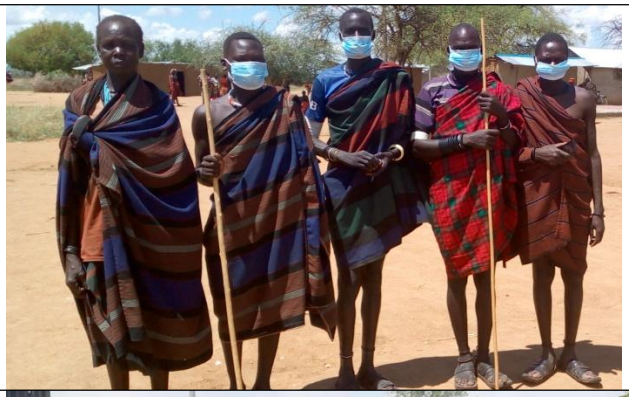
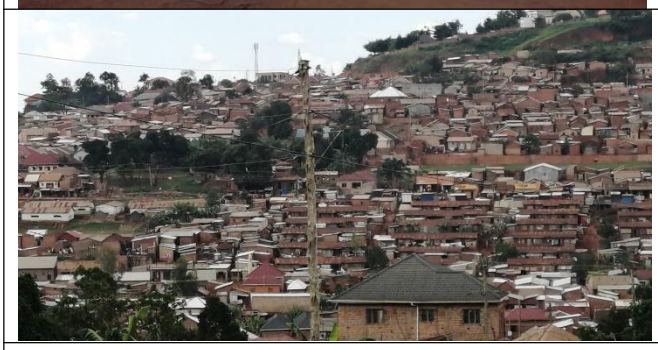
COVID-19 RESEARCH

GCRF_NF138: Uptake of Public Health Practices for Prevention of COVID-19 among Refugees, Pastoralist Communities, Truck Drivers, Slum Dwellers: Uganda


Policy Brief

COVID-19 and the Nature and Extent of Disability Among Refugees in Uganda

By

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1. Introduction

Persons with disabilities (PWD) include those who have long-term physical, mental, intellectual or sensory impairments, which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (UNCRPD,2008). The International Classification of Functioning, Disability and Health (ICF) defines disability as a complex phenomenon, reflecting the interaction between features of a person's body and features of the society in which he or she lives (World Health Organization [WHO] 2002:2).

Among displaced populations, PWDs are often the most hidden, marginalized, socially excluded and vulnerable, and some may miss out in refugee registration and data collection exercises. In every humanitarian emergency, those at higher risks include persons commonly known as 'Persons with Specific Needs'(PSNs), a population category with specific barriers due to discrimination, their identity, or other factors that prevent them from fully enjoying their rights or accessing services they need.(UNHCR, Guidance on the Use of Standardized Specific Needs Codes). The World Health Organization (WHO) estimates that between 7 and 10 percent of the world's population live with disabilities. As such, it can be assumed that between 2.5 and 3.5 million of the world's 35 million displaced persons also live with disabilities. Among displaced persons who have fled civil conflict, war or natural disasters, the number with disabilities may be even higher.

Research on the "Uptake of Public Health Practices for Prevention of COVID-19 among Refugees, Pastoralist Communities, Truck Drivers and Urban Slum Dwellers in Uganda" - a collaboration between the University of Essex (UK) the Lead institution, and Uganda Reach the Aged Association (URAA) the Partner was conducted in Uganda. The UK government funded the study through the GCRF / Newton Fund Agile COVID-19 Rapid Response programme.

2. Approaches and Results

2.1. Approaches

The study used a cross-sectional design that integrated mixed methods comprising quantitative, qualitative and quasi-experiment. Study tools used included: Key Informant Interviews, FGD Guide, Surveys using Smart phones with installed interview questionnaire using Open Data Kit (ODK) programme. Documents review also formed another source of information to support the study findings. The main research objectives were to:

1) Establish how culture, information, attitudes and practices unique to targeted communities influence the risk of COVID-19 transmission.

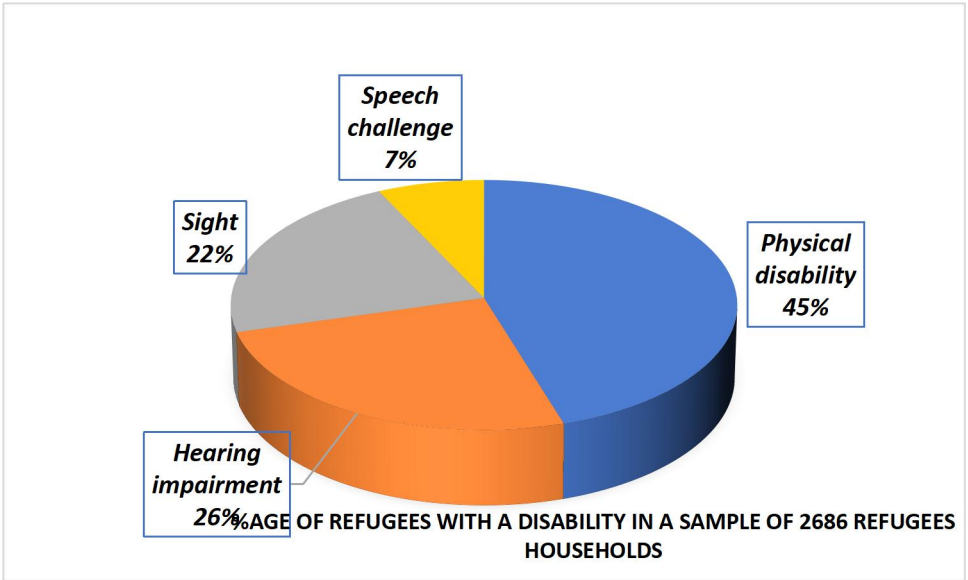
2) Promote culturally sensitive radio and mobile phone communication to enhance awareness of the COVID-19 prevention; specifically, the relevance and the importance of community engagement and local solutions.
3) Examine the role of trust in health organisation with the aim to build local community capacity to respond to pandemics, and to gather local evidence that can inform health policy and humanitarian response.

The research permit was granted by the Uganda National Council for Science and Technology (UNCST), while the ethical approvals were by the UNCST National HIV/AIDS Research Committee and the University of Essex (ETH2021_0084 / ETH2021_0320). Other administrative permissions were from the Office of the Prime Minister, Commissioner for Refugees for entry into the refugees' settlements, and travel permits from the Resident District Commissioners (RDC) of Kotido, Wakiso and Yumbe during periods of lockdown (June – July,2021).

Qualitative data was analysed using content and thematic techniques, while, quantitative data was analysed at two stages; univariate and bi-variate stages using an appropriate software Statistical Package for Social Sciences (SPSS 23.0). Inferential statistics were presented in user friendly tables, figures and charts, showing disaggregated by geographical region, age grouping, sex, category of the study population and other factors in the study

2.2. Results

For the refugee's component of the study, a total of 2,686, (50.7 % female) respondents were interviewed and of these 61.8% were aged 18-35 years, 30.6% aged 36-59 years and 7.7% above 60 years. There were 28% from Bidibidi refugees' settlement in Yumbe district, 38% from Imvepi refugees' settlement in Arua and 34 % from Pakele refugees' settlement Adjumani district. The results showed that a total of 487 refugees from 2,686 households had different disabilities, specifically, 4.1% of the households reported having female and male members with a physical disability, 2.3% female and 1.7% males with hearing disability, 2.3% female and males with sight disability, and 0.4% female and 0.7% males with speech disability.



%AGE OF REFUGEES WITH A DISABILITY IN A SAMPLE OF 2686 REFUGEES HOUSEHOLDS

Majority (45%) of the refugees with disability had physical disability followed by hearing impairment (26%). The survey shows that majority of the refugees came from South Sudan and there are high chances that some of them could have suffered body injuries during the conflict or as they walked long distances to safety.

3. Conclusion

The research data revealed a high extent of refugees with disabilities that surpassed the 10% WHO estimates, hence required application of the UNHCR principles that cover those with specific needs in COVID-19 interventions and services.

4. Implications and Recommendations

With lack of empirical data on the exact number of refugees with specific types of disabilities, complicates and limits services and support to the refugees with disability, They are unknown and unplanned for.

1) Ensure that PWDs are actively engaged in all stages of Disaster Risk Planning and Management RM, in order to reduce their vulnerabilities and enhance their capacities, hence, PWDs are at the heart of decision making and implementation of disaster risk reduction activities
2) It is recommended that setting up a standard, centralized data collection system to collect disaggregated data on the number, age, gender and profile of displaced persons with disabilities be prioritized among the activities under the refugee's response in order to enhance their protection and assistance. Attention should be paid to maintaining the confidentiality of information. Disability awareness training should be provided to all data collection officers.
3) During the District Health Sector planning, provide learning avenues for sectors to shift paradigm from looking at excluded groups as "the recipient" into a more equitable gender-fair and humane categorization, such as persons active in the intervention planning and response in their respective sectors
4) Those involved in addressing refugee response should ensure that making camp/settlement infrastructure and all facilities, services, shelter, organizations and information should be accessible to displaced persons with disabilities. The needs of persons with disabilities should be addressed at the start of the emergency during the site selection, planning and design of camp infrastructure and services.
5) Providing targeted services, as needed, for persons with disabilities (e.g., specialized health services, physical rehabilitation and prosthetics clinics, assistive devices, nutritionally appropriate food, special needs education, case management, protection monitoring and reporting mechanisms).
6) Promoting the inclusion of people with all types of disabilities in camp management structures, community decision-making processes and at all stages of the program cycle, ensuring age and gender diversity.
7) Promoting full and equal access to mainstream services for persons with disabilities (e.g., shelter, water and sanitation, food and nutrition, non-food distributions, health and mental health services, education, vocational and skills training and adult education, income generation and employment opportunities, and psychosocial programs)
8) Identify and work with organizations of persons with disabilities, and other structures of groups with specific needs. Ensure they are included in broader community leadership structures.
9) Integrate into the District Health Sector Plans a community of learning in sharing inclusion on rights, advocacy, livelihoods, and entitlements.

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Photo: BidiBidi refugee settlement in Yumbe district. © URAA, 2021.