Breakout Session 1: Inclusion in COVID-19 care and prevention

14th March 2022

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covid collective

Breakout Session 1:
Inclusion in COVID-19 care and prevention

Inclusion in COVID-19 care and prevention **Chair: Shaffa Hameed**	
Emeka Duru	Ensuring the rights and dignity of persons with disability during COVID-19 response in Nigeria – the CVA approach
Sara Rotenberg	Accessibility of COVID-19 Testing and Vaccination for People with Disabilities in Ontario, Canada
John Ganle	‘We felt left out’: experiences and inclusion of People with Disabilities during the COVID-19 pandemic in Ghana
Thushen Weerasinghe	Effect of health education on improving the knowledge, attitude and practice on proper use of face masks among peoples with disabilities
	Q&A

Emeka Duru
CBM

Ensuring the rights and dignity of persons with disability during COVID-19 response in Nigeria – the CVA approach

Ensuring the rights and dignity of persons with disability during COVID-19 response in Nigeria – the CVA approach

Presented at the

6th International Conference on Disability and Development: Disability and COVID-19

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Outline

- **Background**
- **Methodology**
- **Results**
- **Conclusion/Lessons Learned**
- **Acknowledgement**
- **Photo Documentation**

Background -1

- The COVID-19 pandemic resulted in an unprecedented disruption in socio-economic activities, **causing hardship on mostly persons with disabilities in Nigeria where a significant number of them rely on handouts for survival.**

- Christian Blind Mission (CBM) deploys **both conditional and unconditional cash transfer as a strategy in its emergency response.** Among others, Nigeria, Rwanda and Niger country programmes have used these approaches **to target persons with disabilities and other vulnerable persons at the peak of COVID-19 pandemic.**

Background -2

The Nigeria Inclusive WASH and COVID-19 Response (NIWCR) was funded and implemented by CBM **through local partners** **in the Federal Capital Territory (FCT) and Bauchi state of Nigeria to respond to the food and WASH needs of persons with disabilities.**

The project was implemented **in Bauchi state and the FCT.**

- In FCT - Gwagwalada, Kwali and Abuja Municipal Area Councils
- In Bauchi state, Katagum and Bauchi Local Government Areas

Methodology (Cash and Voucher Assistance)

Rapid Situational Analysis

Figure 2: Sample of NIWCR Cash Voucher

Figure 1: Sample of the NIWCR Token

Cash and Voucher Assistance

- Household Registration – Data collection using kobo Too
- Selection of Beneficiaries - vulnerability criteria
- Token Distribution
- Vendor engagement
- Voucher distribution and Hygiene kits distribution
- Food redemption
- Complaint and feedback mechanism

Post Distribution Monitoring

Results (Rapid Situational Analysis)

Key findings from the rapid situational analysis:

- **Majority of persons with disabilities have limited access to aids from government** due to accessibility barriers such as:
  - Information
  - Distance and Queuing time
  - Limited quantity of palliatives
  - No conscious effort by the government or aid organizations to include persons with disabilities in their interventions
- **Increased poverty among the vulnerable persons especially persons with disabilities** – this was as a result of the inflation in prices of food items during the lock down.
- **Inadequate information on COVID-19 prevention strategies** – inaccessibility of available information.

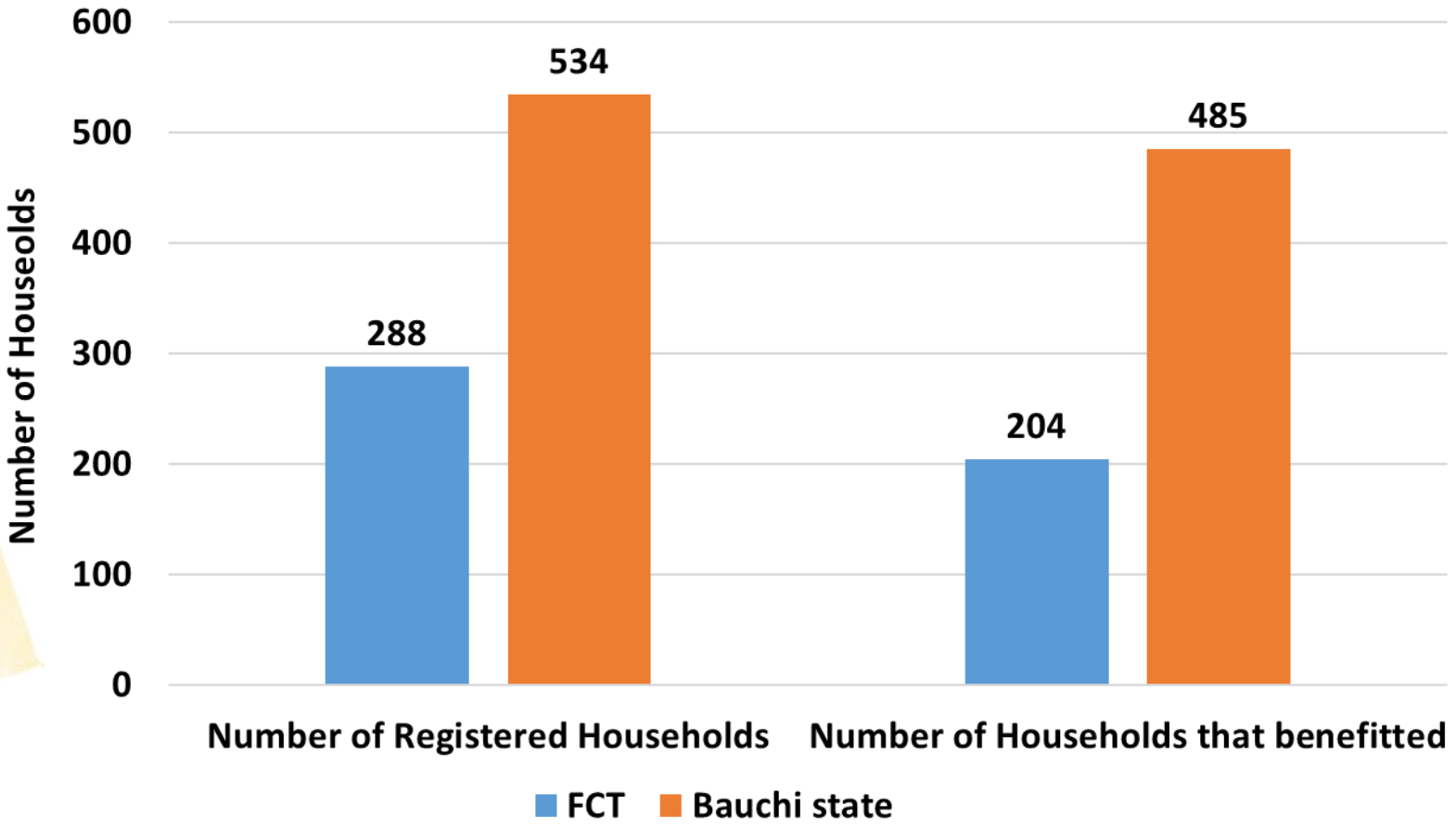
Results (Cash and Voucher Assistance -1)

A total of **822 persons** were registered in the FCT and Bauchi state.

Using the vulnerability criteria,

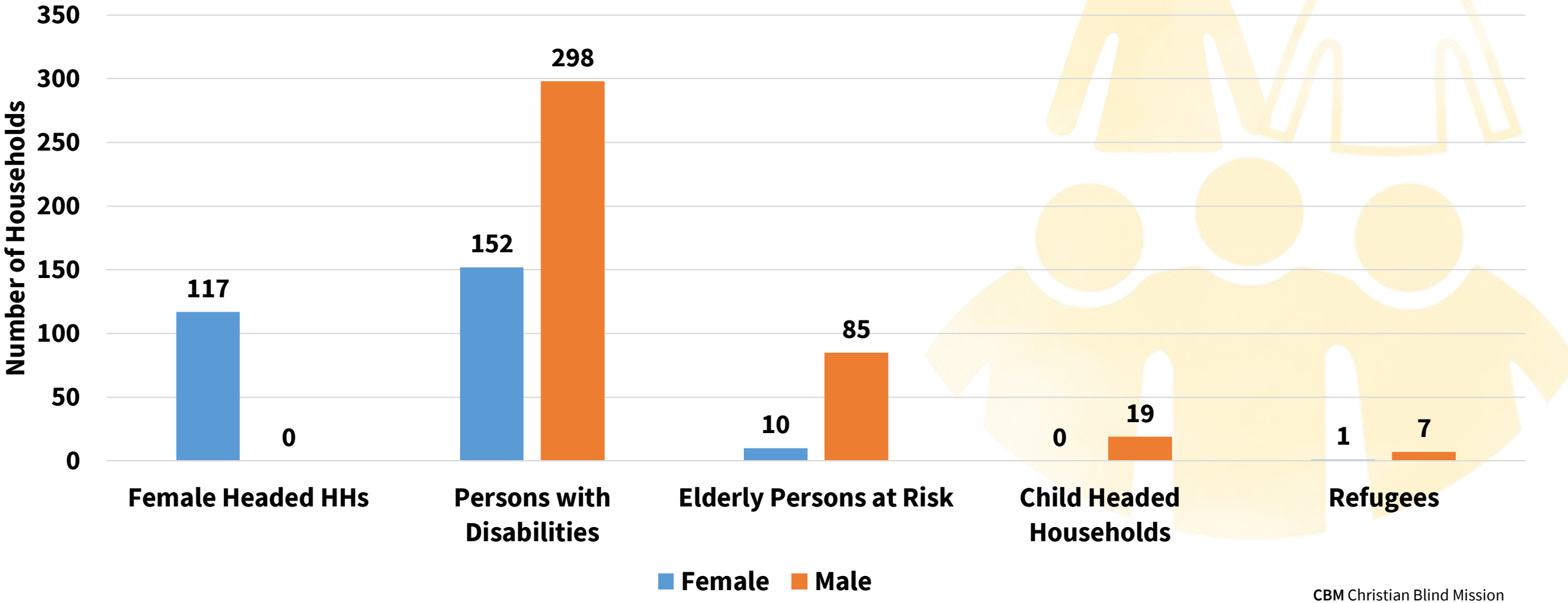
689 persons were selected and benefitted from the food items of their choices and hygiene kit.

Figure 3: Registered and beneficiary households by state



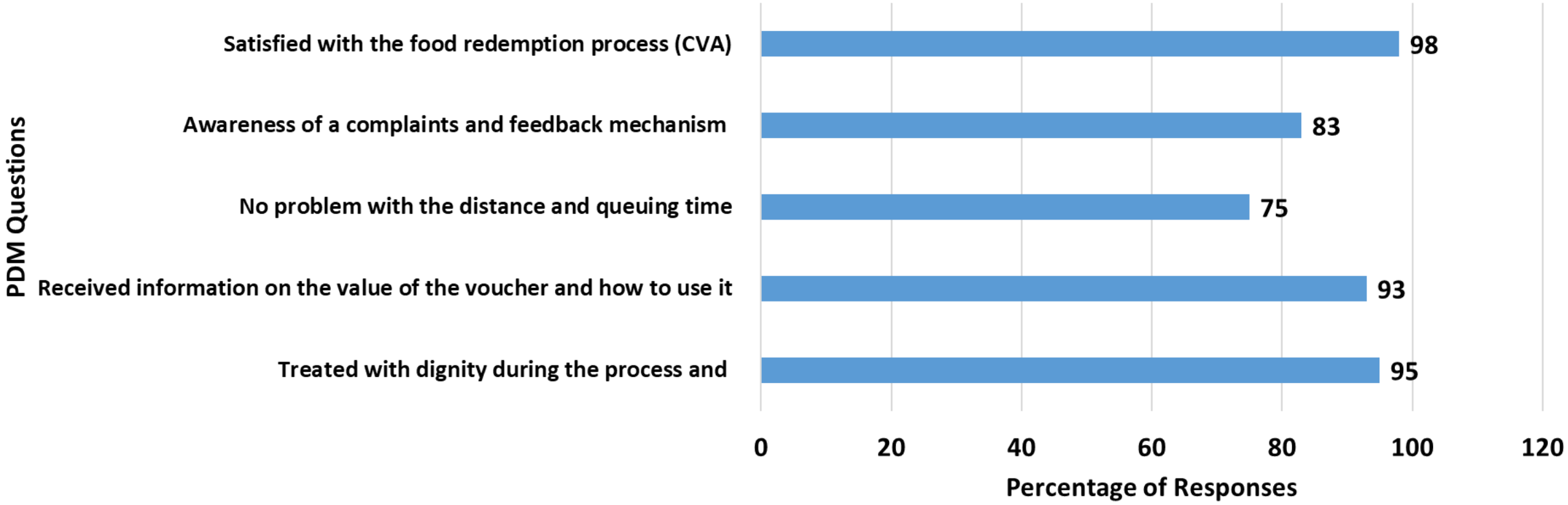
Results (Cash and Voucher Assistance -2)

Figure 4: Disaggregation of Beneficiaries by Vulnerability Criteria and Sex



Results (Post Distribution Monitoring - 1)

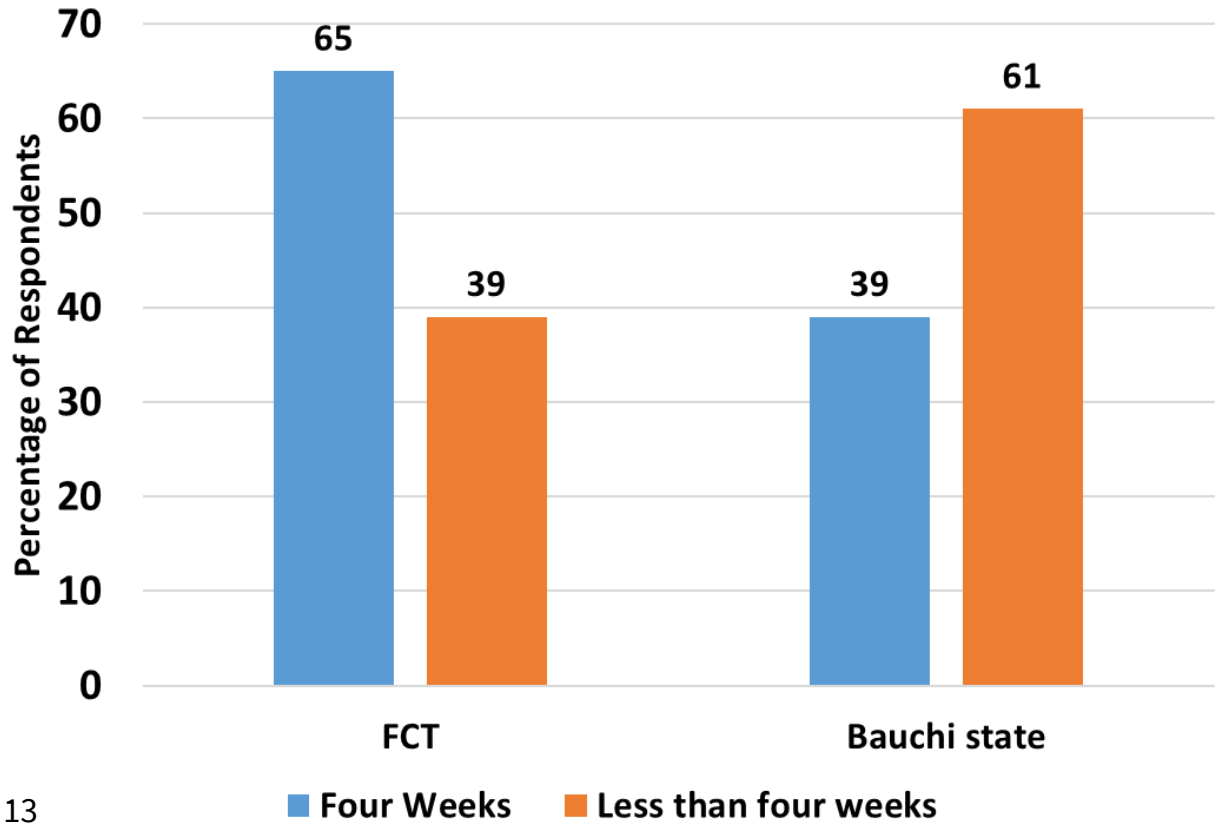
Figure 5: Percentage of responses to the PDM questions



"If I do not go out to beg I will not eat nor feed my family that was how I was before the coming of this program.
But after the intervention me and my entire household smiled like never before"

Results (Post Distribution Monitoring - 2)

Figure 6: Food sufficiency (last four weeks) in beneficiary households in the FCT and Bauchi state



- **61%** and **35%** of the households in Bauchi state and the FCT reported insufficiency of food in the last four weeks prior to PDM.
- The large household size in Bauchi state was responsible for the inadequate food ration as it exceeded the planned household **average of 7 by the project**.
- **25,000 NGN (54 EUR)** was spent **per household.**

"It was like a Sallah celebration when we got this help from CBM; we never expected it and because of this I shed tears of Joy"

Challenges

- Inadequate funding to reach the desired number of beneficiaries

- Inflation during the lockdown affected the prices of food item

Conclusion Lessons Learned -1

To ensure that equality, inclusion and right remain at the center of COVID-19 response, CVA has proven to be the right approach because of the many advantages it offers as against the traditional in-kind food distribution approach.

- CVA addresses some of the barriers that hamper persons with disabilities' access to aid during traditional in-kind distribution
- CVA reduces exposure to community transmission of COVID-19 as it eliminates overcrowding at redemption/distribution points
- Beneficiaries are empowered to make their food choices through the CVA approach as against the traditional in-kind distribution

Conclusion Lessons Learned -2

- The CVA approach protects and enhances the dignity of vulnerable groups especially persons with disabilities
- The engagement of food vendors within the target communities contributed to stimulating the local economy
- Inclusion of persons with disabilities in project cycle management promotes acceptance and boosts their confidence and self esteem – a case of Tijanni Lawal

Acknowledgement

- CBM Humanitarian Team
- CBM International Office, Bensheim, Germany
- CBM Africa West and Central Regional Office, Lome, Togo
- CBM Country Office, Abuja, Nigeria
- Al-Basar International Foundation - Partner in Bauchi state
- ToiletPride Initiative – Partner in FCT

Photo Documentation -1

Figure 7: Tijanni Lawal, a person living with physical disability during the household listing for the food distribution through Cash Voucher Assistance in Gwagwalada.

Figure 8: The Program Officer of ToiletPride explaining to beneficiaries how to use the Cash Voucher

Photo Documentation - 2

Figure 9: Token distribution in Bauchi LGA by an Enumerator who is a person with Physical disability

Figure 10: Exit interview with a beneficiary with visual disability who sent his caregiver to redeem the food items

Leading in disability inclusive development

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Thank you!

Sara Rotenberg
University of Oxford

Accessibility of COVID-19 Testing and Vaccination for People with Disabilities in Ontario, Canada

COVID-19 Testing and Vaccination for People with Disabilities in Ontario, Canada

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6th International Conference on Disability and Development:

Disability and COVID-19 – March 14, 2022

NUFFIELD DEPARTMENT OF PRIMARY CARE HEALTH SCIENCES
Medical Sciences Division

UNIVERSITY OF OXFORD

UNIVERSITY OF TORONTO
FACULTY OF LAW

NUFFIELD DEPARTMENT OF CLINICAL NEUROSCIENCES
Medical Sciences Division

Ontarians with Disabilities and COVID-19 (1)

- 22% of Ontarians have a disability (Statistics Canada, 2017)
- Ontarians with disabilities had worse outcomes for COVID-19 (Brown, H.K, et al., 2022)
  - 23% of hospital admissions
  - Increased risk of mortality (28.1% vs. 17.6%)
  - Longer stays (median 13.9 vs. 7.8 days)
  - More readmissions (17.6% vs. 7.9%)

Ontarians with Disabilities and COVID-19 (2)

- Ontario prioritized people with disabilities across all three phases of its vaccination program
  - Phase 1: People with disabilities living in long-term care and retirement homes, Indigenous Ontarians, and those receiving chronic home care
  - Phase 2: People with disabilities in congregate settings or hot-spot communities, and those with the highest-, high-, and at-risk conditions and their caregivers
  - Phase 3: Other individuals with disabilities not in these groups

Testing

Table 1: Accessibility Information Provided By Provincial Testing Websites (as of March 28, 2021)

Province/Territory	Accessibility Information Provided
Alberta (12)	None
British Columbia (13)	None
Manitoba (14)	None
New Brunswick (15)	None
NL (16)	ASL-specific support lines available
Northwest Territories (17)	None
Nova Scotia (18)	Some accessibility information listed
Nunavut (19)	None
Ontario (20)	Some accessibility info listed
PEI (21)	None
Quebec (22)	None
Saskatchewan (23)	None
Yukon (24)	Information in ASL format only

Table 2: Overview of Accessibility Information for Ontario Testing Locations (as of March 28, 2021)

- [1]Includes multiple booking formats, accessible entrance, care partner permitted, multiple testing modalities, interpreters available

Accessibility Service	Number (%) of Locations Providing Service (N=170)
Appointment Booking only	**86%**
Contact Telephone # Provided	**92%**
Drive-Through Testing Available	**24%**
Wheelchair Available On Site – No Info	**100%**
Booking Format –	
- Phone or Web Options	50%
- Phone	39%
- Web	8%
- No Info	2%
- Phone and Web Both Required	1%
Wheelchair-accessible Entrance Stated	**65%**
Care Partner Permitted	
- No Info	96%
- Yes	2%
- No	2%
Different Testing Modalities Available - Yes	**1%**
ASL/Interpreters Available - Yes	**10%**
Multiple Accessibility Services[1]	
- 0	19%
- 1	41%
- 2	32%
- 3	8%
- 4+	0

Findings and Interpretation

- Only 8.2% of locations had 3 accessibility dimensions measured
- Physical accessibility was the most commonly available piece of information, with 64.7% of Ontario locations noted that they were physically accessible for wheelchair users or people who use mobility aids
    - None had information about on-side mobility aids
- Only 10% had interpreters available, 90% had no information
- Limited accessible information or location-specific guidance at most people's first point of entry—provincial websites—is a significant barrier to the decision and ability to seek testing.

Vaccination

Out of home vaccination journey

Start

1

Information About the Vaccine

- Information about where, when, and how to get vaccinated is in multiple formats including: easy-to-read, audio/video, braille, high-contrast and large font, accessible infographics, etc.
- Include site-specific information about the process of vaccination, including clinic walk-throughs, maps, video/audio descriptions, etc.

2

Booking

- Multiple booking methods (both phone with live assistance and web) for vaccination in various settings (i.e., pharmacy, primary care, mass clinic).
- Information on which accessibility features are available in each clinic location is available.
- Communicate needed accommodations and book essential caregivers at the same time.
- Schedule second dose at the same time as the first for ease of booking.

3

Travel to the Clinic

- Free, accessible transportation programs are noted on the website
- Timing suggestions for booking accessible transportation are provided.
- Well-signed areas for accessible drop-off and pick-up are outside the clinic.

4

Waiting in Line

- Identifiable accessibility champion on-site to answer accessibility questions, organize accommodations, and support people with disabilities throughout vaccination.
- A support person or animal can accompany an individual throughout the entire vaccination process.
- Seating, wheelchairs, and other mobility devices are available.
- Signs direct individuals through accessible routes.
- Physical distancing and other public health measures are strictly enforced, except for individuals who cannot wear or change their mask.
- Rapid lines or access options available for individuals who have difficulty waiting in line or who may miss their accessible transport home, if delayed.

5

Registering

- Greeters should not ask individuals to prove disability
- When registering, individuals wearing clear masks are available to assist with communication.
- Alternative forms of communication (i.e., clipboard to write, ASL interpreter, etc.) should be available upon request with notice.

6

Getting Vaccinated

- Vaccinators should obtain informed consent, through the most acceptable means of communication
- Individuals being vaccinated have the option to lie down, receive the shot in their thigh, or have a private booth.
- On-site attendant or vaccinator can assist with removing jacket or rolling up sleeves, when asked.
- Administer vaccine to the person being vaccinated and essential caregivers.

7

Post-Vaccination Care

- During 15-minute observation period, individuals can remain in the vaccination seat to reduce adjusting to a new setting or additional walking.
- If needed, individual can move around safely during observation period.
- Information, including possible side effects, should be available in multiple formats (i.e., easy-to-read, large font, oral etc.).
- Have mechanisms to collect feedback on accessibility in accessible formats.

8

Second Dose

- Should be booked at the same time and place for continuity, if desired.
- Individuals who do not show up for/book a second dose appointment should be supported to arrange a second, accessible dose.

In-home vaccination journey

Start

1

Information About the Vaccine

- Information about where, when, and how to get vaccinated is in multiple formats including: easy-to-read, audio/video, braille, high-contrast and large font, accessible infographics, etc.

2

Booking

- Multiple booking methods (both phone with live assistance and web) for vaccination in various settings (i.e., pharmacy, primary care, mass clinic).
- Information on which accessibility features are available in each clinic location is available.
- Communicate needed accommodations and book essential caregivers at the same time.
- Schedule second dose at the same time as the first for ease of booking.

3

Individuals Coming to the Home

- Wear appropriate PPE and are familiar with an individual's risk factors and accessibility needs.

4

Getting Vaccinated

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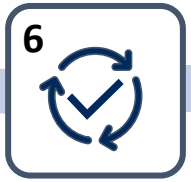

Preparation for Second Dose

- Should be booked at the same time and place for continuity, if desired.
- Individuals who do not confirm a second dose appointment should be supported to arrange a second, accessible dose.

Accessibility Considerations Measures

- **Three domains:**
  - **Communication:** accessible website; multiple booking options; phone number available; ASL; information on changing locations/stations at site during the visit; 2nd appointment provided during 1st appointment.
  - **Physical Accessibility:** ability to book appointments or wait time estimates for pop-up clinics; private booths available; accessible entrance at site; wheelchair available on site; accessible post-vaccination waiting area, drive-through available; home vaccination offered.
  - **Social and Sensory Environment:** ability to bring a care partner; specialized clinic/hours for people with disabilities; no requirement/burden to prove disability; ability to move around while waiting; face mask exemption policy.

PHU Website Review Results

- On website as of May 7, 2021
- 18 key accessibility considerations across three domains for 34 PHUs websites
- Mean = 5.1 of 18 (28%)
  - More than 50%: 4 PHUs
  - Less than 25%: 9 PHUs
- Most frequently available:
  - Phone number (91.2%)
  - Multiple booking options (88.2%)
- Least frequently included:
  - Proof of disability (2.9%)
  - Ability to move around while waiting (2.9%)

Conclusion

Limitations

- Website information might be different than actual accessibility
  - i.e., more available than listed or temporary inaccessibility, such as a broken lift
- Inability to verify accessibility information without site visits

Interpretation and Learnings (1)

- Ontario's Public Health Units have varying amounts of information about accessibility publicly available on their websites, though this could reduce barriers to testing and vaccination for people with disabilities
- Difference between ***availability*** and ***accessibility*** of testing and vaccines.
  - Simply being eligible is not sufficient to ensure access
  - Important to have accessibility champions to answer questions by phone or on-site

Interpretation and Learnings (2)

- Improving communication strategies, physical accessibility, and social and sensory environment accessibility throughout the testing and vaccination journey will more effectively support this at-risk population in getting vaccinated.
- Solutions to accessibility barriers need to be cross-disability and universal, which can be low- or no-cost
  - Government engagement and recommendations for ”quick wins” helped improve accessibility immediately

Acknowledgements

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- **Funders:** Rhodes Trust (SR and MBD)

John Ganle
University of Ghana

‘We felt left out’: experiences and inclusion of People with Disabilities during the COVID-19 pandemic in Ghana

‘We felt left out’: experiences and inclusion of People with Disabilities during the COVID-19 pandemic in Ghana

John Ganle

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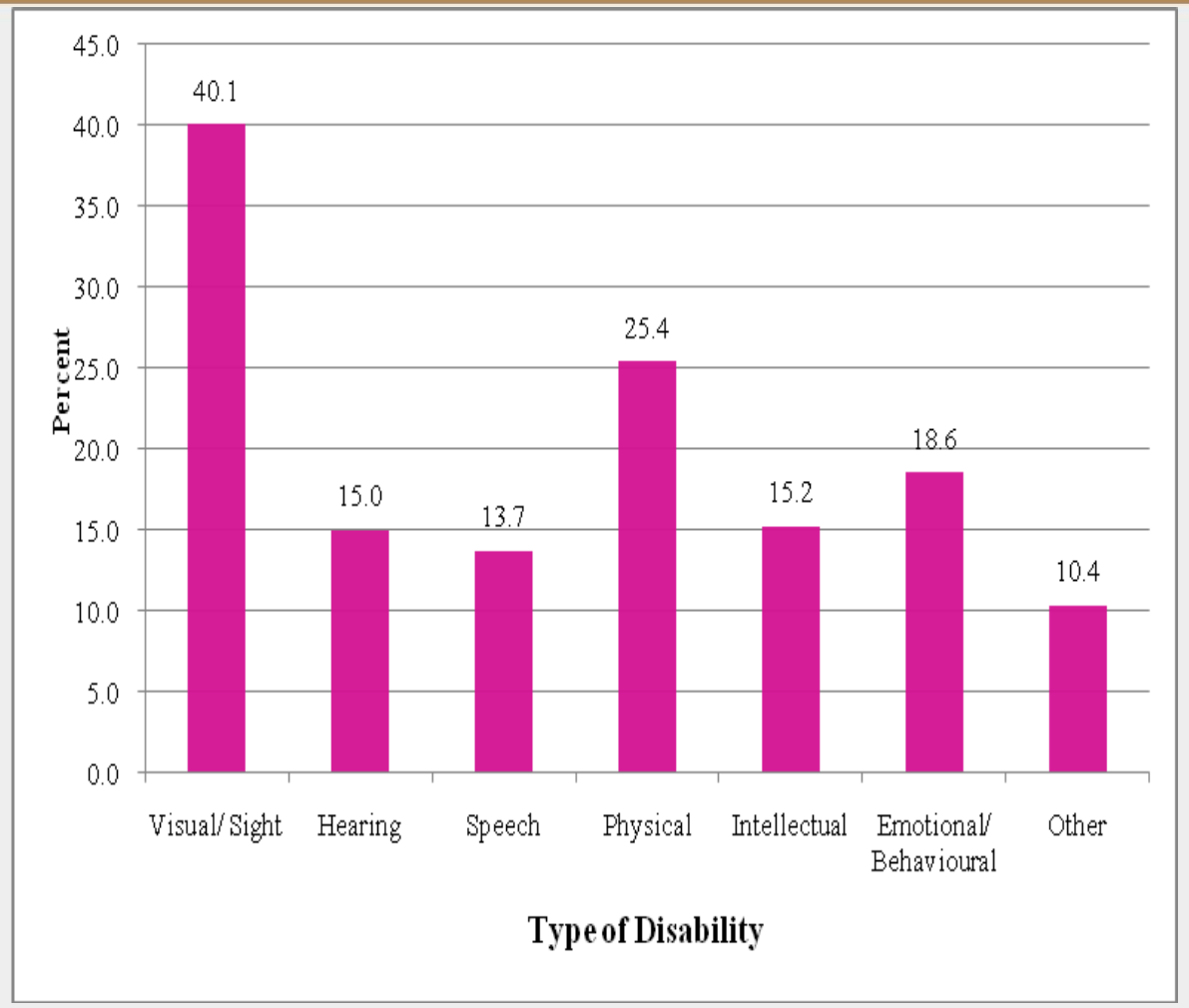
Outline

- **The problem**
  -objective of the study
- **Methods**
  -Design
  -Participants
  -Data collection and analysis
  -Ethics
- **Results**
- **Discussion - programme/policy implications**
- **Conclusion - key messages**

The problem – disability and COVID-19



- Ghana' s disability prevalence from 2010 census: 3%
- But new data suggest 7– 12%, approximately 1.55– 2.2 million people.

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The problem – disability and COVID-19

- Many have ongoing health and social service needs that may be interrupted during the COVID-19 pandemic.
- But they may not be adequately included in the direct response to COVID-19:
  - **Media headlines in Ghana:** 'Blind Couple Dying of Hunger As COVID-19 Cuts Support'; 'Govt's Food Distribution Programme – Special Needs Families Left Out'; 'Blind Union Calls for Uniquely Tailored Packages For Persons with Disabilities'.
- Limited research on the experiences of people with disabilities in Ghana

Objective

- To explore the experiences and inclusion of people with disabilities in Ghana during the COVID-19 pandemic response

Methods – design & study area

- **Design:** qualitative cohort study, with two-rounds of interviews.
- **Study areas:**

➢ Accra (coastal zone)

➢ Kumasi (middle zone)

➢ Tamale (northern zone)

- Study areas selected to capture both country diversity and different COVID-19 experiences

Methods – participants

- **Participants:**

➢adults (18+years), and children (10-17years) with physical impairments, visual impairments, hearing/speech impairments, and cognitive/mental disabilities.

➢Representatives of DPOs, NGOs and government departs

- **Sampling:** purposive and snowballing.

Methods – participants (People with disabilities)

Disability type	Adult (males)	Adult (females)	Children (Males)	Children Females)	Total
Physical	1	2	1	1	**5**
Visual	1	2	1	1	**5**
Hearing	1	1	1	1	**4**
Cognitive/ mental	1	1	1	1	**4**
Total per region	4	6	4	4	**18**
Total for all 3 regions	**12**	**18**	**12**	**12**	**54**

Methods – data collection and analysis

- **Data collection:** In-depth interviews
  - face-to-face
  - telephone
  - zoom
  - WhatsApp
  - Sign language

- **Data analysis**
  - Transcription of Audio/Video recordings
  - Coding of transcript in NVIVO
  - Themes identification
  - Thematic content analysis

Methods –Ethics

- **Ethics:**

➢ Ethical approval from Observational/Interventions Research Ethics Committee (LSHTM) and Ghana Health Service Ethics Review Committee.

➢ Adult participants signed or thumb printed a written informed consent form after detailed explanation.

➢ Child participants assented to parental consent.

- **COVID-19 Education and protocol observation**

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Key findings – awareness, risk perception & experiences

- All participants have heard about COVID-19 and knew the basic preventive measures.
- Information access was however difficult for Deaf and visually impaired participants.
  - **Deaf people without formal education relied on informal family/community sources.**
- Heightened perceptions of risk/personal vulnerability :
  - **‘you see in our case …it is riskier because some of us can’t even board cars without the help of others; and you do not know if the one assisting you has the virus’.**

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Key findings – Compliance with preventive measures

- Many experienced grave difficulty complying with hand-hygiene measures:
  - **Participants with visual impairment who rely on touch in their activities of daily living experienced the most risk and the most difficulty practicing physical/social distancing.**
  - **Locally designed hand washing equipment were mostly less accessible to many people with physical impairments.**

Key findings – economic and social impacts

- Differentiated economic and social impacts.

➢ For those in the informal economy:

- **‘It is this work am doing that the family depends on so when the corona came, it made things difficult for me. Nobody came to the shop to receive service. Somebody comes and goes back due to fears imposed by the disease’.**

Key findings – economic and social impacts

- For those who rely on charity on the streets and at social events (church/funerals)

- **'My brother, I have experienced hardship in my life but what I experienced this COVID period is beyond anything. Before COVID people give me money when I stand at the traffic light…people give me support too when I go to mosques on Friday or when I go to "Awuree". But the lockdown in Accra spoiled everything. Even after lockdown, people are not giving…I think things are hard for people'.**

Key findings – economic and social impacts cont.

- For those who depend on family and relatives:
  - **Interviewer:** so when COVID-19 came did it affect the assistance you were getting from your family?
  - **Interviewee:** Yes.
  - **Interviewer:** how was is affected?
  - **Interviewee:** you know errrm, the kind of food I was served with, and frequency at which I was receiving from them changed for the worse.

Key findings – Inclusion in COVID-19 response measures

- Many participants felt very left out in the state-sponsored response measures.
- **'We felt left out…I personally felt left out because, I didn't get any financial support for my shoe-mending business because they said I wasn't registered. I know other PWDs too who didn't get anything for their small businesses too even though they applied. The free light and water too nil…where I live no light, and the water, we fetched it from a neighbor and we had to pay all the time**'.

Key findings – Inclusion in COVID-19 response measures

- But some Disabled People's Organisations (DPOs), NGOs and church groups were praised as having more disability inclusive measures:

- **'Over here I have not heard that, government has errrmm, sent PPEs or just some support to persons with disability, I have not heard that. But I have seen physically and on TV other non-governmental organizations and churches distribute Verona buckets, PPEs and food items to we the PWDs'.**

Key findings – Inclusion in COVID-19 vaccination

- There was also some level of vaccine resentment/hesitancy:

- **‘Ooo I have heard about the vaccine but have not gone for the vaccination because it was through vaccination that I became disabled so it is disheartening for me to go for the vaccine. So I haven’t gone for it’.**

Discussion - programme/policy implications

- Need to invest resources in producing and disseminating appropriate COVID-19-related information to people with hearing, speech and visual impairments.
- Need for better targeting of COVID-19 response measures to the disability community. A partnership with DPOs, NGOs and churches could help.
- Urgent national and local level communication strategy is required to address vaccine resentment/hesitancy among segments of people with disabilities.

Conclusion - key messages

- Awareness about COVID-19, but information access is limited for many Deaf and visually impaired people.
- COVID-19 has eroded/weakened the social and economic support base for many people with disabilities.
- State-sponsored COVID-19 response measures appear less responsive to the needs of some disability groups.
- Vaccine hesitancy in the disability community needs to be urgently addressed.

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- **Co-Investigators:**
  - **Tom Shakespear**
  - **Hannah Kuper**
  - **Morgon Banks**

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THANK
YOU

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Effect of health education on improving the knowledge, attitude and practice on proper use of face masks among peoples with disabilities

Effect of Health Education on improving the knowledge, attitude and practice on proper use of face masks among peoples with disabilities.

International Conference:
Disability and COVID-19

Principal Investigator:- W.M.S.T. Weerasinghe

School:-Kg/Dehi/ Rajasinghe Central College, Ruwanwella

Principal supervisor:- Mr. T.M.U.S. Thunpaththu

Supervisor:-Mrs. D.M.T.P. Dissanayake

Contents

1. Background
2. Aims and objectives:
3. Hypotheses and Conceptual Framework
4. Methodology
5. Results
6. Conclusion
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Background

- Two spread methods of Covid 19, namely air borne and respiratory droplets can be prevented by proper use of face masks.
- It has been observed the inadequate practice of Proper use of Face masks among peoples with disabilities.
- Knowledge, Attitude and Practice of face masks among peoples with disabilities should be improved.

Different approaches are used Ex:-

- Sinhala medium health education Programs are less

The effect of Sinhala medium health education is not studied.

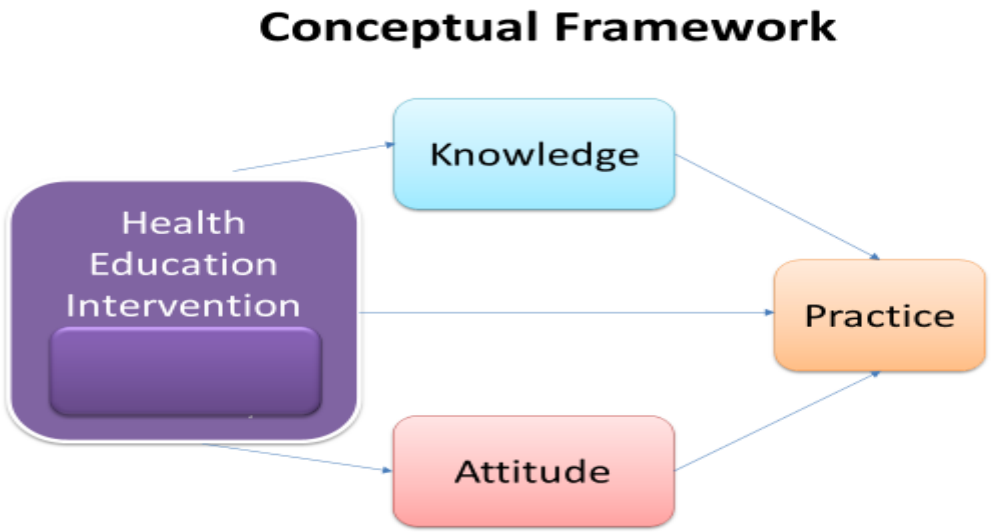
- (3,4,5,6)

Aims and objectives:

1. To determine the effect of a Sinhala language health education on knowledge, attitude and practice on proper use of face masks among peoples with disabilities in Bulathkohupitiya Divisional secretory area of Srilanka

Hypotheses

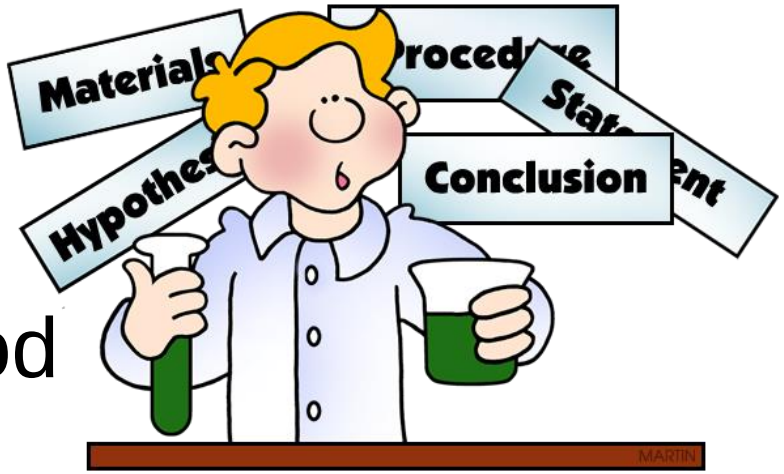
- **Online Health education has positive effect on improving knowledge, attitude and practice on proper use of face mask among Peoples with disabilities ?.**



(3,5,6)

Methodology

1. Research design
2. Ethical considerations
3. Study population and sample
4. Inclusion & exclusion criteria
5. Research variable
6. Research instrument
7. Validity and reliability
8. Data collection method



Methodology-Study design and Sampling Method

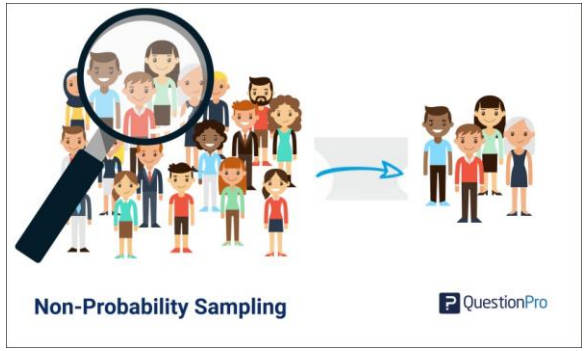
Study design- interventional and prospective design. (one group pre- test post- test)

Sampling Method: Consecutive Sampling Method

Ethical Approval –CSP Sri Lanka

Inclusion Criteria-Exclusion Criteria

Study Population



Methodology- Sample Size:

Sample Size:

- Calculated using Solvin's formula

$$n = \frac{N}{1 + Ne^2}$$

n= Sample size
N= Total population (4007)
e= Margin of error (5%)

Calculated sample size **(n) is 364**

- Sample size calculations with **10% dropouts**(q=0.1)

$$N' = \frac{n}{(1 - q)}$$

Calculated sample size **(N') is 405** **(24, 25)**

Methodology - Research variable

Independent Variable	Dependent Variable
1. Exposure to the Sinhala Language Health education on proper use of face mask 2. Gender	01. Level of knowledge on proper use of face mask 02. Level of attitudes on proper use of face mask 03. Level of correct practice on proper use of face mask

Methodology - Research Instrument

Research Instrument	Use of the Research Instrument
1. Questionnaire	Used for Pre Test and Post Test
2.Online health education lectures	Used to improve the Knowledge , attitudes and practice of the Peoples with disabilities

Methodology-
Development , Validity and Reliability of Questionnaire

Developed with the updated knowledge based on Health guidelines on proper use of face mask; World Health Organization and Ministry of Health

Content Validation - with an expert panel
Face validation -10 homogenous & non participated
Reliability was achieved -
by conducting a pilot study with 40 peoples.
Cronbach's alfa for attitude 0.775 and practices 0.843 was obtained

Methodology- Data Collection Method

Pre test - The questionnaire was distributed by means of google forms to peoples with disabilities in as much as possible through WhatsApp groups of Bulathkohupitiya Divisional secretory area of Srilanka

Data Collection (1st Round)-405 replies were selected as 1st come 1st selected basis.(google form was immediately removed once the 405th submission was completed)

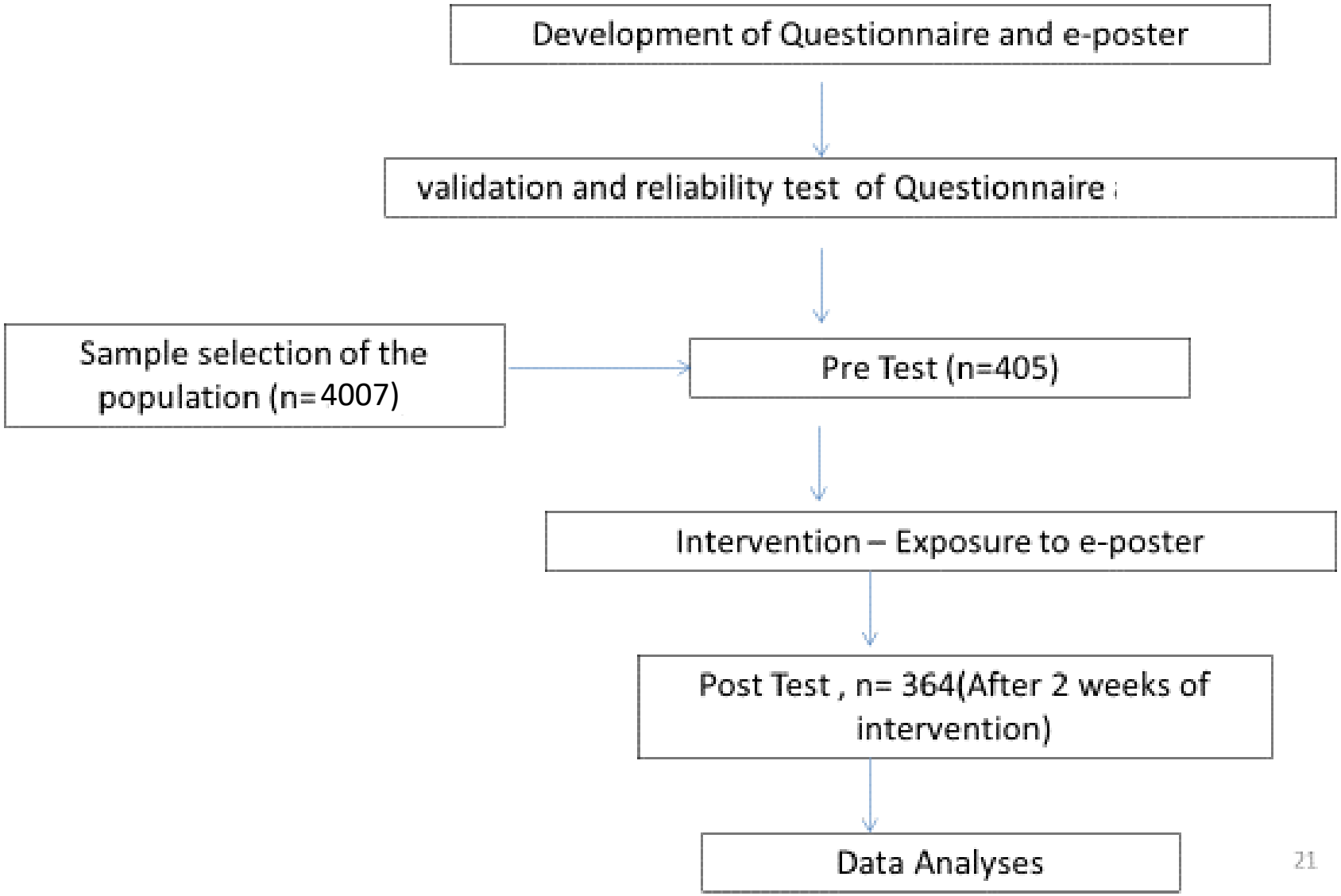
Intervention – 1 hover online health educational lectures was distributed via zoom among all the peoples contacted for pre test.

Methodology - Data Collection Method

Post Test - The questionnaire (with altered sequence of questions) was distributed by means of google forms to all the peoples contacted for pre test and intervention after 2 weeks of intervention. (instructions were given to answer the questionnaire only if they have answered pre test and studied the online-)

Data Collection (2nd Round)- 364 replies were selected as 1st come 1st selected basis. .(google form was immediately removed once the 364th submission was completed)

Methodology



Results

Table 1: Demographic characteristic presentation

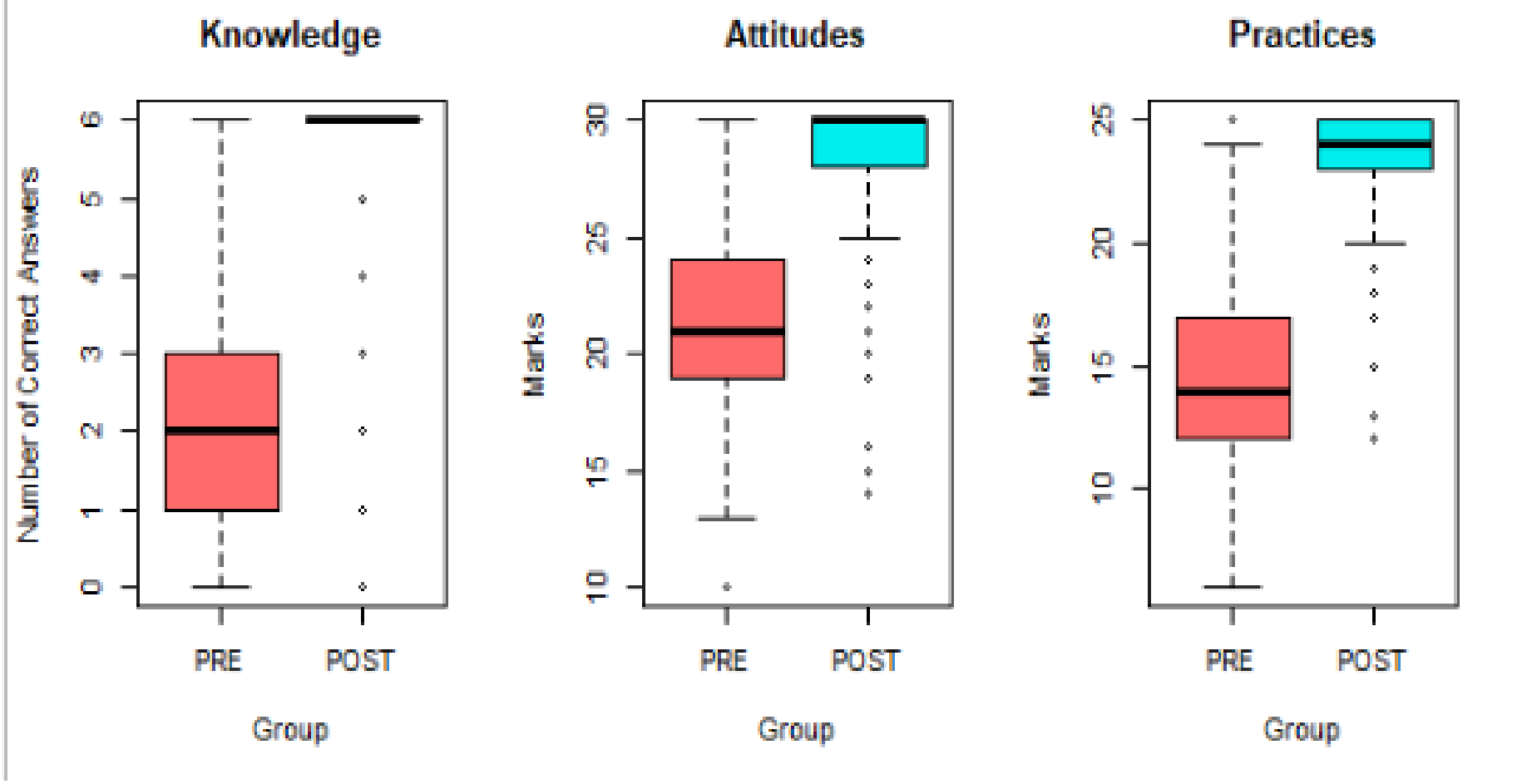
Demographic Characteristic		PRE(N=405)		POST(N=364)		Pearson Chi-Square value	Significance (P value)
		Frequency	Percent (%)	Frequency	Percent (%)		
Gender	F	217	53.6	205	56.3	0.581*	0.446
	M	188	46.4	159	43.7		

* significance at p value 0.05

PRE and POST groups are homogeneous

significance at p value 0.05

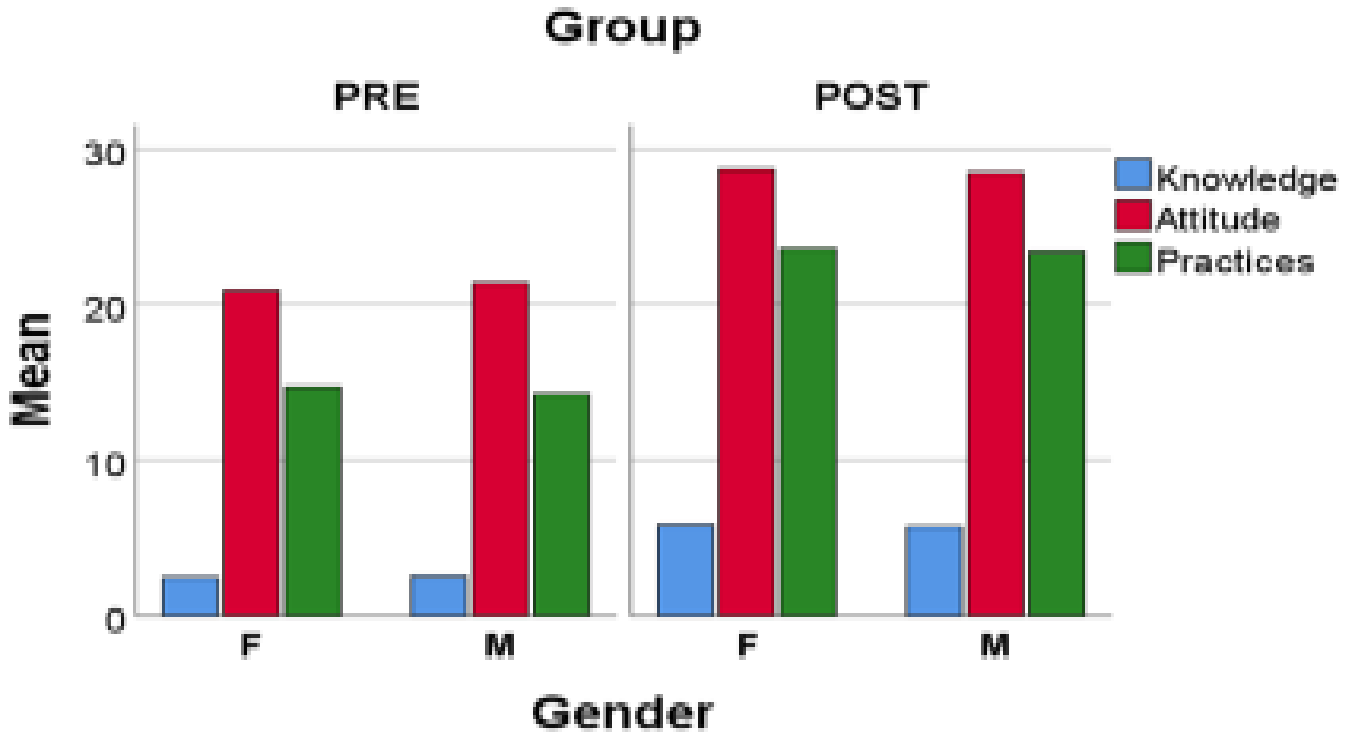
Results ctd…



P value < 0.001

Significant difference between PRE and POST groups

Influence of Gender

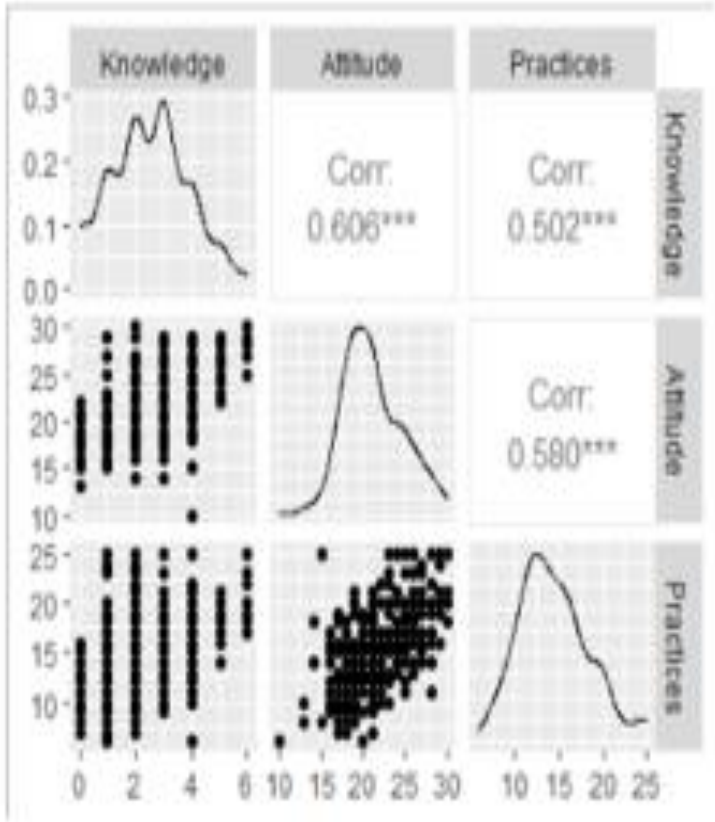


No significant influence of gender on Knowledge, attitude, and practices

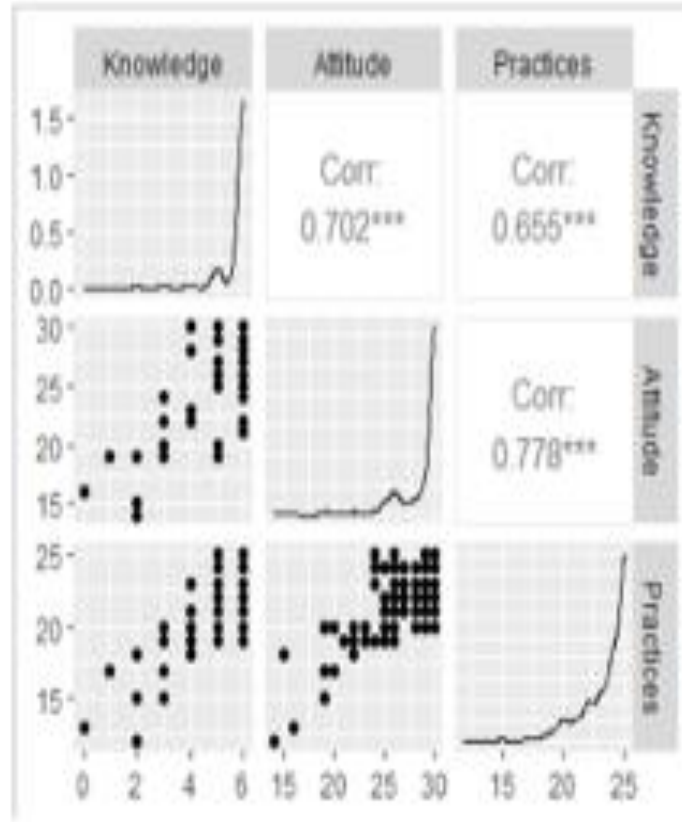
		Knowledge		Attitude		Practices	
		t	P value	t	P value	t	P value
Gender	PRE	-0.564	0.573	-1.277	0.202	1.096	0.274
	POST	1.384	0.167	0.728	0.467	0.918	0.359

Co relational Analysis

PRE



POST



Limitations

- This study was limited to those who had e-learning facilities.
- Results may not be generalized to peoples with disabilities
- There were no plans to test the retention of the effects of the intervention.

This limitation resulted in the unavailability of an assessment of the influence of the intervention approach on retention.

Conclusion

- It can be concluded that the health education on knowledge, attitude, and practice on the proper use of face mask is an effective education measure to improve the knowledge, attitude, and practice on the proper use of face mask among peoples with disabilities regardless of the gender and there is a positive moderate to the high correlation between knowledge, attitudes, and practices.

Conclusion Ctd-
Recommendations and suggestions for Future Research

- Future studies regarding knowledge, attitudes, and practices should specifically assess the attributes that peoples with disabilities have toward proper use of face mask among different age groups of peoples.
- investigating the retention of the effects of e- educational poster on the improvement of knowledge, attitudes, and practice on the proper use of ha face mask is suggested.(27)

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- Peoples with disabilities who participated in the study.

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Thank You