i.e., women and youth organisations). It could also include working closely with information technology actors such as the use of the DAISY system in Bangladesh (see Good practice 17). This may require HI and partners making linkages and building relationships with different sectors at the policy level to improve sustainability of inclusion.

7. Consider the best way to facilitate national learning through HI programmes (district to district or multi-level engagement from district to national):

Many of the approaches taken by HI teams in WISH2ACTION have been bottom up such as advocating for representation of OPDs on village or district level health committees. This could be built upon by adopting a transversal approach learning from country to country or from cluster to cluster to implementation, in which other districts or national actors can learn from successful pilots or centres of excellence in specific districts. This way of working would facilitate training and mentoring between districts. An alternative would be to apply an integrated multi-level approach that engages both district and national levels from the beginning of projects (see Lesson learnt 7).

8. Support national healthcare systems to mainstream disability inclusion into health worker training curriculums:

WISH2ACTION offered extensive training on disability inclusion to different stakeholders but a major challenge to this approach is sustainability. Building disability inclusion (including WG-SS use) into national training programmes could help to create sustainability beyond projects and ensure a critical mass of service providers and HCWs who are competent in disability inclusion.

HI has already begun this work in Madagascar and Bangladesh and could build on this by partnering with more governments to offer technical support on integrating a rights-based disability inclusion module into community healthcare worker and service provider/health professional training programmes.

9. Engage in longer term advocacy for improved national level inclusion:

In the longer term, HI should work in cooperation with other national and international actors such as OPDs and organisations such as Options to undertake advocacy work ensuring that disability and accessibility criteria are included in national quality assessment and quality control programmes. HI could also work in partnership to support improved coordination between different government bodies and systems. This could focus on accessible services for all at the national level: ensuring public buildings following national and international accessibility standards, creating accessible transport systems, and ensuring social protection schemes consider SRHR.

2. Recommendations for SRHR partners (service providers and technical experts)

1. Mainstream inclusion at the organisational level:

WISH2ACTION made some steps to create a more inclusive culture within partner organisations but this should be continued to fully mainstream inclusion. Inclusion should be integrated into organisations at all levels (from management to support staff) and in all programme areas (planning, budgeting, implementation, monitoring and evaluation, quality management, partnerships, safeguarding policies) with the support of technical experts who can provide support, mentoring and expertise.

This could include training all service providers and community healthcare workers on inclusion to address misconceptions about disability and SRH, understand rights to SRH and build confidence around communicating with excluded groups. It also links into the recommendations which follow on data collection, creating disability-inclusive services and community engagement to ensure the meaningful participation of persons with disabilities.

2. Improve disability-inclusive data collection:

WISH2ACTION generated extensive learning about the challenges of collecting disability-inclusive data and the need for training on WG-SS for effective use. Service providers should consider how best to integrate the WG-SS, ensure all data collectors are trained in the WG-SS and commit to improving disability data at the organisational level. This will help better understand the needs of persons with disabilities, gaps in service provision and budgets and work towards a more disability-inclusive service.

3. Assess and improve healthcare facilities:

WISH2ACTION found that HCF assessments were effective for making plans and taking action to improve inclusion. Service providers should work jointly with NGOs and OPDs to assess healthcare facilities for disability inclusion and consider using the results to lobby governments for larger scale infrastructure improvements. In the longer term, service providers should sustainably collaborate with OPDs and other relevant SRHR actors on advocacy to ensure that disability and accessibility criteria are included in national quality assessment and quality control programmes.

4. Facilitate disability-inclusive access to SRH services:

WISH2ACTION collected several good practices on improving disability inclusion in SRH services and service providers should consider implementing these:

- Service providers should be sensitised on attitudinal barriers such as discrimination that prevent persons with disabilities and in particular women and youth from accessing SRHR services.
- Service providers should work with OPDs to understand where persons with disabilities are able to and are comfortable accessing SRH services and therefore increase those service delivery points.
- Disability inclusion should be mainstreamed across all SRH services with the appropriate adaptations made to the needs of persons with disabilities (i.e., home visits, accessible venues, telehealth).
- Service providers should work with OPD members, SBCC experts, sign language interpreters and translators to ensure SRH services are inclusive for persons with disabilities and adapt the format of communication materials to meet the needs of persons with disabilities (in both community engagement and in HCFs).

- Persons with disabilities should be engaged with planning, monitoring and accountability (i.e., client exit interviews).
- Service providers should also consider recruiting and training persons with disabilities and OPDs as community healthcare workers and health professionals.

5. Build equitable partnerships and collaborate with OPDs:

A key learning from WISH2ACTION was the important role of OPDs in setting up sustainable systems for disability inclusion. Service providers should work with and include local OPDs to ensure disability inclusion in SRHR services. OPDs can be included in areas like demand creation and referral networks. Service providers should support OPDs to build technical capacity in SRHR as well as supporting their practical needs such as financial support and logistics. To ensure sustainability of inclusive SRHR, the meaningful participation and ownership of OPDs must be considered.

6. Commit to community engagement and working with community gatekeepers:

WISH2ACTION highlighted the importance of engaging with communities and community-based organisations to understand social norms and address misconceptions to increase the reach and uptake of SRH services. Service providers should identify and engage key community stakeholders on SRH rights including men, community leaders, religious leaders, in-laws, grandparents, and other key actors (depending on context).

Engaging these community members is essential to improve acceptance of SRH for persons with disabilities and change negative attitudes or harmful social norms. Relevant local NGOs and OPDs such as youth and women organisations should also be supported in disability inclusion and as key informants regarding SRH rights for all.

3. Recommendations for donors and policymakers

1. Invest in OPDs:

WISH2ACTION found that OPDs are essential for implementing, supporting, and sustaining access to SRH for persons with disabilities. Despite this, OPDs are under-funded, under-resourced and struggle to establish themselves as independent organisations which receive their own funding. Donors should fund projects that support building the capacity of OPDs, that strengthen national OPD networks and that support OPDs to carry out joint advocacy on disability inclusion.

2. Invest in improving disability-inclusive data:

WISH2ACTION generated extensive learning about the challenges of collecting disability-inclusive data at the national level. Donors should ensure disability disaggregated data collection is in monitoring and reporting requirements and should fund projects that can effectively integrate the Washington Group Short Questions into national data systems. Long-term and sustainable use of the WG-SS requires action by policymakers to ensure the WG-SS is available in local language and that all data collectors in the health system can use this tool appropriately.

3. Embed disability inclusion in donor requirements:

In WISH2ACTION, disability inclusion was a technical area and cross-cutting theme. However, it was not fully integrated in the plans of all consortium members. Donors could ensure disability is fully embedded and mainstreamed in future programme procurements by including more strategic activities and requiring all partners to include this in their budgeting, programming, and monitoring and evaluation at design stage with clear milestones and indicators of success. This could also include payment key performance indicators (KPIs) or requirements. Verification by a third party monitor could also add priority to disability inclusion and increase progress.

4. Use barriers assessments to inform SRHR programmes and services:

WISH2ACTION found that barriers assessments were a valuable tool to identify and change the barriers that persons with disabilities face when trying to access SRHR services. Identifying, addressing, and reducing barriers is a useful approach for policymakers and donors to adopt, potentially with technical support from experts and researchers. This could be taken further by looking in depth at barriers that affect particularly marginalised groups such as women and girls with disabilities.

5. Commit to upholding rights:

WISH2ACTION highlighted the importance of rights and the UN CRPD as the foundation for any work around disability-inclusive SRH. After ratification of the UN CRPD, governments and international development organisations have a legal obligation and duty to uphold the rights of persons with disabilities to access SRH and ensure that existing policies and commitments on disability inclusion are implemented.

Donors and international agencies should hold governments accountable to commitments and ensure inclusion is part of any SRH project, programme, or service. Governments and donors should also ensure inclusion is adequately budgeted for so that persons with disabilities can easily access healthcare and claim their rights, putting between 2-7% of the budget towards inclusion measures (Bruijn 2020).

6. Require representation of persons with disabilities in national health structures:

WISH2ACTION found that membership of OPDs on village and district health committees meant that the voices of persons with disabilities could inform decision making and ensure inclusion was considered. Governments should develop guidelines and policies which require that OPDs are represented in local and district level health committees.

This approach should include budgeting for accessible health infrastructures, accessible equipment and for transport costs and expenses so that persons with disabilities are able to participate. This applies to structures for humanitarian response as well to ensure that responses and communication is disability-inclusive and that no one is left behind.

7. Integrate SRH with other areas of healthcare:

WISH2ACTION generated some examples of good practices in which SRH was linked to other aspects of healthcare for better service integration and referrals. Donors and policymakers should consider how SRH could be better integrated with other areas of healthcare (i.e., vaccination, rehabilitation) or other relevant services (i.e., education) to improve disability inclusion.

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Lessons learned

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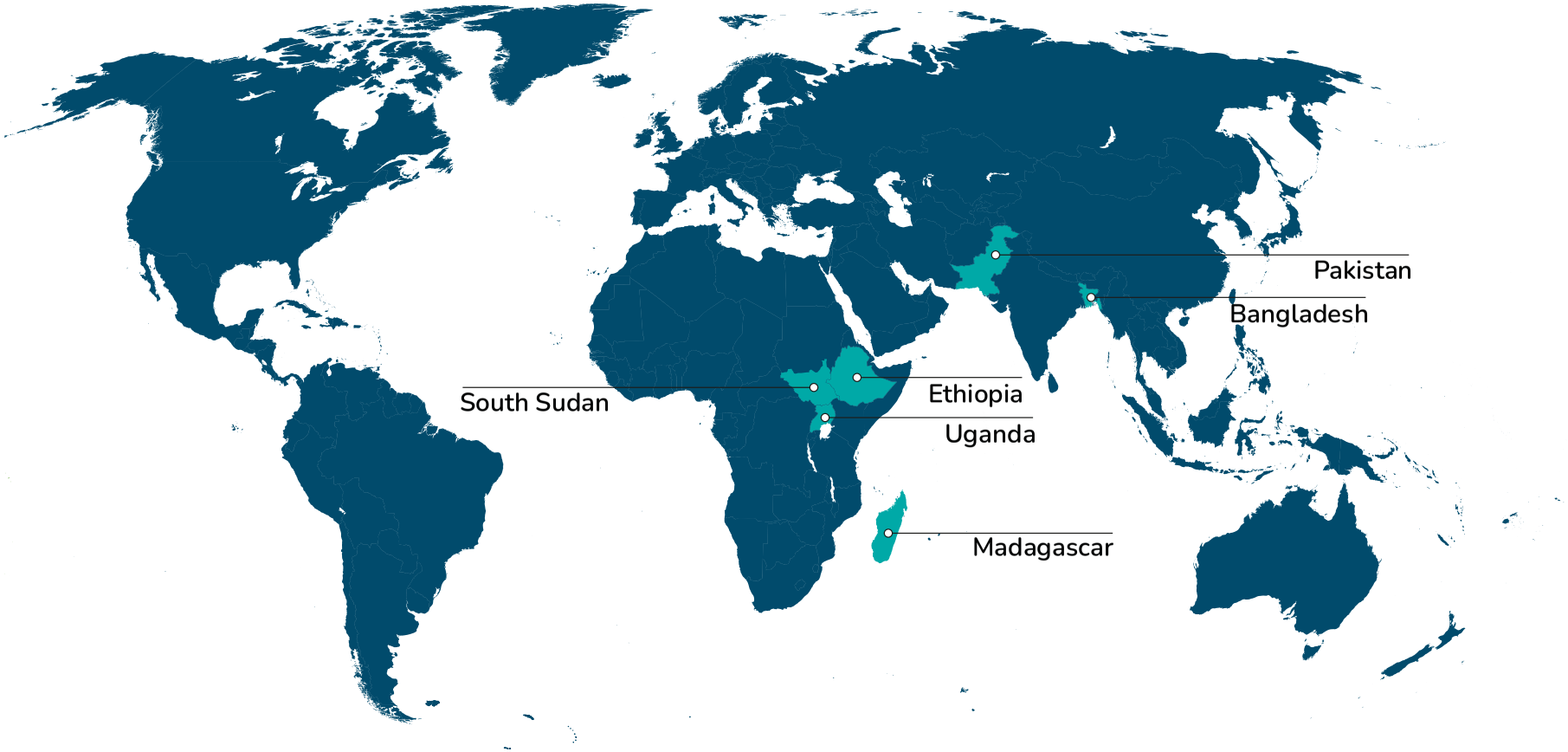
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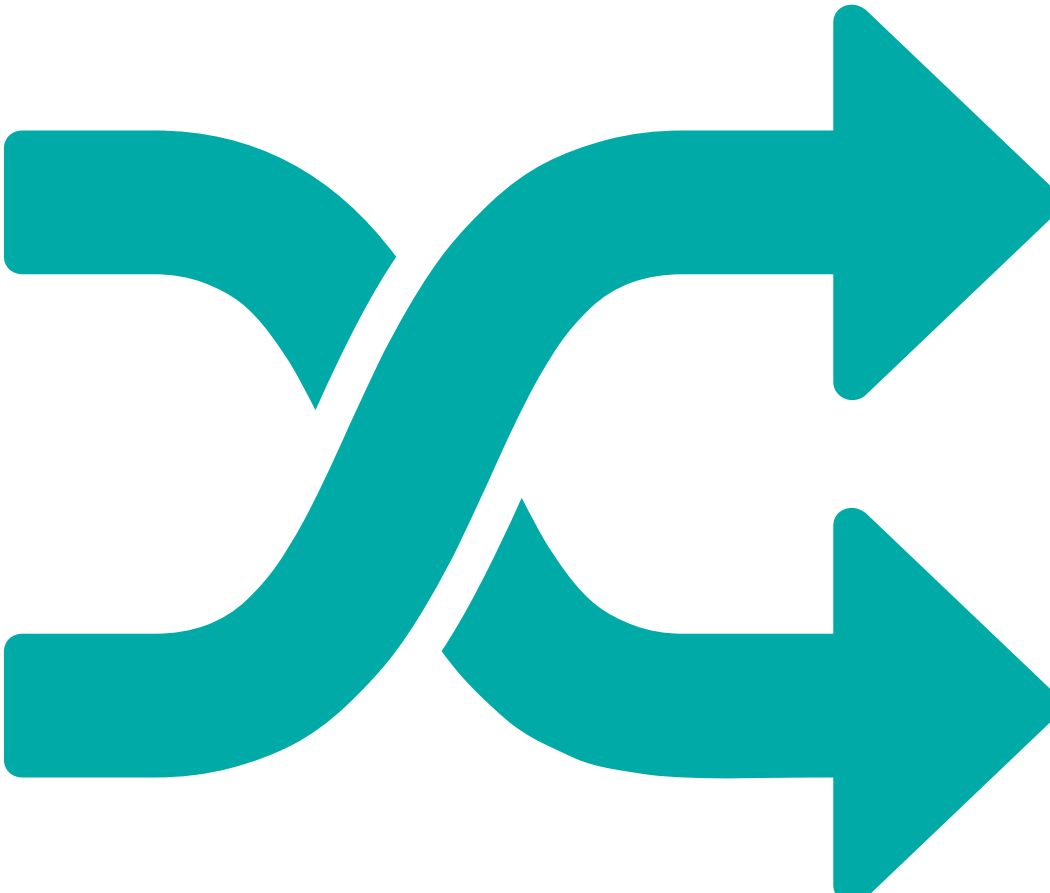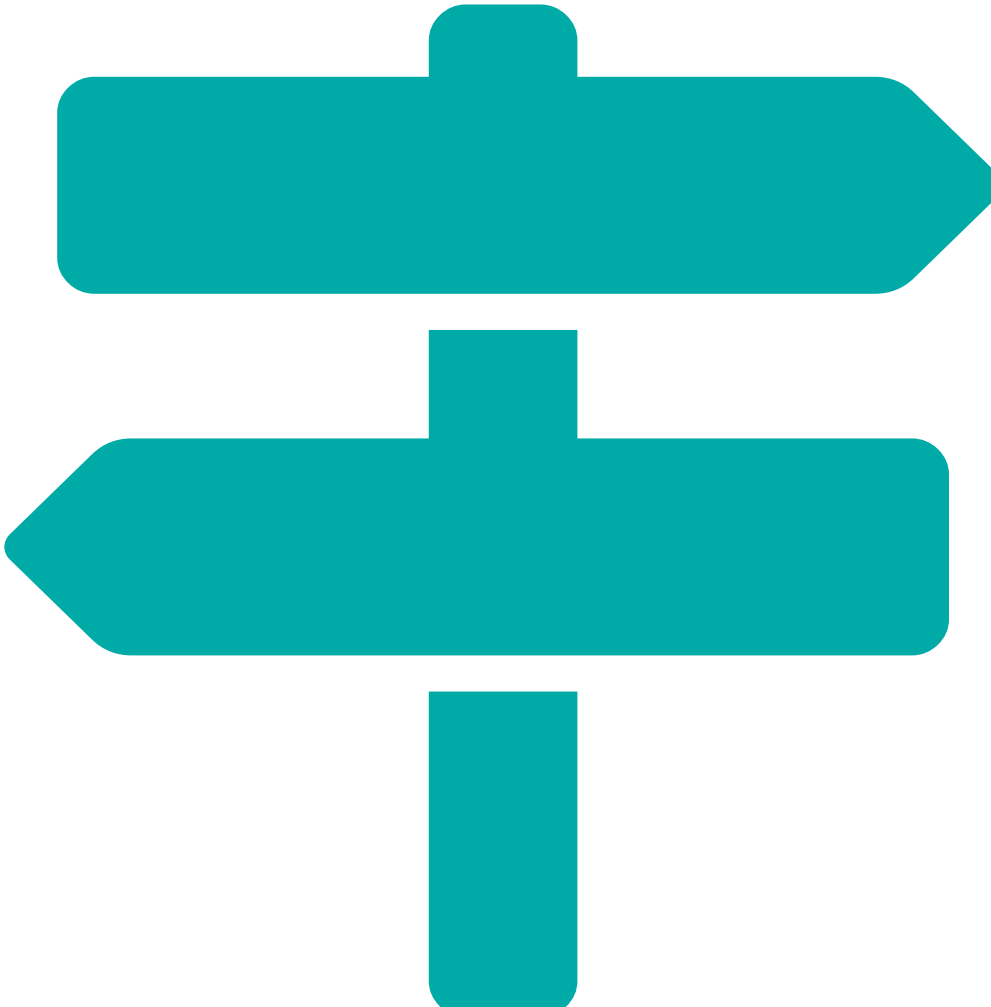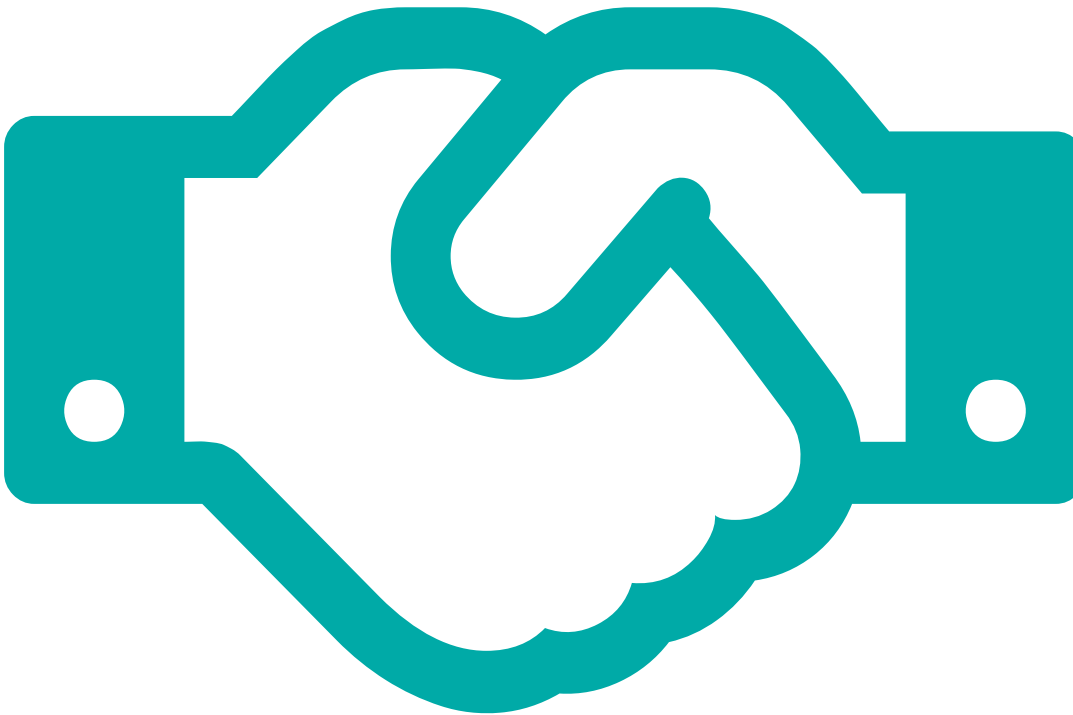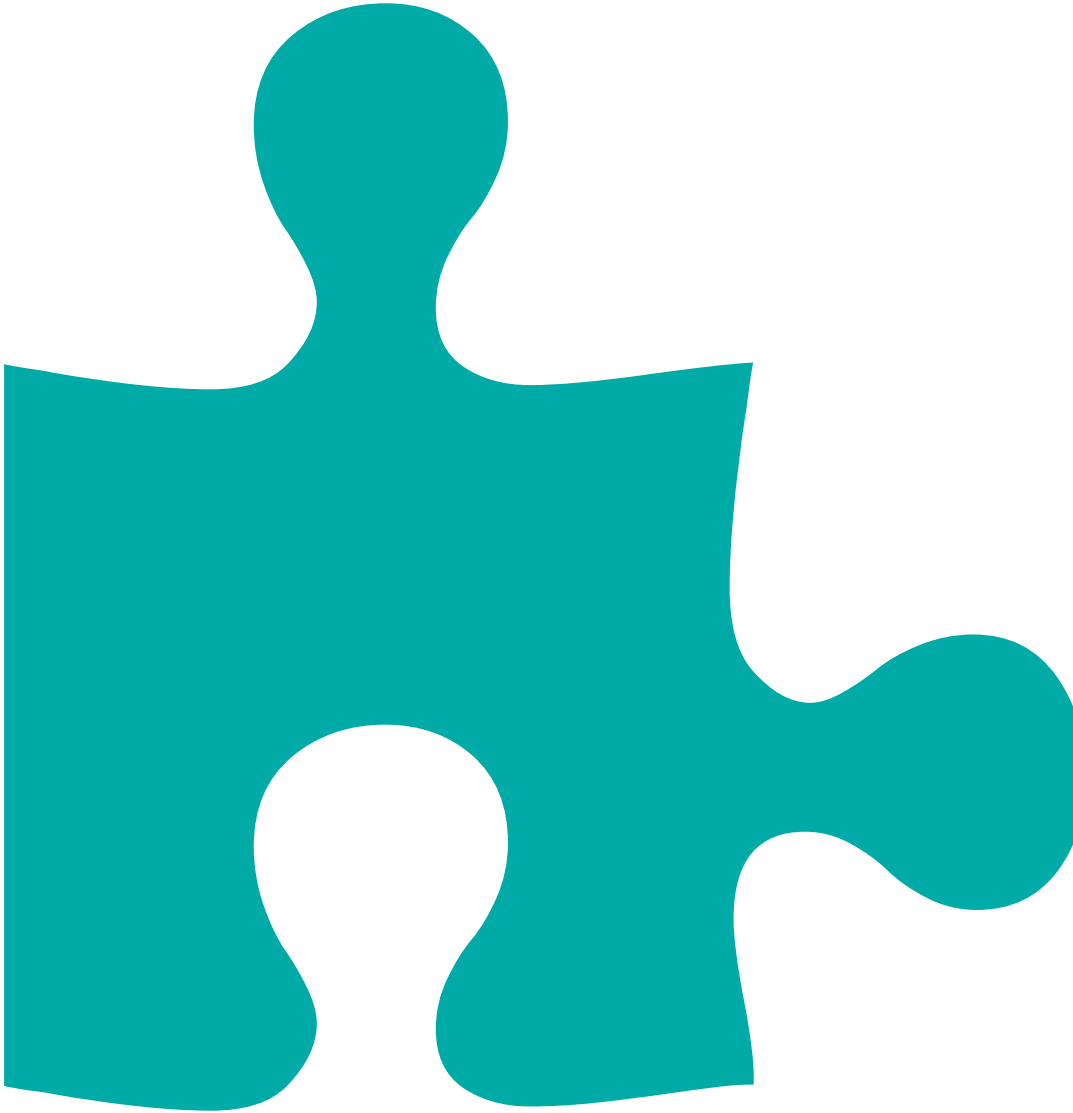
- Coordination
- Data collection and management
- Inclusive culture
- Partnerships and collaboration
- Policy and advocacy
- Quality of care
- Referral networks
- Social and behaviour change communication
- Service integration