

UN COVID 19 Disability Inclusion Strategy: Assessing the Impact on Cultural-Safety and Capability Information Approach

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Abstract: This paper is aimed at exploring the role of the United Nations Disability Inclusion Strategy as a rights-based concept in understanding the recent COVID-19 outbreak; and how Cultural-Safety Capability Information, visible within the DSM-5, is linked with the achievable recovery and inclusion for persons with disabilities and post-COVID-19 pandemic for health and social care practitioners. There are two measured, actionable targets from the Disability Inclusion Strategy that are geared towards achievable standards of health for persons with disabilities, which are the identifying and eliminating of obstacles and barriers to accessibility in healthcare facilities and the training of healthcare personnel on disability inclusion and improving service delivery for persons with disabilities. The concepts of recovery and inclusion are discussed within a rights-based, and Cultural-Safety Capability Information (DSM-5) approaches in order to curb the COVID-19 info-demic (Information epidemic). This paper has recommendations for the United Nations Disability Inclusion Strategy as a rights-based idea and the re-educating and re-orientation of both the right-holders, persons with disabilities, for example, and the duty-bearers. This paper also discusses the health and social care practitioners and their realisation of health care and recovery, curbing inequalities in accessing health care, education, and easing participation for persons with disabilities during the COVID-19 pandemic.

Keywords: Capability Information (DSM-5), COVID-19, Cultural-Safety, Health and Social Care, Persons with Disability, UN-Disability Inclusion Strategy.

1. INTRODUCTION

The COVID-19, or novel coronavirus, is a new viral strain that was uncovered in 2019 and has not been formally recognised in humans. It is a variant of Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV), a family of viruses that spread and cause infection and is transmitted by coughing or sneezing on other people. Covid-19 is zoonotic, indicating that it is spread amongst humans and animals [1, 2]; with no vaccine yet produced, governments have developed lockdown regulations. This paper is aimed at exploring the role of the United Nation's Disability Inclusion Strategy as a rights-based concept in understanding the recent COVID-19 outbreak. And how Cultural-Safety Capability Information visible within the (DSM-5) [3] is linked with its impacts on the two stated measured actions to tackle toward an achievable standard of health for persons with disabilities [1-3]. The socio-cultural perspectives beyond the COVID-19 pandemic for persons with disabilities, during and after recovery, are discussed in the context of the reorientation of primary providers of social care.

The United Nations Disability Inclusion Strategy, launched by the Global Action on Disability Network, [4] seeks the commitment to accomplish transformative and long-lasting change across the United Nations systems, which is geared towards guaranteeing that the needs and rights of persons with disabilities are met during this pandemic COVID-19 [1, 5]. The disability-inclusiveness response to COVID-19 is a priority for the United Nations 2030 Agenda; it strives for a recovery strategy and towards enhancing "response and recovery, accessibility of information, facilities, services and programmes, including meaningful consultation with the active participation of persons with disabilities and their representative organisations" [6:1, 1, 2]. The scope and range of the Disability Inclusion Strategy through the Global Action on Disability Network is positioned to drive a 'Decade of Action' towards the sustainable development goals in association with the Convention on the Rights of Persons with Disabilities and the 2030 Agenda for Sustainable Development' [4, 2, 6, 7]. The United Nations Secretary-General, António Guterres, emphasises that the COVID-19 pandemic is escalating inequalities in accessing health care, education, income prospects, and participation in communities, thus, moving the world further away from a disability-inclusive recovery and response to the crisis [1, 2, 6,7].

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This article is geared towards exploring the inequalities and inadequacies in the access to health

care for both persons with disabilities and their primary social care providers, and the achievement of the Disability Inclusive Strategy. By identifying and eliminating obstacles and barriers to accessibility in healthcare facilities and the training of healthcare personnel on disability inclusion as well as improving service delivery, the Disability Inclusion Strategy can be achieved.

This paper is divided into six parts. After the introductory part, it will discuss the United Nations' COVID 19 Disability Inclusion Strategy as a rights-based concept. It targets implementable utilisation with the Cultural-Safety Capability Information (DSM-5) approach in re-directing the health and social care practice to foster inclusivity and recovery [3]. The Disability Inclusion Strategy [4] links to the socio-economic dimension of inclusion and also to the COVID-19 info-dermic restriction using the DSM-5 [3]. This part will conclude with discussion and recommendations.

2. UNITED NATIONS' COVID 19 DISABILITY INCLUSION STRATEGY: AS A RIGHTS-BASED CONCEPT

In line with the inclusivity of recovery for persons with disabilities during the COVID-19 pandemic, the United Nations' COVID 19 Disability Inclusion Strategy [4] is equipped with the linkages to adjusted social concerns and enshrined in rights-based concepts, as deliberated by Nwachukwu [9]. The strategy is built around the socio-cultural perspectives of the new normal and relates to social relationships, gatherings, transportation, conducts, and aspirations for quality health and social care services, currently being witnessed globally. The response and recovery detailed in the United Nations' COVID-19 Disability Inclusion Strategy can be linked with the Universal Declaration of Human Rights 1948 [10], and the International Convention on Economic, Social, and Cultural Rights 1966 [11, 12], which are all instruments that empower states or nations to include the social disadvantages of persons with disabilities in their domains, as enshrined within the foreword of the United Nations Convention on the Rights of Persons with Disabilities [11, 12].

The Global awareness of disability-inclusive development is on the rise. As such, the United Nations Convention on the Rights of Persons with Disabilities [13] endorses the complete integration of persons with disabilities in their various societies [1, 4, 13]. The CRPD [12] explicitly references the significance of

international development organisations in addressing the rights of persons with disabilities and supports the universal ratification of the CRPD [12], with more than 181 countries ratifications and accessions and 163 signatories for the convection; on the Optional Protocol, it has 96 ratifications and accessions and 94 signatories [11, 12]. The CRPD [12] documents exist as a compulsory permissible force; hence, several nations have developed several disability discrimination laws and constitutional provisions [6, 7, 11, 13]. The United Nations' Sustainable Development Goals outline seven targets directed explicitly at persons with disabilities and six additional targets associated with persons in vulnerable situations or circumstances in which persons with disabilities are included within the 2030 Agenda for Sustainable Development [4, 14, 15]. The goal is not to use disabilities as an excuse not to engage with developmental programming and the realisation of human rights, specifically for persons with disabilities.

The rights-based approach is equipped to assist persons with disabilities to participate in public, governmental, social, economic, and cultural scopes, with equal opportunities [14-16]. Observations indicate that even within the mental health profession, practitioners are advised to report human rights abuses within psychiatry homes, which offers a holistic framework of care, treatment, and rehabilitation [17, 18]. Clarifications were made that the social work profession is changing the healthcare environment as the principal suppliers of behavioural and mental health services in the United States [18]. The Patient Protection and Affordable Care Act of 2010 has been attributed for the essential coverage of the health care rights for over 20 million Americans [18] and might have aided them by providing far-reaching coverage that has delivered health care and access to mental health facilities. Using a rights-based approach for disability and mental health services in their practice mechanisms to assist persons with disabilities might be achievable by allowing them access to health and social care in this COVID-19 era of uncertainty.

Nwachukwu and Segalo's [19] study on Life Esidimeni in South Africa pointed out the cosmetically proper application of health care workers and managers in understanding the nexus of care, treatment, and rehabilitation. Their study showed the gaps in practice, in which practitioners are doing rather than knowing, due to lack of ethical assessments of the overall health care design, budget, and the implementation for people with a mental health

condition, which resulted in tragedy. The United Nations' COVID-19 response [4] of considerations states that the response to COVID-19 should be deliberate and purposeful. And by taking into account the planning required from the onset, which should include the budget and allocation of needed resources as well as the consequential risks that could exclude persons with disabilities, thus, conveying the considerations into the UNICEF operations [2, 20]. Considerations to this mandate for deliberate and purposeful planning, social and health care practitioners need to be acquainted with the United Nations' COVID-19 response [4], to the inclusion strategy from the inception, securing disability-inclusive strategies through identifying and removing impediments and barriers to accessibility in healthcare facilities for persons with disabilities. This can be developed by re-directing the concept of education [21] as a potent tool in instigating social change by utilising the approach to convey opinions freely and through the management of the people.

This concept of re-educating or re-skilling is aligned with rights-based actualisation for accessible healthcare for persons with disabilities, with the assurance that the needs and rights of persons with disabilities are met during the COVID-19 pandemic [4, 13, 14]. The rights-based model unblocks organised interferences which disturb individuals' and the realisation of their own rights; it is a modification of the welfarist and needy techniques of service delivery [9] which social development practitioners and health workers need to discard and reorganise in the COVID-19 pandemic period where the prioritisation for persons with disabilities is imperative. However, its interventions, according to Nwachukwu's [9:543], are concentrated on the "intrinsic-asset-centred approach for person-centred" practice. The person-centred practice is inherent within the rights-based approach that strives for the understanding of persons with disabilities are rights-holders and beneficiaries [9] to the various responses and interventions set for them during the COVID-19 pandemic. Thus, the institutions and authorities that administer resources have to acknowledge the limitations involved in the accessibility of the assets needed by persons with disabilities [4, 13] for their recovery and inclusion.

This might be empowering when practitioners utilise the UN's Disability Inclusive Strategy [4] as a rights based idea because they are cognizant of the fact that it is significantly stretched within the concerns of culture and the context of rights as a potential approach to

humanising the cultural influence for diagnosis and the treatment procedures for persons with disabilities. In the context of re-skilling or training healthcare personnel on disability inclusion and improving service delivery, it is ethically championed with informed consent and indicates action in achieving the Disability Inclusion Strategy. Practitioners in health and social care have to ascertain and eradicate hindrances and barriers to accessibility in healthcare facilities for persons with disabilities if they are considered proficient in the rights-based model [9] to foster recovery inclusivity.

Practicum and ethical assimilation should be taught in school, and practice mechanisms need to be disability-inclusive and strategically motivated in concurrence with the rights-based model as the key training perspective. Thus, healthcare personnel training in disability inclusion and improving service delivery attainment requirements needs to be inclusive, universal, and a recurring process [23], as a rights-based model. The rights-based practicum and ethical practice must outline the importance of the United Nations' interpretations on education as a basic human right that should cater for the imparting process for the majority of the people and not the inclusion of the rights of the many, not the few [22, 23]. The next stage of the paper will link health and social care workers to the United Nations Disability Inclusion Strategy targets for COVID-19.

3. UNITED NATIONS' COVID 19 DISABILITY INCLUSION STRATEGY TARGETS FOR ACHIEVABLE STANDARDS

The United Nations' COVID 19 Disability Inclusion Strategy [4] can be utilised and implemented using the cultural-safety capability information (DSM-5) to improve health and social care practice in this COVID-19 pandemic. The United Nations COVID-19 Response [4:1] has seven noticeable obligated guidelines that states and stakeholders should meet to actualise the rights of persons with disabilities. The following questions are geared towards rekindling the practice of disability care:

- i. "What is the impact of COVID-19 on the rights to health for persons with disabilities?"
- ii. What is the impact of COVID-19 on persons with disabilities who are living in institutions?
- iii. What is the impact of COVID-19 on the right of persons with disabilities to live in a community?

- iv. What is the impact of COVID-19 on the work, income, and livelihood of persons with disabilities?
 - v. What is the impact of COVID-19 on the right to education for persons with disabilities?
 - vi. What is the impact of COVID-19 on the rights of persons with disabilities on protection from violence?
 - vii. What is the impact of COVID-19 on specific population groups in which persons with disabilities are overrepresented? Those being (a) prisoners with disabilities and (b) persons with disabilities without adequate housing.”
- Train healthcare personnel on disability inclusion and the improvement of service delivery for persons with disabilities.
 - Empower persons with disabilities to take control of their own healthcare decisions on the basis of informed consent.
 - Prohibit discriminatory practices in the health insurance industry and promote health insurance coverage for assistive products and rehabilitation services.
 - Improve research and data to monitor, evaluate, and strengthen health systems so as to include and deliver for persons with disabilities [1, 2].

These questions create an impact on awareness of the risks persons with disabilities experience and are geared to improve responses that can alleviate the disproportionate impact of COVID-19.

The United Nations' COVID-19 Response [4:1] document guide has four identifiable aims for better responses for persons with disabilities. They are as follows, bring awareness of the pandemic's impact on persons with disabilities and their rights; draw attention to some promising practices already being undertaken around the world; identify key actions for states and other stakeholders; and provide resources for further learning regarding how to ensure a rights-based COVID-19 response [4], including persons with disabilities.

The United Nations [1] has specified seven objectives for attaining the standard of health for persons with disabilities, who generally have more healthcare needs than others, curtailed by an unreachable or reduced quality of healthcare services than those without disabilities. The United Nations' COVID 19 Disability Inclusion Strategy [4] is designed to accomplish the utmost achievable standard of health for persons with disabilities. The subsequent actions should be considered:

- Strengthen national legislation and policies on health care, in line with the CRPD [16].
- Identify and eliminate obstacles and barriers to accessibility in healthcare facilities.
- Improve healthcare coverage and affordability for persons with disabilities as part of the universal approach to health care.

This paper chose two of the above goals by identifying and eliminating obstacles and barriers to accessibility in healthcare facilities, and the training of healthcare personnel on disability inclusion and improve service delivery for persons with disabilities towards recovery and inclusion. These goals were discussed within the Cultural-Safety Capability Information (DSM-5) [3] approach. The main concerns for persons with disabilities, according to the report [4, 13], in comparison to persons without disabilities, reveals that "persons with disabilities are more likely to have poor health: among 43 countries, 42 per cent of persons with disabilities versus 6 per cent of persons without disabilities perceive their health as poor" [1, 20]. Mr Guterres, the UN Chief, stated that the COVID-19 pandemic has increased the risk of unemployment for persons with disabilities and that they could face employment marginalisation as they are more prone to be laid off. He also states that persons with disabilities could face challenges in returning back to work and that less than 30 per cent of people with substantial disabilities have access to benefits, while only one per cent of those living in low-income countries have access to health benefits [1, 5, 20].

The report goes further to discuss the clarion call for an instant response for disability advocacy organisations and the partnership of disability rights and emergency management experts in host countries in addressing the specific needs of persons with disabilities with the goal of preserving their health, safety, and upholding their dignity and independence in their communities throughout the COVID-19 epidemic and associated health crises [1, 20]. Hence, this paper adheres to that response to disability-inclusive strategies for health and social care practitioners to

utilise the Cultural Formulation Information to formulate a strategy for COVID-19 response for persons with disabilities.

4. ENGAGING CULTURAL-SAFETY CAPABILITY INFORMATION (DSM-5) FOR HEALTH AND SOCIAL CARE

The historical design of the Outline for Cultural Formulation (OCF-DSM-IV) [3] was hailed as a breakthrough for cultural psychiatry, with a succinct list of cultural topics prearranged by extensive fields for clinicians to reflect on the valuation and assessment of patients [24, 25]. The OCF was established through literature appraisals directed by the National Institute of Mental Health, a sponsored group on culture and diagnosis in 1991–1993 [26, 27]. The objective of the OCF was to aid clinicians to identify cultural and appropriate features applicable to diagnosis and treat patients [24, 27]. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) clarified that the OCF was "meant to supplement the multi-axial diagnostic assessment and to address difficulties that may be encountered in applying DSM-IV criteria in a multicultural environment" [3:897].

The question remains on the extent that cultural assessment and treatment planning, cultural formulation, and information addresses cultural-oriented interviews and changes aspects of care, diagnosis, treatment preparation, patient satisfaction, and adherence Kirmayer *et al.* [25]; Lewis-Fernandez *et al.* [24]. However, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) [3] medical model has been criticised for not catering to social workers' model of valuations and interventions, which is empirically within the systems and social levels [28], Frazer *et al.* [29]. Nevertheless, Nwachukwu and Mazibuko's [30] analysis of the Cultural-Safety Capability Information (DSM-5) indicates that its usage with a strength-based interview should assist clients, persons with disabilities, inclusively by disabling impediments and offer problem-solving resolutions that are associated with the resource accessibility within healthcare facilities during the COVID-19 pandemic to achieve the UN's Disability Inclusive Strategy [4, 31].

Furthermore, studies have found out that the DSM-5's utilisation has decreased patients taking psychotherapy in the last decade to 43 per cent from 53 per cent; and more patients have sought other health and social care alternatives [32, 33]. The positive outcomes indicate that psychotherapy is a

better aspect of treatment than medication for trivial or reticent anxiety cases and depression instigated by social and interpersonal causality [32]. As such, this COVID-19 era seems to activate slight and taciturn anxiety and depression cases with the info-demic circulating globally. The health and social care practitioners' should utilise the Cultural-Safety Capability Information (DSM-5) [3] in the actualisation of the UN's Disability Inclusive Strategy [4] towards assisting persons with disabilities in reverberating encouragement, building confidence, and increasing their ability to access capable health care assistance. This health care assistance should enable them within their social and interpersonal connections in surviving life threatening situations, which COVID-19 has increasingly exposed them to.

Nwachukwu and Mazibuko [30], Wakefield [32], and APA [3] are of the view that the Cultural Formulation Interview is a great resource when health and social care practitioners utilise it as it offers procedures to identify cultural explanations for problems, cultural discernment of the original source of the issues, background, and identification of stressors' meanings and provisions. The roles of cultural identity and how cultural features affect self-coping and their previous experiences and barriers they encountered. They argue that employing the Cultural-Safety Capability Information (DSM-5) to assess migrant women and families encourages reverberate motivations for self-reliance and seeks resourceful benefits in handling their life circumstances. The Cultural-Safety Capability Information of DSM-5 has significantly extended the concerns of culture and context as a prospective mode of refining the cultural cogency of diagnosis and treatment arrangement Lewis-Fernández *et al.* [34]; Lewis-Fernández *et al.* [24].

The effectiveness of culturally formulated information that has inclusive strategies for persons with disabilities at remote, inaccessible domains needs to be informed about the issues COVID-19 has instigated in health care arrangements. Some examples of these issues are as follows, basic hygiene requirement, information on health care availability, and social isolation necessities.

The Cultural-Safety Capability Information (DSM-5) asserts that one should be generous with information that could permit the telescoping structure of the DSM-5's core cultural formulation information, its informant version. And how auxiliary segments empower clinicians, including health and social care workers,

towards selecting the preferred level of assessment for each clinical situation Hanson *et al.* [35]; Lewis-Fernández *et al.* [34]. It also provides support regarding psychosocial stressors and distress for persons living with disabilities.

5. SOCIO-ECONOMIC INCLUSION AND THE DSM-5 CULTURAL-SAFETY FORMULATION INFORMATION

The obstacles to complete social and economic inclusion for persons with disabilities comprise discriminatory prejudice and stigmatisation, fissures in service delivery, and non-adopted means of communication [8]. These obstacles can be challenging within the context of COVID-19. The recognition of these socio-economic gaps in achieving the desired level of inclusion should be emphasised by practitioners by engaging with the socio-cultural perspectives in the CFI (DSM-5) [3] to implement the UN's Disability Inclusion Strategy for persons with a disability, towards combating the inaccessibility of health care facilities and promoting recovery from the COVID-19 pandemic. The socio-economic inclusion for the Disability Inclusion Strategy for persons with disabilities would enable clients to understand barriers within their cultural affinities and the knowledge and experience documented within the DSM-5 cross-cultural issues subgroup that reinforces the assessment of the OCF-focused methodological outline Kirmayer *et al.* [36]; Kirmayer *et al.* [25]; and direct the strategy of the Cultural Formulation Information as an instrument for enabling cultural aspects of assessment and treatment planning in clinical practice [34].

Observations indicate that quarantine schemes, transport modes, and health facilities that were established for the response to COVID-19 may be unsuccessful in providing the necessities for persons with disabilities; children and youths with disabilities for example, they could be at risk of exclusion from education if isolated or placed into distance learning programmes. They are not reachable and do not have assistive devices that would allow participation and accommodate their learning needs [8, 1] Campbell *et al.* [38]. The question that comes to mind is how the training or re-skilling of healthcare personnel on disability inclusion and improving service delivery for persons with disabilities can resonate with the empowering of persons with disabilities to take control over their own healthcare decisions? The next subheading will discuss the combatting of the COVID-19 info-demic by using the DSM-5 to aid persons with disabilities.

The global COVID-19 pandemic has dismantled socio-economic and livelihood values, causing insolvency in the adherence to the restrictive measures of social isolation, such as the lockdown regulations in different areas [2, 20]. The projections for the global economic depression pursue the unmitigated pressure on the unemployment rate, prices on food and health care services, and livelihood conditions, and how the worldwide increase of poverty threatens the UN Sustainable Development Goals in eradicating poverty and achieving both standard needs and needs linked to impairments [20, 38].

6. DSM-5 CULTURAL-SAFETY FORMULATION INFORMATION TO COMBAT THE COVID-19 INFO-DEMIC (INFORMATION EPIDEMIC)

The Director-General of the World Health Organization (WHO) has acknowledged that the COVID-19 epidemic has brought about an info-demic of misinformation [39, 40]. Antonio Guterres, the Secretary-General of United Nations, tweeted on March 28, that "Our common enemy is COVID19, but our enemy is also an "infodemic" of misinformation", on his personal Twitter account [1, 2]. The empathetic coverage of the pandemic and COVID-19's info-demic is a challenge for health and social care practitioners. There is also the lack of information about the COVID-19 disease, its symptoms, and prevention, which is not being distributed through reachable and manageable designs, braille and sign language versions, audio transfer, and visuals illustrations for persons with disabilities, for example [5]. When the accessibility of information for persons with disabilities is inadequate, misinformation grows within the COVID-19 info-demic. There is a depressing mental distortion of the news and conflicting information circulating about the COVID-19 pandemic that is challenging for persons with disabilities. Nevertheless, practitioners should be cognizant of the mental health issues that could arise from the info-demic and its psychosocial stressors and impacts on persons with disabilities. Thus, practitioners should try to minimise the effects by utilising DSM-5 Cultural-safety Formulation Information. This can be enriched with the numerous components necessary to advance a standard training procedure because it contains sample interview questions, which are complemented by strategies designating the justification and objective of each item consulted. It also contains case simulations designed for DSM-5 field trials to organise trainees for cultural formulation information that can be appraised by clinicians [34-36].

The training videos and assessment resources provided in the cultural-safety capability information (DSM-5) shared through empirical learning, such as familiarity with community appointments, cultural self-reflection exercises, and basic ethnographic techniques (e.g., simple field notes), particularly through preceptors cross-trained in the social sciences, which guides cultural formulation information training [34-36]. These stated avenues, in conjunction with the United Nations' information on the COVID-19 response, should guide the training of health and social care practitioners in the COVID-19 era. However, the integrated relationship and non-distinction between the notion of ethical practices and competence, which acknowledge the existence of ethical competence, whereby practitioners' competence is balanced with ethical considerations in their practice domain, is achievable and should boost skills gain [41:297-299]. The cultural practices emanating from communal pressure towards genuflect or social conformity to customary belief systems and identity are geared to test practice mechanisms for health and social care practitioners.

The traditional value system emanating from the cultural rites in this COVID-19 pandemic can be drastically tainted with deaths, deprivation of dignity, and the worth of a person's life, as well as the violations of human rights for persons with disabilities. Hence, increasing the disease spread with an info-demic of misinformation is an immense challenge. Observations indicate that, in South Africa, it has been seen that health inspectors have not fully capacitated their professional responsibilities to environmental health by overlooking the conditions of schools that aim to open so as not to interfere with cultural value systems [42]. Some of these cultural value conditions are rife in most African communities, existing in the name of culture preservation, thus, requiring the re-educating or re-skilling of our primary caregivers. The concept of re-educating the educated as advocated by Fisch [43] in probing of James Baldwin's [21] notion of education as a force in empowering societal change through a strategy to impart self-determination and the liberation of thoughts and the decision-making of the people has to be inculcated into the re-skilling of caregivers on environmental health and social care for the COVID-19 response. Nevertheless, the inconsistency in upholding justice from the wrongs in the society needs to be corrected, and society should seek change, which makes it possible for people not to be passive and seek the required change that society

needs [21]. Baldwin's [21] assumptions give credence to the "outdated, white, Eurocentric, and patriarchal ideology" [43:2], which delicately directs societal actions. Most knowledge acquired is of a "fragmented reality" [43:3] and is negligible regarding how the real world evolves and why it works. As such, marginalisation and information need to be eliminated to avert the accepted epistemic injustice predominant in the education system, defined as institutionalised othering [44].

Epistemic injustice is prevalent in institutional structures currently and can increase the obstacles facing persons with disabilities, which includes the inaccessibility to preventative and response measures, and the inadequate obtainability of disaggregated data results that foster incapability of surveillance systems to regulate the impact of COVID-19 on persons with disabilities [43:2;38]. Other areas of response consideration include barriers faced by persons with disabilities in accessing critical health services and 'WASH' amenities as a result of environmental obstacles; unreachable information and communication avenues that persons with hearing, visual, intellectual, or physical disabilities mean that they may not receive key information about prevention and assistance [5, 8] social and health care workers must take these issues into consideration.

The inherent gaps that entangle the current COVID-19 issues, policies, and encumbrances, including the management of the pandemic, are areas that have to be inculcated to a "practice of doing" and not just knowing how to curb the COVID-19 info-demic, thus, assisting persons with disabilities. The DSM-5 Cultural Safety Formulation Information [3] can assist in improving the health and social care competence if practitioners can implement the practice realities and real-life stories inherent in it. It can revamp coursework and fieldwork education for social work education through the inclusion of persons with disabilities and caregivers' capabilities in understanding how advocacy, learning, research, and community engagement works in the actualisation of disability-inclusive strategy approaches and embracing this new normal way of engagement and living.

7. DISCUSSION AND CONCLUSION

The most important aspect of the rights-based approach is its emphasis on the accountability of the activities of actors and policymakers, as Nwachukwu [9] argues in his promotion of a rights-based,

community-oriented approach. Accountability is emphasised in the achievable standards of the United Nations' COVID 19 Disability Inclusion Strategy [1, 13, 20]. Consequently, health and social care development practitioners whose actions can influence the rights of people, especially the rights of persons with a disability, should accordingly need to nurture consciousness in the "practice of doing", so as to curb the info-demic, which can prevent persons with disabilities from achieving health and social care.

The United Nations [10] asserts that medical care and essential social services are human rights. As such, the COVID-19 response from the Disability Inclusion Strategy document seeks to consider that persons with disabilities might be disproportionately at risk of exposure, complications, and death [1, 45, 46] due to a lack of information on health and social care. Some may have causal health conditions that would heighten their likelihood of severe impediments as a result of COVID-19 infection. Also, persons with disabilities are unaccountably represented among individuals living in poverty within lower socio-economic groups [1, 45, 46]. Therefore, it is imperative for health and social care practitioners to provide quality and efficient care within a rights-based approach to implementation of the disability-inclusive strategy; they should advocate for the building of the healthcare system's capacity by using the Cultural Formulation of Information (DSM-5) [3, 47] to overcome barriers and the info-demic. Problem-solving determinations for socio-economic inclusion in the access of healthcare facilities during this COVID-19 pandemic should also be considered.

As culture is constantly changing to accommodate modern ways of practising traditional rites, it is imperative to recognise personal constitutional rights that are enshrined with values of human dignity and respect freedom, which often clashes with exercising cultural rights, which the DSM-5-Cultural-Safety Formulation Information [47, 3] caters for. Thus, this paper recommends employing the rights-based model to the United Nations' Disability Inclusion Strategy [4] so as to actualise achievable standards of health for persons with disabilities. This integrated strategy will focus on recognising and eradicating the impediments and hurdles to convenience in healthcare services and their accessibility, as well as promoting a socio-economic inclusion strategy and the preparation of healthcare workers for meeting achievable standards in accessing and improving service delivery. The paper recommends implementing the United Nations'

Disability Inclusion Strategy [4] including the re-educating and re-orientation of both the right-holders and the duty-bearers, the health and social care practitioners, on the attainment of health care and recovery and curbing inequalities in accessing health care, education, income projections, and the easing participation in communities due to the COVID-19 pandemic.

The South African government is using rights-centred COVID-19 measures to support vulnerable groups, such as persons with disabilities. However, there are concerns regarding an abusive implementation from the South African Defense Force and the police, both of whom should not destabilise the vigorous and vital interventions put in place by the government to safeguard public health and safety [48]. The DSM-5's core Cultural-Safety Formulation Information [3, 47], its informant version, coupled with strength-based interviews [30, 47] and auxiliary sections, are all geared to empower clinicians, precisely health and social care workers in this COVID-19 period that requires efficacious, quality health service. In selecting the preferred level of assessment for each clinical condition and strategising towards disability inclusivity, clinicians are geared towards aiding persons with disabilities in the COVID-19 environment. This research is limited regarding the psychosocial impacts of COVID-19, and further research regarding this topic should aim to fill this gap.

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