



REPUBLIC OF ZAMBIA



UNITED NATIONS  
ZAMBIA

COVID-19 IMPACT  
ASSESSMENT  
ON PERSONS  
WITH DISABILITIES  
IN ZAMBIA







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**JUNE 2023**

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# ABBREVIATIONS AND ACRONYMS

<b>CRPD</b>	Convention of the Rights of Persons with Disabilities
<b>CWDs</b>	Children With Disabilities
<b>DPO</b>	Disabled People's Organisation
<b>DMMU</b>	Disaster Management & Mitigation Unit
<b>DRW</b>	Disability Rights Watch
<b>FGD</b>	Focus Group Discussion
<b>GBV</b>	Gender-Based Violence
<b>ILO</b>	International Labour Organisation
<b>KII</b>	Key Informant Interview
<b>MCDSS</b>	Ministry of Community Development and Social Services
<b>OPD</b>	Organisation of Persons with Disabilities
<b>SRHR</b>	Sexual Reproductive Health Rights
<b>TCM</b>	The Commuter Magazine
<b>UNCT</b>	United Nations Country Team
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>ZAFOD</b>	Zambia Federation of Disability Organisations
<b>ZAPD</b>	Zambia Agency for Persons with Disabilities

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Special thanks go to the individual Persons with Disabilities that shared their experiences, the Government institutions and departments that participated as key informants, Organizations of Persons with Disabilities, and the parents of children with disabilities, who collectively informed the content of this report. The study could not have been successful without the help of the Community Welfare Assistant Officers that helped in mobilizing and identifying the households of Persons with Disabilities.

The report benefited from a series of reviews, including a national stakeholders validation workshop which provided valuable inputs from the Ministry of Community Development and Social Services, Ministry of Finance and National Planning, Zambia Statistics Agency, Ministry of Labour and Social Security, Ministry of Transport and Communication, Ministry of Gender, Ministry of Youth, Sport and Art, Ministry of Education, Ministry of Health, Ministry of Information and Broadcasting Services, Road Transport and Safety Agency, Civil society for Poverty Reduction, Sight Savers, Cheshire Homes, Zambia National Association for the Deaf, National Trust Fund for PWDs, Albino Foundation, Disability Rights Watch, The Commuter Magazine, ZAFOD, ILO, UNFPA and UNDP.

Finally, the leadership, guidance and technical support provided by the UNDP, ILO, UNFPA and ZAPD throughout the undertaking of this study is well noted.



**Agatha Banda Mulenga**

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# FOREWORD

Persons with Disabilities (PWDs) were amongst the most hard-hit groups by the COVID-19 pandemic due to their underlying conditions. PWDs were faced with various challenges which resulted in limited means to survive and provide better options for their families. The third wave of the COVID-19 worsened the situation as their economic activities slowed down and negatively affected most of them due to their heavy dependency on support from Government and other informal support.

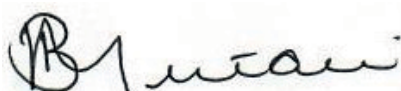
Dissemination of information on COVID-19 did not fully cover all aspects of Persons with Disabilities, particularly related to access to health services, education, and other key drivers of their wellbeing. With the limited financial support from the Government, many African countries, including Zambia, did not have adequate options and means to support all the people, including People with Disabilities.

In line with the integrated approach that holistically addresses the six core programming principles, including the one on "Leaving No One Behind (LNOB)" it is the ambition of the UN to see more Persons with Disabilities progressing through inclusion in all activities, as outlined in the United Nations Sustainable Development Cooperation Framework (UNSDCF) which was launched in November 2022. This inclusion will give the opportunity to PWDs and their families to access the available services and live independently like others, consequently, contributing to reduction of poverty levels and improve their livelihoods.

To this effect, the United Nations, the Zambia Agency for Persons with Disabilities (ZAPD) and other Organisations for Persons with Disabilities (OPDs) undertook a rapid assessment of the impact of COVID-19 on Persons with Disabilities. The objective was to have a clear understanding and identifying the health and socio-economic challenges faced by PWDs and their families during COVID-19 pandemic with a view of formulating recommendations to the Government and other development partners on COVID-19 disability-inclusive response and recovery needs.

The COVID-19 pandemic had devastating effects on PWDs, which exacerbated the existing inequalities and barriers. A number of them were left jobless, with limited opportunities for income generation; low accessibility to health-care and disability-support services and reduced economic activities in key sectors of the economy. There were variations on the impact for those in rural, urban and peri-urban areas, and those in border towns particularly due to availability of information, services and resources relating to COVID-19 recovery needs and support provided by the Government and other partners. While efforts were made to address these challenges, only few Persons with Disabilities and their families benefitted from these support programs.

Addressing the current challenges and barriers faced by Persons with Disabilities requires coordinated efforts and commitment by the Government, private sectors and partners in the spirit of whole-of government and whole-of-society approach. This will require great creativity and a unique opportunity to design and implement disability-inclusive COVID-19 response and recovery, as well as building a more inclusive and accessible societies, in consultation with Persons with Disabilities. As such, I hope that this report will provide in-depth information with regards to the effects and impact of the pandemic in the country, including the proposed recommendations to all the development partners on how we can improve the lives of the PWDs.



**Beatrice M. Mutali**

Resident Coordinator of United Nations System in Zambia

# CHAPTER ONE

## INTRODUCTION AND BACKGROUND



## 1.1. Introduction

This report is based on a countrywide study that was conducted in March and April 2021 to capture the experiences of Persons with Disabilities in light of the COVID-19 pandemic. Specifically, the report presents the results of how the pandemic has impacted Persons with Disabilities differently given the historical barriers and vulnerabilities associated with the interaction of the impairments with the environment. The report presents the methodology, findings, discussion and recommendations to inform programming and financing and disability-inclusive preparedness and response.

The study was conducted during the period when cases of COVID-19 had subsided, hence making it easy for the research teams to be dispatched without the risk of contracting or endangering the respondents. In carrying out this assessment, all the respondents were asked for consent to use their details in this report and other publications of the UN, the Government of the Republic of Zambia and the participating Organisations for Persons with Disabilities. The assessment was conducted primarily in-person while strictly adhering to the WHO and government guidelines on COVID-19 prevention measures; while some key informant interviews were done virtually where possible, with the interview guide shared via a link or email.

This study was meant to be a rapid assessment of the impact of the COVID-19 on Persons with Disabilities measured against their ability to maintain a decent livelihood and cushion the global socioeconomic effects that have left masses jobless and with limited opportunities for income generation; accessibility to continued healthcare and disability-support services, including access to sexual reproductive health; and the situation of sexual and gender-violence particularly on women and girls with disabilities.

The study reached 1,825 households in 30 districts across the 10 provinces of the country. 439 of these were households representing children and young people with disabilities below the age of 18. There were more female respondents than male, with physical disability at 50% of the adult respondents. In terms of representation, the study reached all categories of Persons with Disabilities including those representing marginalized groups like persons with psychosocial disabilities and those with albinism.

## 1.2. Background

The ongoing COVID-19 outbreak poses severe challenges for Zambia's economy and its population's livelihoods, including Persons with Disabilities and disadvantaged girls and women. Zambia recorded its first two cases of COVID-19 on 18 March 2020, and as of February 5th, 2021, the country had 60 427 confirmed cases and 828 COVID-19 and related deaths. The period between December 2020 and February 2021 experienced a doubling of corona virus infections compared to March and November in 2020. To curb the spread of the COVID-19 virus, Zambia put in place pharmaceutical and non-pharmaceutical interventions (NPI), which included the provision of isolated medical care in selected health facilities, the partial lockdown of almost all economic and social activities, including social distancing, going to work, earning a livelihood as well as visiting public places and meeting people. These measures put in place by the Government to curb the spread of the disease have had disproportionately negative consequences for the most vulnerable members of society.

Given that 80% of Persons with Disabilities live in extreme poverty, particularly in developing countries, including Zambia, this group remains the most vulnerable in the wake of COVID-19 containment measures (IASC, 2019). In the case of Persons with Disabilities, the initial partial lockdown measures have negatively affected their lives. The Convention on the Rights of Persons with Disabilities and Optional Protocol recognises «that discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person» (United Nations, 2006).

The Government has articulated strategies to respond to the emergency outbreak in its National COVID-19 Multi sectoral Contingency and Response Plan. This includes, among other things, the provision of operational and logistical support, which enables the Government to respond to COVID-19 and protect livelihoods. The United Nations, through its UN agencies, has been supporting a range of aspects of COVID-19 response in Zambia around ten sectors outlined in the COVID-19 Multisectoral Contingency and Response plan. With support from Cooperating Partners, the UN has supported the formulation of the health COVID-19 Preparedness and Response Plan, and

Multisectoral Contingency and Response Planning, resource mobilisation, risk communication, and community engagement, training of technical staff, strengthening surveillance in communities, procurement of personal protective equipment, promoting WASH in health facilities and strengthening infection prevention measures. In all these programmes, efforts have been made to include Persons with Disabilities. For instance, through the DMMU, the Government transcribed COVID-19 brochures into Braille for use by persons who are blind. The government, through the Ministry of Health, also placed messages with sign-language interpretation on TV. Additional support included procurement by the Ministry of Health of specially designed hand hygiene equipment for Person with Disabilities.

Furthermore, through the Ministry of Community Development and Social Services, the Government, with support from cooperating partners, implemented the COVID-19 Emergency Cash Transfer (ECT) in 2020 with the possibility of extension into 2021. The initiative targeted households affected by COVID-19. The initiative aims to protect livelihoods, strengthen pandemic control and avert negative coping strategies. The programme targeted social cash transfer beneficiaries and other food insecure and low-income households. Besides the deliberate ECT initiative, Government has continued to implement its already existing programmes which include the Social Cash Transfer Programme, the Girls Education and Women's Empowerment and Livelihoods (GEWEL) project, Food Security Pack, and the Public Welfare Assistance Scheme.

With support from cooperating partners, the Ministry also supported childcare facilities, places of safety, homes for older persons, and juvenile rehabilitation facilities with food, materials and PPEs as a response to COVID-19.

With technical support from the United Nations, the Government of the Republic of Zambia has been leading efforts in scaling up the Multisectoral COVID-19 Response Plan by putting in place preventive measures to stop the spread of the virus. Through delivering as one, the UN agencies have been supporting various aspects of COVID-19 response in the country around ten sectors outlined in the COVID-19 Multisectoral Contingency and Response Plan. In all the sectors, efforts have been made to include Persons with Disabilities, and the current study was meant to ascertain how many have benefitted so far.

Persons with Disabilities have faced significant disruption in their way of life resulting from measures put in place due to the COVID -19 pandemic. The slowing down of economic activities due to the pandemic has negatively affected the vast majority of Persons with Disabilities who rely on informal and unpaid family support. In addition, information dissemination on COVID-19 to Persons with Disabilities is hardly available in inaccessible formats, making them vulnerable to infection. This status has compounded the exclusion of Persons with Disabilities from accessing health services, education, and other key drivers of their wellbeing.

In response to disruptions caused by the COVID-19 pandemic, a Technical Working Group was created to develop Draft Guidelines that would help in the mainstreaming of disability in COVID-19 response and mitigation measures by the Ministry of Community Development and Social Services. The Draft Guidelines document was developed and currently circulated to other line ministries for comments before the document's launch.

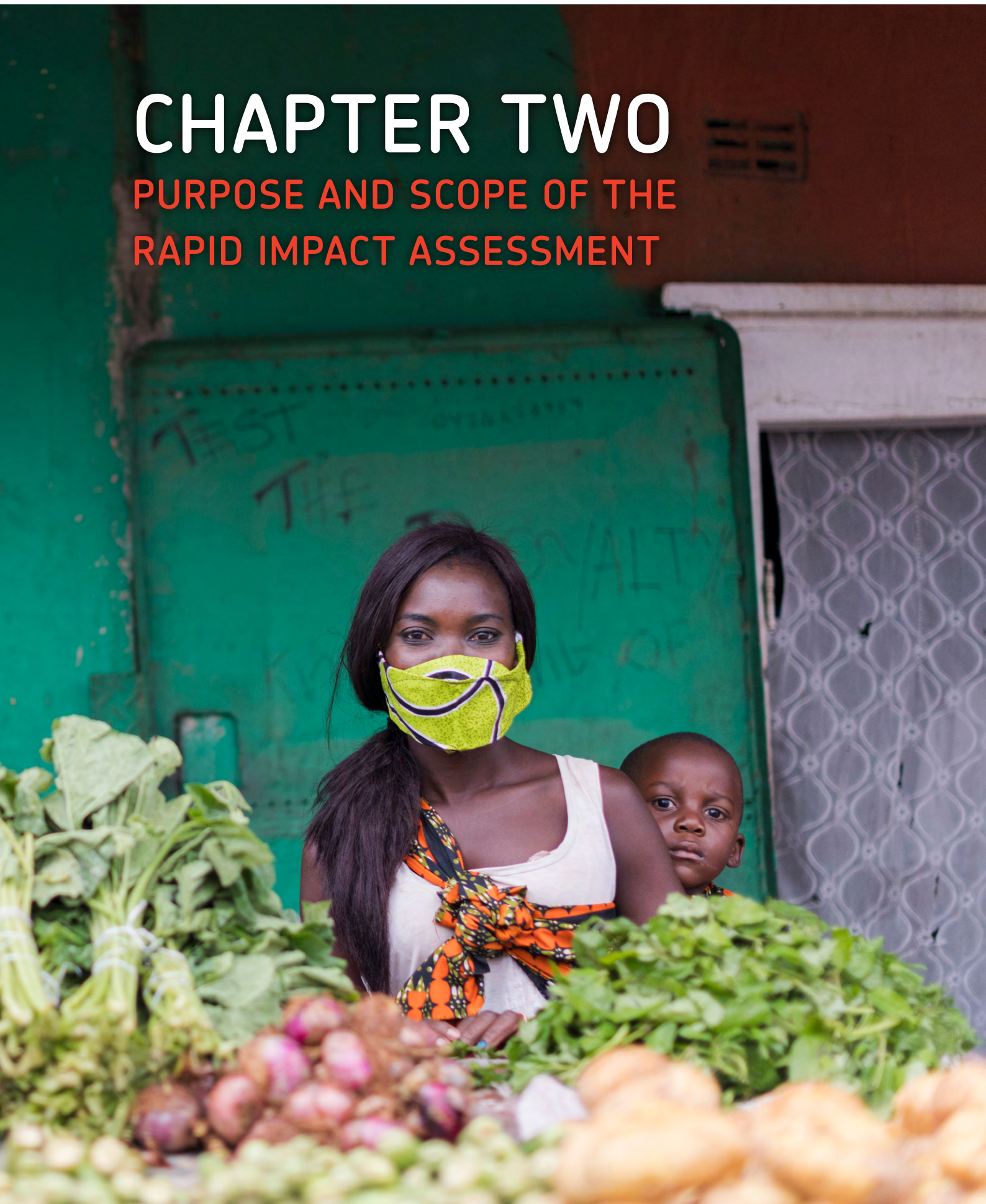
Despite the preventive and mitigation measures, confirmed COVID-19 infections had during the peak period spread to all parts of the country, with Lusaka and the Copperbelt provinces being the hardest hit. A risk analysis survey conducted by the Disaster Mitigation and Management Unit (DMMU) and the Ministry of Health suggests the corona virus can affect 7,616,108 people in 43 districts of the ten provinces of Zambia. The Zambia Health Demographic Survey attributes this to the low general immunity in the population, with prevalence rates for HIV and AIDS and non-communicable diseases (NCDs) standing at 11.1 percent and 23 percent, respectively (Zambia Demographic Health Survey, 2018). According to the World Food Program report on COVID-19 rapid food security vulnerability impact assessment report, much of the impact, whether major or minor, is felt by households with pre-existing vulnerabilities, such as those headed by the elderly or Persons with Disabilities (World Food Programme, 2020).

The United Nations Development Programme in Zambia, in partnership with the Zambia Agency for Persons with Disabilities (ZAPD), and related organisations of Persons with Disabilities, among them the Zambia Federation of Disability Organisations (ZAFOD), Disability Rights Watch (DRW), and The Commuter Magazine (TCM) has developed a COVID-19 response initiative for Persons with Disabilities in Zambia with the main aim of conducting a rapid assessment of the impact of COVID – 19 on Persons with Disabilities. This is being done in collaboration with the United Nations Population Fund (UNFPA) and the International Labour Organisation (ILO). The objective of this

rapid assessment of the impact of COVID – 19 was to contribute to improving coordination and targeted efforts on inclusion of Persons with Disabilities through the national COVID-19 response strategy and design clearly and specific disability targeted and mainstream interventions to address the disability specificities around health, livelihoods, access to income and community participation on COVID-19 for Persons with Disabilities.

# CHAPTER TWO

## PURPOSE AND SCOPE OF THE RAPID IMPACT ASSESSMENT



## 2.1. Study Objective

The rapid assessment's main objective was to understand and identify the health and socio-economic challenges faced by Persons with Disabilities and their families during COVID-19 pandemic and formulate recommendations to the Government and service providers on COVID-19 disability-inclusive response and recovery.

### 2.1.1. Specific Objectives

To carry out quantitative and qualitative data collection and analysis on how COVID-19 has affected the health, social and economic lives of Persons with Disabilities in Zambia. The assessment highlighted the diversity of the situation Persons with Disabilities are confronted with, the challenges, opportunities, needs, and perceptions, to guide the Government and other development partners to develop and implement immediate and medium-term measures.

Specifically, this assessment collected data across the following themes;

1. Impact of COVID-19 among workers with disabilities in the formal sector (public and private)
2. Impact of COVID-19 on the accessibility of the rehabilitation (adults) and habilitation (children) services within the health centre, in terms of provision of physiotherapy, occupational therapy, ophthalmology (eye treatments), psycho-social services (mental health services) and orthotics (neuromuscular and skeletal treatments) and prosthetics (an artificial body part) services.
3. Effects on accessing Sexual Reproductive Health (SRH) and Gender-Based Violence (GBV).

## 2.2. Literature and Policy Review

Approximately 1.3 million people in Zambia live with one form of disability or another. The 2015 Zambia Disability Survey reported that the prevalence of disability was 10.9% among adults (18+ years). It was higher in urban than in rural areas and higher among females than among males. Among children (2–17 years), the prevalence was estimated at 4.4%. Persons with Disabilities are more likely to live in poverty and experience higher violence, neglect, and abuse rates. The pandemic is intensifying these inequalities and producing new threats. Persons with disabilities are disproportionately affected by the health, social and economic impacts of COVID-19, as outlined by the Secretary-General in his policy brief – A Disability-Inclusive Response to COVID-19 (UN, 2020).

Persons with Disabilities are at increased risk in the COVID-19 pandemic due to the need for close contact with support givers, as well as an increased risk of infection and complications due to underlying health conditions and socioeconomic inequalities, including inadequate access to healthcare (World Health Organization, 2018). These risks are made worse by numerous barriers to family crisis preparedness due to extreme changes in living conditions, a lack of access or obstructed access to public health and protection messaging, risks of increased stigma on the basis of disability, inaccessibility of Water, Sanitation, and Hygiene (WASH) infrastructure and potentially disrupted protection and social support mechanisms. The International Disability Alliance, also notes that Persons with Disabilities are at higher risk of contracting COVID-19 due to barriers in accessing prevention and infection control information and hygiene, reliance on physical contact with the environment or support persons, as well as respiratory conditions caused by specific impairments (IDA, 2020). The COVID-19 pandemic poses severe challenges for Zambia's economy and the health and livelihoods of PWDs and disadvantaged girls and women.

The pandemic is thus escalating the inequalities experienced by Zambia's 1.3 million Persons with Disabilities. PWDs are less likely to access education, healthcare, and income opportunities or participate in the community. Inclusion of PWDs in the COVID-19 response and recovery is a vital part of achieving the pledge to Leave No One Behind and a critical test of the global commitments of the Convention on the Rights of Persons with Disabilities (CRPD), the 2030 Agenda for Sustainable Development, the Agenda for Humanity and the United Nations Disability Inclusion Strategy (International Labor Organization, 2020; United Nations, 2019; 2016; 2006). It is also central to the UN's commitment to achieving transformative and lasting change on disability inclusion.

Lack of assistive devices at home means children and young PWDs, particularly those with visual auditory, and intellectual impairments, cannot access inclusive education services and are thus deprived of their right to education during the pandemic (Zambia 2012 Disability Act, 2012) online learning platforms are expensive, given the financial cost of internet data to a population group that experiences high rates of poverty and diverse socio-economic

challenges. Given that children with disabilities receive minimal priority to the allocation of family resources on account of their perceived incapacity and the caregivers' limited knowledge on children's rights, children with disabilities are more likely not to benefit from the e-learning platforms and programs employed by educational institutions in Zambia during the COVID-19 pandemic. This is further compounded by limited access to electricity due to load shedding in some parts of the country.

The situation for women and girls with disabilities, which from time immemorial has been characterized by structural inequalities, is now exacerbated by the multifaceted impact of the pandemic<sup>1</sup> as their marginalization is compounded by both their impairments and the associated negative cultural stereotypes and harmful practices characterising the lives of women in society.<sup>2</sup> Women and girls with and without disabilities are more likely to face an increased risk of GBV, including sexual exploitation and abuse, due to confinement or a shift in roles and responsibilities.<sup>3</sup>

According to a publication of the United Nations Department of Economic and Social Affairs (UNDESA), "women with disabilities are three times more likely to have unmet needs for healthcare; three times more likely to be illiterate; two times less likely to be employed and two times less likely to use the internet."<sup>4</sup> Protection risks for women and girls with disabilities are further increased due to disruption of pre-existing protection mechanisms and essential services such as child and maternal health, sexual and reproductive health care, legal assistance, and counselling services (UNFPA-Zambia, 2017). With this evidence of pre-existing systemic barriers, it is therefore more likely that the impact of the COVID-19 pandemic has exacerbated the barriers to equality and inclusion for women and girls with disabilities.

Emerging research on COVID-19 shows that the corona virus pandemic has increased psychological distress both in the general population and among Persons with Disabilities. Behaviours such as physical distancing and their social and economic impacts, are worsening physical and mental health consequences and livelihoods. Research on the psychological impact of mass trauma (e.g., natural disasters, communicable disease outbreaks) suggests that the pandemic might significantly harm the mental health of marginalized populations such as Persons with Disabilities because they are more likely to have limited access to socio-economic resources and supportive social networks (Goldmann & Galea, 2014).

Some unique stressors and challenges could worsen the livelihoods and mental health of People with Disabilities during the COVID-19 crisis in Zambia. Research on past pandemics shows that Persons with Disabilities find it harder to access educational services, income, and critical medical supplies, becoming even more challenging as resources become scarce (Campbell, Gilyard, Sinclair, Sternberg, & Kailes, 2009). Some Persons with Disabilities report higher levels of social isolation levels compared with their non-disabled counterparts and thus find it hard to participate in community activities (O'Sullivan & Bourgoin, 2010). They may therefore experience intensified feelings of loneliness in response to physical distancing measures. According to the National Academies of Science, Engineering, and Medicine, social isolation and loneliness have been associated with increases in heart disease, dementia, and other health problems. Furthermore, policies around rationing of medical care can intensify discriminatory attitudes towards disabled individuals during times of crisis (Priestley & Hemingway, 2006). This can understandably worsen the anxiety about getting sick and needing to seek medical care.

As the virus continues to spread in Zambia and around the world, data is critical to informing the public health and social-economic response. While adequate research on the specific impact of COVID-19 on the disability community is not yet available, several studies are underway or in the planning phase. Data is needed on social-economic outcomes, family variables including GBV, sexual and reproductive health, rates of infections, hospitalizations, outcomes, and deaths disaggregated by disability, age, gender, and income, among other factors, so that the impact of COVID-19 on Persons with Disabilities can be understood. It's vital to consider the social gradient of risk among Persons with Disabilities as this may influence policies and decision-making related to livelihoods, education, income, and access to care or treatments. Discrimination is always a dangerous reality for many people with disabilities in need of public and private services. Many adults with disabilities and disability rights organizations in Zambia are anxious about how these policies may prevent them from getting equitable and fair treatment.

1 UNDESA, Policy Brief, No. 69, Leaving No One Behind (May, 2020).

2 Zambia Agency for Persons with Disabilities, (2016).

3 Zambia Vulnerability Assessment Committee, (2016).

4 Ibid, 1 above.



## 2.3. Methodology

A mixed-method survey design was utilized to collect both qualitative and quantitative data to satisfy the requirements of the terms of reference. This was preceded by a pilot survey which was conducted in Kanyama, Matero, Kabanana and Mandevu areas of Lusaka District. The quantitative and qualitative data review included a desk review for the secondary data; and for the primary data, informant interviews, focus group discussions and in some instances, some key informant interviews were done virtually where possible, with the interview guide shared via a link or email. The assessment was conducted primarily in-person while strictly adhering to the WHO and government guidelines on COVID-19 prevention measures.

### 2.3.1. Research Approach

The assessment approach emphasised capturing individual experiences of Persons with Disabilities and through their representative organisations and family members. This approach aimed to facilitate the objective gathering, organization, and analysis of information and testimonies, unlock obstacles, encourage participation, and ensure that an inclusive research methodology is achieved. The approach was based on fundamental principles of client ownership of project deliverables and the transparency of the assessment process. The approach was grounded in creating ownership, developing trust, ensuring transparency, building capacity and confidence, collecting as much information as possible, and supporting inclusivity.

### 2.3.2. Study Area

The rapid assessment of COVID-19 on Persons with Disabilities was undertaken in all the ten provinces of Zambia, namely the Copperbelt, Lusaka, Luapula, Central, Southern, Eastern, Northern and Western, North-Western, and Muchinga provinces. All the ten (10) provinces were selected because the COVID-19 had during the peak period spread to all parts of the country.

## 2.4. Sampling Framework

This study utilized a multistage sampling approach which involved selecting the sample size from thirty purposively selected districts to make primary data collection more manageable. This involved at the initial stage, including all the Persons with Disabilities in the participating districts in the study population to ensure minimum appropriate geographical representation in the survey. At the second stage, using the Probability Proportional to Size (PPS) approach, each district's estimated sample size was then proportionally allocated to all thirty districts as indicated in Table 1.

**TABLE 1: Proportion Allocation of Households, Key Informant Interviews and Focus Group Discussions Per District**

SN	Province	Selected Districts	Households	KIIs	Focused Group Discussion
1	Lusaka	Lusaka	150	10	10
		Chirundu	50	5	5
		Luangwa	80	5	5
2	Copperbelt	Ndola	100	5	7
		Mpongwe	50	3	3
		Mufulira	70	3	3
3	Central	Kabwe	80	5	7
		Serenje	40	3	3
		Chibombo	50	3	3
4	Eastern	Chipata	100	5	7
		Chadiza	50	3	5
		Petauke	70	3	5
5	Luapula	Mansa	80	5	7
		Nchelenge	50	5	5
		Chipili	50	3	5
6	Western	Mongu	100	5	7
		Kalabo	50	3	3
		Kaoma	70	3	3
7	Northern	Kasama	80	5	7
		Mpulungu	30	3	5
		Mporokoso	40	3	5
8	Southern	Livingstone	80	5	7
		Kazungula	50	3	4
		Gwembe	70	3	5
9	Muchinga	Nakonde	100	5	7
		Mpika	50	3	3
		Chinsali	70	3	3
10	Northwestern	Solwezi	80	5	7
		Kasempa	30	3	3
		Kalumbila	50	3	3
<b>TOTALS</b>			<b>2020</b>	<b>121</b>	<b>152</b>

The 2,020-sample size estimation for the clusters was made in agreement with the UN and the four collaborating partners targeting a selection of three districts from each of the ten provinces to cover a total representation of 30 districts as presented in the Table 1 above. This was adequate to give reliable estimates. The selection of the districts was made based on the risk areas, provincial capitals, border towns and a combination of both rural, peri-urban and urban areas. In addition, some districts under Copperbelt, Western and Luapula Provinces were selected based on the high prevalence of disability as reported by the 2015 Zambia National Disability Survey.

The sample size for the household interviews was based on the population of Persons with Disabilities in each of the 30 districts, relying heavily on the information provided by the Social Welfare Officers and in some areas, by organisations of Persons with Disabilities through the lead partners. In order to ensure a good representation of the disability categories including those from underrepresented and marginalized groups, respondents were identified through the Community Welfare Assistant Committees under the Social Welfare Department of the Ministry of Community Development and Social Services; and through the ZAPD Provincial and District database. Organisations of and for Persons with Disabilities were also contacted to help in the selection of households, including contact details and addresses for ease of reach.

The assessment was intended to collect both quantitative and qualitative data on the experiences of Persons with Disabilities during the COVID-19 pandemic, including those who are subjected to heightened and multiple vulnerabilities such as women, persons with intellectual disabilities and other accessibility limitations, and on how the government response mainstreams the needs of Persons with Disabilities in Zambia including their level of participation in deciding the priority areas of intervention.

To determine the sample size the following assumptions were made;

**TABLE 2: Sampling Distribution & Parameters**

Total estimated population of Persons with Disabilities in Zambia	1.3 million
Total number of districts that are targeted for the study	30
Total number of households of Persons with Disabilities	2020
Total number of key informant interviews	121
Total number of focus discussions	152
Anticipated non-response distribution (estimated effect size)	50%
Confidence interval width (Margin of error)	5%
Desired level of confidence (90 or 95% recommended)	95%
Estimated design effect (DEFF, recommended 4.0)	4.0

#### 2.4.1. Number of Households Reached

Out of the estimated **2,020** target for household interviews (adults and children), the study reached a total number of **1,825** respondents, representing 89.5% of the target, out of whom 439 represent households where the person with disability was a child or young person below the age of 18. Respondents of the household interviews were all Persons with Disabilities and the key respondents for this assessment. From a statistical point, Lusaka Province recorded the highest number of respondents at 249 (12%) out of the total 1,825 interviewed, covering Kanyama, Mandevu, Matero and Kabanana areas of Lusaka District; Luangwa and Chirundu Districts. However, compared to the data collected within the provinces against the target population, Southern, Western and Eastern Provinces recorded the highest at 100% as presented in the Table 3 below. Out of the 249 respondents under Lusaka Province, 152 was data collected from Lusaka, 40 from Chirundu and 57 from Luangwa. Northern Province recorded the lowest number of respondents at 103 of the target of 150, and 62% against the provincial target.

The Table below gives a summary distribution of the respondents of the household interviews per province for adults and children, against the sample target.

**TABLE 3: Distribution of households per province (Adults & Children Combined)**

Province	Achieved	Target	Percentage against overall target
Central	152 89%	170	7.5
Copperbelt	213 96.8%	220	10.5
Eastern	228 100%	220	11.0
Luapula	112 62%	180	5.5
Lusaka	249 88.9%	280	12.0
Muchinga	168 76%	220	8.0
Northern	103 68.6%	150	5.0
Northwestern	161 100%	160	8.0
Southern	220 100%	200	11.0
Western	219 99.5%	220	11.0
<b>Grand Total</b>	<b>1,825</b>	<b>2,020</b>	<b>89.5</b>

### 2.4.2. Characteristics of Respondents

The Table below presents the distribution of adult respondents in all the ten Provinces for the household interviews. The highest number of respondents was recorded for those falling in the age bracket of 35-44 years, followed by 25-34 years. The number of female adult respondents depicts a higher record at 52.6% of the 1,386 adults, compared to the 47.4% male.<sup>5</sup>

Worth noting is the fact that older persons above the age of 75 were equally targeted and represented in this study. This is important given how older Persons with Disabilities have largely been rendered invisible and their voice rarely represented in the human rights discourse. While the UN Convention on the Rights of Persons with Disabilities does not explicitly cover the rights of older persons except in reference to health access and social protection programmes, the African Disability Protocol on the other hand includes an article on the rights of older persons.<sup>6</sup>

**TABLE 4: Age Distribution for Adults**

	Frequency	Percentage
18-24 years	170	12
25-34 Years	231	17
35-44 years	254	18
45-54 Years	196	14
55-64 Years	226	16
65-74 years	171	12
Above 75 Years	137	10
No Response	1	1
<b>Total</b>	<b>1,386</b>	<b>100</b>

The above Table shows the age distribution for adult respondents as discussed in the text above.

**TABLE 5: Gender – Adults and Children Respondents**

Gender	Frequency (Adults)	Percent %	Frequency (Children)	Percent (Children)	Adults & Children Combined	Cumulative %
Female	729	52.6	247	56.3	976	53
Male	657	47.4	192	43.7	849	47
<b>Total</b>	<b>1386</b>	<b>100</b>	<b>439</b>	<b>100</b>	<b>1,825</b>	<b>100</b>

Table 5 gives a summary of the gender for adults and children. The number of female respondents for both data sets was higher compared to the male respondents, with a cumulative total of 53% and 47% respectively.

**TABLE 6: Disability Category in Adults**

Disability Type	Frequency	Percentage
1. Person with physical disability	695	50
2. Blind person or person with low vision	292	21
3. Person with psychosocial disability (mental health)	120	9.0
4. Deaf person/hard of hearing	77	6.0
5. Multiple Disabilities	42	3.0
6. Person with intellectual disabilities	64	5.0
7. Person with down syndrome	41	3.0
8. Person with albinism	22	2.0
9. Person on the autism spectrum	20	1.0
10. Person with deaf blindness	13	1.0
<b>Total</b>	<b>1,386</b>	<b>100</b>

The above Table gives a summary of the disability categories of adult respondents from the household interviews. Majority of the respondents were persons with physical disabilities, representing 50%, while the least captured were persons with with audio-visual impairments.



Youth with intellectual & hearing impairments participating in a FGD in Eastern Province

The above picture is a category of disabilities which are not obvious and sometimes misdiagnosed. The research team made it a point to find means of ensuring that all disability categories were represented to the greatest extent possible in order to capture their knowledge and experience of the impact of COVID-19 on their daily living.

### Children and Young People

The population of children and young people reached in the study is 439, with a gender representation of 56.3 percent women and 43.7 percent men respectively. The highest target reached was in Eastern Province at 108, 88 in Northwestern, 59 in Muchinga, 50 in Southern, 45 in Western, 39 in Central, and the lowest at 19 in Luapula Province. Lusaka and Northern Provinces did not include children and young people because the interview guide administered under Lusaka Province did not include separate variables for children/young people below the age of 18. Northern Province on the other hand only targeted households with adult respondents. All children below the age of 15 were considered unable to speak for themselves, while for those with intellectual and psychosocial disabilities (both adults and young people) were assessed based on their ability to express themselves without being stripped of their personal autonomy and legal capacity as provided for in Article 12 of the CRPD.

The children were interviewed in the presence of their parents/guardians and teachers and in instances where the child/youth respondent was able to speak for themselves, the questionnaire was administered directly with the consent of an adult.

**TABLE 7: Provincial Distribution of Children/Young People**

Province	Frequency	Percentage
Central	39	8.9
Copperbelt	31	7.1
Eastern	108	24.6
Luapula	19	4.3
North-Western	88	20
Muchinga	59	13.4
Southern	50	11.4
Western	45	10.3
<b>Total</b>	<b>439</b>	<b>100</b>

The age range of the children and young people reached in the study was distributed as presented in Table 8 below with majority of the respondents ranging between the age of 1 -17. Children below the age of 15 were not interviewed directly but represented by their responsible parents/guardians. However, the households representing children under the age of 15 were still counted among the key respondents because they too were impacted by the disruption of services owing to the pandemic. There were no responses recorded from 5 respondents under this category.

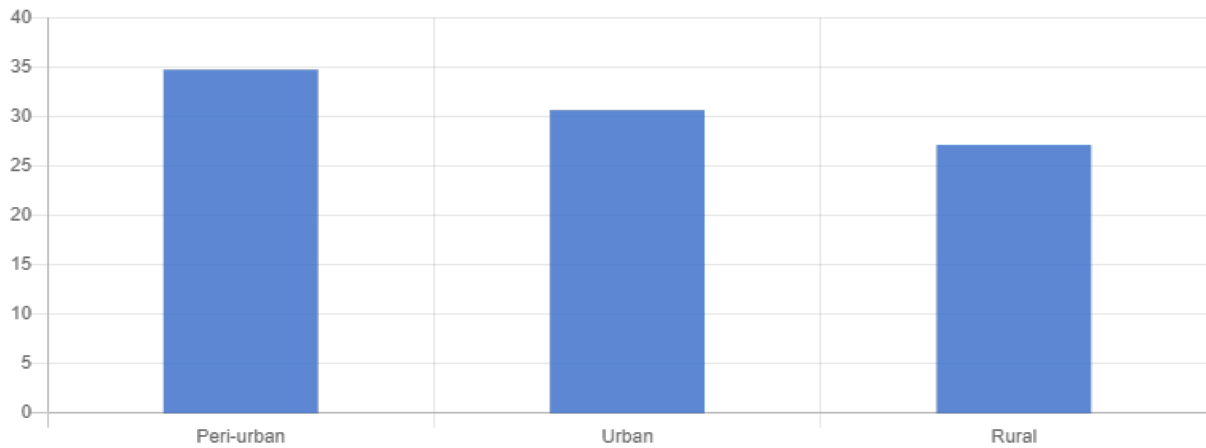
**TABLE 8: Age Range – Children and Young People<sup>7</sup>**

Value	Frequency	Percentage
13 – 17 years	179	41
7 – 12 years	157	36
4 – 6 years	72	16
0 – 3 years	26	6.0
No Response	5	1.0
<b>Total</b>	<b>434</b>	<b>100</b>

## 2.5. Geographical Distribution of Persons with Disabilities

The graph below shows the geographical distribution of the respondents, with peri-urban having the highest reach at 35.35%, while urban and rural areas scored 33.77% and 30.88% respectively. As depicted in the graph, the study was well-representative in terms of geographical coverage. This was purposefully done to enable an unbiased analysis of the urban areas which some were epicenters, peri-urban areas for their dense population, and rural (hard-to-reach) areas where information was less likely to be disseminated in timely and accessible manner.

**GRAPH 1: Geographical Representation of Respondents**



## 2.6. Data Collection, Analysis and Report Writing

### 2.6.1. Data Collection

A total number of 105 out of the 121 targeted **Key informant interviews (KII)**<sup>8</sup> were administered to the following institutions across the 10 Provinces: Organisations of Persons with Disabilities (28), the Human Rights Commission (2), representatives of government Ministries and Agencies (54), Traditional leaders (2), media house (1), Police Service (1), special education schools (3), Cabinet Office (1), District Commissioners (8), DMMU (2), District Health Office (3).

The study also facilitated 66 **Focus Group Discussions (FGDs)**, with an average of 2 groups in each of the target districts. Participants of the focus groups comprised a group of women-only, men only, youth, parents of children with disabilities, and mixed groups of both men and women. The participants of the FGDs were all Persons with Disabilities. The KIIs and FGDs formed the larger part of the narrative.

There was an active participation of young people in the FGDs in all the target districts. Key from the interaction with the young people was the information gap and digital divide that has exposed inequalities in the manner in which COVID-19 has imposed a digitalized economy which is not accessible to most. For instance, a young man with a visual impairment from Kabwe complained of not having accurate information because of not having access to accessible ICT installed with the necessary software that would enable him to be regularly updated on the pandemic.



Focus Group Discussion



Information collected was entered into the Kobo Collect Tool, an electronic system that allows for collection and inputting of real-time data. Quantitative data was exported from Kobo Collect into Excel, then analyzed using SPSS to extract graphs and charts to enable a visual presentation of the data. Qualitative data was analysed by categorising into related thematic areas after transcribing the voice recordings, narratives from the partner organisations, case stories and pictures. Where needed, for the purpose of presenting outstanding narratives, the findings were presented verbatim to provide the reader with a feel of the actual situation on the ground.

## 2.7. Limitations of the Study

Although the study involved a mixed-method design of utilizing both the quantitative and qualitative data collection methods, it was primarily a qualitative one, focusing mainly on capturing the first-hand information and experiences from Persons with Disabilities. The study analysed the barriers and challenges faced from the collective sense of Persons with Disabilities as a holistic group. As such, the recommendations are not presented to address the specific categories of disabilities, but specific reference or mention has been made to some impairments where possible.

## 2.8. Ethical Considerations

Ethical concerns were considered and strictly adhered to in the design and implementation of this assignment. Steps were taken to ensure this is prioritized throughout the process, including after the research was completed.

### 2.8.1. Informed Consent

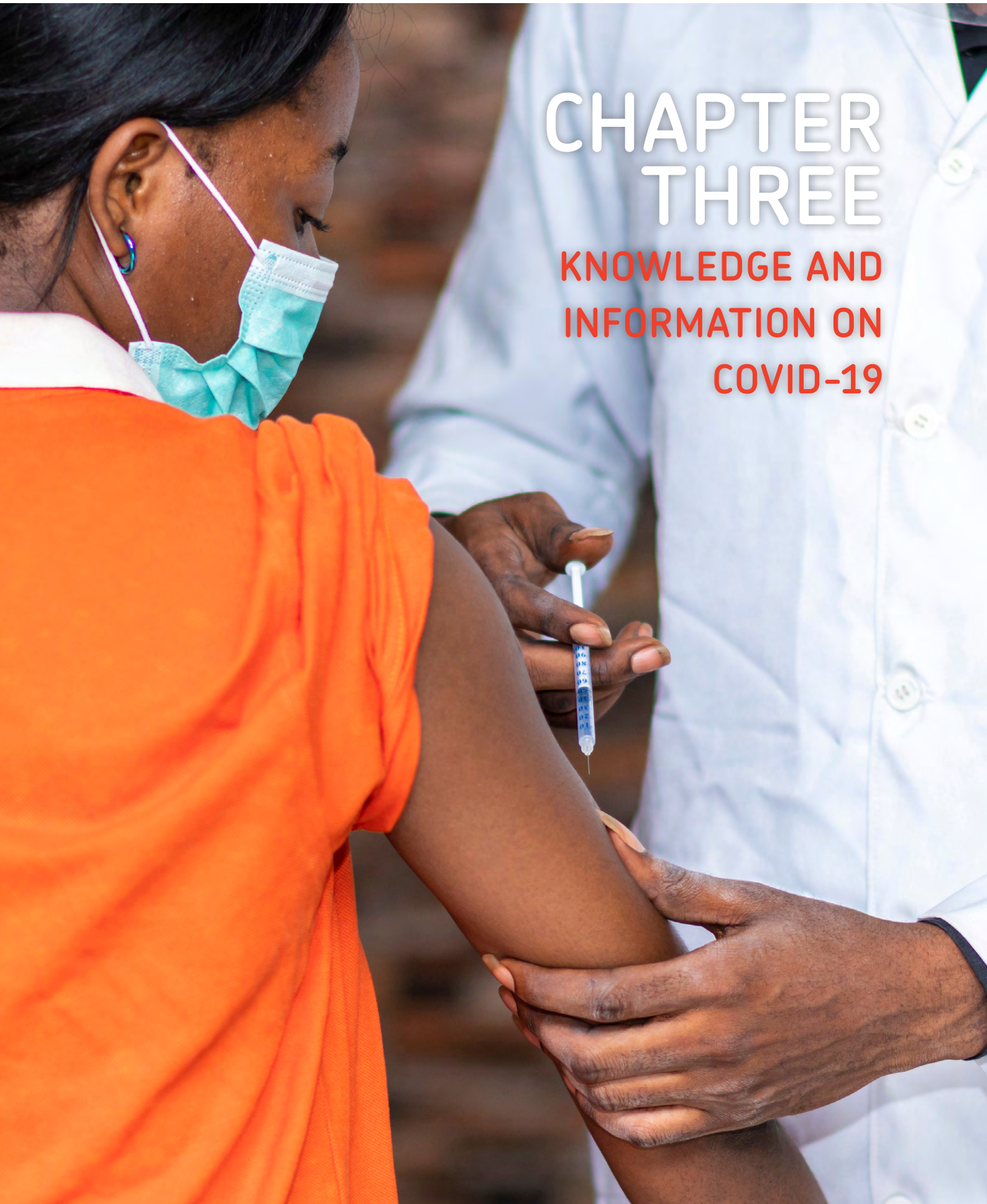
Exceptional interest in safeguarding the integrity and dignity of the respondents was taken. Therefore, the respondents were debriefed on the purpose and intention of the study. All the respondents, including children (through their parents/guardians or teachers) consented to participating in this research and to have their information used for this purpose. No respondent was forced into the study. Evidence of consent was obtained by requiring those that accepted to participate in the study sign the consent form.

### 2.8.2. Confidentiality and Privacy

This included assurance of anonymity of participants in the study to ensure confidentiality, the motivation of respondents to co-operate, arousal of respondents' interest with appealing opening remarks and questions. In all cases, the researchers ensured that the respondents (male, female, youth) fully understand their role in the study. The researchers explained the applicable methodologies for collecting the data and confidentiality to ease their concerns. The researchers also ensured that respondents knew that they could at any point withdraw their consent.

# CHAPTER THREE

## KNOWLEDGE AND INFORMATION ON COVID-19



### 3.1. Knowledge and Information on COVID-19

To assess the level of awareness of the COVID-19 among Persons with Disabilities, the study analysed what information the respondents had in terms of preventive measures, treatment, and myths. In addition, the study analysed the means through which the information was disseminated and its relevance in terms of accessibility and comprehension.

Variations were noted between those in the urban and rural areas. Most respondents in the urban and peri-urban areas demonstrated a good knowledge and awareness of the pandemic and were able to speak confidently about how to protect themselves from it and the measures they needed to take if they or their family member was suspected to have contracted the virus. On the contrary, a few of the respondents from rural areas had little or no knowledge of COVID-19, while some believed that it was a 'foreign' disease that cannot affect them as long as they did not talk about.

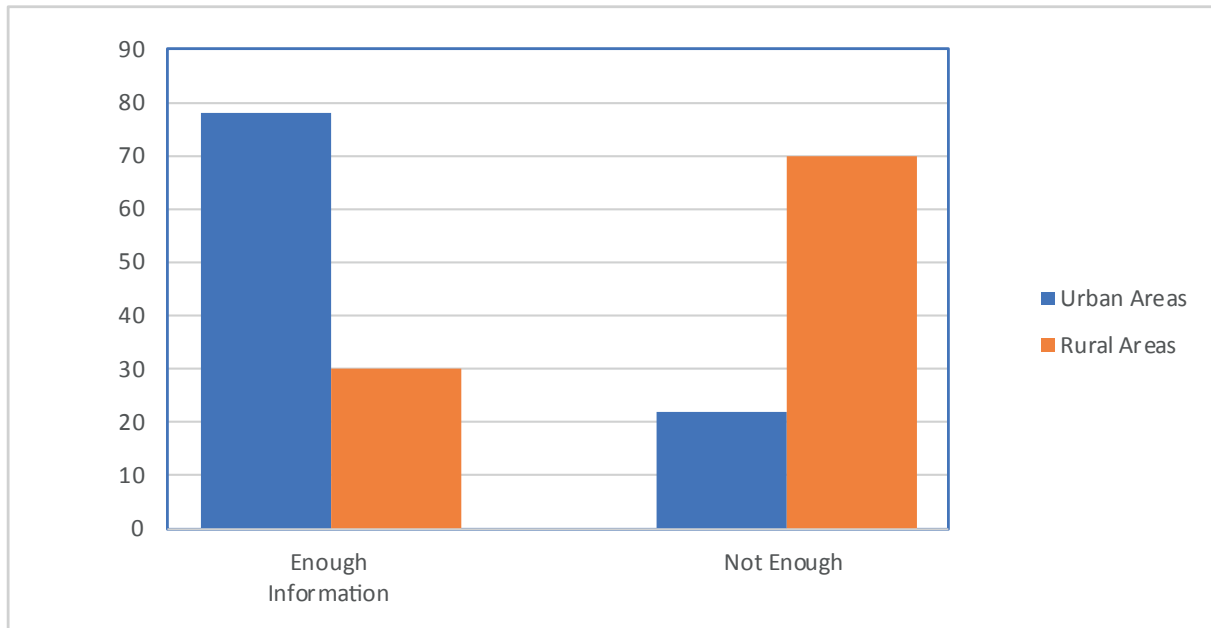
Information on COVID-19 has been mainly disseminated through local radio channels, in church and in a few instances from the health facilities. The information varied for those in the urban areas for whom majority cited radio, television, and social media while for those in rural areas, such traditional means of transmitting information were not available.<sup>9</sup>

While some respondents in urban and peri-urban areas cited having seen some sign-language interpretation of COVID-19 messages on national television, the biggest barrier cited was not having information available in accessible formats such as Braille for persons with visual-impairments, sign-language interpretation for persons with hearing-impairments or easy-read versions for persons with intellectual disabilities. Notably, most of the publications assessed had not been translated into a language that was familiar for 36.9% of respondents have not had any form of education (Refer to Table 18). About 32 percent of the respondents, especially in rural areas said they do not have enough information on COVID-19 as it relates to their disability.

Concern was also expressed over the lack of clarity on the risks of the virus on children. Citing one respondent in Western Province, *"the government is not saying much about the dangers children with disabilities face during this COVID-19 pandemic."*

Evidently, as will be discussed throughout most of the sections of this study, there has been an information gap regarding Persons with Disabilities accessing and interpreting information on COVID-19. There were variations for respondents in the urban areas with 78% citing having had enough information on COVID-19, compared to 34 (22%) who said they did not have enough information; while the rural areas had 30% with enough information and 70% not enough as presented in graph 2.

**GRAPH 2: Information on COVID-19 Prevention Contrasted between rural and urban areas**



**TABLE 9: Number of people tested for COVID-19**

	Where/from whom did you first hear about Coronavirus disease (COVID-19)								Total
	Radio	Television	Internet	Close contacts/ friends	DPO/local NGO	Community leaders	Church	Other	
Central	61 56.5%	2 1.9%	6 5.6%	24 22.2%	0 0.0%	1 0.9%	0 0.0%	14 13.0%	108 100.0%
Copperbelt	93 54.7%	1 0.6%	10 5.9%	36 21.2%	0 0.0%	1 0.6%	4 2.4%	25 14.7%	170 100.0%
Eastern	103 55.7%	0 0.0%	10 5.4%	39 21.1%	0 0.0%	2 1.1%	10 5.4%	21 11.4%	185 100.0%
Luapula	46 66.7%	0 0.0%	5 7.2%	16 23.2%	0 0.0%	0 0.0%	0 0.0%	2 2.9%	69 100.0%
Northern	40 66.7%	2 3.3%	3 5.0%	9 15.0%	0 0.0%	0 0.0%	0 0.0%	6 10.0%	60 100.0%
North-Western	67 56.8%	0 0.0%	8 6.8%	25 21.2%	0 0.0%	0 0.0%	0 0.0%	18 15.3%	118 100.0%
Lusaka	103 52.8%	0 0.0%	7 3.6%	51 26.2%	0 0.0%	0 0.0%	7 3.6%	27 13.8%	195 100.0%
Muchinga	76 59.8%	0 0.0%	8 6.3%	29 22.8%	0 0.0%	0 0.0%	2 1.6%	12 9.4%	127 100.0%
Southern	105 59.0%	0 0.0%	11 6.2%	34 19.1%	0 0.0%	1 0.6%	7 3.9%	20 11.2%	178 100.0%
Western	97 55.1%	4 2.3%	8 4.5%	40 22.7%	2 1.1%	2 1.1%	2 1.1%	21 11.9%	176 100.0%
<b>Total</b>	<b>791</b> <b>57.1%</b>	<b>9</b> <b>0.6%</b>	<b>76</b> <b>5.5%</b>	<b>303</b> <b>21.9%</b>	<b>2</b> <b>0.1%</b>	<b>7</b> <b>0.5%</b>	<b>32</b> <b>2.3%</b>	<b>166</b> <b>12.0%</b>	<b>1386</b> <b>100.0%</b>

Table 9 shows data of the various sources or medium through which PWDs received information on COVID-19. Regardless of the geographical location, radio was cited as the most common medium through which information on COVID-19 was transmitted (57%). This was followed by 21.9% representing close relatives/friends. The category for 'other' represented public announcements and posters.

**TABLE 10: Persons with Disabilities tested for COVID-19**

	Have you ever been tested for corona virus			Total
	Yes	No	No Response	
Central	33 30.6%	75 69.4%	0 0.0%	108 100.0%
Copperbelt	44 25.9%	125 73.5%	1 0.6%	170 100.0%
Eastern	58 31.4%	127 68.6%	0 0.0%	185 100.0%
Luapula	44 63.8%	21 30.4%	4 5.8%	69 100.0%
Northern	16 26.7%	44 73.3%	0 0.0%	60 100.0%
North-Western	65 55.1%	53 44.9%	0 0.0%	118 100.0%
Lusaka	48 24.6%	147 75.4%	0 0.0%	195 100.0%
Muchinga	48 37.8%	79 62.2%	0 0.0%	127 100.0%
Southern	74 41.6%	102 57.3%	2 1.1%	178 100.0%
Western	71 40.3%	97 55.1%	8 4.5%	176 100.0%
<b>Total</b>	<b>501</b> <b>36.1%</b>	<b>870</b> <b>62.8%</b>	<b>15</b> <b>1.1%</b>	<b>1386</b> <b>100.0%</b>

A question was also asked on how many Persons with Disabilities had been tested for COVID-19; and to this 62.8% said they had not been tested, while 36.1% said they had been tested. Most of those that had been tested further clarified that they had been compelled to do so because of the mandatory requirement when one goes to seek other medical services. Out of those that were tested, 118 said they or someone they know with a disability had tested positive for COVID-19. Only one household in Luapula Province that confirmed that the whole family had tested positive for COVID-19. Table 11 below gives a distribution of the number of Persons with Disabilities that tested positive to COVID-19 within 30 days of the study.

**TABLE 11: Persons with Disabilities that contracted COVID-19 in last 30 days**

	Persons with Disabilities that tested positive for COVID-19 in the last 30 days			Total
	Yes	No	No Response	
Central	13 12.0%	95 88.0%	0 0.0%	108 100.0%
Copperbelt	10 5.9%	159 93.5%	1 6.0%	170 100.0%
Eastern	13 7.0%	172 93.0%	0 0.0%	185 100.0%
Luapula	3 4.3%	65 94.2%	1 1.4%	69 100.0%
Northern	17 28.3%	43 71.7%	0 0.0%	60 100.0%
North-Western	10 8.5%	107 90.7%	1 0.8%	118 100.0%
Lusaka	12 6.2%	179 91.8%	4 2.1%	195 100.0%
Muchinga	14 11.0%	113 89.0%	0 0.0%	127 100.0%
Southern	7 3.9%	170 95.5%	1 6.0%	178 100.0%
Western	19 10.8%	149 84.7%	8 4.5%	176 100.0%
<b>Total</b>	<b>118</b> <b>8.5%</b>	<b>1252</b> <b>90.3%</b>	<b>16</b> <b>1.2%</b>	<b>1386</b> <b>100.0%</b>

### National Response Plan

The Multi-sectoral Contingency and Response Plan developed by the Government in March 2020, supported by bilateral partners and the UN Country Team (UNCT) to Zambia aimed to provide a coordinated, multi-sectoral preparedness and response mechanism to COVID-19. In an effort to support the government plan, the UNCT developed the Zambia UN Covid-19 emergency appeal with the aim of integrating the health, humanitarian and socio-economic responses. In all these plans, Persons with Disabilities have been listed among the target beneficiaries to be prioritized for emergence support programs, recognizing their structural exclusion, stigma and inequalities that exacerbate their inclusion and participation on an equal basis with others.

Persons with Disabilities were consulted at the national level during the formulation of the Plan. The participants to the consultation were drawn from the active organisations of persons registered under ZAPD. Nevertheless, the information was not adequately disseminated to the district or grassroots level as evident by the limited information or awareness portrayed by Persons with Disabilities in these areas. As such, out of the 28 OPDs that were interviewed as key informants, 26 reported not having been consulted in the formulation of the plan. Consequently, very limited information is known on its content and how it will benefit Persons with Disabilities in building back better. In response to how best the Response Plan could better benefit Persons with Disabilities, all the organisations interviewed mentioned the need to actively consult and involve Persons with Disabilities at all levels in the formulation of the Plan, its implementation and subsequent monitoring. This is especially important given that not all disability categories have representation at the national level, and for those that do, structures for effective dissemination of information to the grassroots do not exist. This is supported by the UN CRPD which obligates the Governments in its decision-making to closely consult with and actively involve Persons with Disabilities, including children through their representative organisations.

A clearly defined criteria that prioritises Persons with Disabilities in the rural areas would greatly benefit those that expressed real need unlike targeting those in urban areas like Lusaka, Kitwe and Livingstone as was the case with the food support distributed by the WFP. Awareness raising on the availability of the Response Plan should be intensified by disseminating widely including in accessible formats. Key in the effective roll-out of the plans is having statistics on Persons with Disabilities desegregated according to the age, gender, and disability category.

# CHAPTER FOUR

## LIVELIHOOD: EMPLOYMENT STATUS AND INCOME LEVELS





## 4.1. Impact of the Pandemic among Workers with Disabilities in the Public and Private Sector

For the purpose of understanding the employment situation of Persons with Disabilities in relation to the dynamics of livelihood and income stability, it was necessary to analyse the education levels. As presented in Table 12, majority of the respondents (36.7%) stated not having any form of education whatsoever, 33.8% had reached primary level, 22.2% had attained secondary education, 5.4% attained college education, and only 2% had gone up to the university level.

**TABLE 12: Education Level in Adults**

Province * Formal education Cross-tabulation							
	Formal education						Total
	None	Primary	Secondary	College	University	No Re- sponse	
Central	28 25.9%	51 47.2%	27 25.0%	1 9%	1 9%	0 0.0%	108 100.0%
Copperbelt	31 18.2%	89 52.4%	41 24.1%	7 4.1%	2 1.2%	0 0.0%	170 100.0%
Eastern	63 34.1%	59 31.9%	46 24.9%	10 5.4%	7 3.8%	0 0.0%	185 100.0%
Luapula	16 23.2%	17 24.6%	22 31.9%	9 13.0%	3 4.3%	2 2.9%	69 100.0%
Northern	13 21.7%	28 46.7%	13 21.7%	6 10.0%	0 0%	0 0%	60 100.0%
North-Western	66 55.9%	17 14.4%	28 23.7%	7 5.9%	0 0%	0 0%	118 100.0%
Lusaka	113 57.9%	62 31.8%	20 10.3%	0 0.0%	0 0.0%	0 0.0%	195 100.0%
Muchinga	47 37.0%	33 26.0%	37 29.1%	10 7.9%	0 0.0%	0 0.0%	127 100.0%
Southern	77 43.3%	46 25.8%	31 17.4%	14 7.9%	9 5.1%	1 6.0%	178 100.0%
Western	55 31.2%	60 34.1%	43 24.4%	11 6.2%	7 4.0%	0 0.0%	176 100.0%
<b>Total</b>	<b>509</b> <b>36.7%</b>	<b>462</b> <b>33.8%</b>	<b>308</b> <b>22.2%</b>	<b>75</b> <b>5.4%</b>	<b>29</b> <b>2.1%</b>	<b>3</b> <b>2.0%</b>	<b>1386</b> <b>100.0%</b>

**TABLE 13: Current Employment Status**

	What is your current job status					Total
	Employed	Unemployed	Retired	Other. Specify	No Re- sponse	
Central	4 3.7%	72 66.7%	26 24.1%	6 5.6%	0 0.0%	108 100.0%
Copperbelt	8 4.7%	153 90.0%	5 2.9%	3 1.8%	1 0.6%	170 100.0%
Eastern	18 9.7%	142 76.8%	22 11.9%	3 1.6%	0 0.0%	185 100.0%
Luapula	5 7.2%	51 73.9%	3 4.3%	5 7.2%	5 7.2%	69 100.0%
Northern	6 10.0%	50 83.3%	4 6.7%	0 0.0%	0 0.0%	60 100.0%
North-Western	11 9.3%	92 78.0%	13 11.0%	0 0.0%	2 1.7%	118 100.0%
Lusaka	8 4.1%	163 83.6%	19 9.7%	5 2.6%	0 0.0%	195 100.0%
Muchinga	13 10.2%	110 86.6%	2 1.6%	2 1.6%	0 0.0%	127 100.0%
Southern	12 6.7%	133 74.7%	20 11.2%	7 3.9%	6 3.4%	178 100.0%
Western	6 3.4%	150 85.2%	9 5.1%	9 5.1%	2 1.1%	176 100.0%
<b>Total</b>	<b>91</b> <b>6.6%</b>	<b>1116</b> <b>80.5%</b>	<b>123</b> <b>8.9%</b>	<b>40</b> <b>2.9%</b>	<b>16</b> <b>1.2%</b>	<b>1386</b> <b>100.0%</b>

Note: Other includes Marketeers, farmers, owns a kantemba, small-scale trader, self-employed

The assessment depicts a total of 80.5% of the respondents of households interviewed as unemployed at the time of the study, 6.6% were in formal employment, 8.9% were retired, 2.9% for "other", while 1.2% had no response. For those that were not in formal employment, most of them reported to be engaged in vending activities, general work, backyard farming, repairing of shoes, radios and phones, and poultry farming. A small number reported to be dependent on street begging and family support. The significantly low number of Persons with Disabilities that are economically active in the labour force could signify the lack of statistics on Persons with Disabilities that are active in the labour market, or the fact that few Persons with Disabilities are in employment when compared to those without disabilities.



**When the company I was working for saw that the business was tough owing to the restrictions of COVID-19, they decided to lay off workers they thought were less productive. It seemed natural to them that a person with albinism needed to have his job terminated and yet they forgot that I had more need for income due to my condition"**

*A youth with albinism said*

Given the high number of respondents not in employment or let alone engaged in any form of income-generation activities, the continued spread of the pandemic is likely to have even worse socio-economic consequences beyond what has so far been experienced.

**TABLE 14: Type of Employment**

Type of Employment	Frequency	Percentage
In the formal sector (with a contract)	67	3.06
In the informal sector (without a contract)	21	1.34
Own an informal business	9	0.52
Freelancer	8	0.45
Own a formal business	6	0.3
<b>Total</b>	<b>111</b>	<b>5.67</b>

The study further analysed the form of employment for those that stated to have been in formal employment, to which the findings were as stated in Table 14 above. Compared to the 131 respondents that confirmed being in employment (2.9% for other, and 6.6% for employed), 15.3% respondents under the category of 'form of employment' did not provide feedback. For those that own businesses, 0.3 stated to be engaged in formal businesses, while 0.52% stated to in the informal business sector.

For those that confirmed to be in formal employment backed by a contract, majority were employed under the teaching service of the Ministry of Education, with the least being in the transportation field as drivers. The high number of respondents under the teaching service was attributed to the affirmative action by the government through the introduction of a quota system of allocating 10% of the recruitment of teachers to qualifying Persons with Disabilities; a Policy that was introduced in 2018. In contrast, comparing the data collected from the other provinces and that collected from the pilot phase in Lusaka, a sharp contrast is obvious with only one respondent recorded under 'education'. For Lusaka Province, the highest score was 69.6% respondents under the category of 'trading' as shown in Table 15 below. Lusaka recorded more respondents under the category of 'trading' because most of the ones that participated in the study were found to be engaged in small and medium-scale enterprises such as manufacturing of mobility aids for children, wheelchair manufacturing and repair, carpentry and other small businesses within their communities.

**TABLE 15: Form of Employment – Lusaka and Other Provinces**

Value	Other Provinces	Lusaka
Education	28	1
Trading	20	32
Agriculture /forestry /fishery	9	5
Healthcare & Therapy	6	0
Social protection	5	1
Tourism and hospitality (e.g., restaurant /hotel)	3	1
Manufacturing	1	6
Information, Communication Technology (ICT)	3	0
Transportation	2	0

## 4.2. Analysis of Income Levels – Current Average and before the Pandemic

As a consequence of the COVID-19 pandemic, 67% of the respondents have had their income reduced, while only 2% reported that their income level had gone up despite the pandemic. Current average income per month for a family of up to 8 members now stands at less than eight hundred Kwacha (ZMW800.00), with majority of them unable to afford three meals a day. Variations were noted in urban and rural areas. For instance, while respondents in urban and peri-urban areas noted the challenge of having reduced income and limited opportunities for income generation, those in rural areas reported no change at all.

As noted by a respondent in a rural district of Southern Province, “People with Disabilities in this village have no monthly paying jobs, they survive on self-help activities and self-employment”. Similarly, a male respondent in Luapula Province employed in the civil service noted that his income level had not changed because of the nature of his job.

Some Districts like Gwembe which is predominantly an agricultural area reported having reduced opportunities for paid work and reduction in economic activity as their income was dependent on how active the economy is at any given time. Although this is not specific to Persons with Disabilities, the impact cuts across the whole district but more so for Persons with Disabilities who in many instances solely depend on income from piece work and selling of agricultural products. Parents of children with disabilities in Mpongwe District complained of their farm products going to waste because their usual customers from Luanshya were not coming to buy the farm products due to COVID-19 restrictions.

Another respondent from Kabwe, in Central Province cited how the closure of some business entities at the mall had resulted in loss of income for the head of the house whom although was herself not a person with disability. Such ripple effects were common in almost all the districts, particularly those in urban and peri-urban areas.

The findings also revealed that there was reduced livelihood activity especially during the peak of the pandemic as most people were no longer available to work in the community. While previously people could easily call on hired help or other family/friends in the community to join arms in performing tasks, the COVID-19 era brought a disruption to this practice for fear of contracting the virus, and thereby slowing down the rate at which work used to be done. Some respondents whose income was sourced from the sale of food items to school-going children also noted reduced income owing to the pro-longed closure of schools.

Similarly, for those that depend on alms, the flow of income was reduced owing to the restricted movements which meant that few people were out in the streets. Some respondents also noted that well-wishers were using the pandemic as an excuse not to give because money was said to be ‘scarce’ for most. Others said, people would avoid any attempt to get close especially if one did not have a face mask on.

For border towns, variations were equally noted depending on the economic activities undertaken between the neighbouring towns. For instance, while Livingstone, Kazungula, Chirundu, Nakonde and Luangwa had more respondents complaining about the reduced economic activity resulting in shutting down of local businesses owing to the closure of borders, others like Chanida (bordering Mozambique and Chadiza), and the Chipata/Malawi border reported no change at all. Despite the closure of all boarders, people living around the Chanida and Chipata/Malawi boarders continued to cross the borders because these two boarders are permeable.

The data collected from the pilot in Lusaka shows that 95 out of the 152 respondents interviewed had their income reduced, 21 stated no change, 1 stated an increase in their income, while 35 did not give any response. A group of youth from Lusaka’s Kanyama compound similarly expressed concern at the reduced income levels in their households, noting the fact that their guardians had their work days reduced to two or three times a week, their salaries had equally been reduced.

**TABLE 16: Income Levels for the Lusaka District Pilot**

Income	Frequency	Percentage
Reduced Income	95	63
No change	21	14
Increase	1	0.0
No Response	35	23
<b>Total</b>	<b>152</b>	<b>100</b>

**TABLE 17: Income Level before COVID-19**

Income Range	Frequency	Percentage
Less than ZMW 800	914	68.11
Between ZMW 800 and ZMW 2000	157	11.7
Between ZMW 2000 and ZMW 3000	23	1.71
Between ZMW 3000 and ZMW 4000	16	1.19
Between ZMW 4000 and ZMW 5000	14	1.04
Above ZMW 5000	13	0.97
<b>Total</b>	<b>1,137</b>	<b>84.7</b>

**TABLE 18: Current Average Income (Refer to Table IV in the appendix for a cross-tabulation by district)**

Income Range	Frequency	Percentage
Less than ZMW 800	1000	74.52
Between ZMW 800 and ZMW 2000	85	6.33
Between ZMW 2000 and ZMW 3000	17	1.27
Between ZMW 3000 and ZMW 4000	10	0.75
Above ZMW 5000	10	0.75
Between ZMW 4000 and ZMW 5000	8	0.6
<b>Total</b>	<b>1,130</b>	<b>84.2</b>

Tables 17 and 18 present the findings of the changes in income levels to depict the impact of the pandemic on the economic situation of Persons with Disabilities. While the findings show that 68% of the respondents were earning less than ZMW800 per month before the pandemic, the variation for the current income stands at 74.5%, with only a 6.5% variable for those whose income has reduced. The Jesuit Centre for Theological Reflection (JCTR) projected the cost of food items under the Basic Needs and Nutrition Basket (BNNB) for a family of five in Lusaka to be at ZMW 2,496, while the cost of essential non-food items was projected at ZMW 4,517.75 for the month of March 2020. Given the additional costs of having a disability such as double cost of transportation when travelling with a personal assistant, the cost buying and maintaining assistive devices, the cost habitation and rehabilitation services, among others, the findings translate into 74% of Persons with Disabilities not having enough income to afford the BNNB. The findings further reveal that most Persons with Disabilities are earning below the set threshold of revised minimum wage for 2021 of ZMW 1,050.

The situation is therefore likely to worsen with the economic hardships exacerbated by the global pandemic translating into reduced income especially for households that were already living below a standard income threshold. As was projected in the hypothesis, the income level for most households of Persons with Disabilities with an average of 8 people per household has gone down, with 6 of the 14 respondents that were earning between ZMW 4,000 and ZMW 5,000 now earning less as a result of the pandemic. Consequently, the implication of the reduced income is more likely to affect the ability to meet basic needs, including healthcare services. More than 80% of the respondents including those whose income had remained the same said they are now having challenges in stocking enough food for their families because of the high price of food.

Evidence from past studies on the living conditions of Persons with Disabilities shows a relationship between disability and poverty. Persons with Disabilities are more at risk of living in poverty, and there is a likelihood of poverty increasing the chances of acquiring a disability. The loss of income associated with the irregular and limited economic activity is therefore more likely to increase the economic vulnerability of Persons with Disabilities, particularly for small-scale traders given the restricted mobility and closure of borders to ensure a continuous supply of their merchandise.

### 4.3. Educational Access

For children, the study sought to assess the impact of the pandemic on educational access. The countrywide closure of schools has had a huge impact on the progression rate of Persons with Disabilities as reported by some respondents. Whereas, increasing the participation of some learners with disabilities requires practical activities in group set-ups, the restrictions of maintaining social distance mean that some of these activities have had to be suspended. A member of staff at the District Education Board Secretary (DEBS), had this to say about this,

**“The DEBS office has been vocal in promoting Covid adherence in school. The office has continued to monitor adherence by schools. School with learners with disabilities have been guided to consider making facilities user friendly for all. The office is also lobbying for PPEs from government and other stakeholders. These PPEs are distributed in schools with priority to vulnerable children”**

A respondent from a special school noted how the school has taken a deliberate step to distribute at least two reusable masks to every child and placed hand washing water points at every key point in the school surrounding. He further noted that sensitization on social distancing, overcrowding and unnecessary movements is a daily reminder as some children with disabilities need constant reminders.

**“Transparent masks are not readily available thus affecting learners who depend on lip reading. Deaf learners are not participating in radio programs the government has come up with. TV is not available in most households where learners with disabilities come from so many are missing out academically to educational programs on TV. Sanitation is a challenge as surfaces are not clean in toilets, the blind and wheel chair users touch unclean facilities when answering the call of nature.”**

**“These children who are totally blind have found the face mask as a mobility barrier. They depend on face wind direction, smell and known voice projections for orientation and mobility. They have found it difficult to use face masks because they get disoriented in terms of movement and interaction with the environment through smell and sunlight direction on their faces.”**

*Head Teacher, Sefula School for the Blind*



Home of Happiness for Children with disabilities

to catch up with the school syllabus as all learners were required to move at the same pace in terms of the school calendar. He noted how due to the prolonged closure of schools countrywide and subsequent reopening, there was no consideration for accommodating learners with intellectual disabilities. While their school had extended the calendar to allow such learners an extra week of learning at no cost so that they could catch up, other schools did not make such concessions thereby greatly disadvantaging some children with disabilities who need such affirmative actions.

Although not directly related to Persons with Disabilities only, a focus group discussion in the community of Samfya District revealed that early marriages and teenage pregnancies in the communities have increased due to the prolonged closure of schools. A case of early marriage was recorded in Mongu District at Sefula Basic for learners who blind as a direct result of the prolonged closure of schools. A youth with disability from Nchelenge District in Luapula Province noted that due to the rural set-up of their school, they had continued learning in small groups because they had no alternatives of using e-learning platforms. Of the 1,386 parents/guardians that participated in the study, only 15% (206) stated that their children had access to e-learning platforms.

Table 19 below shows the type and level of school attended by the children that participated in the study. The highest percentage (47.84%), represent children of school-going age but currently not in school. Some of the reasons given for the children for not being in school include the long distance to the schools, fear of being bullied by other children because of being regarded as different, difficulties in mobility because of not having assistive devices, inaccessible school infrastructure and environments around the school premises and enroute, such as sandy terrains, inaccessible toilets and classrooms, and negative attitudes of some teachers (interpreted as not able to provide individualized support where needed to accommodate the diverse learning needs of children with disabilities). Those that reported to be attending primary school were in three categories, and these represent children that were integrated in primary schools under a 'special unit' of a mainstream regular school, those that were in an all 'special school', and those that were included within the regular mainstream schools. When analysing the data, the children that were in special units and special schools at primary level were categorized under one group and these represent 21.18% of the respondents, while 12.76% were children with disabilities enrolled in regular classes.

Another category of children representing 3.87% were reported to be home-schooled, mainly because they were not able to attend regular school. Home-schooling was reported in urban and peri-urban schools and none in rural areas. This was because of the presence of NGOs working in partnership with Community Assistant Workers to ensure that such children were reached within their homes by teachers. The 2.5% (11) that responded to never being enrolled in school were mainly from the rural-based schools and the reasons varied from the long distance to the nearby schools, inaccessible infrastructure, and a lack of interest on the part of the parents to have their children enrolled in school.

**TABLE 19: Education Status of Children Represented (Refer to Table III in the appendices for a breakdown of the distribution at district level)**

Education Access	Frequency	Percentage
Not in school	210 <sup>10</sup>	48
Primary – special school	93	21
Primary – regular or mainstream school	56	13
Early Childhood Education and Care	22	5.0
Home school	17	4.0
Secondary – regular or mainstream school	15	3.0
Secondary – special school	15	3.0
Other (Never been enrolled)	11	3.0
<b>Total</b>	<b>439</b>	<b>100</b>



# CHAPTER FIVE

## ACCESSIBILITY OF SERVICES AND ACCESS TO SUPPORT PROGRAMS



## 5.1. Impact on the accessibility of Habitation and Rehabilitation

Access and accessibility of services is key to the inclusion of, and a determinant of the mainstreaming of disability in various programming and services to enable the participation of Persons with Disabilities on an equal basis with others. Given the historical and systemic barriers associated with access, and some pre-existing health conditions that would require access to public health services, this study addressed the question of gaps in accessing services during the period of the pandemic, and whether the services related to their specific impairments have continued in spite of the shifted focus to the pandemic.

In terms accessing health services, 348 adults reported to have conditions that require periodic medical review, compared to the 1,011 that do not require it, 27 did not give any response. The study results further show that 993 respondents reported that nothing had changed in their access to the required medical reviews and have not experienced any notable challenges, while about 325 reported having experienced challenges, most of whom cited the shortage of drugs.

Data analysed from the FDGs show that some respondents access to health services has been heavily impacted by COVID-19 pandemic. This was clarified not only in the disruption of the actual services, but rather the requirement to have one tested and/or screened for COVID-19 before receiving the treatment.

A group of women with disabilities from Lusaka Province indicated not having experienced any challenges in accessing health services as they were always given priority even during the pre-covid days and that had not changed. One of the women interviewed noted that in addition to her being a woman with a disability, she also had a child with a disability that requires periodic medical reviews and physiotherapy. She admitted that while there wasn't much change in accessing health services, she was constantly given prescriptions to buy her own medication which she cannot afford to buy because of the reduced income as she now has limited opportunities to engage in income-generating activities.

Another respondent cited the biggest challenge being the long travel distances to the health centres seeing that the two nurses that would follow them to their community to carry out under-five clinic for children and in the process administer family-planning jabs/medication to the women are no longer able to do so and instead require



Group of Persons with Disabilities



**There is too much focus on COVID-19 restrictions at the health centres and people are now resorting to traditional medicines for treatment of minor illnesses such as colds and flu's."**

**"I was told to be administering physiotherapy at home' and one mother notes 'we were not allowed to take children for under-five clinic in our area"**

*(A parent in Southern Province)*

that women access the services from the health centres. In view of this, the women with disabilities failed to go to health centres as a result of the nurses not conducting the outreach. The pandemic, limited the ease of access to family planning services.

The concerns raised were genuine especially for parents who rely on health practitioners to administer proper habilitation services to their children. The health workers were said to be doing everything to ensure the continuation of services as needed.

The study also revealed a heightened level of myths and misconceptions surrounding the spread of the virus. For instance, a District Health Worker noted the reduced number of people in their community that were accessing their service as compared to the period before the pandemic. She notes



**The reduced income means rehabilitation will not be a priority for households of Persons with Disabilities. Service providers such as physiotherapists are avoiding contact so may not provide service and stigma has increased"**

**"At the moment there is no segregation as everyone, including Persons with Disabilities are required to be tested for covid -19. Those positive are put in isolation then discharged upon certified"**

*(Extract from a KII)*

On the contrary, some respondents noted that they avoided going to access healthcare services for fear of being turned away if they did not have a face mask, while others noted the challenge of not having support persons to assist with mobility. Others further noted that the health workers were sensitized on the need to ensure that Persons



**People are scared to take their disabled loved ones to health centers. The community believes health workers are the ones with COVID-19 and spreading it so they are avoiding them. Not only children but even adults shun our Services after hearing we had COVID-19"**

with Disabilities were given priority and were therefore not required to wait in line.



**The constant exposure to chemicals in hand sanitisers for us persons with albinism makes us develop sores easily because of the nature of our skin type"**

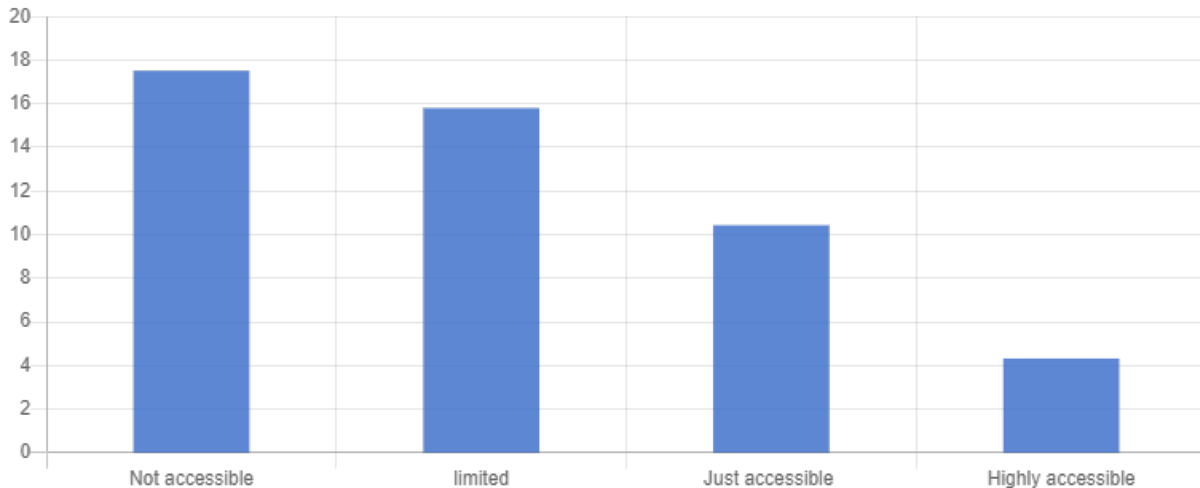


Pictured here is a child that has had challenges in accessing rehabilitation services due to reduced income by his father

**TABLE 20: Government Support in Accessing Healthcare Services**

Type of Support	Frequency	Percentage
I did not receive any support	787	58.64
I was given face masks and sanitizers	268	19.97
I received financial support	254	18.93
I received food support	154	11.48
I received Free COVID-19 Testing and health education	19	1.42
<b>Total</b>	<b>1,482</b>	

The above Table shows responses to the question on whether and what type of support Persons with Disabilities had received in accessing healthcare services.

**GRAPH 3: Accessibility of Physiotherapy Services**

The graph shows the level of limitation for adult respondents in accessing physiotherapy services; of whom 17.5% said the service was not accessible due to environmental, communication and attitudinal barriers. The other 15% said they had limited accessibility with the support of family members who stepped in to assist where possible. The 10% for just accessible, and 4% for highly accessible said they had not experienced any challenges in accessing physiotherapy services despite the restrictions of the pandemic.

For Lusaka Province, all respondents confirmed the suspension of physiotherapy services from the time the pandemic was confirmed to have reached Zambia. A focus group discussion with a team that works at the Appropriate Paper Technology (APTERS), in Lusaka, a company run by Persons with Disabilities specialized in making adjustable mobility aids for children with disabilities complained of their sales having gone down owing to the reduced referrals from the physiotherapy centres. Their work is closely linked with physiotherapy services and as long as that remains suspended, their business is equally affected.

The same question and reasoning were applied to the accessibility of audiology, speech and occupational services, the results of which showed the same trend as presented in graph No. 3.

## 5.2. Government and Stakeholders' Support in managing the Effects of COVID-19

From the onset of the pandemic in Asia, before it had spread to the rest of the world, it was feared and projected that the pandemic would have devastating effects on the economies of third world countries like Zambia.

As noted in the preceding sections, the government of Zambia in partnership with the United Nations under the UN Framework for the Socio-economic Response to COVID-19 in Zambia, issued a Multi-sectoral Contingency and Response Plan in March 2020 with the aim of providing a coordinated, multi-sectoral, preparedness and response mechanism. To assess whether and how many Persons with Disabilities have benefited from this response plan, the current study analysed the number of beneficiaries targeted for the food security packs, health and non-food relief items.

To start with, a general question was asked to ascertain whether the respondents had received any form of support from the government or any cooperating partners, including the UN. Feedback from this question is summarised in the Table below.

**TABLE 21: COVID-19 Specific Support Received**

Type of Support	Frequency	Percentage
I did not receive any support	1,056	58
I was given face masks and sanitizers	299	16.3
I received financial support	276	15
I received food support	163	8.9
I received hand washing basins and soap	25	1.3
No Response	6	0.5
<b>Total</b>	<b>1,825</b>	<b>100</b>

As presented in Table 16, 58% of the respondents have not received any COVID-19 specific support either from the government or other cooperating partners. The 16.3% that said they had received face masks and hand sanitisers were mainly from the urban and per-urban areas, while 1.3% that said to have received handwashing basins and soap were mainly from the rural areas. The 15% that received financial support were from urban areas that were targeted for the emergence cash transfer distributed by the government through the Ministry of Community Development and Social Services with the technical support of the United Nations and other international cooperating partners to specifically target beneficiaries in Kabwe, Kitwe, Livingstone and Chipata among others.

The study revealed that different forms of supports have been distributed by various stakeholders including the government through the DMMU. It should be noted nonetheless that some form of support was not directly linked to the mitigation of the impact of the pandemic, particularly that which relates to the welfare packages such as the farmer input support program and the social cash transfer scheme.

The distributions specifically targeted households that fitted the category of “vulnerable” as defined by the Social Welfare department. These were not specific to disability but included child-headed households and those with elderly guardians among other criteria.

The study showed some variations, but this was to be expected, given that the cash transfer program is yet to be rolled out countrywide. For instance, while some respondents admitted having received some mobile phones which were distributed to beneficiaries of COVID relief funds as the mode through which the funds would be distributed, others noted that it was not everyone that had been issued with the mobile phones that had received the money. Important to note is also the restricted target districts for the food security pack distributed by the World Food Programme, covering only six districts of Lusaka, Chilanga, Kafue, Livingstone, Kitwe and Kalulushi.

- A respondent from Central Province specifically admitted having received a mobile phone with the assurance that they would receive a notification of some money having been issued to relieve them of the economic hardships arising from the pandemic, but no such funds had been paid to her two months down the line although she was aware of some people in other areas who had since benefited from the program.
- Another respondent confirmed that their district had received emergency cash transfer from UNICEF to cushion the impact of the pandemic, but Persons with Disabilities despite being on the list of legible beneficiaries did not benefit as funds were paid to those on the regular scheme. Another respondent attributed the lack of access to the COVID-19 relief to information not being widely disseminated to include those in the rural areas.

*“We only hear the government is making donation, such as Covid relief emergency social cash transfers but we have not received anything. There is need to bring such things to us too.”*

Some government departments at the district level reported that they had lobbied for funds, and non-monetary items from the DMMU of which the response had been positive. These items were distributed to households that were considered as most affected by the economic impact of the pandemic including households of Persons with Disabilities.

### 5.3. Access to Non-Income Support

Table 22 below provides a summary of the type of support provided by the government and other stakeholders as COVID-relief support during the period under review. The total number of respondents (both adults and children) to the question was 1,819 out of 1,825 households, 58% of the respondents stated that they had not received any support, 16% received face masks and hand sanitisers, 15% received food support, 1% received other forms of support and 1% did not give feedback.

The Table further gives a summary of responses to the question on how many Persons with Disabilities were participating in government support programs, without being specific to COVID-relief. This question was intended to get an understanding of whether there was a disruption in the other support programs that Persons with Disabilities have been benefiting from as part among the various government welfare/relief packages targeting households that fit under a prescribed category of vulnerability as a consequence of the pandemic.

**TABLE 22: Access to Non-Income Support**

Whether or Not Accessed Income Support	Frequency	Percentage
Yes	220	16
No	1,142	82
No Response	24	2
<b>Total</b>	<b>1,386</b>	<b>100</b>

As presented in Table 23 and discussed in the above narrative, majority of the respondents (54%) reported not having ever received any form of support either before or during the period of the pandemic. On the other hand, 32% confirmed being beneficiaries of the social cash transfer (SCT) even prior to the pandemic. A common complaint among those that were on the SCT program was the delay in the disbursement of the fund which they said was not consistent as per prescribed schedule. Other support programmes cited were the farmer input support programme at 7%, food basket support at 4%, and other food items such as maize and maize meal distributed through the Disaster Management and Mitigation Unit at 2%.

**TABLE 23: No. of households participating in government support programs**

Type of Support	Frequency	Percentage
None	985	54
Social cash transfer	586	32
Farmer input support programme	119	7
Food basket support	78	4
Other (Maize & Maize meal from DMMU)	39	2
No Response	18	1
<b>Total</b>	<b>1,825</b>	<b>100</b>

## 5.4. Loss of Support Services and Community Supports, and Restrictions on Movements and Gatherings

47% of Persons with Disabilities interviewed reported to have faced more challenges associated with not only their general well-being but equally with their mobility and social life as they were no longer able to meet in the groups/clubs and associations for Persons with Disabilities. Most of the respondents admitted that the social distance restriction was not practical for most Persons with Disabilities because of the support needs that are in many instances provided by support persons. This is especially the case for persons who have visual, hearing, audio-visual, and other physical disabilities.

- In terms of Community participation, some respondents in Chadiza District noted how their social life has been affected significantly due to the restrictions on gathering. Cultural and traditional events that used to bring people together have been suspended.
- The children with disabilities have also been affected because before the pandemic the parents of children with disabilities were sensitized not to lock up their children indoors and had started letting their children interact with other children in the community and go to school. Consequently, some parents have resorted to their old ways of confining their children indoors.

Traditional ceremonies have been a key opportunity for people to earn money, either through selling of their merchandise or engaging in temporary jobs. However, with the cancellation of gatherings including traditional ceremonies, this has reduced opportunities for Persons with Disabilities to earn money and find temporary jobs.

The findings further showed that the requirement to maintain social distance was construed in the context of couples no-longer sharing the same bed and thus denying their partners of conjugal rights. This has resulted in a lot of conflicts and misunderstandings amongst some couples interviewed some of whom complained that they had since separated from their spouses on those grounds. Such misinterpretations are an indication of the need to disseminate information in a manner that could easily be understood by the masses.

Relationships are getting weaker as visitations among relatives have reduced. One parent from Western Province notes *“some family members think our children with disabilities have the disease, so the bond between our disabled children and their able cousins for example will be damaged greatly”*.

A male respondent from Luangwa cited the restriction on gatherings to be particularly problematic to follow through because it was not possible to avoid funerals or other family events. Yet, they also tend to live with the fear that the family member that goes out would expose the others to the risk of infection.

With the restrictions on social interactions, communities and schools are less able to protect girls with disabilities who are at increased risk of sexual violence. One respondent of a DPO noted with concern the fact that many girls with disabilities were dependent on peer networks, schools and other community structures to access health services. COVID-19 has made this very difficult for these girls who are wholly dependent on others when accessing medical appointments and collecting prescriptions. The closure of key services, such as schools, had also meant many girls with disabilities who rely on therapy sessions for mobility or growth in early childhood experienced setbacks in their developmental milestones. For persons who have hearing impairments and rely on sign-language interpreters, the restriction on movements and social distancing is likely to cause social isolation.



**TABLE 24: Has the physical/social distancing affected your communication with others**

Effect of Social Distancing on Communication	Frequency	Percentage
Yes, very much	630	45
Yes, to some extent	668	48
No	80	6
No Response	8	1
Total	1,386	100

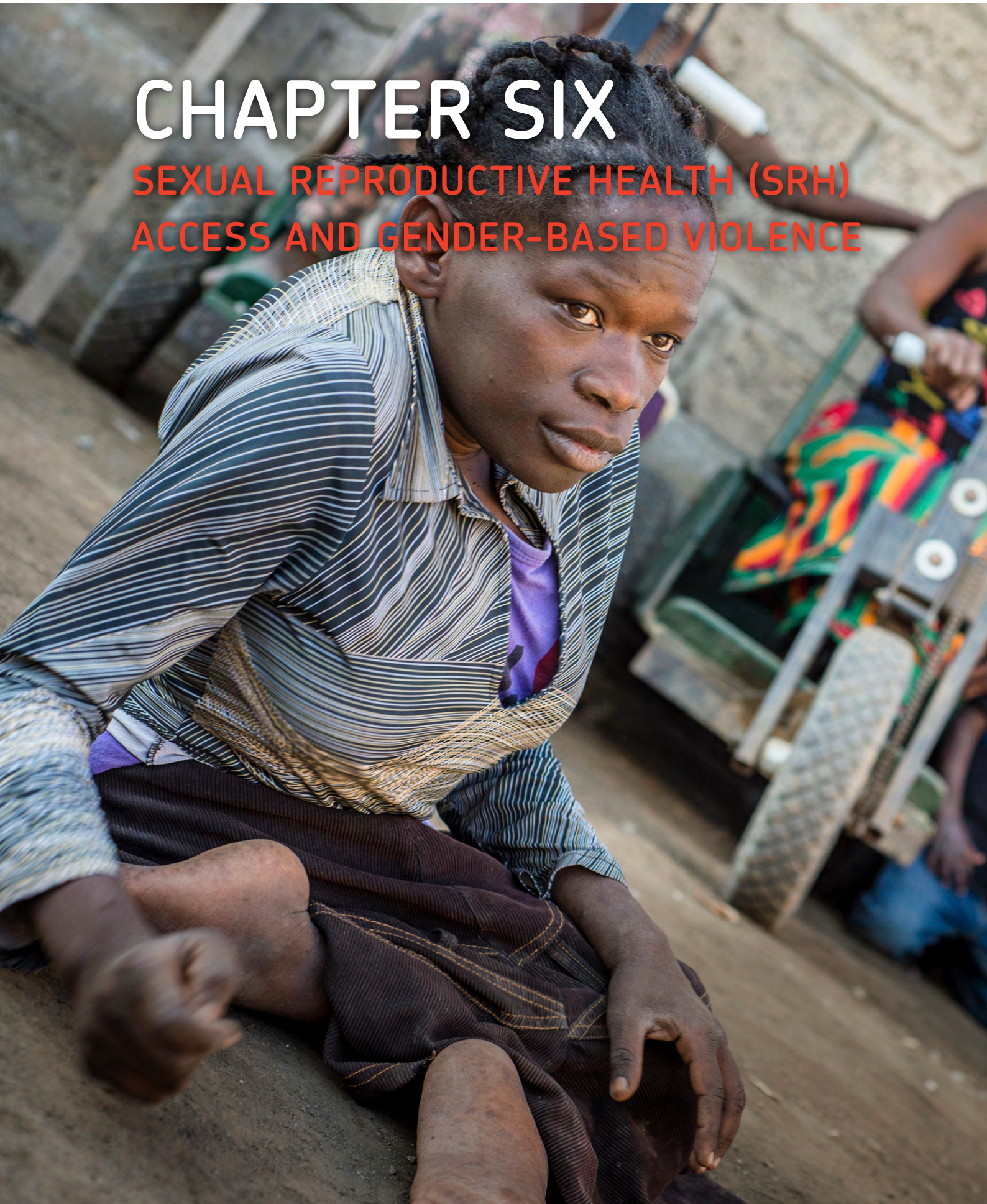
Table 24 presents a summary of number of respondents that reported having experienced challenges in their communication with others as a consequence of the need to maintain social distance. As discussed in the narrative above, the challenges related to the need to maintain social distance for Persons with Disabilities extends beyond communication as for most require support to live independently and participate in the community by enabling 'access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community'.<sup>11</sup>



Disabled Shop Owner

# CHAPTER SIX

## SEXUAL REPRODUCTIVE HEALTH (SRH) ACCESS AND GENDER-BASED VIOLENCE



## 6.1. Gender-Based Violence

According to a report of the Victim Support Unit of the Zambia Police Service, Zambia recorded 5,040 cases of Gender-Based Violence (GBV) countrywide in the first quarter of 2020, with 42.9% of those cases being physical violence.<sup>12</sup> However, without the data being desegregated according to gender and disability, there are generally no accurate records of the number of women and girls with disabilities. Evidently, some studies conducted during the period of the pandemic show that women and girls with disabilities compared to other women were three times more likely to experience sexual violence.<sup>13</sup> A qualitative survey conducted by Women Enabled International shows that the pandemic has worsened the pre-existing inequalities for marginalized communities, particularly for women and girls with disabilities.<sup>14</sup> For instance, the restrictions on movements in an effort to prevent the spread of the virus have to a large extent heightened the risk to sexual and gender-based violence for women and girls with disabilities whom because of various realities such as being confined to households with limited access to support services, and the reduced income levels (discussed in an earlier section).

Similarly, this study shows that the pandemic has contributed to incidences of domestic violence for women and girls with disabilities in Zambia as presented in the narratives below.

A respondent from the Victim Support Unit of the Zambia Police in Mongu District of Western Province admitted to having an increase in the number of cases involving gender-based violence during the period of the pandemic, but the statistics were not disaggregated by disability, hence hard to tell how many of the cases represented Persons with Disabilities. The case record does not have a specification to record disability.

The study results further show that the economic hardships are likely to increase the tension in some homes, and thereby spike or escalate cases of physical violence. One of the interviewees indicated that there have been constant quarrels with her husband as he is now mainly at home and she notes;

Most of the respondents of the focus groups noted that girls with disabilities were negatively affected by the closure of schools, and thereby exposing them to heightened risk of gender-based violence and sexual abuse due to their proximity to the community male folk who take advantage of their vulnerability.



**The loss of piece works brought frustration in my husband. so sometimes from nowhere he would start calling me names to an extent of wanting to beat me. I remember one day he went out when he came back, he found that there was no food at home. He started shouting at me for not preparing food as there was nothing to prepare. When I answered back, he hit me"**

*(Narrated a respondent from Petauke)*

The question on how many people had experienced domestic violence during the period of the pandemic was asked to both men and women during the household interviews, and also discussed in groups during the FDGs. Quantitatively, those that confirmed having experienced verbal abuse were 511 (36.9%) of the total respondents, as compared to 74 that stated having suffered sexual abuse. Of the 74 that reported having experienced sexual abuse, 57 were adult women, while 17 represent young girls.

In terms of seeking support for victims of sexual violence, only 2 confirmed to have sought services of the Legal Aid, another 2 sought shelter away from the perpetrator, while 23 reported the matter to the Police. Some of the reasons given for not taking action were;

**It is difficult to go and report at the police station because I am unable to walk”**

**“My complaints are not taken anywhere even when they know the culprit”**

**“I feel inferior to report my problem to anyone”**

**TABLE 25: Nature of Domestic Violence Suffered (refer to Table VII in the appendix for a detailed tabulation by district)**

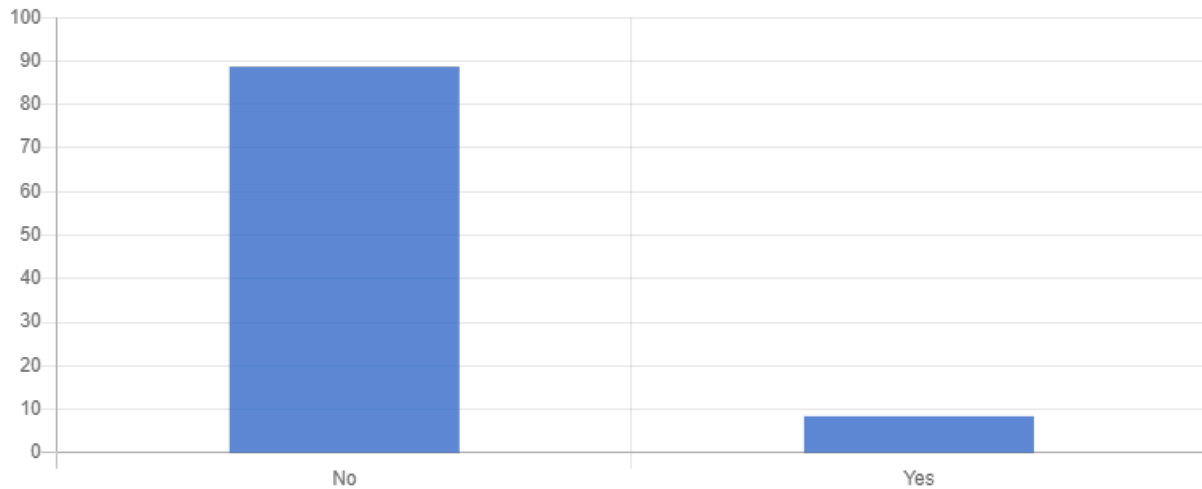
Type of Abuse Experienced	Frequency	Percentage
Verbal abuse	511	37
Physical abuse	112	8
Sexual abuse	74	5
Emotional abuse	208	15
No Response	481	35
<b>Total</b>	<b>1,386</b>	<b>100</b>

The results further show a spike in the cases of domestic violence, ranging from physical violence resulting from the heightened tension of reduced income to sustain the households in instances where the person with disability is the head of the house and main provider but no longer in a position to provide the basic needs consistently. Similarly, cases of physical and emotional abuse among spouses were found to have increased for various reasons, of which the reduced income for the household was again the major attributing factor. Interestingly, the study also reveals a huge information gap in interpretation of the COVID-19 guidelines as evident from 434 respondents that confirmed not having enough information on COVID-19. For instance, the social distancing was for many interpreted as couple were no longer allowed to share the same bed. Thus, contributing to a lot of tension and accusations of infidelity which in a few cases resulted in domestic violence.

In terms of sexual violence, some respondents were reluctant to openly speak about it, especially in rural areas. Nevertheless, there were a few incidences of teenage pregnancies which were attributed to the prolonged period during which the school-age children were made to stay in the communities during the period of the school closure, and therefore exposed them to situations of risks. In a few instances, the reduced recreational and cultural activities were cited to have contributed to the increase in the number of girls that had fallen pregnant.

## 6.2. Access to Sexual Reproductive Health Services

**GRAPH 4: Access to Sexual Reproductive Health and Family Planning Services**



Graph no. 4, shows the number of people that accessed SRH services since the start of the pandemic. From this presentation, few people accessed the service. Out of the 1,386 adults of whom 729 were female, only 81 said they or their spouse had accessed SRH services during the period of the pandemic. Challenges cited for the limited access of SRH services include the negative attitudes of health workers that deem women with disabilities to be asexual and subject them to negative and demeaning remarks when they try to access such services. Others cited the long distance to the clinics, including the inaccessibility of infrastructure and information. Other reasons cited for not accessing the services are noted verbatim below

**“ I was asked to buy the medicine for family planning and inject myself from home, I was scared because I have never used a syringe to inject myself and I felt my life was at risk”.**

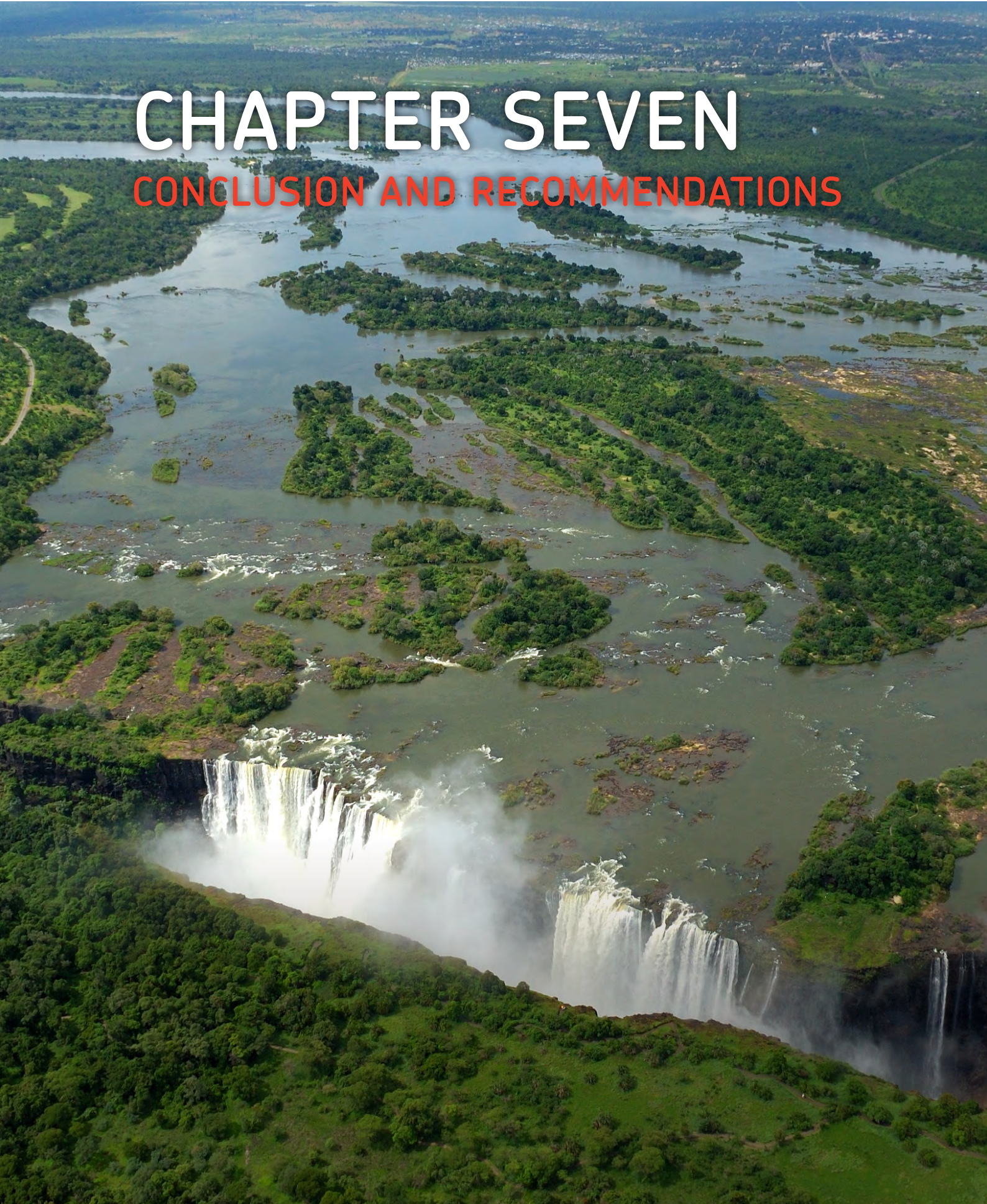
**“ A lot of them were returned as only severe cases were being entertained”**



A woman with a visual impairment being interviewed in Western Province

# CHAPTER SEVEN

## CONCLUSION AND RECOMMENDATIONS



## Conclusion

The study results show that the pandemic has had devastating effects on Persons with Disabilities and exacerbated the existing inequalities and barriers. While only a few were found to be in formal employment to determine their retention, the study results reveal that there has been reduced economic activity, including those that were involved in small-medium enterprises, agriculture and for those who were dependent on other family support systems. While there were variations for those in rural areas, urban and peri-urban areas, and those in border towns that rely on cross-border trading, a common theme among them all was the economic impact resulting from the reduced income levels as a result of high inflation rate that has affected the cost of commodities and the restrictions on gatherings which have in-turn affected the community support structures.

Accessing rehabilitation and habitation services, including to SRH has to a certain extent been limited. A biggest limitation was information not being available in accessible formats and language to enable a wider reach, particularly for those in the rural areas with limited access to technology. While a lot has been done to disseminate information through traditional media such as the radio, television and social media, the study confirmed the hypothesis that these were not the most effective means of disseminating to persons with various disabilities such as those requiring ease-read versions, Braille transcription, audio, or sign -language interpretation. A missing factor in disseminating COVID-19 information was the limited information in the local languages that can easily be understood in the specific areas, which to a certain extent contributed to the misinformation on the spread of the virus. This information gap is likely to exacerbate the pre-existing barriers that hinder the participation of Persons with Disabilities on an equal basis with others.

While efforts have been made to supplement the income gaps and cushion the economic impact of the pandemic on marginalized households including those with disabilities through the Multi-Sector Response Plan, the study results show that few have benefitted from these support programs. In addition, Persons with Disabilities were not involved in the formulation and roll-out of the Response Plan. As such, only a few Persons with Disabilities benefitted from the planned interventions as outlined in the Response and Recovery Plan. With the socioeconomic challenges likely to increase with the looming third wave of the pandemic, if the specific challenges and barriers faced by Persons with Disabilities outlined in this report are not addressed in a manner that will respond to the added vulnerabilities, the inequality gap is likely to widen and perpetuate the disability-poverty vicious cycle. Practical and realistic measures require the active involvement and consultation of Persons with Disabilities. These should be short-term, medium and long-term measures agreed upon by all stakeholders, especially those representing the voice of Persons with Disabilities.

The lack of gender and disability disaggregated data was also found to be a limiting factor in ensuring a coordinated response that will address the intersectional challenges faced by women and girls with disabilities as a consequence of the heightened risk to GBV and limited access to support systems that guarantees their safety.

## General Recommendations

1. The government and stakeholders through the ministry of education should introduce education support programs for primary and secondary schools to increase the school enrollment rate for Persons with Disabilities.
2. All stakeholders engaged in the supply of Covid-19 intervention and prevention measures to design accessible handwashing points to enable use by all people, including Persons with Disabilities and especially children, girls, women and those with physical disabilities.
3. Government and other stakeholders, including private and public service providers need to work closely to provide a twin-track system of supporting the needs of Persons with Disabilities by encouraging collaboration and partnerships specifically through a multi-sectoral approach that involves different players. This is specifically on the target to engage rural based Persons with Disabilities who should be reached through OPDs.
4. Prioritise the needs of Persons with Disabilities, especially girls and women with disabilities, specific to their access to HIV, GBV, SRH, education, economic empowerment and rehabilitation services in hard-to reach rural areas and ensure they, too are consulted before national plans are implemented
5. Accurate and real-time gender and disability disaggregated data on Persons with Disabilities should be collected regularly to inform government programming and budgeting in the social sectors of health, education, employment, and social welfare, including during times of humanitarian emergency.

6. Information should also be available in braille and sign-language, and this should be encouraged at every health facility and learning institutions.
7. Research outcomes should be shared with the respondents in simple and accessible formats. *“We want to be briefed on the outcome of this research you are undertaking. We are getting tired of these research works because we don’t see any changes. Many of our members feel that you use us and when you get the money you forget about us”.*
8. Increase the availability of primary health care and community-based treatment and support opportunities such as mental health, psychosocial support, physiotherapy and other accessible treatment options especially for children with disabilities.
9. Explore alternative means of curbing the spread of the virus for Persons with Disabilities that rely on physical touch and personal assistants for their mobility especially by ensuring regular access to free sanitisers and hand washing soap for both the support persons and Persons with Disabilities.

## Recommendations to the Government – for Addressing the COVID-19 Impact

1. The government should design specific entrepreneurship and empowerment programs aimed at reducing the high unemployment rate and increasing income levels among Persons with Disabilities as part of a COVID-19 mainstreaming, and or recovery strategy. The program(s) must be tailored to capture factors such as financial literacy.
2. Government should expedite the launch and implementation of the National Disability Mainstreaming Strategy on COVID-19. This will accelerate the effective participation of Persons with Disabilities, especially those in rural areas, in the COVID-19 interventions. Issues affecting children and women with disabilities should be specifically prioritised and delivered in child and gender friendly approaches.
3. The government should ensure that the training and human resource development curriculum of health workers and other emergency service workers include knowledge and skills to increase the capacities of such human resource to effectively handle Persons with Disabilities during any emergency like COVID-19. Such knowledge and skills include sign-language and acceptable disability language and etiquette.
4. Government, through the Zambia Agency for Persons with Disabilities, should heighten an aggressive awareness raising campaign on the rights and fundamental freedoms during national health emergencies and situations of humanitarian risks of Persons with Disabilities, especially among decision makers and policy makers at all levels. This should include awareness among the private sectors. Such rights include access to information, treatment, protection and decision-making. Such awareness campaigns should take into consideration child and gender specific issues.
5. Priority should be given to diagnostic tests for Persons with Disabilities who present symptoms of COVID-19. In so doing, known barriers to treatment should be eliminated by ensuring that hospitals and health facilities for testing and quarantine are physically accessible. This should include having front-line health workers who are equipped with disability inclusive information and skills to receive, admit, communicate, and treat or care for different categories of Persons with Disabilities. This, apart from the curriculum focused training, should be included in the continuous short-term in-service training specific on COVID-19 capacity building workshops for health staff.
6. Prioritise youth and women and girls with disabilities (particularly those in rural areas) when implementing entrepreneurship and innovation opportunities. Information about these opportunities should be shared in accessible formats. Opportunities for up-skilling should be provided where needed to promote targeted interventions for those less likely to have opportunities to formal education (low-skilled)
7. The emergency cash transfer program should be expanded to include those districts that are not currently benefiting. This should be done in a phased manner with priority given to those which were economically negatively affected. Modes of distributing the funds should be made accessible with flexible timeframes to allow a reasonable time for beneficiaries to access the money without the limitation of a time-expiration code/PIN. This is to allow persons with visual impairment who only get access to their short messages on their mobile phones when there is someone to read for them. Usually, by the time they get access to their messages, the time would have expired as reported.
8. Access to sexual and reproductive health, HIV and GBV services should remain promoted and protected for Persons with Disabilities, especially girls and women, amidst the COVID-19 pandemic challenges that has drawn the attention of the health and socio-economic systems of the country. This should form part of the awareness raising campaigns to be carried out by ZAPD and other stakeholders.



9. Consider making accessible ICT available to learners with disabilities to enable e-learning and home schooling. This calls for procurement and delivery of computers with screen readers for visually impaired learners to schools so that learners who can afford may access online education. This should be equated to how far government has provided this ICT service to other mainstream schools. An example of an accessible digital portal has been designed by UNICEF to provide accessible digital content and tools in high and low-resource environments that address disability-specific user needs to support universal design learning that caters for the needs of learners with disabilities and is available here- [www.accessibledigitallearning.org](http://www.accessibledigitallearning.org).

## Recommendations to Other Development Partners

1. Increase technical and financial support towards COVID-19 programs, specifically on training of health front line personnel on disability inclusion COVID-19 inclusive service delivery. This includes technical and financial support to training and capacity building in disability communication inclusion and acceptable language and etiquette during the short-term training workshops of health personnel.
2. Increase and scale-up the COVID-19 emergency cash transfer to all districts with priority to those which have been more economically negatively affected. This support should be gradual but treated as an emergency funding to government.
3. Increase technical and financial support towards Organizations for Persons with Disabilities (OPDs) to engage in strategic advocacy work for disability-inclusive programming at the community, national and international level. This is specifically meant to respond to the little knowledge the Persons with Disabilities have rural and community level on the awareness raising campaigns the OPDs have been carrying out. This is to ensure OPDs engage in accountability activities on ensuring that Persons with Disabilities fully and effectively participate and benefit equally from all COVID-19 intervention without any form of discrimination, including discrimination on the basis of specific disability, age and gender.

## Suggestions of Required Support as Suggested by Respondents

1. School-going children with visual impairments and other physical disabilities should be supported with bicycles to help them overcome the barrier of walking long distances to schools especially in rural areas.
2. Provide accurate information on COVID-19 in accessible formats, in local languages and in easy-read versions to include children and those persons living in rural areas.

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# ANNEXES

**TABLE I – Age Range of Adult Respondent**

	Age range of adult respondents								Total
	18-24 years	25-34 Years	35-44 years	45-54 Years	55-64 Years	65-74 years	Above 75 Years	No Response	
Chibombo	1 2.6%	4 10.3%	5 12.8%	3 7.7%	7 17.9%	10 25.6%	9 23.1%	0 0.0%	39 100.0%
Kabwe	2 3.6%	7 12.5%	5 8.9%	11 19.6%	15 26.8%	15 26.8%	1 1.8%	0 0.0%	56 100.0%
Serenje	1 6.7%	3 20.0%	2 13.3%	5 33.3%	0 0.0%	3 20.0%	1 6.7%	0 0.0%	15 100.0%
Ndola	15 24.6%	9 14.8%	11 18.0%	6 9.8%	13 21.3%	5 8.2%	2 3.3%	0 0.0%	61 100.0%
Mpongwe	5 10.9%	4 8.7%	14 30.4%	4 8.7%	9 19.6%	5 10.9%	5 10.9%	0 0.0%	46 100.0%
Mufurila	3 4.8%	4 6.5%	10 16.1%	6 9.7%	17 27.4%	15 24.2%	7 11.3%	0 0.0%	62 100.0%
Chipata	1 2.1%	17 36.2%	8 17.0%	5 10.6%	8 17.0%	6 12.8%	2 4.3%	0 0.0%	47 100.0%
Chidiza	1 5.0%	2 10.0%	3 15.0%	6 30.0%	6 30.0%	2 10.0%	0 0.0%	0 0.0%	20 100.0%
Petauke	12 10.3%	25 21.4%	30 25.6%	12 10.3%	22 18.8%	4 3.4%	12 10.3%	0 0.0%	117 100.0%
Nchelenge	3 13.0%	6 26.1%	2 8.7%	3 13.0%	5 21.7%	1 4.3%	3 13.0%	0 0.0%	23 100.0%
Mansa	7 15.2%	20 43.5%	7 15.2%	3 6.5%	4 8.7%	3 6.5%	2 4.3%	0 0.0%	46 100.0%
Kasama	2 7.7%	8 30.8%	4 15.4%	2 7.7%	9 34.6%	0 0.0%	1 3.8%	0 0.0%	26 100.0%
Mporokoso	2 7.4%	2 7.4%	5 18.5%	10 37.0%	6 22.2%	0 0.0%	2 7.4%	0 0.0%	27 100.0%
Mpulungu	0 0.0%	2 28.6%	2 28.6%	3 42.9%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	7 100.0%
Kalumbila	13 19.4%	24 35.8%	20 29.9%	8 11.9%	1 1.5%	1 1.5%	0 0.0%	0 0.0%	67 100.0%

	Age range of adult respondents								Total
	18-24 years	25-34 Years	35-44 years	45-54 Years	55-64 Years	65-74 years	Above 75 Years	No Response	
Kasempa	2 7.1%	4 14.3%	4 14.3%	6 21.4%	8 28.6%	2 7.1%	2 7.1%	0 0.0%	28 100.0%
Solwezi	4 17.4%	12 52.2%	5 21.7%	0 0.0%	2 8.7%	0 0.0%	0 0.0%	0 0.0%	23 100.0%
Feira/Luangwa	10 27.8%	8 22.2%	2 5.6%	0 0.0%	2 5.6%	0 0.0%	14 38.9%	0 0.0%	36 100.0%
Chirundu	6 24.0%	6 24.0%	2 8.0%	5 20.0%	1 4.0%	4 16.0%	1 4.0%	0 0.0%	25 100.0%
Lusaka	11 8.2%	0 0.0%	16 11.9%	25 18.7%	25 18.7%	17 12.7%	40 29.9%	0 0.0%	134 100.0%
Chinsali	8 22.9%	2 5.7%	7 20.0%	6 17.1%	5 14.3%	6 17.1%	1 2.9%	0 0.0%	35 100.0%
Nakonde	5 14.7%	6 17.6%	7 20.6%	6 17.6%	0 0.0%	8 23.5%	2 5.9%	0 0.0%	34 100.0%
Mpika	3 5.2%	11 19.0%	13 22.4%	0 0.0%	10 17.2%	13 22.4%	8 13.8%	0 0.0%	58 100.0%
Choma	6 9.5%	9 14.3%	18 28.6%	17 27.0%	5 7.9%	4 6.3%	4 6.3%	0 0.0%	63 100.0%
Gwembe	10 19.6%	6 11.8%	12 23.5%	12 23.5%	6 11.8%	3 5.9%	1 2.0%	1 20.0%	51 100.0%
Livingstone	9 13.4%	9 13.4%	5 7.5%	11 16.4%	13 19.4%	15 22.4%	5 7.5%	0 0.0%	67 100.0%
Kalabo	12 21.4%	4 7.1%	6 10.7%	6 10.7%	10 17.9%	14 25.0%	4 7.1%	0 0.0%	56 100.0%
Kaoma	5 9.8%	6 11.8%	8 15.7%	9 17.6%	11 21.6%	10 19.6%	2 3.9%	0 0.0%	51 100.0%
Mongu	11 16.7%	11 16.7%	21 31.8%	6 9.1%	6 9.1%	5 7.6%	6 9.1%	0 0.0%	66 100.0%
<b>Total</b>	<b>170</b> <b>12.3%</b>	<b>231</b> <b>16.7%</b>	<b>254</b> <b>18.3%</b>	<b>196</b> <b>14.1%</b>	<b>226</b> <b>16.3%</b>	<b>171</b> <b>12.3%</b>	<b>137</b> <b>9.9%</b>	<b>1</b> <b>0.1%</b>	<b>1386</b> <b>100.0%</b>

**TABLE II – Current Job Status by Disability Category**

Which disability category do you identify with or represent		What is your current job status					Total
		Employed	Unemployed	Retired	Other. Specify	No Response	
Person with blindness or low vision	Central	2 6.9%	21 72.4%	4 13.8%	2 6.9%	0 0.0%	29 100.0%
	Copperbelt	2 6.1%	30 90.9%	0 0.0%	1 3.0%	0 0.0%	33 100.0%
	Eastern	4 14.3%	19 67.9%	3 10.7%	2 7.1%	0 0.0%	28 100.0%
	Luapula	0 0.0%	8 61.5%	0 0.0%	3 23.1%	2 15.4%	13 100.0%
	Northern	2 22.2%	7 77.8%	0 0.0%	0 0.0%	0 0.0%	9 100.0%
	North-Western	3 12.5%	21 87.5%	0 0.0%	0 0.0%	0 0.0%	24 100.0%
	Lusaka	0 0.0%	38 74.5%	8 15.7%	12 20/6%	0 0.0%	58 100.0%
	Muchinga	3 12.0%	18 72.0%	2 8.0%	2 8.0%	0 0.0%	25 100.0%
	Southern	4 11.4%	25 71.4%	5 14.3%	1 2.9%	0 0.0%	35 100.0%
	Western	4 10.5%	27 71.1%	0 0.0%	5 13.2%	2 5.3%	38 100.0%
	<b>Total</b>	<b>24</b> <b>8.4%</b>	<b>214</b> <b>75.1%</b>	<b>22</b> <b>7.7%</b>	<b>21</b> <b>7.4%</b>	<b>4</b> <b>1.4%</b>	<b>292</b> <b>100.0%</b>
Hard of hearing person	Central	0 0.0%	2 100.0%	0 0.0%			2 100.0%
	Copperbelt	0 0.0%	3 100.0%	0 0.0%			3 100.0%
	Eastern	0 0.0%	10 90.9%	1 9.1%			11 100.0%
	Luapula	0 0.0%	1 100.0%	0 0.0%			1 100.0%
	North-Western	0 0.0%	8 66.7%	4 33.3%			12 100.0%
	Lusaka	1 11.1%	5 55.6%	3 33.3%			9 100.0%
	Muchinga	0 0.0%	4 100.0%	0 0.0%			4 100.0%
	Southern	0 0.0%	8 100.0%	0 0.0%			8 100.0%
	Western	1 20.0%	4 80.0%	0 0.0%			5 100.0%
	<b>Total</b>	<b>2</b> <b>3.6%</b>	<b>45</b> <b>81.8%</b>	<b>8</b> <b>14.5%</b>			<b>55</b> <b>100.0%</b>

Which disability category do you identify with or represent		What is your current job status					Total
		Employed	Unemployed	Retired	Other. Specify	No Response	
Deaf person	Central	2 33.3%	2 66.7%	0 0.0%		0 0.0%	4 100.0%
	Copperbelt	1 14.3%	5 71.4%	0 0.0%		1 14.3%	7 100.0%
	Eastern	4 36.4%	7 63.6%	0 0.0%		0 0.0%	11 100.0%
	Luapula	0 0.0%	5 62.5%	3 37.5%		0 0.0%	8 100.0%
	Northern	0 0.0%	1 33.3%	2 66.7%		0 0.0%	3 100.0%
	North-Western	0 0.0%	4 100.0%	0 0.0%		0 0.0%	4 100.0%
	Lusaka	0 0.0%	4 100.0%	0 0.0%		0 0.0%	4 100.0%
	Muchinga	0 0.0%	4 100.0%	0 0.0%		0 0.0%	4 100.0%
	Southern	0 0.0%	11 78.6%	2 14.3%		1 7.1%	14 100.0%
	Western	0 0.0%	17 94.4%	1 5.6%		0 0.0%	18 100.0%
	<b>Total</b>	<b>6</b> <b>7.9%</b>	<b>60</b> <b>78.9%</b>	<b>8</b> <b>10.5%</b>		<b>2</b> <b>2.6%</b>	<b>77</b> <b>100.0%</b>
Person with intellectual disabilities	Copperbelt	0 0.0%	7 100.0%	0 0.0%	0 0.0%		7 100.0%
	Eastern	2 20.0%	4 40.0%	4 40.0%	7 100.0%		10 100.0%
	Luapula	0 0.0%	3 100.0%	0 0.0%	0 0.0%		3 100.0%
	North-Western	0 0.0%	8 100.0%	0 0.0%	0 0.0%		8 100.0%
	Lusaka	0 0.0%	0 0.0%	2 100.0%	0 0.0%		2 100.0%
	Muchinga	0 0.0%	11 100.0%	0 0.0%	0 0.0%		11 100.0%
	Southern	0 0.0%	9 56.2%	5 31.2.0%	2 12.5%		16 100.0%
	Western	0 0.0%	7 100.0%	0 0.0%	0 0.0%		7 100.0%
	<b>Total</b>	<b>2</b> <b>3.1%</b>	<b>49</b> <b>76.5%</b>	<b>11</b> <b>17.1%</b>	<b>2</b> <b>3.1%</b>		<b>64</b> <b>100.0%</b>

Which disability category do you identify with or represent	What is your current job status						Total
	Employed	Unemployed	Retired	Other. Specify	No Response		
Person with psychosocial disability (mental health)	Central	0 0.0%	8 100.0%	0 0.0%		0 0.0%	8 100.0%
	Copperbelt	0 0.0%	13 100.0%	0 0.0%		0 0.0%	13 100.0%
	Eastern	0 0.0%	17 100.0%	0 0.0%		0 0.0%	17 100.0%
	Luapula	0 0.0%	3 100.0%	0 0.0%		0 0.0%	3 100.0%
	North-Western	4 33.3%	6 50.0%	0 0.0%		2 16.7%	12 100.0%
	Lusaka	3 0.0%	9 100.0%	0 0.0%		0 0.0%	12 100.0%
	Muchinga	0 0.0%	16 100.0%	0 0.0%		0 0.0%	16 100.0%
	Southern	3 9.1%	5 45.5%	1 9.1%		4 36.4%	13 100.0%
	Western	5 0.0%	19 90.5%	2 9.5%		0 0.0%	26 100.0%
	<b>Total</b>	<b>15 12.5%</b>	<b>96 80%</b>	<b>3 2.5%</b>		<b>6 5%</b>	<b>120 100.0%</b>
Person with physical disability	Central	0 0.0%	40 63.5%	19 30.2%	4 6.3%	0 0.0%	63 100.0%
	Copperbelt	5 5.0%	91 91.0%	4 4.0%	0 0.0%	0 0.0%	100 100.0%
	Eastern	5 5.0%	81 80.2%	14 13.9%	1 1.0%	0 0.0%	101 100.0%
	Luapula	2 5.4%	30 81.1%	0 0.0%	2 5.4%	3 8.1%	37 100.0%
	Northern	4 8.7%	40 87.0%	2 4.3%	0 0.0%	0 0.0%	46 100.0%
	North-Western	0 0.0%	28 80.0%	6 20.0%	0 0.0%	0 0.0%	35 100.0%
	Lusaka	7 7.1%	85 85.9%	7 7.1%	0 0.0%	0 0.0%	99 100.0%
	Muchinga	8 13.3%	52 86.7%	0 0.0%	0 0.0%	0 0.0%	60 100.0%
	Southern	5 6.5%	58 75.3%	10 13.0%	4 5.2%	0 0.0%	77 100.0%
	Western	1 1.3%	67 85.9%	8 10.3%	2 2.6%	0 0.0%	78 100.0%
	<b>Total</b>	<b>37 5.3%</b>	<b>572 82.3%</b>	<b>70 10%</b>	<b>13 1.8%</b>	<b>3 0.4%</b>	<b>695 100.0%</b>

Which disability category do you identify with or represent		What is your current job status					Total
		Employed	Unemployed	Retired	Other. Specify	No Response	
Person with down syndrome	Central	0 0.0%	1 100.0%	0 0.0%			1 100.0%
	Copperbelt	0 0.0%	5 83.3%	1 16.7%			6 100.0%
	Northern	0 0.0%	2 100.0%	0 0.0%			2 100.0%
	North-Western	0 0.0%	5 100.0%	0 0.0%			5 100.0%
	Lusaka	0 0.0%	20 100.0%	0 0.0%			20 100.0%
	Muchinga	2 40.0%	3 60.0%	0 0.0%			5 100.0%
	Southern	0 0.0%	2 100.0%	0 0.0%			2 100.0%
	Western	0 0.0%	100.0%	0 0.0%			0 100.0%
	<b>Total</b>	<b>2</b> <b>4.8%</b>	<b>39</b> <b>92.9%</b>	<b>1</b> <b>2.4%</b>			<b>41</b> <b>100.0%</b>
Person on the autism spectrum	Copperbelt		4 100.0%				4 100.0%
	Eastern		4 100.0%				4 100.0%
	North-Western		5 100.0%				5 100.0%
	Lusaka		1 100.0%				1 100.0%
	Muchinga		3 100.0%				3 100.0%
	Western		3 100.0%				3 100.0%
	<b>Total</b>		<b>20</b> <b>100.0%</b>				<b>20</b> <b>100.0%</b>
Person with albinism	Central	1 100.0%	0 0.0%	0 0.0%			1 100.0%
	Eastern	3 75.0%	1 25.0%	0 0.0%			4 100.0%
	Luapula	3 75.0%	1 25.0%	0 0.0%			4 100.0%
	North-Western	4 36.4%	6 54.5%	1 9.1%			11 100.0%
	Southern	0 0.0%	1 100.0%	0 0.0%			1 100.0%



Which disability category do you identify with or represent		What is your current job status					Total
		Employed	Unemployed	Retired	Other. Specify	No Response	
Person with albinism, cont.	Western	0 0.0%	1 100.0%	0 0.0%			1 100.0%
	<b>Total</b>	<b>11</b> <b>50.0%</b>	<b>10</b> <b>45.5%</b>	<b>1</b> <b>4.5%</b>			<b>22</b> <b>100.0%</b>
Multiple	Central		2 40.0%	3 60.0%	0 0.0%		5 100.0%
	Copperbelt		1 33.3%	0 0.0%	2 66.7%		3 100.0%
	Eastern		6 100.0%	0 0.0%	0 0.0%		6 100.0%
	North-Western		6 75.0%	2 25.0%	0 0.0%		8 100.0%
	Muchinga		2 100.0%	0 0.0%	0 0.0%		2 100.0%
	Southern		12 100.0%	0 0.0%	0 0.0%		12 100.0%
	Western		6 100.0%	0 0.0%	0 0.0%		6 100.0%
	<b>Total</b>		<b>35</b> <b>83.3%</b>	<b>6</b> <b>14.2%</b>	<b>2</b> <b>4.7%</b>		<b>42</b> <b>100.0%</b>
Deaf-blindness	Eastern	3 60%	2 40%			0 0.0%	5 100.0%
	Muchinga	0 0.0%	2 100.0%			0 0.0%	2 100.0%
	Southern	2 40.0%	3 40.0%			1 20.0%	6 100.0%
	<b>Total</b>	<b>5</b> <b>25.0%</b>	<b>7</b> <b>62.5%</b>			<b>1</b> <b>12.5%</b>	<b>13</b> <b>100.0%</b>

**TABLE III – Government Support Programmes**

	Type of government support programme that you are participating in						Total
	Farmer input support programme	Social Cash Transfer	Food basket support	None	Other	No Response	
Chibombo	1 2.6%	23 59.0%	0 0.0%	13 33.3%	2 5.1%	0 0.0%	39 100.0%
Kabwe	1 1.8%	21 37.5%	0 0.0%	26 46.4%	8 14.3%	0 0.0%	56 100.0%
Serenje	2 13.3%	2 13.3%	0 0.0%	11 73.3%	0 0.0%	0 0.0%	15 100.0%
Ndola	0 0.0%	20 32.8%	0 0.0%	40 65.6%	0 0.0%	1 1.6%	61 100.0%
Mpongwe	1 2.2%	14 30.4%	1 2.2%	30 65.2%	0 0.0%	0 0.0%	46 100.0%
Mufurila	1 1.6%	50 80.6%	1 1.6%	9 14.5%	1 1.6%	0 0.0%	62 100.0%
Chipata	3 6.4%	12 25.5%	0 0.0%	30 63.8%	1 2.1%	1 2.1%	47 100.0%
Chidiza	4 20.0%	5 25.0%	3 15.0%	8 40.0%	0 0.0%	0 0.0%	20 100.0%
Petauke	8 6.8%	49 41.9%	8 6.8%	50 42.7%	2 1.7%	0 0.0%	117 100.0%
Nchelenge	2 8.7%	1 4.3%	0 0.0%	20 87.0%	0 0.0%	0 0.0%	23 100.0%
Mansa	2 4.3%	20 43.5%	0 0.0%	23 50.0%	0 0.0%	1 2.2%	46 100.0%
Kasama	3 11.5%	15 57.7%	0 0.0%	8 30.8%	0 0.0%	0 0.0%	26 100.0%
Mporokoso	0 0.0%	4 14.8%	0 0.0%	21 77.8%	2 7.4%	0 0.0%	27 100.0%
Mpulungu	0 0.0%	4 57.1%	0 0.0%	3 42.9%	0 0.0%	0 0.0%	7 100.0%
Kalumbila	11 16.4%	1 1.5%	0 0.0%	55 82.1%	0 0.0%	0 0.0%	67 100.0%
Kasempa	6 21.4%	10 35.7%	0 0.0%	10 35.7%	0 0.0%	2 7.1%	28 100.0%
Solwezi	3 13.0%	7 30.4%	0 0.0%	13 56.5%	0 0.0%	0 0.0%	23 100.0%
Feira/Luangwa	2 5.6%	12 33.3%	2 5.6%	20 55.6%	0 0.0%	0 0.0%	36 100.0%
Chirundu	0 0.0%	6 24.0%	0 0.0%	19 76.0%	0 0.0%	0 0.0%	25 100.0%
Lusaka	0 0.0%	100 74.6%	5 3.7%	29 21.6%	0 0.0%	0 0.0%	134 100.0%

Type of government support programme that you are participating in							
	Farmer input support programme	Social Cash Transfer	Food basket support	None	Other	No Response	Total
Chinsali	3 8.6%	13 37.1%	2 5.7%	17 48.6%	0 0.0%	0 0.0%	35 100.0%
Nakonde	4 11.8%	2 5.9%	3 8.8%	25 73.5%	0 0.0%	0 0.0%	34 100.0%
Mpika	0 0.0%	20 34.5%	3 5.2%	35 60.3%	0 0.0%	0 0.0%	58 100.0%
Choma	8 12.7%	17 27.0%	0 0.0%	34 54.0%	3 4.8%	1 1.6%	63 100.0%
Gwembe	3 5.9%	10 19.6%	2 3.9%	35 68.6%	0 0.0%	1 2.0%	51 100.0%
Livingstone	1 1.5%	21 31.3%	1 1.5%	44 65.7%	0 0.0%	0 0.0%	67 100.0%
Kalabo	0 0.0%	20 35.7%	2 3.6%	34 60.7%	0 0.0%	0 0.0%	56 100.0%
Kaoma	3 5.9%	16 31.4%	0 0.0%	31 60.8%	1 2.0%	0 0.0%	51 100.0%
Mongu	0 0.0%	15 22.7%	1 1.5%	47 71.2%	0 0.0%	3 4.5%	66 100.0%
<b>Total</b>	<b>72</b> <b>5.2%</b>	<b>510</b> <b>36.8%</b>	<b>34</b> <b>2.5%</b>	<b>740</b> <b>53.4%</b>	<b>20</b> <b>1.4%</b>	<b>10</b> <b>0.7%</b>	<b>1386</b> <b>100.0%</b>

**TABLE IV – Educational Access for Children with Disabilities by District**

District \* Is the child or young person with disability currently participating in any of the following school related activities Crosstabulation

	Is the child or young person with disability currently participating in any of the following school related activities								Total
	Early Childhood Education and Care	Primary – special school	Primary – regular or mainstream school	Secondary – special school	Secondary – regular or mainstream school	Home school	Not in school	No Response	
Chibombo	6 50.0%	3 25.0%	1 8.3%	0 0.0%	2 16.7%	0 0.0%	0 0.0%	0 0.0%	12 100.0%
Kabwe	5 29.4%	7 41.2%	1 5.9%	0 0.0%	2 11.8%	1 5.9%	0 0.0%	1 5.9%	17 100.0%
Serenje	7 70.0%	0 0.0%	3 30.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	10 100.0%
Ndola	7 50.0%	3 21.4%	2 14.3%	0 0.0%	1 7.1%	1 7.1%	0 0.0%	0 0.0%	14 100.0%
Mpongwe	9 90.0%	0 0.0%	1 10.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	10 100.0%
Mufurila	6 85.7%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 14.3%	0 0.0%	0 0.0%	7 100.0%
Chipata	29 67.4%	9 20.9%	4 9.3%	0 0.0%	0 0.0%	1 2.3%	0 0.0%	0 0.0%	43 100.0%
Chadiza	20 43.5%	8 17.4%	15 32.6%	0 0.0%	2 4.3%	0 0.0%	1 2.2%	0 0.0%	46 100.0%
Petauke	10 52.6%	1 5.3%	6 31.6%	1 5.3%	0 0.0%	1 5.3%	0 0.0%	0 0.0%	19 100.0%
Mansa	2 40.0%	2 40.0%	1 20.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	5 100.0%
Nchelenge	6 75.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 12.5%	1 12.5%	8 100.0%
Samfya	1 16.7%	5 83.3%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	6 100.0%
Kalumbila	14 56.0%	5 20.0%	3 12.0%	0 0.0%	0 0.0%	3 12.0%	0 0.0%	0 0.0%	25 100.0%
Kasempa	9 50.0%	5 27.8%	2 11.1%	0 0.0%	2 11.1%	0 0.0%	0 0.0%	0 0.0%	18 100.0%
Solwezi	18 40.0%	13 28.9%	7 15.6%	4 8.9%	0 0.0%	2 4.4%	1 2.2%	0 0.0%	45 100.0%
Chinsali	20 71.4%	3 10.7%	1 3.6%	0 0.0%	0 0.0%	1 3.6%	0 0.0%	3 10.7%	28 100.0%
Nakonde	14 73.7%	1 5.3%	1 5.3%	1 5.3%	0 0.0%	2 10.5%	0 0.0%	0 0.0%	19 100.0%
Mpika	7 63.6%	3 27.3%	1 9.1%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	11 100.0%
Choma	3 25.0%	4 33.3%	1 8.3%	0 0.0%	2 16.7%	2 16.7%	0 0.0%	0 0.0%	12 100.0%

Is the child or young person with disability currently participating in any of the following school related activities									
	Early Childhood Education and Care	Primary – special school	Primary – regular or mainstream school	Secondary – special school	Secondary – regular or mainstream school	Home school	Not in school	No Response	Total
Kazungula	9 30.0%	13 43.3%	3 10.0%	0 0.0%	3 10.0%	1 3.3%	1 3.3%	0 0.0%	30 100.0%
Gweembe	6 66.7%	1 11.1%	2 22.2%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	9 100.0%
Kalabo	8 80.0%	1 10.0%	0 0.0%	0 0.0%	0 0.0%	1 10.0%	0 0.0%	0 0.0%	10 100.0%
Kaoma	4 44.4%	5 55.6%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	9 100.0%
Mongu	13 50.0%	2 7.7%	1 3.8%	9 34.6%	1 3.8%	0 0.0%	0 0.0%	0 0.0%	26 100.0%
<b>Total</b>	<b>233 53.1%</b>	<b>94 21.4%</b>	<b>56 12.8%</b>	<b>15 3.4%</b>	<b>15 3.4%</b>	<b>17 3.9%</b>	<b>4 0.9%</b>	<b>5 1.1%</b>	<b>439 100.0%</b>

**TABLE V – Current Average Monthly Income**

Current average monthly income								
	Less than ZMK 800	Between ZMK 1000 and ZMK 2000	Between ZMK 2000 and ZMK 3000	Between ZMK 3000 and ZMK 4000	Between ZMK 4000 and ZMK 5000	Above ZMK 5000	No Response	Total
Chibombo	18 46.2%	2 5.1%	2 5.1%	1 2.6%	0 0.0%	0 0.0%	16 41.0%	39 100.0%
Kabwe	54 96.4%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	2 3.6%	56 100.0%
Serenje	14 93.3%	1 6.7%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	15 100.0%
Ndola	46 75.4%	6 9.8%	3 4.9%	2 3.3%	0 0.0%	0 0.0%	4 6.6%	61 100.0%
Mpongwe	23 50.0%	1 2.2%	1 2.2%	0 0.0%	1 2.2%	0 0.0%	20 43.5%	46 100.0%
Mufurila	49 79.0%	3 4.8%	0 0.0%	0 0.0%	0 0.0%	1 1.6%	9 14.5%	62 100.0%
Chipata	31 66.0%	13 27.7%	1 2.1%	0 0.0%	1 2.1%	0 0.0%	1 2.1%	47 100.0%
Chidiza	14 70.0%	2 10.0%	0 0.0%	0 0.0%	0 0.0%	4 20.0%	0 0.0%	20 100.0%
Petauke	82 70.1%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	2 1.7%	33 28.2%	117 100.0%
Nchelenge	20 87.0%	3 13.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	23 100.0%

	Current average monthly income							Total
	Less than ZMK 800	Between ZMK 1000 and ZMK 2000	Between ZMK 2000 and ZMK 3000	Between ZMK 3000 and ZMK 4000	Between ZMK 4000 and ZMK 5000	Above ZMK 5000	No Response	
Mansa	36 78.3%	2 4.3%	0 0.0%	3 6.5%	0 0.0%	0 0.0%	5 10.9%	46 100.0%
Kasama	24 92.3%	2 7.7%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	26 100.0%
Mporokoso	13 48.1%	6 22.2%	4 14.8%	0 0.0%	2 7.4%	0 0.0%	2 7.4%	27 100.0%
Mpulungu	6 85.7%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 14.3%	7 100.0%
Kalumbila	57 85.1%	3 4.5%	3 4.5%	4 6.0%	0 0.0%	0 0.0%	0 0.0%	67 100.0%
Kasempa	16 57.1%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	12 42.9%	28 100.0%
Solwezi	11 47.8%	12 52.2%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	23 100.0%
Feira/Lu-angwa	34 94.4%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	2 5.6%	36 100.0%
Chirundu	24 96.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 4.0%	25 100.0%
Lusaka	117 87.3%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	17 12.7%	134 100.0%
Chinsali	34 97.1%	1 2.9%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	35 100.0%
Nakonde	34 100.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	34 100.0%
Mpika	54 93.1%	2 3.4%	0 0.0%	0 0.0%	2 3.4%	0 0.0%	0 0.0%	58 100.0%
Choma	44 69.8%	2 3.2%	1 1.6%	3 4.8%	2 3.2%	2 3.2%	9 14.3%	63 100.0%
Gwembe	40 78.4%	4 7.8%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	7 13.7%	51 100.0%
Livingstone	54 80.6%	3 4.5%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	10 14.9%	67 100.0%
Kalabo	36 64.3%	2 3.6%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	18 32.1%	56 100.0%
Kaoma	45 88.2%	0 0.0%	3 5.9%	0 0.0%	0 0.0%	0 0.0%	3 5.9%	51 100.0%
Mongu	25 37.9%	2 3.0%	0 0.0%	3 4.5%	1 1.5%	2 3.0%	33 50.0%	66 100.0%
<b>Total</b>	<b>1055</b> <b>76.1%</b>	<b>72</b> <b>5.2%</b>	<b>18</b> <b>1.3%</b>	<b>16</b> <b>1.2%</b>	<b>9</b> <b>0.6%</b>	<b>11</b> <b>0.8%</b>	<b>205</b> <b>14.8%</b>	<b>1386</b> <b>100.0%</b>

**TABLE VI – Is the Child or Young Person with Disability Currently Participating in Any of the Following School Related Activities**

Early Childhood Education and Care		Primary – special school	Primary – regular or mainstream school	Secondary – special school	Secondary – regular or mainstream school	Home school	Not in school	No Response	Total	
Male	Central	10 58.8%	2 11.8%	3 17.6%	0 0.0%	1 5.9%	1 5.9%	0 0.0%	0 0.0%	17 100.0%
	Copperbelt	15 75.0%	2 10.0%	3 15.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	20 100.0%
	Eastern	19 57.6%	4 12.1%	5 15.2%	1 3.0%	2 6.1%	2 6.1%	0 0.0%	0 0.0%	33 100.0%
	Luapula	5 50.0%	4 40.0%	1 10.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	10 100.0%
	North-West-ern	23 50.0%	11 23.9%	7 15.2%	2 4.3%	0 0.0%	3 6.5%	0 0.0%	0 0.0%	46 100.0%
	Muchinga	16 61.5%	3 11.5%	2 7.7%	1 3.8%	0 0.0%	1 3.8%	0 0.0%	3 11.5%	26 100.0%
	Southern	6 30.0%	6 30.0%	3 15.0%	0 0.0%	4 20.0%	0 0.0%	1 5.0%	0 0.0%	20 100.0%
	Western	12 60.0%	3 15.0%	0 0.0%	4 20.0%	1 5.0%	0 0.0%	0 0.0%	0 0.0%	20 100.0%
	<b>Total</b>	<b>106 55.2%</b>	<b>35 18.2%</b>	<b>24 12.5%</b>	<b>8 4.2%</b>	<b>8 4.2%</b>	<b>7 3.6%</b>	<b>1 0.5%</b>	<b>3 1.6%</b>	<b>192 100.0%</b>
Female	Central	9 40.9%	7 31.8%	2 9.1%	0 0.0%	3 13.6%	0 0.0%	0 0.0%	1 4.5%	22 100.0%
	Copperbelt	7 63.6%	1 9.1%	0 0.0%	0 0.0%	1 9.1%	2 18.2%	0 0.0%	0 0.0%	11 100.0%
	Eastern	40 53.3%	14 18.7%	20 26.7%	0 0.0%	0 0.0%	0 0.0%	1 1.3%	0 0.0%	75 100.0%
	Luapula	4 44.4%	3 33.3%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 11.1%	1 11.1%	9 100.0%
	North-West-ern	18 42.9%	12 28.6%	5 11.9%	2 4.8%	2 4.8%	2 4.8%	1 2.4%	0 0.0%	42 100.0%
	Muchinga	25 75.8%	5 15.2%	1 3.0%	0 0.0%	0 0.0%	2 6.1%	0 0.0%	0 0.0%	33 100.0%
	Southern	11 36.7%	12 40.0%	3 10.0%	0 0.0%	1 3.3%	3 10.0%	0 0.0%	0 0.0%	30 100.0%
	Western	13 52.0%	5 20.0%	1 4.0%	5 20.0%	0 0.0%	1 4.0%	0 0.0%	0 0.0%	25 100.0%
	<b>Total</b>	<b>127 51.4%</b>	<b>59 23.9%</b>	<b>32 13.0%</b>	<b>7 2.8%</b>	<b>7 2.8%</b>	<b>10 4.0%</b>	<b>3 1.2%</b>	<b>2 0.8%</b>	<b>247 100.0%</b>

**TABLE VIII – Have You Ever Experienced Any Gender Related Form of Abuse During the COVID-19 pandemic \* Gender of Respondent**

Gender of Respondent		Have you ever experienced any gender related form of abuse during the COVID-19 pandemic			Total
		Yes	No	No Response	
Female	Central	0 0.0%	57 98.3%	1 1.7%	58 100.0%
	Copperbelt	1 1.2%	82 98.8%	0 0.0%	83 100.0%
	Eastern	0 0.0%	109 100.0%	0 0.0%	109 100.0%
	Luapula	0 0.0%	31 100.0%	0 0.0%	31 100.0%
	Northern	0 0.0%	35 100.0%	0 0.0%	35 100.0%
	North-Western	0 0.0%	66 100.0%	0 0.0%	66 100.0%
	Lusaka	0 0.0%	96 100.0%	0 0.0%	96 100.0%
	Muchinga	0 0.0%	61 96.8%	2 3.2%	63 100.0%
	Southern	0 0.0%	98 98.0%	2 2.0%	100 100.0%
	Western	0 0.0%	88 100.0%	0 0.0%	88 100.0%
	<b>Total</b>	<b>1 0.1%</b>	<b>723 99.2%</b>	<b>5 0.7%</b>	<b>729 100.0%</b>
Male	Central	0 0.0%	50 100.0%	0 0.0%	50 100.0%
	Copperbelt	0 0.0%	86 98.9%	1 1.1%	87 100.0%
	Eastern	3 3.9%	73 96.1%	0 0.0%	76 100.0%
	Luapula	0 0.0%	37 97.4%	1 2.6%	38 100.0%
	Northern	0 0.0%	25 100.0%	0 0.0%	25 100.0%
	North-Western	0 0.0%	52 100.0%	0 0.0%	52 100.0%
	Lusaka	0 0.0%	99 100.0%	0 0.0%	99 100.0%
	Muchinga	0 0.0%	64 100.0%	0 0.0%	64 100.0%
	Southern	0 0.0%	73 93.6%	5 6.4%	78 100.0%
	Western	2 2.3%	85 96.6%	1 1.1%	88 100.0%
	<b>Total</b>	<b>5 0.8%</b>	<b>644 98.0%</b>	<b>8 1.2%</b>	<b>657 100.0%</b>



**TABLE IX – If YES, What Was the Nature of the Abuse \* Which Disability Category do You Identify With or Represent**

Which disability category do you identify with or represent		If YES, what was the nature of the abuse					Total
		Verbal abuse	Physical abuse	Sexual abuse	Emotional abuse	No Response	
Person with physical disability	Central	16 55.2%	0 0.0%	0 0.0%	9 31.0%	4 13.8%	29 100.0%
	Copperbelt	12 36.4%	1 3.0%	0 0.0%	0 0.0%	20 60.6%	33 100.0%
	Eastern	18 64.3%	2 7.1%	6 21.4%	0 0.0%	2 7.1%	28 100.0%
	Luapula	2 15.4%	0 0.0%	0 0.0%	0 0.0%	11 84.6%	13 100.0%
	Northern	4 44.4%	4 44.4%	0 0.0%	0 0.0%	1 11.1%	9 100.0%
	North-Western	11 45.8%	0 0.0%	0 0.0%	0 0.0%	13 54.2%	24 100.0%
	Lusaka	4 7.8%	2 3.9%	0 0.0%	21 41.2%	24 47.1%	51 100.0%
	Muchinga	0 0.0%	0 0.0%	0 0.0%	0 0.0%	25 100.0%	25 100.0%
	Southern	24 68.6%	8 22.9%	0 0.0%	1 2.9%	2 5.7%	35 100.0%
	Western	12 31.6%	6 15.8%	7 18.4%	10 26.3%	3 7.9%	38 100.0%
	<b>Total</b>	<b>103 36.1%</b>	<b>23 8.1%</b>	<b>13 4.6%</b>	<b>41 14.4%</b>	<b>105 36.8%</b>	<b>285 100.0%</b>
Hard of hearing person	Central	2 100.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	2 100.0%
	Copperbelt	2 66.7%	0 0.0%	0 0.0%	0 0.0%	1 33.3%	3 100.0%
	Eastern	3 27.3%	0 0.0%	8 72.7%	0 0.0%	0 0.0%	11 100.0%
	Luapula	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 100.0%	1 100.0%
	North-Western	5 41.7%	0 0.0%	0 0.0%	0 0.0%	7 58.3%	12 100.0%
	Lusaka	2 22.2%	0 0.0%	0 0.0%	7 77.8%	0 0.0%	9 100.0%
	Muchinga	0 0.0%	0 0.0%	0 0.0%	0 0.0%	4 100.0%	4 100.0%
	Southern	5 62.5%	2 25.0%	0 0.0%	1 12.5%	0 0.0%	8 100.0%
	Western	1 20.0%	0 0.0%	3 60.0%	1 20.0%	0 0.0%	5 100.0%
	<b>Total</b>	<b>20 36.4%</b>	<b>2 3.6%</b>	<b>11 20.0%</b>	<b>9 16.4%</b>	<b>13 23.6%</b>	<b>55 100.0%</b>

Which disability category do you identify with or represent	If YES, what was the nature of the abuse					Total	
	Verbal abuse	Physical abuse	Sexual abuse	Emotional abuse	No Response		
Deaf person	Central	2 66.7%	0 0.0%	0 0.0%	1 33.3%	0 0.0%	3 100.0%
	Copperbelt	2 28.6%	0 0.0%	0 0.0%	0 0.0%	5 71.4%	7 100.0%
	Eastern	8 72.7%	1 9.1%	0 0.0%	0 0.0%	2 18.2%	11 100.0%
	Luapula	1 12.5%	0 0.0%	0 0.0%	0 0.0%	7 87.5%	8 100.0%
	Northern	2 66.7%	0 0.0%	0 0.0%	0 0.0%	1 33.3%	3 100.0%
	North-Western	4 100.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	4 100.0%
	Lusaka	0 0.0%	0 0.0%	0 0.0%	0 0.0%	4 100.0%	4 100.0%
	Muchinga	0 0.0%	0 0.0%	0 0.0%	0 0.0%	4 100.0%	4 100.0%
	Southern	6 42.9%	4 28.6%	0 0.0%	0 0.0%	4 28.6%	14 100.0%
	Western	2 11.1%	2 11.1%	4 22.2%	8 44.4%	2 11.1%	18 100.0%
	<b>Total</b>	<b>27</b> <b>35.5%</b>	<b>7</b> <b>9.2%</b>	<b>4</b> <b>5.3%</b>	<b>9</b> <b>11.8%</b>	<b>29</b> <b>38.2%</b>	<b>76</b> <b>100.0%</b>
Person with blindness or low vision	Copperbelt	0 0.0%	0 0.0%		0 0.0%	1 100.0%	1 100.0%
	North-Western	0 0.0%	0 0.0%		0 0.0%	2 100.0%	2 100.0%
	Lusaka	0 0.0%	0 0.0%		1 100.0%	0 0.0%	1 100.0%
	Southern	0 0.0%	1 100.0%		0 0.0%	0 0.0%	1 100.0%
	Western	1 100.0%	0 0.0%		0 0.0%	0 0.0%	1 100.0%
	<b>Total</b>	<b>1</b> <b>16.7%</b>	<b>1</b> <b>16.7%</b>		<b>1</b> <b>16.7%</b>	<b>3</b> <b>50.0%</b>	<b>6</b> <b>100.0%</b>
Person with intellectual disabilities	Copperbelt	3 60.0%	0 0.0%	0 0.0%	0 0.0%	2 40.0%	5 100.0%
	Eastern	8 80.0%	0 0.0%	2 20.0%	0 0.0%	0 0.0%	10 100.0%
	Luapula	1 33.3%	0 0.0%	0 0.0%	0 0.0%	2 66.7%	3 100.0%
	North-Western	2 40.0%	0 0.0%	0 0.0%	0 0.0%	3 60.0%	5 100.0%

Which disability category do you identify with or represent		If YES, what was the nature of the abuse					Total
		Verbal abuse	Physical abuse	Sexual abuse	Emotional abuse	No Response	
Person with intellectual disabilities, cont.	Lusaka	0 0.0%	0 0.0%	0 0.0%	1 100.0%	0 0.0%	1 100.0%
	Muchinga	0 0.0%	0 0.0%	0 0.0%	0 0.0%	11 100.0%	11 100.0%
	Southern	11 91.7%	1 8.3%	0 0.0%	0 0.0%	0 0.0%	12 100.0%
	Western	1 16.7%	0 0.0%	2 33.3%	3 50.0%	0 0.0%	6 100.0%
	<b>Total</b>	<b>26</b> <b>49.1%</b>	<b>1</b> <b>1.9%</b>	<b>4</b> <b>7.5%</b>	<b>4</b> <b>7.5%</b>	<b>18</b> <b>34.0%</b>	<b>53</b> <b>100.0%</b>
Person with psychosocial disability (mental health)	Central	3 75.0%	0 0.0%	0 0.0%	0 0.0%	1 25.0%	4 100.0%
	Copperbelt	3 30.0%	0 0.0%	0 0.0%	0 0.0%	7 70.0%	10 100.0%
	Eastern	12 100.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	12 100.0%
	Luapula	0 0.0%	0 0.0%	0 0.0%	0 0.0%	3 100.0%	3 100.0%
	North-Western	4 33.3%	0 0.0%	0 0.0%	0 0.0%	8 66.7%	12 100.0%
	Lusaka	2 22.2%	2 22.2%	0 0.0%	1 11.1%	4 44.4%	9 100.0%
	Muchinga	0 0.0%	0 0.0%	0 0.0%	0 0.0%	11 100.0%	11 100.0%
	Southern	7 63.6%	2 18.2%	0 0.0%	0 0.0%	2 18.2%	11 100.0%
	Western	8 38.1%	3 14.3%	4 19.0%	6 28.6%	0 0.0%	21 100.0%
	<b>Total</b>	<b>39</b> <b>41.9%</b>	<b>7</b> <b>7.5%</b>	<b>4</b> <b>4.3%</b>	<b>7</b> <b>7.5%</b>	<b>36</b> <b>38.7%</b>	<b>93</b> <b>100.0%</b>
Person with physical disability	Central	30 47.6%	0 0.0%	1 1.6%	21 33.3%	11 17.5%	63 100.0%
	Copperbelt	45 45.0%	1 1.0%	4 4.0%	2 2.0%	48 48.0%	100 100.0%
	Eastern	67 66.3%	1 1.0%	25 24.8%	2 2.0%	6 5.9%	101 100.0%
	Luapula	4 10.8%	0 0.0%	0 0.0%	0 0.0%	33 89.2%	37 100.0%
	Northern	22 47.8%	16 34.8%	0 0.0%	1 2.2%	7 15.2%	46 100.0%
	North-Western	12 34.3%	1 2.9%	0 0.0%	4 11.4%	18 51.4%	35 100.0%

Which disability category do you identify with or represent		If YES, what was the nature of the abuse					Total
		Verbal abuse	Physical abuse	Sexual abuse	Emotional abuse	No Response	
Person with physical disability, cont.	Lusaka	8 8.1%	9 9.1%	0 0.0%	53 53.5%	29 29.3%	99 100.0%
	Muchinga	0 0.0%	0 0.0%	0 0.0%	0 0.0%	60 100.0%	60 100.0%
	Southern	36 46.8%	21 27.3%	0 0.0%	6 7.8%	14 18.2%	77 100.0%
	Western	20 25.6%	14 17.9%	7 9.0%	33 42.3%	4 5.1%	78 100.0%
	<b>Total</b>	<b>244</b> <b>35.1%</b>	<b>63</b> <b>9.1%</b>	<b>37</b> <b>5.3%</b>	<b>122</b> <b>17.5%</b>	<b>230</b> <b>33.0%</b>	<b>696</b> <b>100.0%</b>
Person with down syndrome	Central	0 0.0%	0 0.0%		1 100.0%	0 0.0%	1 100.0%
	Copperbelt	2 33.3%	0 0.0%		0 0.0%	4 66.7%	6 100.0%
	Northern	2 100.0%	0 0.0%		0 0.0%	0 0.0%	2 100.0%
	North-Western	1 20.0%	0 0.0%		0 0.0%	4 80.0%	5 100.0%
	Lusaka	0 0.0%	2 10.0%		9 45.0%	9 45.0%	20 100.0%
	Muchinga	0 0.0%	0 0.0%		0 0.0%	5 100.0%	5 100.0%
	Southern	0 0.0%	2 100.0%		0 0.0%	0 0.0%	2 100.0%
	Western	0 0.0%	0 0.0%		1 100.0%	0 0.0%	1 100.0%
	<b>Total</b>	<b>5</b> <b>11.9%</b>	<b>4</b> <b>9.5%</b>		<b>11</b> <b>26.2%</b>	<b>22</b> <b>52.4%</b>	<b>42</b> <b>100.0%</b>
Person on the autism spectrum	Copperbelt	2 100.0%			0 0.0%	0 0.0%	2 100.0%
	Eastern	1 100.0%			0 0.0%	0 0.0%	1 100.0%
	North-Western	1 33.3%			2 66.7%	0 0.0%	3 100.0%
	Lusaka	0 0.0%			1 100.0%	0 0.0%	1 100.0%
	Muchinga	0 0.0%			0 0.0%	3 100.0%	3 100.0%
	Western	1 100.0%			0 0.0%	0 0.0%	1 100.0%
	<b>Total</b>	<b>5</b> <b>45.5%</b>			<b>3</b> <b>27.3%</b>	<b>3</b> <b>27.3%</b>	<b>11</b> <b>100.0%</b>

Which disability category do you identify with or represent		If YES, what was the nature of the abuse					Total
		Verbal abuse	Physical abuse	Sexual abuse	Emotional abuse	No Response	
Person with albinism	Central	0 0.0%			0 0.0%	1 100.0%	1 100.0%
	Eastern	2 50.0%			0 0.0%	2 50.0%	4 100.0%
	Luapula	0 0.0%			0 0.0%	4 100.0%	4 100.0%
	North-Western	3 27.3%			0 0.0%	8 72.7%	11 100.0%
	Southern	1 100.0%			0 0.0%	0 0.0%	1 100.0%
	Western	0 0.0%			1 100.0%	0 0.0%	1 100.0%
	<b>Total</b>	<b>6</b> <b>27.3%</b>			<b>1</b> <b>4.5%</b>	<b>15</b> <b>68.2%</b>	<b>22</b> <b>100.0%</b>
Other. Specify	Central	5 100.0%	0 0.0%	0 0.0%		0 0.0%	5 100.0%
	Copperbelt	1 33.3%	1 33.3%	0 0.0%		1 33.3%	3 100.0%
	Eastern	6 100.0%	0 0.0%	0 0.0%		0 0.0%	6 100.0%
	North-Western	5 100.0%	0 0.0%	0 0.0%		0 0.0%	5 100.0%
	Muchinga	0 0.0%	0 0.0%	0 0.0%		2 100.0%	2 100.0%
	Southern	10 83.3%	2 16.7%	0 0.0%		0 0.0%	12 100.0%
	Western	2 33.3%	1 16.7%	1 16.7%		2 33.3%	6 100.0%
	<b>Total</b>	<b>29</b> <b>74.4%</b>	<b>4</b> <b>10.3%</b>	<b>1</b> <b>2.6%</b>		<b>5</b> <b>12.8%</b>	<b>39</b> <b>100.0%</b>
No Response	Eastern	1 100.0%				0 0.0%	1 100.0%
	Muchinga	0 0.0%				2 100.0%	2 100.0%
	Southern	5 100.0%				0 0.0%	5 100.0%
	<b>Total</b>	<b>6</b> <b>75.0%</b>				<b>2</b> <b>25.0%</b>	<b>8</b> <b>100.0%</b>

**Table X – Where/From Whom Did You First Hear About Corona virus Disease (COVID-19)**

	Radio	Television	Internet	Close contacts/friends	DPO/local NGO	Community leaders	Church	Other	Total
Chibombo	21 53.8%	2 5.1%	2 5.1%	9 23.1%	0 0.0%	1 2.6%	0 0.0%	4 10.3%	39 100.0%
Kabwe	34 60.7%	1 1.8%	3 5.4%	11 19.6%	0 0.0%	0 0.0%	0 0.0%	7 12.5%	56 100.0%
Serenje	7 46.7%	0 0.0%	1 6.7%	4 26.7%	0 0.0%	0 0.0%	0 0.0%	3 20.0%	15 100.0%
Ndola	31 50.8%	0 0.0%	4 6.6%	13 21.3%	0 0.0%	0 0.0%	2 3.3%	11 18.0%	61 100.0%
Mpongwe	25 54.3%	0 0.0%	3 6.5%	10 21.7%	0 0.0%	0 0.0%	1 2.2%	7 15.2%	46 100.0%
Mufurila	37 59.7%	0 0.0%	3 4.8%	13 21.0%	0 0.0%	1 1.6%	1 1.6%	7 11.3%	62 100.0%
Chipata	27 57.4%	0 0.0%	5 10.6%	7 14.9%	0 0.0%	2 4.3%	0 0.0%	6 12.8%	47 100.0%
Chidiza	13 65.0%	0 0.0%	1 5.0%	5 25.0%	0 0.0%	0 0.0%	0 0.0%	1 5.0%	20 100.0%
Petauke	62 53.0%	0 0.0%	4 3.4%	27 23.1%	0 0.0%	0 0.0%	10 8.5%	14 12.0%	117 100.0%
Nchelenge	11 47.8%	0 0.0%	2 8.7%	9 39.1%	0 0.0%	0 0.0%	0 0.0%	1 4.3%	23 100.0%
Mansa	35 76.1%	0 0.0%	3 6.5%	7 15.2%	0 0.0%	0 0.0%	0 0.0%	1 2.2%	46 100.0%
Kasama	20 76.9%	0 0.0%	0 0.0%	4 15.4%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	26 100.0%
Mporokoso	17 63.0%	0 0.0%	2 7.4%	4 14.8%	0 0.0%	0 0.0%	0 0.0%	4 14.8%	27 100.0%
Mpulungu	3 42.9%	0 0.0%	1 14.3%	1 14.3%	0 0.0%	0 0.0%	0 0.0%	2 28.6%	7 100.0%
Kalumbila	40 59.7%	0 0.0%	4 6.0%	10 14.9%	0 0.0%	0 0.0%	0 0.0%	13 19.4%	67 100.0%
Kasempa	14 50.0%	0 0.0%	0 0.0%	12 42.9%	0 0.0%	0 0.0%	0 0.0%	2 7.1%	28 100.0%
Solwezi	13 56.5%	0 0.0%	4 17.4%	3 13.0%	0 0.0%	0 0.0%	0 0.0%	3 13.0%	23 100.0%
Feira/Lu-angwa	23 63.9%	0 0.0%	2 5.6%	4 11.1%	0 0.0%	0 0.0%	0 0.0%	7 19.4%	36 100.0%
Chirundu	14 56.0%	0 0.0%	1 4.0%	5 20.0%	0 0.0%	0 0.0%	2 8.0%	3 12.0%	25 100.0%
Lusaka	66 49.3%	0 0.0%	4 3.0%	42 31.3%	0 0.0%	0 0.0%	5 3.7%	17 12.7%	134 100.0%
Chinsali	18 51.4%	0 0.0%	1 2.9%	9 25.7%	0 0.0%	0 0.0%	2 5.7%	5 14.3%	35 100.0%

	Radio	Television	Internet	Close contacts/ friends	DPO/ local NGO	Community leaders	Church	Other	Total
Nakonde	22 64.7%	0 0.0%	4 11.8%	7 20.6%	0 0.0%	0 0.0%	0 0.0%	1 2.9%	34 100.0%
Mpika	36 62.1%	0 0.0%	3 5.2%	13 22.4%	0 0.0%	0 0.0%	0 0.0%	6 10.3%	58 100.0%
Choma	36 57.1%	0 0.0%	3 4.8%	14 22.2%	0 0.0%	1 1.6%	4 6.3%	5 7.9%	63 100.0%
Gwembe	33 64.7%	0 0.0%	5 9.8%	8 15.7%	0 0.0%	0 0.0%	1 2.0%	4 7.8%	51 100.0%
Livingstone	37 55.2%	0 0.0%	3 4.5%	13 19.4%	0 0.0%	0 0.0%	2 3.0%	12 17.9%	67 100.0%
Kalabo	28 50.0%	4 7.1%	0 0.0%	16 28.6%	0 0.0%	2 3.6%	0 0.0%	6 10.7%	56 100.0%
Kaoma	29 56.9%	0 0.0%	3 5.9%	10 19.6%	0 0.0%	0 0.0%	2 3.9%	7 13.7%	51 100.0%
Mongu	39 59.1%	0 0.0%	5 7.6%	13 19.7%	2 3.0%	0 0.0%	0 0.0%	7 10.6%	66 100.0%
<b>Total</b>	<b>791</b> <b>57.1%</b>	<b>9</b> <b>0.6%</b>	<b>76</b> <b>5.5%</b>	<b>303</b> <b>21.9%</b>	<b>2</b> <b>0.1%</b>	<b>7</b> <b>0.5%</b>	<b>32</b> <b>2.3%</b>	<b>166</b> <b>12.0%</b>	<b>1386</b> <b>100.0%</b>

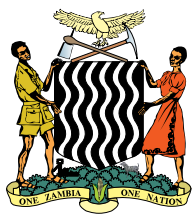












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