COVID-19
HygieneHub

LEARNING BRIEF

# Including people with disabilities, older adults, and their caregivers in COVID-19 prevention programmes

## What is in this brief?

This brief summarises lessons learned about how COVID-19 prevention programmes can be inclusive of people with disabilities, older adults, and caregivers. The brief covers:

- an overview of why inclusion is critical to COVID-19 response programming,
- a summary of lessons and key actions to strengthen inclusion planning, implementation actions and monitoring, and
- a checklist to assess inclusion in your programming.

The brief is primarily oriented towards organisations working to improve hygiene related behaviours such as handwashing with soap, mask use, surface cleaning and physical distancing.

**HBCC and the COVID-19 Hygiene Hub**

HBCC

**HBCC is a partnership between Unilever and the UK's Foreign, Commonwealth and Development Office (FCDO) which provided £100 million to fund COVID-19 response programmes undertaken by 21 organisations in 38 countries. The COVID-19 Hygiene Hub is a free service to help actors in low- and middle-income countries (LMIC) share, design, and adapt evidence-based hygiene interventions to combat COVID-19. Since April 2020, the Hub has provided rapid technical advice and project support to more than 267 organisations across 60 countries and developed over 55 long-term partnerships to support global or national-level initiatives. The global nature of the work done by HBCC and the Hygiene Hub puts us in a unique position to understand common challenges and identify innovative solutions to strengthen inclusion within COVID-19 programming.**

This brief is based on the insights that have been gained through programming funded by the Hygiene and Behaviour Change Coalition (HBCC) and/or supported by the COVID-19 Hygiene Hub.

In addition to this brief we encourage you to read the Hygiene Hub resources on considering disability and ageing in COVID-19 response programmes as well as our inclusion resources related to other vulnerable groups.

**WaterAid Zambia have advocated for distributions and programmes to focus on people with disabilities and older people. This photo shows hygiene products being distributed at an aged care home**
**© WaterAid Zambia**

## Inclusion in the time of COVID-19

There are estimated to be more than one billion people living with disabilities in the world and around 900 million older adults (aged 60 years and above). Furthermore, nearly half of the global population of older people have a disability. People with disabilities, older adults and older adults with disabilities face a greater risk of becoming infected with COVID-19 and are more likely to experience severe symptoms leading to hospital admission, intensive care, and death. People with disabilities (including children and young people) are disproportionately impacted by COVID-19 not only because it can exacerbate underlying medical conditions, but because of attitudinal, environmental and institutional barriers to their participation in and benefit from the pandemic response. This includes inaccessible public health messaging and healthcare facilities, alongside more generalised stigma and discrimination.

**Defining disability**

**Persons with disabilities are:**

**'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.'**

(Article 1, UN Convention on the Rights of Persons with Disabilities, 2008)

Whilst many people with disabilities and older adults live fully independently, some rely on caregivers to support activities for daily living. Whether these caregivers are paid professionals or unpaid carers, working in the formal care system or in informal home care settings, they are an important public health resource. Their needs and challenges have been largely overlooked during this pandemic, placing them and those they support at high risk. People aged over 60 and living in care institutions have seen significantly higher rates of infection and death than those outside the care system.

COVID-19 WASH response programmes should be inclusive of high-risk groups from the start because:

- Access to water and sanitation is recognised as a fundamental human right, including during humanitarian emergencies.
- All adults, children and young people have the right to the best possible health and wellbeing, and none should be excluded from interventions seeking to improve this.

Programming that is inclusive will be more likely to successfully curb transmission and mortality rates within these populations.

- Inclusive crisis responses and programming could lead to longer-term shifts, for example by leading water, sanitation and hygiene (WASH) programmes to be inclusive of the rights of older adults and people with disabilities as part of their normative ways of working.

Making COVID-19 prevention programmes inclusive could therefore not only improve life expectancy during this global health emergency, but also ensure longer-term improvements in hygiene practice for everyone.

**Table 1: Why are people with disabilities, older adults and caregivers at higher risk during the pandemic?**

| Greater risk of exposure to infection | Greater risk of severe disease | Greater risk of secondary impacts |
|---|---|---|
| Some people with disabilities and older adults rely on services provided by caregivers and therefore have less control over their ability to physically distance or isolate themselves | Risk increases with age. | People with disabilities and older people are likely to have less income security and may face greater economic concerns during the pandemic. |
| Some people with disabilities and older adults may face increased exposure to infected surfaces due to inaccessible infrastructure or use of assistive devices for daily activities. | Risk increases if a person has other pre-existing health conditions like heart and lung diseases. These conditions are more common among people with disabilities and as people age. | Older people and people with disabilities who are shielding (self-isolating) may feel cut-off during the pandemic and need greater social and mental health support. |
| Barriers to accessing and understanding information or participating in programme activities can leave people with disabilities and older adults less informed about how they can protect themselves. This may be exacerbated by social distancing protocols. | People with disabilities and older people may struggle to seek healthcare due to inaccessible transport and services or because of stigma and negative past experiences. | People with disabilities, older adults and caregivers may face interruptions to other non-COVID services that they rely on (such as health services or in-home care support). |

## Lessons and key actions to strengthen WASH inclusion planning from COVID-19 experiences

Our review of HBCC and COVID-19 Hygiene Hub supported projects has identified a number of useful lessons for addressing inclusion within COVID-19 prevention programmes being delivered by WASH actors. Examples from partner organisations have helped us to identify 10 key actions related to defining and planning for inclusion, building inclusiveness into programme activities and strengthening how we monitor, report and advocate for inclusion. More detail around specific activities for including people with disabilities, older adults and caregivers can be found in the COVID-19 WASH checklist.

**Defining and planning for inclusion**

LESSON 1

**Programmes that consider disability, ageing and caregiving from the outset are likely to be more inclusive in practice, but this needs to go beyond broad statements on inclusion.**

Most projects did well to reference people with disabilities, and to a lesser extent older adults, as being especially vulnerable to COVID-19. However, despite talking about high levels of risk, few projects designed activities specifically with these target groups in mind and the role of caregivers was rarely considered. One explanation for this was that organisations had to make compromises to the way they conducted assessments which informed their programme design. These compromises were understandable given the rapid nature of COVID-19 responses and concerns about risk, but it had the unintentional effect of excluding people with disabilities, older adults and their carers from consultations prior to proposals being drafted. Additionally, we found that budgets rarely included costs associated with inclusive activities and it was not clear whose responsibility it would be to ensure inclusion was considered throughout programming.

**Emerging Positive Practice: Example 1**

*In Syria Oxfam trained community volunteers to adapt their hygiene promotion activities for people with different impairments as part of a capacity strengthening approach. This was an effective approach because it showed an appreciation of the fact that those who are on the frontline delivering COVID-19 response programmes, need to be aware that people with different impairments can find it challenging to access standardised interventions. Equipping frontline staff with skills to understand disability or challenges that may be faced by older adults can allow for response actions to be tailored to the individual and household level.*

*This project also designed activities that targeted caregivers. By doing this they learned that most caregivers in their region were themselves older people. Oxfam adapted their programme activities so that they were at times that were convenient*

**Frontline staff conduct a practical handwashing activity with a child at Al-Nour Center for Children with Disability in rural Damascus. © Oxfam Syria**

**A trained community volunteer uses sign language to provide COVID-19 information to a woman with a hearing impairment. © Oxfam Syria**

Oxfam adapted their existing hygiene programme approach (Mum's Magic Hands) to suit the needs of carers. © Oxfam Syria

*for caregivers and were in locations near to where they lived. They specifically discussed their caregiving roles and the challenges the pandemic had created and connected carers to each other to create local support networks. The recognition that this group of people needed specific hygiene information is a good example of how important it is to view the family as a resource for public health programmes.*

**KEY ACTION 1:**
Gather information about the situation facing people with disabilities, caregivers and older adults during rapid assessments, before putting programme plans together. Finance and staff the inclusive aspects of programmes sufficiently. This may include investing in staff capacity in this area.

**Defining and planning for inclusion**

LESSON 2

## Apply inclusion systematically across programme locations and activities.

Many organisations wrote about the importance of inclusive programming in project proposals, but fewer included practical examples of actions that they were taking to make programme activities more inclusive. Even when specific actions were taken, they were not applied systematically across their project sites. For example, organisations carrying out quite similar interventions in multiple countries reported the production of Braille or large print materials only in one or two locations, or the construction of physically accessible facilities in a small number of places within one country programme. In some locations, older adults were a target group for the distribution of hygiene products (such as soap, cleaning materials and masks) but not in others, even though the implementing agency was the same.

Overcoming this challenge requires a change in the way we think about inclusion. If programmes adopt a 'rights-based perspective' programmes may be less likely to be sporadic or tokenistic with their inclusivity actions. Frameworks like the International Classification of Functioning, Disability and Health can also be used by response actors to systematically consider the various factors that can affect an individual's participation within programmes and their access to services.

**Rights-based approaches to development**

**Inclusive programming requires that organisations pay attention to the underlying denial of rights that have led to the marginalisation and exclusion of certain groups of people. Whilst there is no single agreed definition of a rights-based approach, it is generally understood to mean the practical implementation of human rights principles including: access to information, participation, accountability, non-discrimination and sustainability. Rights-based programming should also aim to enable rights-holders to claim their rights (such as access to safe water and sanitation) whilst holding those responsible for the provision of services accountable for inclusion (whether that is government or development agencies).**

**KEY ACTION 2:**
Use inclusion frameworks to systematically identify barriers to participation and access.

**Defining and planning for inclusion**

LESSON 3

## The pandemic has deepened existing inequalities, but COVID-19 programmes haven't always addressed these inequalities.

Only a small number of the projects included provisions for ensuring that households with an older adult or person with a disability received appropriate subsidies for accessing existing water or hygiene facilities or the skills, support and financing to build their own accessible facilities. This oversight was noted despite many programmes recognising that households with an older adult or person with a disability were at risk of increasing economic and social marginalisation. Examples of measures that can reduce economic barriers include: the provision of suitable transport to public distribution sites or locations for project activities; working with neighbours, landlords and village leaders to facilitate increased access to water and hygiene facilities; distribution of products such as masks or soap that can support preventative behaviours, and direct economic support to households that include vulnerable people.

**KEY ACTION 3:**
Actively assess economic barriers and include activities which increase the accessibility, affordability and feasibility of COVID-19 preventative actions for people with disabilities, older adults and/or caregivers of all genders.

**Building inclusiveness into programme activities**

LESSON 4

## Engaging representative organisations and caregivers is key to working effectively with people with disabilities, older adults and caregivers.

Projects that worked with representative organisations found it easier to tailor their activities to reach more diverse groups and different types of needs. Engagement of representative organisations typically led response organisations to produce behaviour change materials in a range of formats or to identify processes for specifically targeting households where vulnerable people were living. If planning to work with representative organisations, be mindful that they are often quite poorly resourced, that they may rely on volunteers to manage their work and that they may have to support the work of multiple NGOs or government actors. Where possible, consider how you can fund the core costs of representative organisations so they can increase their capacity to engage with your work into the future. Also, be mindful of who representative groups can speak on behalf of. For example, an Association for the Blind will be well placed to speak on behalf of people with visual impairments but less well placed to recommend programmatic changes that would make response work more accessible for people with intellectual impairments.

**Representative organisations**

**Organisations of Persons with Disabilities (OPDs) and Older Persons Associations (OPAs) are entities that are governed, led and directed by persons with disabilities or older people. Some countries also have carer support networks. OPDs, OPAs and carer networks are membership organisations, with most members being persons with disabilities, older people or carers. They are set up mostly with the aim of acting collectively to pursue and defend the rights of their membership as well as providing advice and support. They can operate as individual organisations (for example associations for people who are blind or deaf) or in coalitions (as in older women's networks and national federations of organisations of persons with disabilities).**

**Emerging Positive Practice: Example 2**


*In June 2020, the Pacific Disability Forum launched a report on Gender, Disability and Inclusion during the COVID-19 pandemic. This highlighted several important gaps and prompted UNICEF to work with them to strengthen their WASH programming. UNICEF Fiji collaborated with the Pacific Disability Forum to conduct an additional assessment of the appropriateness of WASH facilities for people living with disabilities. They have been using the results to adjust guidelines for improved WASH services for people with disability; to improve awareness and visibility*

**Some of the artwork developed through the partnership.**
**© UNICEF**

*of people with disabilities, and to ensure that their COVID-19 WASH communication materials were more accessible to those with visual and hearing impairments. This partnership resulted in mutual learning and opportunities – the UNICEF team were able to provide the Pacific Disability Forum with a platform to share their expertise and influence decisions during the pandemic ,while UNICEF leaned about the possible ways that they could support the disability community and empower representative organisations.*

**Who are caregivers?**

**Caregivers include both paid and unpaid carers of persons with disabilities and/or older adults. They may be family or local community members, or they may be working in a professional capacity having been trained specifically to meet the personal care needs of their clients. In most countries, caring roles are still disproportionately fulfilled by women and in low- and middle-income countries caring is often done informally by family members.**

Caregivers were mentioned as an important target group by some projects but even when this was stated, there were rarely any activities which intentionally focused on engaging and supporting caregivers and none mentioned the gendered aspects of caregiving. This could be a significant gap because the nature of the relationship between caregivers and those receiving personal care means that it is not possible to maintain physical distancing. This puts both parties at high risk, requiring the use of personal protective equipment (such as face masks), good ventilation, handwashing and frequent surface cleaning. It is therefore important that response actors seek to deepen their understanding of who caregivers are within the contexts where they are working, the roles they are fulfilling, and the barriers they are facing during the pandemic.

**KEY ACTION 4:**
Target some programme activities specifically at caregivers and actively engage with the expertise provided by organisations working with and representing older people and people with disabilities at all stages of programming.

**Building inclusiveness into programme activities**

LESSON 5

## Providing accessible information is key during a pandemic

Many projects did quite well in recognising the need to provide COVID-19 prevention information in alternative formats (such as Braille or large print) and tried to utilise a range of media and communication channels to increase accessibility. When developing television or video-based content, organisations often included sign language interpreters. Some organisations also developed communication materials which intentionally depicted a diverse range of people including older adults and women, men and children with disabilities. Approaches like this play an important role in changing social perceptions about older people or people with disabilities. Normalising and visualising the participation of vulnerable groups in COVID-19 prevention programmes and media can contribute to reducing stigma towards these groups.

**Emerging Positive Practice: Example 3**

*Water and Sanitation for the Urban Poor (WSUP) worked with the Kenyan Society for the Blind (KSB) to ensure that communications materials were produced in a range of accessible formats. WSUP used Unilever's 'School of 5' hygiene promotion approach that was adapted for COVID-19 and delivered this in Kenyan schools following their extended closure. To make the approach inclusive they involved the KSB to translate posters about the 10 steps of handwashing into braille. They also invited students to role-play some of the key messages and behaviours. These role-plays were audio recorded so that they could be shared with other pupils with visual impairments. KSB joined WSUP staff to visit schools so that they could assist in communications and understanding of the braille content. KSB representatives also joined WSUP on local radio talk shows to advocate for the need for inclusive communications during the pandemic.*

Image © iStock

It is important that communication materials which target older women and men or people with disabilities, or which are designed to be accessible for these groups, are not done as an afterthought, but rather rolled out alongside mainstream communication approaches in a timely manner. The most effective way to ensure that this is feasible within the context of pandemic response, is to build relationships with representative groups so that they are available to provide timely inputs. As previously mentioned, this is likely to require resourcing representative groups appropriately for their time.

**KEY ACTION 5:**
Provide public health information in a range of formats and portray the diversity of the population within communication materials.

**Building inclusiveness into programme activities**

LESSON 6

**Targeted information and activities are sometimes necessary to address specific risks or requirements.**

Addressing inclusion often requires the mainstreaming of inclusive principles as well as activities which are targeted to the specific needs of older adults and people with disabilities. Doing this is not just about having materials in different formats, it also requires specialised content or activities to be developed just for these groups. This is because people with different impairments, older adults and caregivers living in different circumstances will have different requirements and experiences of the pandemic.

## Emerging Positive Practice: Example 4


**Amref's training package targeting people with disabilities. © Amref**

*In Kenya, Amref worked with seven Organisations of Persons with Disabilities to create a training package about COVID-19 preventative behaviours. The training uses inclusive messages and a range of delivery modalities to ensure that the content is relevant for persons with disabilities and their carers. At the same time Amref is trying to mainstream disability within their broader COVID-19 communications initiatives. For example, they partnered with Project HandUp with the aim to make the public more aware of the challenges people with disability are facing during the pandemic. It uses puppets that are based on people with disability in their community.*


**One of the puppets which has been modelled on a person with disability © Amref**

We have seen some organisations share information about how to keep assistive devices clean (like wheelchairs or walking aids) or guidance for caregivers about when to wash hands, and how to use personal protective equipment (PPE) within their caring role. Others have worked to set up special social support measures for vulnerable households (e.g., food and medicine deliveries) to minimise the need for them to undertake non-essential travel. As previously mentioned, the best people to advise on the targeting of messages and activities are older people, those living with disabilities, and those who are providing care. Building in time to learn from these individuals or representative organisations on a rolling basis will help you to ensure messaging reflects changing concerns and needs during the pandemic.

## Emerging Positive Practice: Example 5

*In Sierra Leone, Plan International worked with One Family (a representative organization for people with disabilities) to better understand the specific needs and barriers faced by people with disabilities so that COVID-19 programming could be more inclusive. One Family explained that there as a significant lack of trust between people with disabilities and NGOs due to a history of humanitarian and response programmes where engagement has been superficial. They explained that people with disabilities had often been asked for inputs, or even had their photos taken, but that these interactions were never followed up and people with disabilities were not actually engaged in projects. To rebuild trust Plan International worked with One Family's organisational representatives in each of their target communities. The representatives helped them to*

*draft communications materials which explained their project and what they were doing to make activities accessible to all. Representatives also informed populations about feedback mechanisms so vulnerable populations could easily share any concerns they faced. In addition to tailored programming and messaging which targeted older people and people with disabilities, One Family also helped plan to develop some general messaging which was more disability inclusive. For example, in Sierra Leone, there is a high number of people with amputated limbs. As such, messaging focusing on hand washing, was not deemed appropriate – and was adapted to focus more widely on cleanliness and how one could achieve this.*


One of the posters created by Plan International to promote inclusive action around hygiene. © Plan International

Providing handwashing facilities at an aged care facility. ©Plan International

**KEY ACTION 6:**
Don't assume that generalised messages or activities will have an impact on everyone equally. Work with representative organisations to identify where targeted approaches are needed.

**Building inclusiveness into programme activities**

LESSON 7

## A person's vulnerability isn't just determined by their disability or age.

There are multiple aspects of a person's identity and personal circumstances that could affect their behavioural and health outcomes and social situation - sometimes this is described as 'intersectional barriers'. Most projects we reviewed tended to talk about older adults and people with disabilities in narrow and stereotypical ways. They assumed that their disability or age was the most important aspect of their identity and paid less attention to barriers that they may have faced because of their gender, sexuality, race, ethnicity, religion, geography (e.g. whether the person lives in an urban or rural area) or their economic and educational standing. These multiple aspects of a person's identity can affect their overall vulnerability

during the pandemic. For example, older women or women with disabilities may have different experiences of the pandemic to older men or men with disabilities. Paying attention to these differences can help to mitigate against the unintended consequences of COVID-19 response programmes. The best way of addressing the intersections between disability, age and other traits is simply to ask people about their experiences of the pandemic and to strengthen the active listing skills of programme staff. This could be achieved by using safe forms of qualitative data collection activities or setting up remote feedback mechanisms like hotlines or message groups (e.g. on WhatsApp). Response actors should avoid equating vulnerability with inability and instead staff should actively try to identify local coping mechanisms and strengthen these.

**Emerging Positive Practice: Example 6**


One of the public sanitation facilities constructed by engineers that UNICEF trained on inclusivity. © UNICEF

*UNICEF India conducted a rapid assessment during the pandemic to understand WASH access. This included consultations with specific vulnerable groups such as people with disability and the transgender community. They found that these vulnerable groups were particularly reliant on accessing public sanitation facilities during the pandemic. Their rapid assessment also found that women with disabilities often lacked access to hygiene products which would allow them to practice COVID-19 prevention behaviours. UNICEF used the findings to adapt their programmes. They provided inclusivity training to 150 engineers involved in constructing sanitation infrastructure and decided to target hygiene kit distributions to women with disabilities to help address unequal access barriers.*

**KEY ACTION 7:**
Approach disability, ageing and caregiving holistically by listening and taking time to understand how all aspects of a person's identity and circumstances affect their situation during the pandemic.

**Strengthening how we monitor, report and advocate for inclusion**

LESSON 8

**Adequately addressing inclusion also requires advocating for policy-level changes.**

COVID-19 response programme activities may alleviate some of the immediate needs of people with disabilities and older adults. However, the pandemic has also highlighted many pre-existing inequalities and provides an opportunity for response actors to contribute to longer-term change. One way of doing this is to influence the policies and strategies of governments and service providers, so that they can more effectively fulfil their obligations to provide accessible services to all. Despite the 'window of opportunity' created by the pandemic, we found that few COVID-19 projects included advocacy activities related to

people with disabilities, older adults or caregivers. Advocacy efforts should not start from scratch. Many representative organisations have a history of policy influencing work and so COVID-19 response programmes can contribute effectively by understanding and strengthening the work of these organisations. Response actors can also help to create new spaces for discussing issues related to people with disabilities or older adults by raising these issues at coordination meetings, through media or in other settings. Experiences of inclusive programming during the pandemic should also be fed back to donors to highlight areas where limited funding for inclusion may have curtailed effective action.

**Emerging Positive Practice: Example 7**

**WaterAid Zambia have advocated for distributions and programmes to focus on people with disabilities and older people. This photo shows hygiene products being distributed at an aged care home © WaterAid Zambia**

*WaterAid Zambia worked with disability organizations to engage and lobby local and national leaders to support an inclusive COVID-19 response. This led to the formation of an 'inclusion sub-group' under the national COVID-19 WASH response team. This enabled conversations on inclusivity to happen throughout the response and the group developed an inclusion framework to guide all WASH-related COVID-19 interventions.*

*WaterAid Zambia also carried out a COVID 19 assessment which focused on physical, social and economic vulnerability. The assessment targeted women, girls and people living with disabilities. The assessment showed that people living with disabilities were particularly vulnerable due to difficulties accessing WASH services. To respond to these findings, WaterAid Zambia engaged with the private sector to jointly design a hand washing facility that could easily be used by wheelchair users and those using crutches. This facility was adopted in many public institutions and places enabling easy access to hand washing for all.*

**An inclusive handwashing facility that can be operated by people using crutches or a wheelchair. © WaterAid Zambia**

**KEY ACTION 8:**
Find opportunities to support the advocacy work of representative groups of persons with disabilities, older adults and carers. Where appropriate, strengthen government systems so that they can become more inclusive.

**Strengthening how we monitor, report and advocate for inclusion**

LESSON 9

## Disaggregating programme data is a useful starting point but does not necessarily result in inclusive programmes.

Many organisations collected data on the reach of their COVID-19 response work and included indicators to specifically track the participation of people with disabilities (this is often called 'disaggregation'). However, monitoring plans often didn't provide descriptions of how this data was collected. Specific mentions of internationally recognised standards for the collection of data on disability, such as use of the Washington Group Short Set of Questions on disability, were rare. Disability measurement is complex. It is useful for organisations to use standardised approaches for the following reasons:

1. Non-standardised measures are likely to be biased towards people who have disabilities that you can see, and overlook non-visible impairments (e.g., sensory impairments, neurological conditions etc).
2. By using standard questions, organisations strengthen our global understanding of disability and allow comparability between programmes and locations.
3. Disability is subjective and context dependent. For example, if social and physical environments are designed well, then certain individuals might not view their impairments as disabling.
4. When standardised measures are not used, there is a risk that disability monitoring processes could be stigmatising and offensive.

Across many of the programmes we looked at, there was a disproportionate focus on people with physical impairments and those with mental health or intellectual impairments were rarely considered in programmatic decision making. These groups may be even more isolated during the pandemic and may face particular difficulties in understanding or remembering requirements for physical distancing, face mask wearing, hand-washing and other ways to protect themselves, increasing their risks of contracting COVID-19.

In contrast, there were relatively few programmes that disaggregated data by age cohorts beyond the age of 60 - despite the fact that people this age group are at high risk and are likely to experience quite diverse and differing needs. Disaggregating data by disability and age cohort is normally insufficient to inform ongoing programme adaptation. There is a wealth of information to be gained by including qualitative monitoring approaches, such as interviews with older adults, people with disabilities and caregivers as long as these can be conducted in ways that are safe and respectful of people's immediate needs.

**KEY ACTION 9:**
Use standardised measurements to disaggregate data and complement this with safe or remote qualitative data collection approaches.

**Strengthening how we monitor, report and advocate for inclusion**

LESSON 10

**Well-designed programme reporting can cue improved practice.**

We found that if organisations adapt their reporting templates to include sections on inclusion, this can act as a reminder to staff to continue to think about inclusion throughout all aspects of their work. Without the space or prompts to talk about inclusion and rights, organisations are not necessarily reporting on their inclusive approaches. It is likely that there are more examples of good practices within COVID-19 response programmes but that these lessons often go unreported. It is also important to actively learn from frontline staff who might be interacting with vulnerable groups on a daily basis. Holding weekly meetings to share programmatic reflections on inclusion can allow for timely adaptation and may allow organisations to strengthen community or household level innovations or coping mechanisms. Since there is no 'one size fits all' model for doing inclusive programming, it is also valuable to create opportunities for knowledge exchange between organisations so that you can share examples of good practice and discuss common challenges.

**KEY ACTION 10:**
Design reporting tools to allow the inclusive aspects of your programming to be described and create spaces for discussions about inclusion within your organisation.

## A checklist to assess inclusion in your programming.

Many of the lessons and actions described above came from applying a new inclusive checklist for COVID-19 or WASH programmes. We encourage you to apply this checklist to your own work.

### What is the checklist?

The checklist itself is built around three key target groups:

- People with disabilities
- Older adults
- Caregivers (appears as a cross-cutting element in both target groups).

The checklist comprises **15 core human rights concepts,** each of which are clarified using statements referred to as **guiding principles.** These are broken down into potential activities which, if implemented, would demonstrate that the core concepts are being delivered. Since this is a monitoring tool, there is space provided so that each core concept can be scored on a sliding scale from 0 (concept not mentioned) to 4 (actions and targets monitored and evaluated against core concept).

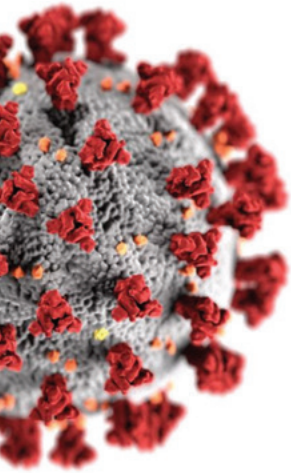
### When can it be used?

It is never too late to apply this checklist! Ideally, the checklist would be used at the programme design stage as a way to check if plans and budgets are paying due attention to key human rights principles. But, it can be used once the intervention is underway to monitor

the extent to which key groups are being included, or at the end during an evaluation as a way to learn lessons to inform future work.

**How we applied the checklist**

We asked projects to submit all planning and reporting documents and ended up reviewing proposals, work plans, budgets, quarterly reports and any media content created for the programmes. In total, we reviewed 416 individual documents from 21 organisations.



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COVID-19 HygieneHub

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