



Disability inclusion training curriculum

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Foreword

This training manual is the result of a collaboration between Sightsavers and Ghana Health Service as part of the Accelerate Social and Behavioral Change activity funded by USAID aimed at enabling Ghana's Health Promotion Division to achieve its Strategic Objective to lead social and behavior change efforts using tested mass media and community engagement tools, and to magnify communication for Health learnings whereby target populations sustainably adopt healthy behaviors and practices, including timely use of health services and products nationally.

As part of this activity, the Health Promotion Division staff will be able to access training around creating Health Promotion and Social Behaviour Change programming that are is responsive to the needs of the disabled community.

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Introduction

This toolkit is for facilitators running a two-day in-person training session for Health Promotion Division staff at the Ghana Health Service. It includes a manual which covers details on how to run the training, plus a section for each of the activities and topics covered throughout the training.

Each section of the training manual covers:

- Duration of the activity.
- Methodology used for the activity.
- Resources needed for the activity.
- Slides the section is referring to and that the facilitator will need to use to run the activity.

The toolkit comes with slides to be used throughout the whole training, as well as supportive resources to run the various activities. These will need to be printed out ahead of the training.



Planning the training

The importance of planning

To ensure training is successful, it's important that adequate time and resources are invested in the preparation stage. This important preparatory phase includes identifying suitable trainers, finding a suitable venue, making necessary logistical arrangements, and ensuring that participants have all the necessary information and resources needed to fully participate in the training session.

Identify suitable trainers

Good trainers can make the difference between a boring training session and a stimulating, effective and enriching experience.

For a two-day training session, a minimum of two trainers is recommended. However, it is possible (and even recommended) to identify more facilitators where appropriate. For example, two facilitators could run the entire two-day training session, but may invite other people to lead presentations or group activities which focus on specific topics in which they have particular expertise.

Given the focus of this specific training – disability inclusion in health promotion – it is highly recommended to **identify trainers with disabilities** who have experience of working in the health sector.

Involving people with disabilities as trainers has the following benefits:

- It can be really effective in challenging existing and perceived power dynamics.
- It can help to portray a positive image of people with disabilities as individuals with valuable skills, experiences and competencies.
- It will enrich the training experience. Trainers with disabilities may be able to share personal experiences of stigma, discrimination and barriers in society – as well as positive examples of accessible and inclusive environments and services.
- It will ensure that people with disabilities are involved in the implementation of a specific activity aimed at promoting disability inclusion in society.

In order to identify suitable trainers with disabilities, consider reaching out to local Organisations of Persons with Disabilities (OPDs), such as the **Ghana Federation of Disability Organisations**, and their members.

When selecting trainers with disabilities, **consider the following aspects:**

- Select individuals with proven prior experience of conducting training sessions.
- Identify trainers who have prior experience of working in the health sector.
- Select trainers of different genders, and aim for gender balance.
- Select trainers with different impairments – such as a wheelchair user or a person who is deaf – as they will be able to bring different personal experiences to the training room.
- Ask whether they require any reasonable accommodations (see box).

Reasonable accommodations

Reasonable accommodations are changes or adjustments that must be put in place to ensure that people can participate in a specific activity on an equal basis with others. In the case of this training, both facilitators and participants may require reasonable accommodations.

Here are some examples:

- **A person who is deaf may require sign language interpretation** to participate in the training. Remember that sign language interpretation can be extremely tiring; for this reason, it is usually necessary to hire two sign language interpreters, so that they can alternate and take some breaks.
- **A person with visual impairments may require materials in accessible formats**, such as braille or large print.
- Other people with disabilities, such as **people with physical impairments, intellectual impairments or psychosocial disabilities may require personal assistants** to participate in training activities. In many circumstances, they will have their own personal assistants, and these people will need to be counted when planning refreshments and lunches. Additional per diems or reimbursements may also need to be provided.
- Some people with disabilities will also face **disproportionate barriers in reaching the training venue**, due to a lack of accessible public transportation or additional costs to hire private accessible transport. Consider discussing with these individuals how best they can be supported. For example, you could arrange transportation options for them, or provide additional reimbursements to cover transportation costs.

Once trainers have been identified, it is important to ensure they have adequate time and resources to prepare for the delivery of the training. For example, ensure that:

- Trainers have access to this training toolkit.
- Trainers contribute to the development of the training plan, e.g. selection of dates, venue etc.

Experienced trainers should be able to organise and facilitate the activities proposed in this manual, given adequate time is provided for them to review all the resources. However, in some circumstances it may be appropriate to organise a **training of trainers**. This could be led by experienced trainers of OPDs, such the Ghana Federation of Disability Organisations, to equip more junior members of their organisations with the necessary skills to deliver the training. It could also be led by other organisations with disability inclusion expertise, such as Sightsavers.

Find a suitable venue

One of the first tasks for training organisers is to identify a venue where the training will be conducted.

The expected number of participants is an important factor to consider: the venue needs to have **sufficient space** to accommodate all of them during the training activities. Remember that participants will not remain seated in the same position for the entire duration of the training; rather, they will be asked to conduct activities in small groups, as well as to conduct exercises that will require adequate space for them to move freely.

Ideally, select a venue which has **multiple rooms available**, so that people can move between different spaces during the day, particularly for breaks and lunches.

Consider aspects related to **light, sound and ventilation**:

- If participants are asked to spend the day in a dark room, they will get tired more easily. Select a training venue which has good lighting, and ideally natural light.
- If the training room has poor acoustics and a lot of background noise (from an electric generator, for example), participants will be more easily distracted and will struggle to hear properly. Choose a room with good acoustics, far away from background noises. Consider using microphones and loudspeakers to increase sound accessibility for everyone.
- If participants are too hot or cold, they will not be able to concentrate on the training. Ensure your venue has an adequate temperature (not too hot and humid, nor too cold due to excessive use of air conditioners) and that there is adequate ventilation.

A fundamental aspect that needs to be considered is the **accessibility of the venue**. Both participants and facilitators, as well as other individuals supporting the logistics of the training, may be people with disabilities, older people or people with other accessibility requirements. Selecting an accessible venue is a prerequisite to ensuring everyone involved has a positive experience in an inclusive setting.

When exploring a potential training venue, ask the owner what accessibility features they have in place. Additionally, visit the site and verify whether the venue is sufficiently accessible and whether any adjustments are required.

For example, **consider the following aspects:**

- Does the venue have accessible parking spaces?
- Is the main entrance to the building accessible? If there are steps, is an accessible ramp provided? If not, is there a more accessible alternative entrance elsewhere in the building?
- Is the route from the entrance to the training rooms accessible (e.g. clear pathways, no obstacles, no steps etc.)?
- Is the training room accessible (e.g. clear space for wheelchair users to move around, adequate lighting etc.)?
- Are there accessible toilets for people with disabilities (e.g. larger barrier-free toilets with support rails, clear space near the toilet seat, lower washbasin etc.)?

Remember, even if you are familiar with trainers and participants, not all disabilities are visible, and people may choose not to disclose their disability. Each trainer still has a right to participate in the training activities on an equal basis with others in an accessible environment.

Once a suitable venue has been identified, confirm the training dates with the owners and ensure the venue is reserved.

Inviting participants

Once the training venue and dates have been confirmed, send invitations to each participant with plenty of advance notice for them to plan their participation. In some circumstances, invitations may need to be sent to a specific authority, who will then be responsible for sharing the invite with their staff and encouraging them to participate. It is always useful to request that people confirm their participation, so you can adequately plan the session.

When sending the training invites, **provide clear information on key details** such as date, time and address. Use simple language and accessible materials to do this. You should also specify whether there is any task that needs to be completed before the training, or any materials that participants are expected to bring.

It is very important to **ask whether participants require reasonable accommodations** (see previous box).

Preparing training materials

Before the training session, organisers and facilitators will need to prepare necessary training materials and equipment.

This may include verifying whether tools such as a projector, flipcharts, pens, markers and sticky notes will be provided by the training venue, or whether they need to be procured separately.

The following resources will need to be printed before the training session:

- Tool 1: Printed pictures
- Tool 2: Character profiles
- Tool 3: Health equity recipe
- Tool 4: Alt text example image cards
- Tool 5: Accessible language and text exercise supporting document
- Tool 6: Accessible visual content exercise
- Tool 8: Accessibility checklist

Additionally, facilitators may benefit from having a printed copy of this training manual, and are encouraged to use the slide deck included in the training pack.

The last exercise of day 2 of the training requires the use of laptops by the participants (one laptop for each group of 6-8 people). Tool 7 needs to be provided to participants in a digital format to complete the last exercise.

Preparing the training room

Different seating arrangements can influence the experience of training participants.

The **boardroom-style seating arrangement** is commonly used for training sessions. In this scenario, chairs and desks are organised in a rectangular U-shape. Participants sit on the outside of the desks looking inwards, and everyone faces each other. Facilitators can also sit at the desks and stand up occasionally to deliver presentations or for specific activities.

This arrangement has a few advantages. First of all, participants are facing each other, which make the setting more inclusive. Additionally, sitting at a desk makes it easier for participants to take notes and to keep water and refreshments close to hand. This seating style is also useful for participants who may require the use of accessibility devices such as braille readers. This seating arrangement is very common. Participants, including those in more senior roles, will be familiar and comfortable with it, plus it brings everyone together while preserving a certain amount of personal space.

However, this setup also has a few disadvantages. Participants may keep their laptops, tablets

and phones in front of them, which could end up being a source of distraction during the session. Additionally, this arrangement is very formal and not particularly dynamic; participants cannot easily move for group activities, and their static position may lead them to become tired more easily.

Another type of arrangement is the **semi-circle without desks**. In this setup, chairs are arranged in a semi-circle with everyone facing one another, and the facilitator standing in front of the semi-circle.

One of the advantages of the semi-circle is that it is much more participatory and dynamic. Participants do not have a desk in front of them, and chairs can easily be re-arranged for group activities, forming smaller circles. Additionally, in this setup participants will not be able to keep their computers in front of them, which could lead to distraction, and therefore allow much more

Training module overview

Training participants

This module was designed to train headquarters staff of the Health Promotion Division (HPD) in Ghana.

Overall goal

To equip staff of Ghana HPD with the knowledge and practical skills to incorporate disability inclusion into their work.

Training objectives

By the end of this training, participants will be able to:

1. Describe key **human rights principles related to disability**.
2. Explain the correlation between gender, disability, poverty and health.
3. Compare positive and negative **disability terminology**.
4. Describe key **factors leading to health inequities experienced by people with disabilities** in all their diversity.
5. Identify **practical solutions to incorporate disability inclusion into their work**.
6. Design **accessible information and communication materials**.

Duration

Two days

Modality

In-person / face to face

Facilitators

It is recommended to involve two people with disabilities (including at least one woman) as facilitators.

Training agenda overview

Day one

Time

Topic

9:00 – 9:35

Session 1: Introduction

9:35 – 10:40

Session 2: Introduction to disability

10:40 – 11:00

Break

11:00 – 13:30

Session 2: Introduction to disability (continued)

13:30 – 14:30

Lunch

14:30 – 16:15

Session 3: Health equity for people with disabilities

16:15 – 16:25

End of day 1

Day two

Time

Topic

9:00 – 9:30

Session 4: Recap of day one

9:30 – 10:35

Session 5: Inclusive and accessible communication

10:35 – 10:55

Break

10:55 – 12:50

Session 6: General accessibility guidelines

12:50 – 13:50

Lunch

13:50 – 14:40

Session 7: Accessible video and website content

14:40 – 15:40





Session 8: Final group exercise

15:40 – 16:00

Conclusion

Session 1: Introduction





1.1 Welcoming participants

	Duration	25 minutes
	Methodology	Frontal presentation + individual introductions
	Resources	Slides
	Slides	1-4

At the beginning of this section, facilitators introduce themselves and welcome participants. Participants are then invited to introduce themselves one by one.

Facilitators provide an overview of the training structure and objectives.

1.2 Ground rules

	Duration	10 minutes
	Methodology	Plenary discussion
	Resources	Flipchart + markers + tape or Blu Tack
	Slides	5

When all participants have completed the questionnaires, facilitators invite participants to agree on a set of ground rules. Participants are invited to share their ideas in plenary, and facilitators write them on a board or flipchart that will be visible for the entire duration of the training.





Facilitators and participants will be able to refer to these ground rules whenever they feel they are not being observed.

Examples of ground rules include:

- All contributions are valuable.
- There is no 'right' or 'wrong' question.
- Everyone is encouraged to participate.
- Give time and space for everyone to express themselves.
- Respect each other.
- Do not criticise other people's ideas.
- Mobile phones should be switched off.
- Respect punctuality in the morning and after breaks.

Session 2: Introduction to disability

2.1 Disability pictures

	Duration	30 minutes
	Methodology	Team activity + plenary discussion
	Resources	Tool 1: Printed pictures
	Slides	6-7

Before the session, facilitators arrange a series of images on a table (Tool 1). Print two sets of images if you have more than 10 participants.

Participants are invited to select an image that catches their attention, and to return to their seats.

Once all participants have chosen a picture, facilitators invite them to explain why they chose it and how it relates to disability. For example, a participant may select an image portraying a group of children in school, and they could explain that this reminds them of the right to education for all children, including those with disabilities. Another participant may select an image of a staircase, and explain that it reminds them of environmental barriers in society.

Facilitator also invite participants to conduct an “alternative text” exercise. Facilitators explain that blind people would not be able to see the images, and that alt-text is a short description usually incorporated into images within documents to allow blind people who use screen readers to access a description of the image. In order to practise their alt-text skills, participants are then invited to provide a short but accurate description of the image they have selected, before sharing their own reflections on the picture.

Facilitators prompt participants to share thoughts and reflections on the images selected and the topics raised.

Facilitators thank all participants for their contributions, explaining that many of these topics will be further elaborated on during the training.

2.2 People with disabilities: a small minority?

	Duration	15 minutes
	Methodology	Plenary discussion
	Resources	Slides
	Slides	8

Facilitators explain that people with disabilities are often considered a small minority group, and they are often not prioritised for this reason.





The World Health Organisation (WHO) estimates that 16 per cent of the global population lives with a disability – that's 1.3 billion people (or one in six people). While people with disabilities are often considered a minority group, the global population of people with disabilities is nearly 39 times the entire population of Ghana!



The number of people with disabilities is destined to increase due to the interplay of numerous factors such as ageing and an increase in non-communicable diseases. Nearly one in three people over the age of 60 lives with a disability, and disability is more prevalent among women compared to men.

In Ghana, according to 2021 Population and Housing Census, over two million people (approximately 8 per cent of the population) live with a disability. However, the WHO estimates that nearly 80 per cent of the 1.3 billion people with disabilities live in low- and middle-income countries. The prevalence for the African region is estimated at 12.8 per cent, but it is worth highlighting that underdiagnosis and underreporting may lead to underestimation in many countries.

2.3 Defining disability

	Duration	20 minutes
	Methodology	Group activity + plenary discussion
	Resources	Paper and pens
	Slides	9

Facilitators divide participants into small groups and invite them to come up with a shared **definition of disability**.

Splitting participants into small groups

Participants usually tend to sit near people they already know; additionally, women tend to sit with women, and men tend to sit with men. For these reasons, it is useful to mix participants when conducting activities in small groups; this will give them the opportunity to interact with new people, and will make the training experience more engaging and enriching.





You can use different techniques to divide participants into different teams. For example, one option is to arbitrarily assign each of them to a specific team; this gives facilitators more control, and can help the creation of more gender balanced teams. Alternatively, if they are sitting in a semi-circle, you could ask the first four participants to tell you their favourite animal. You will then assign those animals to each participant using a sequential pattern (e.g. elephant, tiger, cat, penguin; elephant, tiger, cat, penguin; etc.). All elephants will form a team, all tigers will form another team, and so on.

After 10 minutes, participants are invited to sit again in plenary and to share the definitions elaborated by each group.

Facilitators thank participants for their contributions and invite them to reflect on the definitions presented, identifying similarities and differences.

At this stage, facilitators do not yet share a correct definition – this will be presented later.

2.4 Models of disability

	Duration	30 minutes
	Methodology	Frontal presentation + plenary discussion
	Resources	Slides
	Slides	10-17

Using the slides facilitators present an overview of different so-called models of disability. These are theoretical frameworks which underpin different understandings of disability.

Medical model of disability

The first model presented by facilitators is the **medical model of disability**. For a long time, disability has been portrayed as an **individual problem**. The medical model of disability has historically focused on **“curing” individual impairments**, without considering any changes which may be required in society.

Proponents of this approach looked at people with disabilities as “defective” or “abnormal”, and focused their resources on “fixing” their bodies and minds in order to conform with what society considers to be “normality”. In this framework, it is responsibility of individuals with disabilities to adapt to the way in which society is constructed and organised.

This approach is incredibly stigmatizing and has led many people to be over-medicalised and abused.

Example of a medical model approach

- A child is born deaf and is given a cochlear implant at the age of two.
- The child is also given speech therapy and encouraged to speak.
- The child is not exposed to the Deaf community, nor invited to learn sign language.
- The focus is on fixing the child’s hearing impairment.
- The family does not receive any form of social support.

Important: promoting a medical model of disability and promoting access to healthcare for people with disabilities are very distinct approaches. People with disabilities, like anybody else, require access to quality healthcare, which is a fundamental human right (more on this in Session XX). Historically, however, proponents of the medical model imposed a medicalised understanding of disability, in which the treatment of individual impairments and health conditions was seen as the only intervention required to “cure” people with disabilities and integrate them in society. Additionally, in this context, people with disabilities have often been deprived of their agency and bodily autonomy, and medical interventions have been carried out without their consent and without access to clear and accessible information.

As we will see with other models, access to healthcare – based on informed consent and bodily autonomy – is fundamental; however, on its own it cannot lead to the meaningful inclusion and participation of people with disabilities in society.

Charity model of disability

Facilitators explain that the **charity model of disability** is closely related to the medical model.

Within this framework, people with disabilities have been historically seen as **helpless “victims” who need charity and protection**.

This approach is very patronising, as it assumes that people with disabilities cannot be independent and always require others to protect them and make decisions on their behalf.

Example of a charity model approach

- A child is born deaf and people assume they will never be able to attend school like other children.
- When people find out that the child is deaf, they use expressions like ‘poor child’ and ‘such a misfortune’.
- People feel that the child will not be able to achieve much in life, and that they may end up begging in the street.

Social model of disability

Facilitators explain that in the 1970s, people with disabilities started to organise themselves in different countries to contrast the dominant medical model. It was at this point that the **disability rights movement** was born.

Facilitators further explain that activists of the disability rights movement began to describe disability from a social perspective, demanding civil rights and fighting discrimination. As part of this approach, they started **separating the concept of individual impairments from disability**, which is seen as a **form of oppression imposed by society, giving birth to the social model of disability**.

In this model, **it is society that disables the individual, rather than their individual impairments**. For this reason, activists start demanding the removal of external barriers in society.

Example of a social model approach

- A deaf woman struggles to access information on sexual and reproductive health and rights, because no one at the local clinic is able to communicate with her.
- A local activist group requests a meeting with the managers of the health facility and convinces them to connect with the local association of sign language interpreters to provide interpretation services to deaf patients.
- The facility also develops accessible information materials on available services, including an educational video with captions and sign language interpretation.
- When the deaf woman returns to the facility, she is able to watch the video and learn about different contraceptive services available. She is also able to request sign language interpretation for her private meeting with the health counsellor.

Interactional models of disability

Facilitators explain that, over time, new **interactional models of disability** emerged. These tend to be less polarised frameworks compared to the medical and social models, and recognise that internal and external factors act simultaneously.

These models consider the interplay of different factors, in which impairments, social influence and disability are placed in a continuum.

Example of an interactional model approach

The World Health Organisation (WHO)'s International Classification of Functioning (ICF) is based on an interactional model of disability.

For example:

- A child is born deaf. This is considered an impairment in their body function or structure.
- The child cannot hear. This is an activity limitation, resulting from their health condition.
- There is no sign language interpreter in the school. This is an environmental factor.
- The child cannot attend school alongside other children. This is a participation restriction, resulting from the combination of activity limitations and lack of environmental adaptations.

Human rights model of disability

Facilitators explain that the **human rights model** differs from every other model as it does not focus on what people can or cannot do. Instead, it focuses on this fundamental principle:

People with disabilities have the same rights as everyone else in society.

This model recognises disability as a natural and common aspect of the human experience and is based on the principle that all individuals are entitled to inalienable human rights.

Example of a human rights model approach

- A child is born deaf. Their right to healthcare, social inclusion and education must be guaranteed.
- The child is supported to access necessary health services – both general healthcare required by all children (such as vaccinations) as well as specialist health services related to their impairments.
- The health facility has been designed to be accessible to people with different impairments, and staff and volunteers have received disability inclusion training.
- At the same time, the family of the child receives information on available social protection schemes, social support services and organisations in their local area which support children with disabilities.

Group reflection

In plenary, facilitators invite participants to reflect on the different models, sharing their thoughts and observations.

Facilitators can ask the following questions to guide the conversation:

- Do you have any questions on the differences between models?
- What are your views on the different models?
- Do you think there is a predominant model in Ghana?

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)

Facilitators ask participants whether they know any international treaty which could underpin the human rights model. Subsequently, they explain that this approach is grounded in a revolutionary international document, the **United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)**.

Spotlight on the UNCRPD

The UNCRPD is an international human rights treaty which entered into force in 2008. The Convention represents a paradigm shift from viewing people with disabilities as “objects” of charity and medical treatment towards viewing **people with disabilities as “subjects” with human rights** who are capable of claiming those rights and making decisions for their lives based on their free and informed consent, as well as being active members of society.

The UNCRPD describes the rights of people with disabilities in many areas, including education, employment, health, political participation and justice.

The UNCRPD is legally binding. This means that when a State ratifies the Convention, they commit to upholding the rights and obligations contained in the Convention. As of May 2022, it has 164 signatories and 185 ratifications. **Ghana ratified the UNCRPD on 12th March 2012.**

After a general introduction to the UNCRPD, facilitators present the **definitions of disability provided in the preamble (e) of the UNCRPD:**





Disability is an evolving concept that results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.

And the **definition of persons with disabilities in Article 1 of the UNCRPD:**

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Participants are invited to discuss and share their thoughts on the different models, and to compare their definitions of disability with the definition presented in the UNCRPD.

2.5 Understanding disability constituencies

	Duration	30 minutes
	Methodology	Frontal presentation + plenary discussion
	Resources	Flipchart and marker
	Slides	18-20

Facilitators invite participants to share in plenary the different groups of people with disabilities they are familiar with. As participants provide their responses, facilitators write them on a flipchart.

Grouping people with disabilities

Once all inputs have been recorded, facilitators explain that people who have similar impairments are very often grouped in so-called 'disability constituencies'.

Sometimes, **this process is led by people with disabilities themselves**. This happens when individuals with similar impairments decide to form an organisation to advance the rights of people experiencing similar barriers. These organisations are often called **Organisations of Persons with Disabilities (OPDs)**. People choosing to join these organisations will generally self-identify with that disability constituency. At this stage, facilitators ask participants in plenary to name some of these organisations.

The disability movement in Ghana

In Ghana there is a national network of people with disabilities which brings together different constituencies. The network is called **Ghana Federation of Disability Organisations (GFD)** and is formed by nine member organisations:

- Ghana Blind Union
- Ghana National Association of the Deaf
- Ghana Society of the Physically Disabled
- Ghana Association of Persons with Albinism
- Mental Health Society of Ghana
- Inclusion Ghana – a group of people with intellectual disability
- Share Care Ghana – a group of people with auto-immune and neurological disorders
- Burns Survivors Association – Survivors of various degrees of burns
- Ghana Stammering Association – people with various levels of speech impediment.

The GFD generally focuses on cross-cutting disability issues, while its member organisations focus on their specific disability needs (although GFD also has a specific focus on people with deaf-blindness and leprosy).

These OPDs are also organised with smaller chapters in different regions of the country. Additionally, many smaller OPDs exist in Ghana and advocate for the inclusion of people with disabilities at local level.

Facilitators go on to explain that, in other circumstances, people with disabilities are **grouped into constituencies by other stakeholders and for different purposes**. For example, government agencies or non-government organisations may label people into different groups for narrative, planning or monitoring purposes. In this case, however, it is important to recognise that people with disabilities who supposedly belong to those groups may not necessarily identify as such.

The Washington Group questions

In recent years, there have been considerable efforts to systematise processes aimed at collecting data on people with disabilities. One of the most common tools used around the world, as well as in Ghana in the 2021 Census, is the **Washington Group Short Set on Functioning**. This questionnaire does not ask directly about impairments or disability; rather, it includes six questions on functional limitations related to key domains, such as hearing, seeing, walking or climbing steps, remembering or concentrating, self-care and communication. This is based on the ICF and is an interactional model of disability (see previous section). The tool is useful to identify people who experience disability in different domains and it can be used for planning purposes. However, not all people who report a disability responding to these questions will identify as a person with a disability. For example, older people often report severe functional limitations in multiple domains (such as hearing or walking). Due to their functional limitations and barriers in society (such as lack of elevators in a building or limited access to hearing aids) they will experience disability. However, they may not necessarily identify as individuals with disabilities when asked directly.

Read the Census report: **Ghana 2021 Population and Housing Census. General Report, Volume 3F. Difficulty in Performing Activities**

Learn more about disability data: **Washington Group Short Set on Functioning**

Identity as a fluid concept

Additionally, facilitators remind participants that **identity is a fluid concept** and individuals with similar physical characteristics may identify in very different ways. For example:

- Some people born with hearing impairments use assistive devices such as hearing aids and cochlear implants, and view themselves as individuals with a hearing loss. Despite their impairment, they aim to function within the broader hearing community using their residual hearing as well as through speech.
- Other people with the same condition consider themselves to be deaf, belong to the deaf community, consider their local sign language as their native language, and often regard themselves as belonging to a socio-linguistic minority. Deaf people don't aim to integrate into society despite their impairment – rather, they are often proud of their deaf identity.

Disability constituencies

As we have seen, defining disability and people with disabilities is less straightforward than it may seem.

At this stage, facilitators share a list of some of the most common disability constituencies found in Ghana and abroad. They remind participants that these are not fixed and clearly defined groups, and that not everyone will self-identify with them:

- **People with visual impairments.** This label often refers to a broad range of people – from individuals who are fully blind, to people with extremely limited residual sight, to people with mild eye conditions.
- **People with hearing impairments.** As we have seen in the example above, this not only includes people with different levels of residual hearing – from fully deaf to some residual hearing – but also very different identity connotations.
- **People with physical impairments.** This is a broad category often used to refer to very diverse groups of individuals who were born with specific health conditions or who acquired them later in life. Examples include individuals with cerebral palsy, multiple sclerosis, amputations, dwarfism and spinal cord injuries.
- **People with cognitive or intellectual impairments.** These definitions are often used to refer to individuals who may experience difficulties with one or more types of mental tasks, such as remembering, reading, linguistic and verbal comprehension, math comprehension, visual comprehension, paying attention, processing or producing information. Several conditions can be linked to cognitive and intellectual impairments, such as:
 - **Learning difficulties** such as dyslexia, dyscalculia or dysgraphia, which can cause problems with reading, writing, spelling or numbers, but don't impair general intelligence.
 - **Developmental disabilities** including autism and Asperger syndrome, which influence how people perceive the world and interact with others.
 - **Genetic or congenital conditions** such as Down syndrome or microcephaly, which can cause a range of intellectual disabilities.
 - **Conditions such as dementia**, an umbrella term used to describe several progressive or chronic diseases affecting memory, other cognitive abilities and behaviour.

- **People with mental health conditions and psychosocial disability.** These include individuals with conditions such as anxiety, depression, phobias, bipolarism and schizophrenia.
- **People with chronic illnesses and energy-limiting conditions.** These include people living with conditions such as heart disease, cancer, diabetes, stroke, arthritis, fibromyalgia and chronic fatigue syndrome.
- **People with multiple impairments.** Some people live with more than one impairment. For example, deaf-blind people experience impairments both in the sight and the hearing domains.

Remember: some individuals may not identify as people with disabilities, but may experience very similar barriers. For example, older people may not consider themselves to have a disability, but they often experience functional limitations in many domains – which are further aggravated by barriers in society.

Invisible disabilities

Certain individuals can be **easily identified as people with disabilities**, for example those using specific assistive devices, such as wheelchairs, crutches, walking sticks, white canes or hearing aids. It is also the case for people whose conditions have visible manifestations – such as albinism, dwarfism, cerebral palsy, Down syndrome or amputations.

Many people with disabilities, however, live with so-called **invisible disabilities**. These are individuals who experience numerous barriers in society on a daily basis, but their health conditions and impairments may not be immediately obvious. This is the case, for example, of people with anxiety, depression, schizophrenia, autism, energy limiting conditions and many others.

Remember: be kind, and don't make assumptions!

Disability and intersectionality

As we have seen in this section, the expression 'people with disabilities' hides an incredibly diverse and rich world of individuals with their own unique characteristics and experiences. However, this goes beyond individual impairments.

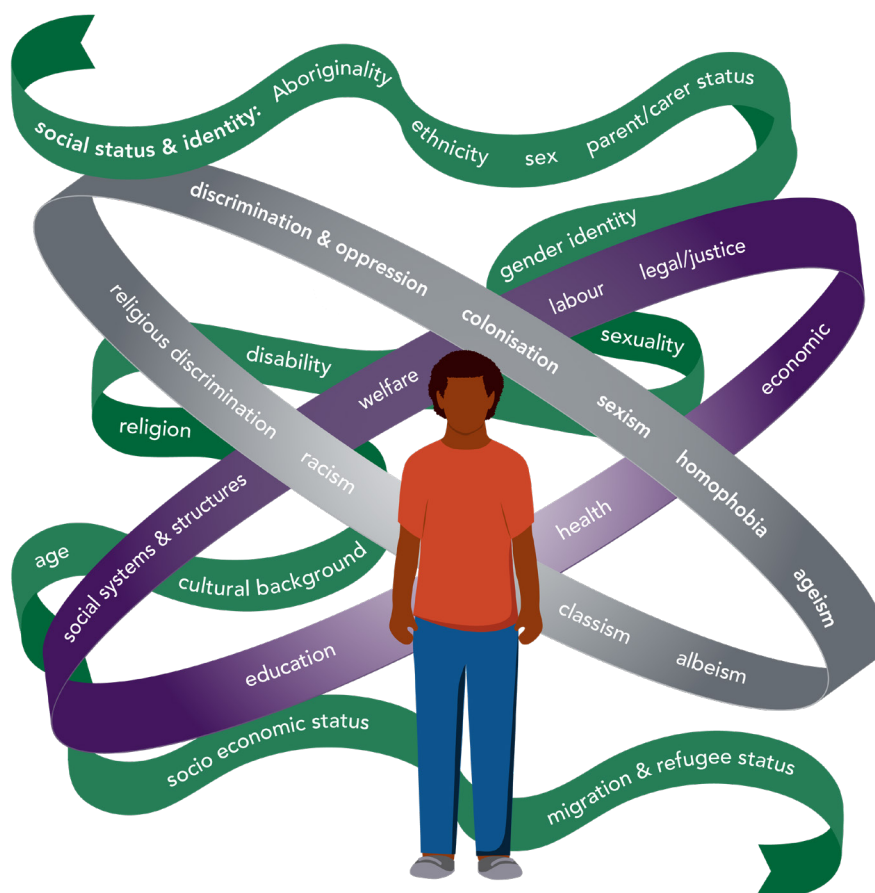
Facilitators now invite participants to share in plenary examples of other traits which could define the identity of people with disabilities, on top of their individual impairments and health conditions. As participants provide their responses, facilitators write them on a flipchart.

Once all inputs have been received, facilitators explain that people with disabilities, in fact, are not just “people” with disabilities: they are mothers, sons, grandfathers, architects, priests, engineers, artists. **People with disabilities have multiple intersecting identities, exactly like any other human being.** Therefore, it is essential to consider the inclusion of people with disabilities in society – including within the health sector – not only in light of their individual impairments, but also in relation to their complex identities.





For example, **women with disabilities** often experience multiple layers of discrimination on the grounds of their disability and their gender. In fact, they can be discriminated against by both men and women without disabilities because of their impairments, while still experiencing discrimination due to their gender and their existence in a patriarchal society.

Multiple layers of identities – such as gender, age, ethnic group, language, socioeconomic status, sexual orientation, migratory status and many other factors – **can add up to cause multiple layers of discrimination.**

It is therefore crucial to not look at people with disabilities just as people with disabilities – but to consider the multiple forms of exclusion they face, linked to their intersecting identities.



2.6 The language of disability

	Duration	45 minutes
	Methodology	Group activity + plenary discussion
	Resources	Sticky notes and pens + flipchart
	Slides	21-22

In this session, facilitators invite participants to explore the language of disability, identifying positive terminology as well as negative expressions that should be avoided.

The power of language

Facilitators explain that the language we use defines reality. Language is never neutral: positive language can empower people, while derogatory terms can have a real negative impact on the lives of people and their inclusion in society.

Facilitators explain that language is fluid and dynamic. Terminology evolves over time: certain expressions that were considered acceptable 50 years ago may not be acceptable today. Similarly, some expressions may have different meanings in different places.

Identifying positive and negative disability terminology

Facilitators divide participants into small groups and invite them to identify positive and negative words used to describe disability and people with disabilities. Participants can use words in English as well as terms in local languages and dialects. Participant are invited to write each word on a separate sticky note.

While participants conduct their group work, facilitators draw a line in the middle of a flipchart sheet. On one side, they draw a happy face (representing positive words); on the other, they draw a sad face (representing negative words).

After 10 minutes, participants are invited to stick their notes on the flipchart in either the positive or negative column.

Facilitators go through each of the words, asking participants to share their reflections and explain why they think certain words are positive or negative. Facilitators should aim to create an open space for participants to share their thoughts, and should not express any judgment on the opinions presented.

Once all the words have been discussed, facilitators show a slide and distribute a handout with a list of suggested disability terminology. Facilitators go through each term, explaining why some are encouraged and some are discouraged.

Use	Avoid
People with disabilities / person with a disability / disabled people/person	Differently abled / PWD / special needs / cripple / invalid / victim / handicapped / suffering from
Person or people with [name of disability]	The blind / the deaf etc.
People without disabilities / person without a disability	Able-bodied / normal
Blind / partially sighted person / person with low vision / person with visual impairment / person with albinism	
Person with a physical disability / wheelchair user / person with cerebral palsy	Confined to a wheelchair / wheelchair-bound / spastic
Deaf person / person with a hearing loss / person who is hard of hearing	Deaf and dumb / deaf-mute
Person with restricted growth / short stature / dwarfism / little person	Midget
Person with cognitive / intellectual / learning / developmental disability / autistic person / person with autism / person on the autism spectrum / dyslexic person / person with dyslexia / person with Down syndrome / person with dementia etc. / neurodiversity	Mentally handicapped / mentally defective / retarded / subnormal / mongoloid
Person with mental health condition / psychosocial disability / depression / bipolar / anxiety etc.	Insane / mad / crazy / stupid / mental / imbecile

Identity-first language

Facilitators explain that some people, such as proponents of the social model of disability, often prefer to use the terms **'disabled person'** and **'disabled people'**. This is generally called an **'identify-first' approach**. Their argument is that the expression 'disabled person' intuitively suggests that the individual is in fact disabled by society. Additionally, many people consider their disability as a fundamental element of who they are – and therefore choose to use identity-first language.

For example, many people prefer to self-identify using the following terms:

- Autistic
- Blind
- Deaf
- Dyslexic

Facilitators explain that people without disabilities should not define how people with disabilities should identify themselves. Their own preferences and choices should always be respected.

Facilitators further remind participants that if in doubt, there is a simple guiding principle that they should follow: **ask people with disabilities themselves what terminology and expressions they prefer.**

Person-first language

Facilitators explain that, following the adoption of the UNCRPD, the expression '**persons with disabilities**' has become standard in the development sector. This is based on the so-called '**person-first**' approach, which highlights how people with disabilities are, first and foremost, individuals. In formal contexts, such as in United Nations documents, the plural expression 'persons' is generally used, while in less formal circumstances the plural 'people' is more commonly used.

Expressions that are commonly used include:

- Person with Down syndrome
- Person with cerebral palsy
- Person with a mental health condition
- Person with hearing impairments
- Person with visual impairments
- Person with intellectual impairments
- Person with albinism

Patronising and offensive language

Building on terminology shared by participants, facilitators explain that there are certain expressions which are generally well intended, but which are often considered very **patronising** by people with disabilities.

Examples include:

- Differently abled
- Physically or mentally challenged
- Person with special needs

These terms are often considered very condescending. Rather than promoting the inclusion of people with disabilities, they seem to somewhat deny the reality of disability as a concrete and meaningful experience of each individual.





Facilitators further explain that other terms are now considered **outdated and very offensive**, and they should never be used.

These include:

- Handicapped
- Retarded
- Defective
- Crippled
- Spastic
- Wheelchair-bound
- Dumb
- Imbecile
- Mental
- Midget

Facilitators check if there are any final questions or comments before moving to the next activity.

2.7 Game of life

	Duration	45 minutes
	Methodology	Group activity + plenary discussion
	Resources	Tool 2: Character profiles
	Slides	23

Facilitators divide participants into three or four small groups, and invite them to take part in the 'game of life'¹.

Facilitators distribute a 'character profile' card (Tool 2) to each group, explaining that they will need to identify with their character during the following activity.

Each character profile includes a picture of the character along with their name, gender, disability and socioeconomic status.

Facilitators invite each group to select a volunteer who will represent the specific character during the activity. Volunteers are then asked to stand in line in the middle of the room, facing the same direction.

Facilitators explain that they will read a life story, taking the characters on a journey from birth to old age. At each significant life event, each group will need to think how their character will be impacted, and will have a few seconds to discuss and identify possible barriers that their character may face.

Facilitators emphasise that group members must focus on what they think is the reality of the situation for those individuals in Ghana – and not what they think should be morally right or the ideal scenario.

Based on the consensus within their respective groups, at each life event the volunteers will need to take one step forward for a positive or successful experience, or one step backward for a negative or unsuccessful experience.

Facilitators explain that volunteers are not allowed to participate in the discussion. Their task is simply to follow the instructions of their group members.

Facilitators ask whether anyone has any questions, and make sure everyone is ready to start the activity. Once everyone is ready, facilitators pause for a few seconds in silence, allowing participants to concentrate and enter the right mood for the activity. Using a soft and calm voice, one of the facilitators starts reading the following story.

The image displays five character identity profile cards, each featuring a photograph of a person and a list of attributes. The cards are arranged in two rows: Grace, Daniel, and Esther in the top row; Emmanuel and Linda in the bottom row. Each card has a yellow header with the name and 'IDENTITY PROFILE', a white box with the location, and a list of attributes with corresponding icons.

Name	Location	Attributes
Grace	NUNGUA	Female, Blind, Urban town location, Family is below the poverty line
Daniel	EKUMPOANO	Male, Deaf, Rural community location, Family has a minimal income
Esther	ACCRA	Female, No disability, Urban city location, Family is below the poverty line
Emmanuel	KPANDU	Male, Born without legs, Urban city location, Family is wealthy
Linda	GBUGLI	Female, Intellectual disability, Rural village location, Family has an average income

¹ This activity was adapted from a training resource originally developed by World Vision: www.worldvision.org.uk/media/ngtl0cz4/training_activity_4_game_of_life.pdf

Game of life story

1. One fine day, after a long wait of nine months, your character is born. How does your family feel when they see who you are? Think about their reactions and make your moves.
2. An international organisation is conducting vaccination camps for children in the local area. How likely is it that you will be included in these camps?
3. Now you are a bit older. Most children of your age are attending school, where they get a free eye check-up supported by a local hospital. How likely is it for you to be screened at school? Think about barriers and make your moves.
4. You are now a teenager. Local organisations are conducting awareness campaigns on sexual and reproductive health within social and sport clubs. How likely will it be for you to be reached by these messages?
5. Now you are 20. You want to make some money for your family and do something to support your community. You try to get a paid job in the healthcare sector. How easy will it be for you to find one? Think about barriers and make your moves.
6. Everyone in your age group is getting married and planning to have babies. Will this be a possibility for you? Think about barriers and make your moves.
7. Thanks to a local radio programme, young families in your community are learning about the importance of family planning. How easy will it be for you to access this information? Think about barriers and make your moves.
8. Now you are in your 40s. International organisations are running awareness campaigns and screening camps on HIV, malaria and other diseases. How likely is it that you will have access to the information shared in the campaigns and be included in the health screenings? Think about barriers and make your moves.
9. You are in your 50s. Today you are not feeling very well and you think it may be a good idea to get some help. However, you are very busy, the hospital is far away, and you are afraid of doctors. How likely is it that you'll be able to get to a health facility? Think about barriers and make your moves.
10. You've managed to reach a hospital. How likely is it that you will be able to move independently around the facility? Think about barriers and make your moves.
11. Other patients at the hospital receive information at the reception desk, discuss their conditions with doctors, receive advice from a counsellor and purchase medicines in the shop. How likely is it that you'll be able to go through the same process? Think about barriers and make your moves.
12. Doctors inform you that you require a minor surgery. At the moment there is a long waiting list, and they invite you to come back in two weeks for the surgery. How likely is it that you'll be able to return in two weeks? Think about barriers and make your moves.

At the end of the activity, it is likely that the volunteers representing the different characters are in different parts of the room: some of them will have advanced a lot, while others may be near their starting position – or even behind.

Facilitators invite the volunteers to remain where they are in the room, observing the position of the other characters and reflecting on the exercise they have just completed. Facilitators can ask the following questions – starting from the character who is most behind:

- How do you feel?
- Did you agree with the decisions that were taken for you?
- Would you have made different choices?

As volunteers were not able to influence their own lives and had to follow instructions from the groups, they will likely express frustration. Facilitators explain that the motto of the disability movement is **'Nothing About Us Without Us'** and highlight how important it is to include people with disabilities in decisions that impact them.

Facilitators invite other participants to share their reflections and feelings. As part of this reflection, facilitators point out specific dynamics related to the intersection of disability gender and socioeconomic status.

For example:





- Why did a certain character remain behind?
- Was it mostly because of their disability?
- What about their wealth or poverty?

At the end of the group reflection, facilitators remind participants that this was just an exercise; the outcomes of the activity are based on the assumptions made by each group and are not representative of the real experiences of all people with disabilities. So not all people who have similar characteristics of the characters will experience the same outcomes in life. The purpose of the activity was just to enable participants to reflect on potential barriers experienced by people with disabilities in accessing healthcare – and the interplay of different identities and individual factors.

Facilitators close the activity by thanking all the participants and inviting them to take their seats.

Session 3: Health equity for people with disabilities

3.1 Health requirements of people with disabilities

	Duration	20 minutes
	Methodology	Plenary discussion
	Resources	Sticky notes + pens + flipchart
	Slides	24-26

Exploring health requirements

Facilitators invite participants to think about the health services which may be required by people with disabilities and to write them on individual sticky notes. Each participant can use as many sticky notes as they like to suggest the services they think are relevant. Participants are encouraged to think about the characters of the 'game of life', as well as to draw from their personal and professional experiences.

After a few minutes, participants are invited to put the sticky notes on a flipchart. Facilitators then organise them by theme, grouping together all the recommendations related to similar services.

Once all sticky notes have been divided, facilitators review the suggestions with participants in plenary, and stimulate a conversation on the type of services that have been highlighted.

Facilitators can use the following guiding questions to initiate the conversation:

- What are the most common services that have been suggested?
- Are these general healthcare services required by the entire population, or specific services required by people with disabilities?
- Is there any major area which is missing – and why?

Based on the suggestions provided by participants and the responses to these questions, facilitators can invite participants to reflect on their own assumptions and biases. For example, if no one or very few people indicated sexual and reproductive health and rights services, facilitators may ask participants why they think these have not emerged during the exercise. Through this process, participants may realise that they may have never thought about people with disabilities as people who are sexually active, who may desire to form families, and who may require access to information and services. However, it is the responsibility of the facilitators to ensure participants feel comfortable to share their reflections in a safe space, without any fear of being judged.

Understanding the healthcare requirements of people with disabilities

Facilitators explain that **people with disabilities have the same health requirements as everybody else**: for example, children with disabilities need access to vaccinations, and women with disabilities require access to sexual and reproductive health services.

At the same time, people with disabilities are **more likely to have poor mental and physical health**, and are **more likely to have specific health requirements**, linked to secondary conditions or co-morbidities associated with their primary impairment or underlying health condition.





For example:

- Almost 50 per cent of people with Down syndrome are born with congenital heart disease and many have high prevalence of refractive errors.
- A high percentage of wheelchair users experience pressure ulcers during their lives.
- People with schizophrenia have a higher prevalence of diabetes compared to the rest of the population.

Additionally, **many people with disabilities require access to specialist health services and rehabilitation** (such as physiotherapy or assistive devices), and many people with disabilities have a **higher risk of physical and mental ill health** due to higher exposure to negative social determinants of health, such as poverty, stigma and discrimination, violence and abuse.

As a consequence of all these factors, **people with disabilities are likely to experience a higher requirement of both general and specialist health and rehabilitation services** compared to the rest of the population.

3.2 The right to the highest attainable standard of health for people with disabilities

	Duration	15 minutes
	Methodology	Short presentation + video
	Resources	Slides
	Slides	27-30

Health as a human right

Facilitators explain that **people with disabilities have the same right to the highest attainable standard of health as any human being**. This right is inherent, universal and inalienable, and is enshrined in international law through human rights treaties, as well as in domestic legal frameworks.

Facilitators provide an overview of relevant frameworks and policies.

Universal Declaration of Human Rights (UDHR)

- Developed in 1948, after the Second World War, to define and protect the basic rights of every human being.
- The UDHR includes 30 rights and freedoms, including the right to freedom from torture, the right to free speech and the right to education.
- The rights included in the UDHR form the basis for all international human rights law.

UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW)

- Human rights treaty that focuses specifically on equality between women and men in all areas of life.
- It provides the basis for achieving equality between women and men in many areas, including education, employment, political and public life, healthcare, marriage and family relations.

Health in the UNCRPD

Article 25 – Health

States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- a. Provide persons with disabilities with the same range, quality and standard of free or affordable healthcare and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes.
- b. Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimise and prevent further disabilities, including among children and older persons.
- c. Provide these health services as close as possible to people's own communities, including in rural areas.
- d. Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and the promulgation of ethical standards for public and private healthcare.
- e. Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner.
- f. Prevent discriminatory denial of healthcare or health services or food and fluids on the basis of disability.

Article 26 - Habilitation and rehabilitation

1. States Parties shall take effective and appropriate measures, including through peer support, to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life. To that end, States Parties shall organise, strengthen and extend comprehensive habilitation and rehabilitation services and programmes, particularly in the areas of health, employment, education and social services, in such a way that these services and programmes:
 - a) Begin at the earliest possible stage and are based on the multidisciplinary assessment of individual needs and strengths.
 - b) Support participation and inclusion in the community and all aspects of society, are voluntary, and are available to persons with disabilities as close as possible to their own communities, including in rural areas.

2. States Parties shall promote the development of initial and continuing training for professionals and staff working in habilitation and rehabilitation services.
3. States Parties shall promote the availability, knowledge and use of assistive devices and technologies, designed for persons with disabilities, as they relate to habilitation and rehabilitation.

Disability and the Sustainable Development Goals

The 2030 Agenda for Sustainable Development is an ambitious plan of action by the international community towards a peaceful and prosperous world, where the dignity of an individual person and equality among all is applied as the fundamental principle.

The 2030 Agenda and the Sustainable Development Goals (SDGs) are underpinned by a pledge to “leave no one behind”. In order for this to be achieved, it is fundamental to ensure the full and equal participation of people with disabilities in all spheres of society, in line with the UNCRPD.

The first-ever United Nations flagship report on disability and the SDGs published in 2018 clearly demonstrates that people with disabilities are at a disadvantage regarding most SDGs.

Read more about [disability and the SDGs](#).

Ghana Persons With Disability Act, 2006 (act 715)

Part 5: Healthcare and facilities

Medical treatment

- The Ministry of Health in formulating health policies shall provide for free general and specialist medical care, rehabilitative operation treatment and appropriate assistive devices for persons with total disability.

Training of health professionals

- The Ministry of Health shall include the study of disability and disability-related issues in the curricula of training institutions for health professionals to develop appropriate human resources to provide general and specialised rehabilitation services.

Health programmes

- The Ministry of Health shall include education on disability and disability issues in healthcare programmes.

Periodic screening of children

- The Ministry of Health in collaboration with the Ministries responsible for Education and Social Welfare shall provide for the periodic screening of children in order to detect, prevent and manage disability.

Establishment of assessment centres

- The Ministry of Health in collaboration with District Assemblies and the Ministry responsible for Social Welfare shall establish and operate health assessment and resource centres in each district and provide early diagnostic medical attention to mothers and infants to determine the existence or onset of disability.

Facilitators explain that while progress has been made in recent years, Ghana – like most countries around the world – is still far from realising the right to the highest attainable standard of health for people with disabilities who continue to experience a wide range of health inequities.

People with disabilities experience worse health outcomes

Facilitators explain that while people with disabilities have a higher requirement of both general and specialist healthcare compared to the rest of the population, on average **they experience worse health outcomes** compared to the rest of the population.

Health outcomes of people with disabilities

According to the recent **WHO Global Report on Health Equity for Persons with Disabilities**:

- People with disabilities have **more than double the risk** of developing conditions such as diabetes, stroke or depression.
- Inaccessible health facilities are up to **six times more hindering** for people with disabilities compared to people without disabilities.
- People with Down syndrome **die 20 years younger**, on average, than the general population.
- Mortality rates for people with a learning disability are **six times higher** than the general population.

The recent **Missing Billion report** also highlighted disproportionate health outcomes for people with disabilities.

For example:

- People with disabilities were **2.8 times more likely to die from COVID-19** than their peers without disabilities globally.
- Children with disabilities are **26% more likely to experience acute respiratory infection** compared to children without disabilities.
- Adults with disabilities in Sub-Saharan Africa are **less likely to have comprehensive knowledge about HIV prevention and transmission** (23%) compared to people without disabilities (33%).
- Women with disabilities have **lower coverage of modern contraceptives** (44%) compared to women without disabilities (48%).
- Children with multiple disabilities in the poorest wealth quintile have **lower basic vaccination coverage** (34%) compared to average children without disabilities (58%).

Find out more:

[Download the WHO Global Report on Health Equity for Persons with Disabilities](#)

[Download the Executive Summary of the WHO report](#)

[Download the Missing Billion report](#)

Facilitators explain that many of the differences in health outcomes between people with and without disabilities cannot be explained by their underlying health conditions or impairments. Rather, they are associated with unjust or unfair factors that are avoidable. These are called **health inequities**.

Facilitators explain that Ghana, like any other country, has an obligation under international human rights law to **ensure that the legal and policy frameworks do not discriminate on the basis of disability**, and to **act upon the multiple and intersecting forms of discrimination** faced by people with disabilities in the health sector and beyond.

Addressing health inequities experienced by people with disabilities is crucial. This is not only to ensure they can enjoy their inherent right to the highest attainable standard of health, but also to achieve broader health priorities, such as progressing towards Universal Health Coverage.

Facilitators further explain that addressing health inequities experienced by people with disabilities benefits everyone. Making health systems and services more disability inclusive, in fact, will contribute to reaching other marginalised populations, such as older people, migrants and refugees, and people with non-communicable diseases.





The experience of people with disabilities

Facilitators show a short video, in which people with disabilities from different countries share their experiences of accessing healthcare.



Credit: World Health Organisation, Liliane Foundation, Humanity & Inclusion, Sightsavers, The Leprosy Mission Nigeria.

3.3 Understanding health inequities

	Duration	30 minutes
	Methodology	Group activity
	Resources	Sticky notes + pens + flipcharts
	Slides	31

Facilitators explain that health inequities experienced by people with disabilities can be grouped into four interrelated categories:

1. Structural factors
2. Social determinants of health
3. Risk factors
4. Health system factors

Facilitators divide participants into four groups, with each group assigned one of the above categories. Participants in each group are invited to reflect on those categories and to identify suitable examples of factors which can contribute to the health inequities experienced by people with disabilities.

While participants conduct the exercise, facilitators arrange four flipcharts on the wall – one for each category.





Once all groups have identified a few factors, participants are invited to return to plenary and to share their inputs. Facilitators ask for feedback from other participants and, if everyone agrees, they write the factors identified by each group on the correct flipchart. When required, facilitators can prompt participants to reflect upon whether the factors identified by a specific group correctly fit into that category – or whether they should be assigned to a different one.

Facilitators can use the following table for reference.

Category	Description
Structural factors	These refer to broad socioeconomic and political factors which generate social stratification.
Social determinants of health	These are the conditions in which people are born, grow, live, work and age.
Risk factors	These are factors associated with non-communicable diseases, such as alcohol consumption, tobacco use, diet and amount of exercise – as well as environmental factors such as air pollution
Health system factors	These relate to aspects such as service delivery, health and care workforce, health information systems, health systems, medical products and technologies, financing and governance.

Download the [WHO Global Report on Health Equity for Persons with Disabilities](#) and learn more about contributing factors to health inequities for persons with disabilities (from page 65).

3.4 The health equity recipe

	Duration	40 minutes
	Methodology	Group activity
	Resources	Flipchart + Tool 3: Health equity recipe
	Slides	32

Facilitators explain that everyone can play a role in promoting greater access to healthcare for people with disabilities. Therefore, in this activity, participants are encouraged to **prepare their own 'health equity recipe'**.

In a section of the room, facilitators put a flipchart on the wall with the sentence **'health equity kitchen'** written in large, bold letters. Under the flipchart, facilitators display on a table a series of cards, ensuring there is sufficient space for all participants to gather round.

Tool 3: Health equity recipe is a document with nine pages and 36 cut out cards, divided as follows:

- 22 ingredient cards
- 7 utensil cards
- 7 blank secret spice cards

Facilitators are required to prepare the cards included in “Tool 3” before the beginning of the training, following these simple steps:

1. Print as many copies of “Tool 3: Health equity recipe” as the total number of training participants. For example: if you are expecting 15 participants, print 15 copies of the document.
2. Important: ensure you print the document “single-sided” – if possible, use colour print.
3. Once all copies have been printed, cut each sheet following the dotted lines.
4. Once all cards have been cut out, create small piles for each ingredient and utensil card. For example, you should have a pile of 15 cards saying “Prioritise people with disabilities and other marginalised groups from the design stage of your next activity”, another pile of 15 cards saying “Incorporate disability inclusion indicators within monitoring and evaluation plans”, and so on – for each ingredient and utensil card. You can then arrange one or more piles for the blank secret spice card.
5. Arrange all the cards on a table, and ensure there is sufficient space for participants to gather round.



If you have followed these steps correctly, each participant should be able to select one copy of each ingredient and utensil card, as well as multiple secret spice cards.

Facilitators explain that there are two main types of cards on the table:

- **Health equity ingredients:** Each of these cards includes a recommended action to promote disability inclusion in the health sector.
- **Health equity utensils:** Each of these cards includes a recommended tool that can be used to support specific actions.

Participants are invited to go to the kitchen and explore the **health equity ingredients and utensils cards**. Thinking about the position they occupy in the health sector in Ghana, they are encouraged to **reflect on the roles they can play to promote greater disability inclusion** – and to identify the **best ingredients for their recipes**.

To guide their thinking, participants can reflect on the following questions:

- What activities do you normally engage with?
- Who are the people you can influence?
- What resources could you mobilise for your recipe?

- What ingredients and tools can be incorporated into your existing projects and activities?
- What new initiatives could you propose, using the recommended actions and tools?

Facilitators explain that a few additional spices can make any recipe taste even better. While some basic ingredients and utensils are available in the kitchen, participants will find there are also some blank cards that they can use to write their own **secret spices** – additional interventions or tools which they think would be particularly effective in the local context to promote health equity for people with disabilities.

Facilitators invite participants to explore the available health equity ingredients and utensils, and to pick those they think would fit best in their own personal recipe – reminding them to add their secret spices.




After some time, when all participants have selected their cards, facilitators divide them into small groups. Within each group, participants are invited to share the ingredients, utensils and spices they have selected – explaining to others why they have chosen those cards, and how they plan to conduct those activities and use those tools. While certain family recipes are secretly passed down from generation to generation, facilitators explain that in this context we are all for sharing!

Facilitators encourage the aspiring health equity chefs to learn from each other and to be inspired by the recipes of fellow participants. Whenever they hear that someone is planning to conduct a specific activity or use a specific tool – and they feel that they would be able to conduct similar activities – they are invited to go back to the kitchen and add new ingredients, utensils or spices to their personal recipe.

Once all participants have had a chance to share their recipes within the small groups, they are invited to return to plenary. Before closing the activity, facilitators invite each participant to share their cards in front of everyone, and to briefly explain how and when they'll plan to conduct that activity or use that tool as a form of public commitment in front of their peers.

At the end of the session, participants are invited to keep their cards and to bring them to work, as reminders of the entry points they have identified and the commitments they have taken.

End of day one





	Duration	10 minutes
	Methodology	Plenary discussion
	Resources	Slides
	Slides	33

Facilitators thank participants for their active engagement and ask if anyone has any final question before closing the first day of training.

Before closing, facilitators provide logistical reminders for the second day of training, such as arrival time etc.

Session 4: Recap of day one

4.1 Welcome and recap of day one

	Duration	30 minutes
	Methodology	Group activity + plenary discussion
	Resources	Paper and pens
	Slides	34

At the beginning of this section, facilitators welcome participants before engaging them in an interactive activity to recap key learning points from the previous day.

Examples of activities that can be used for this purpose include:

Snowball fight:





- Each participant writes two questions on two pieces of paper. The questions must be related to something learnt the previous day (for example, “what are the different models of disabilities?” or “what are the key barriers experienced by women accessing cataract surgery?”)
- Participants wad up their pieces of paper to form ‘snowballs’.
- Participants start a ‘snowball fight’, throwing the paper ball to each other for 30 seconds. When the balls fall down, participants are encouraged to pick them up and throw them again.
- When the 30 seconds have passed, each participant must collect two balls and open them up to read the questions. If a participant ends up with a question they wrote themselves, they must swap the question with somebody else.
- Participants take turns to read the questions and try to answer them in plenary. If they don’t know the answer, other participants can support them.

Speed date:

- Participants stand forming two lines and facing each other.
- Facilitators ask a question, such as “what are the different models of disabilities?”
- Participants have one to two minutes to discuss their answer(s) with the person standing directly opposite them.
- Facilitators announce when the discussion time is up.
- Participants of one line don’t move, while the participants in the other line take a step to their left so they are facing a new person. The person who was standing at the end of the moving line (left) moves to the other end (right).
- The whole activity (facilitators ask question; participants respond; line shifts) is repeated several times, until all relevant questions identified by facilitators have been answered.

Session 5: Inclusive and accessible communication

5.1 Defining accessible communication





	Duration	20 minutes
	Methodology	Group activity + plenary discussion
	Resources	Paper and pens
	Slides	36

Facilitators divide participants into small groups and invite them to come up with a definition of accessibility.

After 10 minutes, participants are invited to sit again in plenary and to share the definitions elaborated upon by each group.

Facilitators thank participants for their contributions and invite them to reflect on the definitions presented, identifying similarities and differences.

5.2 Introduction to accessible communication

	Duration	10 minutes
	Methodology	Frontal presentation
	Resources	Slides
	Slides	37-40

The facilitator shares the definition of accessible communication with the group. Using slides, they cover:

- The importance of making communication accessible.
- Who benefits from accessible communication (highlighting that it is not just for people with disabilities).

The facilitator explains that accessibility is about creating content that can be used by everyone. It's often defined as removing barriers for people with disabilities, but the benefits extend to everyone.

Accessibility always starts at the very beginning of the communication process. It should never be an afterthought. Consider your audience to be as diverse as possible and understand that people access and process information in different ways. By removing barriers for people with disabilities or learning difficulties, you will make the experience better for everyone.

Wider benefits of accessible content

The facilitator shows how people can have different needs, not just based on whether they have a disability or not, and highlights other factors that impact the way someone accesses content. Some examples are provided in the slides.

Finally, the facilitator highlights that everyone, regardless of their job role, is responsible for creating accessible content.





They give examples, such as:

- Writing accessible emails or reports.
- Talking to people.
- Designing communication content.

Introduction to the topics for day two

The facilitator explains that day two will focus on creating accessible content. The day will cover general accessibility concerning text, language, visual and digital content. These are principles that can be applied to different kinds of content. A good understanding of these will allow participants to create accessible material regardless of the specific kind of content they need to produce. The last part of the day will cover guidelines on specific content, to give participants examples of how these principles can be applied to their daily work.

5.3 Screen readers and alt text

	Duration	15 minutes
	Methodology	Frontal presentation
	Resources	Slides
	Slides	41-52

Screen readers

The facilitator starts by introducing screen readers.

Screen readers convert text and image content into speech or braille. They help people with visual impairments or conditions, such as dyslexia, to interact with a computer, phone or tablet without needing to see a screen or a mouse.

These help the user navigate documents, websites or applications by reading or describing what is on screen. The importance of including alt text on images or graphics is made clear.

Alt text

Alt text stands for alternative text or image description and should be a brief description of the image in context.

Include alt text

When writing alt text, there is no need to write 'image of...' or 'picture of...' as the screen reader will do this automatically. If the image contains a graph or other numerical data, include key points from the data in the alt text.

Mark non-essentials as decorative

Unimportant images and backgrounds should be marked as 'decorative'. This means a screen reader will ignore them when reading page content.

Write alt text for embedded text

Screen readers cannot read text that is embedded in an image, which includes labels on graphs and charts. Embedded text will need to be included in the alt text.

Add value to images

Screen readers read the alt text of an image aloud to enable people with visual impairments and other disabilities to understand important images. It is best to use simple language to describe what the image shows and the value it adds to the document. Avoid using complicated language, acronyms, slang and jargon.

Describe the image

Include a concise description of what you see in the picture. Examples of how a caption and alt text can complement one another and provide greater context for screen reader users are provided in the slides.

Be concise

Screen readers only read out about 125 characters for alt text, so you will need to write succinctly. If you require more space for any valuable information, write it in the image caption or consider including it in the main copy.

How to add alt text in Word, Excel and PowerPoint

These simple steps can be followed to add alt text to any of your Word, Excel and PowerPoint documents.

1. Right-click on an image with your mouse.
2. Select View Alt text.
3. A box will appear on the right-hand side.
4. Type your alt text into the box.

While it may be helpful, do not rely on Microsoft's auto-generated alt text as it is not sufficient

You can turn off Microsoft's auto alt text by going to File, Options and then Accessibility and making sure there is no checkmark in the 'automatically generated alt text for me' box.





To mark something as decorative, follow the same steps but check the 'mark as decorative' box instead of writing alt text.

How to add alt text in Adobe Acrobat

If you are working on a PDF document and/or you are working with Adobe Acrobat, follow these steps to add alt text:

1. If possible, when converting from Microsoft Office to PDF, use Adobe Acrobat to ensure all accessibility elements are picked up.
2. Check for accessibility issues in Adobe Acrobat by selecting Accessibility in the Tools menu. It will open a toolbar.
3. You can identify tagging, reading order and accessibility problems by selecting Accessibility Check.
4. Write accessible text by selecting Set Alternate Text.

5.4 Screen readers and alt text - exercise

	Duration	20 minutes
	Methodology	Group presentation
	Resources	Tool 4: Alt text example image card, pens and paper
	Slides	53-54

The facilitator divides participants into groups. They give one card (Tool 4) depicting the photograph below to each group, asking them to write appropriate alt text for it. The facilitator explains that this image needs to go on a blog that covers trachoma prevention.



After 10 minutes, participants are invited to sit again in plenary and to share the text that has been discussed and decided upon by each group.





Facilitators thank participants for their contributions before commenting on the text produced.

A good example of alt text for this image could be:

- An eye health worker wearing a surgical mask checks a boy's eyes.

Session 6: General accessibility guidelines

6.1 Accessible language

	Duration	15 minutes
	Methodology	Frontal presentation
	Resources	Slides
	Slides	55-62

Facilitators explain that while confusing copy is an accessibility barrier to all readers, it is particularly difficult for non-native English speakers and people with dyslexia, autism or other cognitive conditions.

Facilitators invite participants to think, when writing, about the words they would use when having a conversation, highlighting that our brains absorb information more easily when it is broken into small chunks. It's also good practice to read your writing line by line, removing unnecessary words and rewriting sentences if they are too long. If there are large blocks of text, it's best to break them up into digestible paragraphs.

Use simple words

Think about the words that you use. Can you use shorter, simpler words instead of longer, more complex ones? Some examples are provided in the slides.

Use bullet points to summarise key points

Bullet points can help your audience to read and digest information quickly. Do not replace bullets with other symbols, as screen readers may read them out, making it confusing for users. Some examples are provided in the slides.





Avoid acronyms

Make your language as clear as possible. Jargon, slang and idioms may only make sense to people who live in a particular region or work in a specific industry. A glossary can help if you are mentioning a lot of organisations, phrases and words that can be abbreviated. Some examples are provided in the slides.

Write in active sentences

These follow the sequence: subject > verb > object. Active sentences are direct, easy to understand and are close to how people speak. Some examples are provided in the slides.

6.2 Accessible text

	Duration	20 minutes
	Methodology	Frontal presentation
	Resources	Slides
	Slides	63-72

The facilitator explains that the visual aspect of text should also be taken into consideration. This will make it easier for people to read.

Use large, clear fonts

- Check that fonts are clear and that letters in words have adequate spacing between them.
- Text for websites and documents must be at least 12-point in size. Text for PowerPoint presentations must be at least 20-point.
- Avoid using serif or decorative fonts. The hooks and decoration make it difficult to distinguish letters.

Examples are provided in the slides.

Avoid using too many typefaces

Designs that use only one or two typefaces, weights and styles are usually easier on the eye. Too many can create a confusing visual layout, particularly for people with reading difficulties such as dyslexia.

Examples are provided in the slides.

Align text to the left

Aligning all text to the left in left-to-right reading languages, including in tables and blocks of text in diagrams, makes it easier for people to see where each line begins. Don't justify (centre) text, as this creates uneven gaps between words. Centred text makes it difficult to see where each line begins.

Examples are provided in the slides.

Avoid multiple line breaks

Any extra spacing or paragraph breaks using the enter key will be read out by a screen reader as 'space', 'blank' or 'return', which can be annoying for listeners. Use line and paragraph space settings or page breaks instead.

Examples are provided in the slides.

Use sentence case

Capitalise just the first letter of a sentence. Words in all capitals can be problematic for people with dyslexia and visual impairments. It can also prove tricky for screen readers, which may interpret consecutive uppercase letters as acronyms.

Examples are provided in the slides.

Take care with symbols

Screen readers do not always recognise symbols, so use words instead. For example, write 'per cent' instead of using the symbol %. The exception is currencies (£, \$, €). As stated above, don't use unusual glyphs or ornaments for bullets.

Examples are provided in the slides.

Avoid underlining and italics

These can make words difficult to read. Use regular for your main text, and bold for headings and to highlight key words if necessary. Large passages of bold text are hard to read, and some screen readers will shout out words in bold, so use them sparingly.

Examples are provided in the slides.

Colour emphasis

Is there enough contrast between the colour of the text and the background? Is there enough contrast between normal body text and text that has been highlighted for emphasis?

Examples are provided in the slides.

Line length





Ensure the number of characters per line of text is appropriate for the format. For example, print and web text should be kept to a maximum of about 60-70 characters, depending on font size. Video captions should be a maximum of 40 characters.

Examples are provided in the slides.

Avoid using emojis instead of words for digital content

Emojis should never replace words as they can completely change the meaning of a message. Screen readers will read the alt text description of an emoji and you run the risk of users interpreting the message in a completely different way to what you intended.

6.3 Accessible language and text - exercise

	Duration	40 minutes
	Methodology	Group presentation
	Resources	Tool 5: Accessible language and text exercise supporting documents, pens and paper
	Slides	73-79

The facilitator divides participants into groups. Each group is tasked with writing the text for a social media card which explains, in simple terms, what neglected tropical diseases (NTDs) are. Each group is given a one-page document defining NTDs, along with three visual options to choose from (Tool 5).

After 20 minutes, participants are invited to sit again in plenary. Each group shares its text, plus which visual they decided to opt for.

The visuals provided as options are:

This is an example of accessible text and how it should look on a page or a screen.

This option is difficult to read because:

- The font is too small.
- There is not enough contrast between the colour of the text and the background.

This is an example of accessible text and how it should look on a page or a screen.

This option is difficult to read because:

- The text is justified.
- It uses underlining.

This is an example of accessible text and how it should look on a page or a screen.

This option is difficult to read because:

- This option uses a decorative font, which is hard to read.
- The text is centred. Aligning text to the left makes it easier to read.





This is an example of accessible text and how it should look on a page or a screen.

This option is the most accessible.

An example of accessible language to describe NTD is:

Neglected tropical diseases are a major cause of preventable blindness around the world. These diseases affect more than a billion people and can cause severe and lifelong impairment. They are most frequent in rural regions, poor urban areas and conflict zones.

6.4 Accessible visual content

	Duration	20 minutes
	Methodology	Frontal presentation
	Resources	Slides
	Slides	80-91

Choose contrasting colours

Good colour contrast between text, images, logos and the background will make your content legible and easy to identify. Black text on a white background is usually the first choice for maximum legibility.

For digital content, the Web Content Accessibility Guidelines are usually referred to. These explain how to make web content more accessible, but indications on colour contrast can be applied to print material, too. The guidelines cover three levels of conformance:

- Level A is the minimum level. Content that reaches A standard is not fully accessible.
- Level AA is the middle level and indicates content that has good accessibility. Many organisations strive to meet Level AA.
- Level AAA content is the most accessible and should ideally be referred to when creating content to maximise its reach.

Aim to ensure all materials conform to at least the Web Content Accessibility Guidelines AA standard. Aim for AAA if possible.

To check whether your content is AA or AAA conformant, you can use a colour contrast analyser. There are many available online, like the one offered by **Adobe Color**. Once on, the contrast analyser will require the HEX code of the colours you are using. You can easily find these in Microsoft Programmes through the colour selection button.

Select a tinted background

Include a background tint for PowerPoint presentations. Note that a pure white background can cause problems for people with visual impairments or neurodiverse conditions. A very pale grey often works well.

Label charts clearly

Charts and graphs must be clearly labelled and should not solely rely on contrasting colours. Use additional patterns or data labels to make it easier for readers to differentiate between piece of data.

People with low vision or colour blindness find it easier to differentiate segments of a chart or graph with contrasting tones and shades.

If graphs have legends and axis labels, make sure the text is large enough to read.

Use high-quality images

Use crisp, clear photographs with good resolution and ensure they accurately reflect the situation being portrayed. Also check that a photo has been cropped appropriately and is telling the whole story. When placing text over a picture, ensure the background offers sufficient contrast to make it legible. Avoid low-resolution, blurry images.

Include alternative (alt) text

Add alt text to images, including photographs, charts, icons, logos and diagrams. This will allow people using screen readers to recognise them.

Logos

Ensure logos have enough contrast so that they stand out against the background. There should also be sufficient white space between logos and surrounding text. Separating elements in this way will allow your content to read much more easily.

Examples are provided in the slides.

Create an uncluttered design

Cluttered layouts with information scattered across a page can be overwhelming and hard to follow.





It is best to use a logical, linear design, presenting information in columns and using images and headings to break up large passages of text. Separating sections with borders, headings and white space will help to make the information easier to read.

Make content more inclusive

When producing print or digital content, think about displaying a diversity of people in videos, illustrations and photographs, taking into account gender, age, disability and ethnicity. Include positive images and representations of people with disabilities in materials, messages and activities.

Listen to a diversity of people, including Organisations of People with Disabilities (OPDs), in the planning, creative design, decision making and testing of materials and activities. Foster meaningful participation and feedback loops.

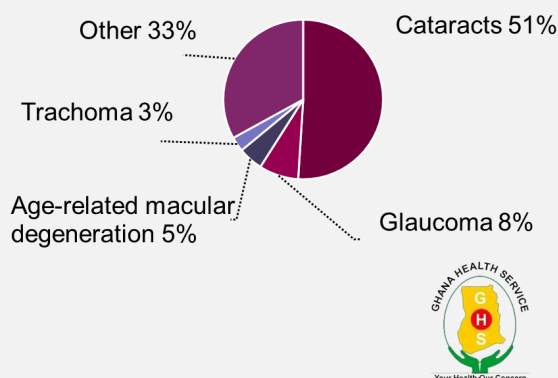
6.5 Accessible visual content - exercise

	Duration	20 minutes
	Methodology	Group presentation
	Resources	Tool 6: Accessible visual content exercise, pens and paper
	Slides	92-97

The facilitator divides participants into groups and hands out images of four graphs (Tool 6). The groups need to discuss which image is the most accessible and why the other three are not as accessible.

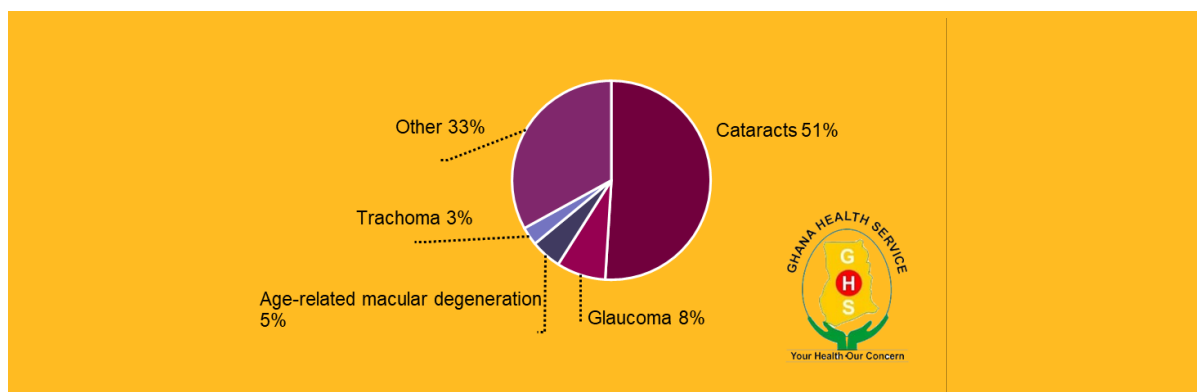
After 10 minutes, participants are invited to sit again in plenary and to share with the rest of the group.

A pie chart showing the causes of blindness worldwide: cataracts 51 per cent, glaucoma 8 per cent, age-related macular degeneration 5 per cent, trachoma 3 per cent and other 33 per cent.



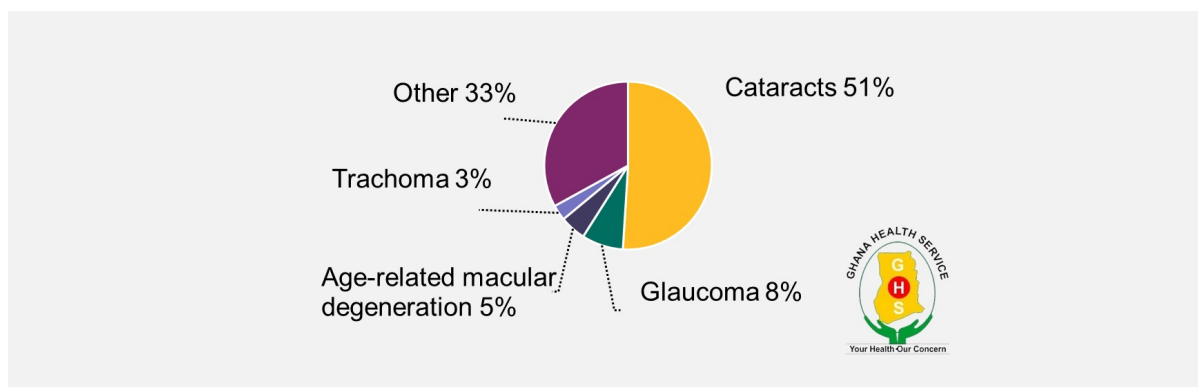
This option is not the most accessible because:

- There is not enough difference between the colours in the chart. Someone with colour blindness could struggle to access this graph.



This option is not the most accessible because:

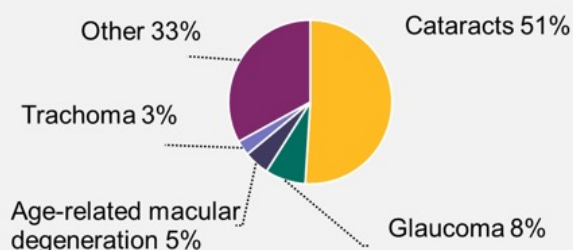
- The font size is too small.
- There is not enough difference between the colours in the chart. Someone with colour blindness could struggle to access this graph.
- There is not enough contrast between the background colour and the logo.
- There is no description of the chart or alt text.



This option is not the most accessible because:

There is no description of the chart or alt text describing what the chart represents.





A pie chart showing the causes of blindness worldwide: cataracts 51 per cent, glaucoma 8 per cent, age-related macular degeneration 5 per cent, trachoma 3 per cent and other 33 per cent.



This option is the most accessible from the ones provided.

Session 7: Accessible video and website content

7.1 Accessible video content

	Duration	30 minutes
	Methodology	Frontal presentation
	Resources	Slides
	Slides	98-116

Always add captions

One of the most important factors in making a video accessible is including captions.

People often get confused between subtitles and captions. Subtitles only show spoken words, whereas captions describe spoken words and important sounds. There are two types of captions: open and closed. Open captions are embedded in the video and cannot be turned off. Closed captions are not embedded and can be turned on and off by the viewer.

Here are some things to consider when producing captions:

- Keep them centred, at the bottom of the screen and always in the same place.
- Use a large, clear font on a contrasting background.
- Break them at logical points and don't show more than two lines at once.
- Give meaningful audio descriptions. You might want to reference the language and/or the name of a person at the start of the caption when they first speak. If you have music, instead of writing 'music', describe what it sounds like. For example, what instruments can you hear playing? Is the tempo upbeat or slow?
- Captions should be no longer than 40 characters per line and a maximum of two lines.
- Break captions at logical points.
- Use a separate subtitle for each sentence.
- Leave a gap of four frames between each caption. This makes them easier to read.

Examples are provided in the slides.

Include names

Adding the names of the people speaking in your captions can be helpful if you're not using motion graphics to identify the subjects, or when it's not clear who is talking.

Names should be displayed in sentence case followed by a colon or in square brackets.

Monologue: add the person's name when they first speak. You don't need to repeat it thereafter.

Dialogue: start the caption with the person's name throughout the video so the viewer knows who is speaking. Use different colours for each person.

Voiceover: if you add the name of the subjects in your video, you should also identify in the captions if the audio is from a voiceover.

Examples are provided in the slides.

Identify the language

Make sure people understand which language is being spoken.

If the majority of your video is in a single language, but other languages are also used, insert the language being spoken in square brackets at the start of the caption.

Examples are provided in the slides.

Describe music and sound

Provide a meaningful description of any music and sound that is part of the action, significant to the experience and essential to successfully communicating your message.

Try to be objective when describing the mood. You don't want to influence the viewer's experience.

Examples are provided in the slides.

Include a voiceover

Any video that contains text on screen should always include a voiceover to ensure it is accessible for people who may not be able to read the text.

When producing a voiceover, it is good practice to:

- Speak clearly and enunciate.
- Make sure the sound quality is good. The sound shouldn't be muffled or pick up background noise.

Examples are provided in the slides.

Pay attention to audio

Sound is important for telling a story. The music you choose should complement the message, support the tone of the story and be appropriate for the target audience.

Here are some points to consider:

- Music with vocals can be distracting and add another level of information that viewers will need to process.

- Sound effects should have a practical purpose. For example, include a 'click' sound if you're showing a cursor clicking a button.
- The volume of the soundtrack and sound effects should be loud enough for viewers to hear but should not overpower the audio from your footage or voiceover. Viewers need to clearly hear the voices over the soundtrack and background audio.

Produce an audio description

Another method of conveying what's on screen to viewers who are unable to see the footage clearly is to provide an audio description.

Audio description is additional voiceover (narration/commentary) that explains what's happening on screen. It should describe body language, expressions, movements and anything else that's happening in the video.

Depending on how the script flows, a video can be paused at natural points and the screen frozen in order to add additional voiceover that describes the visual information. It is most valuable for videos that include important visual information.

Pay attention to pace

Allow viewers enough time to understand what's in the shot, listen to the voiceover and/or read the captions.

All text should appear on screen for the amount of time it takes to read it twice.

Give people enough time to read the text and process the movement, if using text motion graphics.

Slow motion and timelapse can highlight elements of the story.

Provide a transcript

Providing a transcript ensures greater accessibility. If, for any reason, the video doesn't work with captions, then offering a transcript is crucial.

A transcription is a text alternative to a video and should contain dialogue, descriptions of actions and information that the viewer would get from viewing the screen. It should be easily found alongside the video, perhaps pasted directly beneath the video on YouTube. Alternatively, a link could be provided to a separate web page or PDF.

- Freeze footage at natural breaks and describe the scene coming up.
- Describe visual information that is critical to understanding the video.
- Ensure any newly recorded voiceover is clear and appropriate to the video.
- Link to the audio-described version from the main film version.

Consider adding sign language

Consider whether your target audience could benefit from viewing a signed version of your video.

Signed videos are created by filming someone signing the words from the video, then overlaying this footage in the corner of the video.

Here are a few things to consider:

- Use a language appropriate for your audience. Consider using International Sign for social media videos, which reaches a wider international audience.
- Keep the signer footage in the same position throughout the video.
- Signer should stay visible, looking towards the main footage during short pauses. For longer pauses, fade the signer footage out, then fade it in after the pause, in the same position.
- Place motion graphics away from the signer footage, so they don't interfere.

If your budget allows, it's best to film the signer against a green screen so it can be placed directly over the main footage.

- The signer should be smaller than the subjects in the main footage.
- Position the signer to the right of the footage, behind the captions.

If green screen isn't an option, add the signed footage to your video in a square box.

- Film the interpreter against a plain, light-coloured background.
- The box should be large enough so the signer is clearly visible. You can add a thin outline to the box to increase contrast against the main footage.
- Position the box in the top-right corner of the screen. If this interferes with the main footage, place it in the bottom-right corner, above the captions.

Examples are provided in the slides.

Avoid fast, flashing content

Flashing content in videos should be avoided.





If included, this content should meet the 'three flashes or below threshold', which requires that no content flashes more than three times per second. Videos that contain more than three flashes within one second can provoke seizures in people who suffer from photosensitive epilepsy.

Consider movement

Avoid animations that cause the foreground and background to move at different speeds.

Moving content (for example a small, shaking logo; a moving background; or a short, animated cartoon to draw people's attention) can be distracting and cause people to struggle to focus on reading motionless text that surrounds it. It can be particularly confusing for people with low vision and attention deficit disorders.

7.2 Accessible website content

	Duration	20 minutes
	Methodology	Frontal presentation
	Resources	Slides
	Slides	117-127

Structure content in a logical way

This enables people to adapt the content according to their needs and still understand it. Always use the appropriate HTML header tags for headings and use the correct HTML for all structural elements. All pages should have clear, unique titles.

Provide alt text for visuals

Use alt text for all logos, photographs, graphs and illustrations. Alt text is a short description of an image that is read aloud by screen readers, helping people with visual impairments to understand content.

Add captions and other alternatives for multimedia

Captions, text transcripts, audio description, sign language and audio-only formats all provide alternative ways to convey information, allowing a wider audience to access your content.

Use multiple descriptors

Don't rely solely on shape, sound, position or size. Website instructions such as 'click on the green button' may be meaningless to people with colour blindness. It is much better to use multiple descriptors, such as 'click on the instructions button – the green button with a book icon, located on the right.'

Make links easy to understand

All links should be clearly labelled with descriptive anchor text. People who use a screen reader can choose to hear all links on a page read out in a list, which isn't much use if all links are labelled 'read more' or 'click here'. Instead, try 'read more about our organisation' or 'visit our blog'. Links that point to the same destination should have the same description.

Use a dark font against a light background

Good colour contrast between text and the background will make your content legible and easy to identify.

Black text on a white background is usually the first choice for maximum legibility. Coloured text on a bright background will be difficult to read.

Provide clear error messages

Error messages can be frustrating for users, especially if they are ambiguous, so provide a clear description and instructions to help visitors correct their mistakes.

Create an uncluttered design

Cluttered layouts with information scattered across a page can be overwhelming and hard to follow.

It is best to use a logical, linear design. Separating sections with headings and white space will help to make the information easier to read.

Avoid flashing content

Flashing content in videos and animations can provoke seizures in people who suffer from photosensitive epilepsy.

Use animations sparingly as they can be confusing for people with low vision, and always include captions with videos.





Make sure you can navigate via keyboard

A lot of assistive technology depends on a keyboard to navigate a website. For a website to be considered accessible, users should be able to access and move between the site's different elements without using a mouse.

Ensure all links, buttons and pages on a website can be accessed with the tab key. Websites should also be fully optimised for mobile and touchscreen devices, which can be achieved by following the Web Content Accessibility Guidelines.

Session 8: Final group exercise

8.1 Group exercise: accessible social media content

	Duration	60 minutes
	Methodology	Group exercise
	Resources	One laptop per group, Tool 7: social media card template, Tool 8: Accessibility checklist
	Slides	128-130

The facilitator divides participants into groups. Participants are then invited to consider the creation of a social media card for Facebook which encourages women to get a Pap test to prevent cervical cancer.

The groups are then asked to perform two tasks:

1. Each group is provided with a list of all the accessibility tips provided during day two (Tool 8). They must choose the ones that they need to implement for the creation of an accessible social media card.
2. Each group, following the tips they selected, creates the social media card using the template provided as part of the toolkit (Tool 7). They can go online to find images and information to help them put together their card.

After 40 minutes, participants are invited to sit again in plenary and to share with the rest of the group. The selected accessibility tips are covered first and discussed with the support of the facilitator. The ones that should be selected are listed below.

Afterwards, each group shares their social media card, while other participants discuss whether it is fully accessible or not.

Here are the tips for the creation of an accessible social media card:

Use clear and simple language

Confusing writing is an accessibility barrier to all readers, and particularly difficult for people with dyslexia, autism or other cognitive conditions.

When writing, think about the words you use when having a conversation, remembering that our brains take in information more easily when it's broken into small chunks. It's also good practice to read your writing line by line, removing unnecessary words. Avoid large blocks of text and think about breaking up key pieces of information with bullet points to help your audience read and

digest it quickly.

Examples are provided in the slides.

Use sentence case for sentences

Capitalise just the first letter of a sentence. Words in block capitals can be problematic for people with dyslexia and visual impairments, particularly if sections of text are in capitals. It can also prove tricky for screen readers, which may interpret consecutive uppercase letters as acronyms and read them out letter by letter.

Use camel case for multi-word hashtags.

Camel case is when phrases are written without spaces or punctuation. Words in a phrase are separated by uppercasing the first letter of each word.

Examples are provided in the slides.

Avoid jargon and acronyms

Make your language as clear as possible. If you must use confusing, technical language to express an idea, provide a definition. The only time to use acronyms is when they are more widely recognised than when spelled out. Examples include URL, QR code and USB.

Examples are provided in the slides.

Avoid using emojis instead of words

Emojis should never replace words as they can completely change the meaning of a message. Screen readers will read the alt text description of an emoji and you run the risk of users interpreting the message in a completely different way to what you intended.

Create meaningful links

Change long URL links to more meaningful shorter ones (vanity URLs). A meaningful link will benefit everyone, not just screen reader users.

Examples are provided in the slides.

Provide captions and transcripts for videos and podcasts

Captions are essential for people who cannot hear the audio. Some social media platforms provide features with accessibility in mind, offering automatic, editable captions.

Providing a transcript ensures greater accessibility and should contain dialogue and important visual information in a video. Text in videos needs to be legible against the background, so use good colour contrast and a large, clear font. Provide captions and transcripts for videos and podcasts.

Add appropriate titles and descriptions to videos

The title and description of a video should accurately reflect the subject. Avoid using ambiguous or misleading words.

Examples are provided in the slides.

Use an easy-to-read font

A clear font is best for viewing on a screen. Decorative or handwritten fonts are much harder to read and therefore less accessible. Use a large, clear font for visual content such as videos and infographics.

Avoid italics, decorative typefaces and underlining

Words that are in italic type or underlined are difficult to read. Use regular for your main text. Large passages of bold text are hard to read, and some screen readers will shout out words in bold, so use them sparingly.

Handwritten and decorative typefaces are best avoided. Choose a simple font that allows letters in words to be easily distinguishable from one another and with adequate spacing between them.

Avoid large blocks of text

Large blocks of text can be tricky to read for lots of people, including people with dyslexia who can experience visual distortion, where words appear to be jumbled up. It's best to use bite-sized chunks of information where possible, using short paragraphs to create space. Images are also a great way to illustrate a point and help break up text.

Avoid using moving images behind text

Moving images can be distracting and cause people to struggle to focus on reading text. It can be particularly confusing for people with low vision and attention deficit disorders. A busy background will affect legibility, so always ensure text has a solid background behind it.

Use high-quality images

Crisp, clear images will be easily seen by followers and will also make your posts look much better. Avoid low-resolution or blurry images. Also check that the photo has been cropped appropriately and is telling the whole story.

Create clear charts and graphs

Keep charts and graphs as simple as possible and don't forget to add alt text to them.

They must be clearly labelled and should not solely rely on contrasting colours. Use additional patterns or data labels to make it easier for readers to differentiate each piece of data. Do not use similar tones and shades in different segments of a chart or graph, as they will be difficult to tell apart, especially for people with low vision or colour blindness.

If the graphs have legends and axis labels, make sure the text is large enough to read.





Create clear captions

Ensure the background offers sufficient contrast when placing text over a picture so that it can be read easily. The caption itself should add context to the image.

Add alt text to images

Include alt text on images, including photographs, charts, icons, logos and diagrams. This will allow people using screen readers to recognise them.

8.2 Conclusion

	Duration	10 minutes
	Methodology	Group discussion
	Resources	Slides
	Slides	131

Facilitators thank participants for their contributions and ask each person to share with the group the two most important things they have learnt during the training.



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