IASC Inter-Agency Standing Committee

Guidelines

INCLUSION OF PERSONS WITH DISABILITIES IN HUMANITARIAN ACTION

July 2019

IASC Task Team on Inclusion of Persons with Disabilities in Humanitarian Action

Endorsed by IASC October 2019

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Acronyms

5W	Who does What, Where, When, for Whom
AAP	Accountability to affected populations
AOR	Area of responsibility
CA	Camp administration
CAAP	Commitments on Accountability to Affected Populations
CCCM	Camp coordination and camp management
CHS	Core humanitarian standards
CMT	Camp Management Toolkit
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DHS	Demographic and health survey
DFID	Department for International Development
ERW	Explosive remnants of war
FAO	Food and Agriculture Organization
GBV	Gender-based violence
HC	Humanitarian Coordinator
HCT	Humanitarian Country Team
HLP	House, land and property
HIS	Humanitarian Inclusion Standards
HNO	Humanitarian needs overview
HPC	Humanitarian programme cycle
HRP	Humanitarian response plan
IASC	Inter-Agency Standing Committee
IFRC	International Federation of the Red Cross and Red Crescent Societies
IHL	International humanitarian law
IHRL	International human rights law
IMAS	International Mine Action Standards
INEE	Inter-Agency Network for Education in Emergencies
INGO	International non-governmental organization
IOM	International Organization for Migration
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
MICS	Multiple indicator cluster survey
NCD	Non-communicable diseases
NFI	Non-food items
NGO	Non-governmental organization
OCHA	Office of the Coordinator for Humanitarian Affairs
OECD-DAC	Organization for Economic Cooperation and Development - Development Assistance Committee
OFDA	Office of US Foreign Disaster Assistance
OHCHR	Office of the High Commissioner for Human Rights
OPD	Organization of persons with disabilities
PSEA	Protection against sexual exploitation and abuse
RC	Resident Coordinator
SDGs	Sustainable Development Goals
SGBV	Sexual and gender-based violence
SRH/ SHRH	Sexual health and reproductive health
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, sanitation and hygiene
WHO	World Health Organization
WRC	Women's Refugee Commission

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The Inter-Agency Standing Committee (IASC) Task Team on Inclusion of Persons with Disabilities in Humanitarian Action developed these Guidelines through a consultative, participatory and inclusive process. They reflect the input of more than 600 stakeholders across the disability, humanitarian and development sectors.

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Foreword

In 2011, as armed militias were burning down homes in Tawergha in Libya, a woman named Hawa was unable to run because of a disability. Fortunately, she had two sisters who could carry her to safety. In the eight years since living in displacement, Hawa says she has only seen a doctor once.

I have met several people like Hawa with disabilities, who are among those displaced either by raging conflicts or extreme weather events. Adapting to the new and the unfamiliar is challenging for anyone. But when speaking to people with disabilities in humanitarian settings from Bangladesh to Haiti, it brings home their added difficulties if our responses fall short.

Our job is to ensure that people like Hawa are counted like any other in a humanitarian response during a crisis. It is her fundamental right – and the right of hundreds of thousands more – to access the same protection and care we provide to others.

And we must ensure that special focus is on the most marginalized amongst them, such as children and older people, who often run the risk of being the most invisible.

To make this a reality the Inter-Agency Standing Committee (IASC) *Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action* is a welcomed and timely step in the right direction. I am grateful to the members of the Task Team on Inclusion of Persons with Disabilities in Humanitarian Action and its co-chairs UNICEF, Humanity and Inclusion (also known as Handicap International) and the International Disability Alliance, for their work in preparing these guidelines on behalf of the IASC. It comes amid a growing global awareness of the rights of persons with disabilities.

These crucial system-wide Guidelines, which are a first, will ensure the inclusion of persons with disabilities in all sectors and in all phases of humanitarian action. They are a result of an inclusive consultative process, which involved more than 600 stakeholders from the humanitarian and disability sectors, including many organizations of persons with disabilities from around the world. In the endeavour to save lives and reduce human suffering in humanitarian crises, United Nations' agencies will implement these guidelines in accordance with their respective mandates and the decisions of their governing bodies.

The idea to develop the Guidelines originated with the *Charter on Inclusion of Persons with Disabilities in Humanitarian Action* launched at the 2016 World Humanitarian Summit in Istanbul. The Charter has been endorsed in the meantime by more than 220 stakeholders, including 30 Member States and 14 UN agencies.

The Guidelines are a key contribution of the humanitarian sector to the United Nations Disability Inclusion Strategy (UNDIS) that the United Nations Secretary General launched in June 2019.

Everyone benefits, when we remove biases and provide opportunities for people with disabilities. The International Labour Organization found that excluding people with disabilities from the world of work can rob countries of as much as 7 per cent of their Gross Domestic Product.

Not only are we doing the right thing, our response also becomes more effective as we give voice to the voiceless and leave no one behind.

Mark Lowcock
Under-Secretary General for
Humanitarian Affairs
and Emergency Relief Coordinator

Preface

The Convention on the Rights of Persons with Disabilities (2006) introduced a new paradigm for persons with disabilities. It shifted policy and policy implementation from a charitable and medical approach to one based on rights.

The international system has also become more inclusive following adoption of the *2030 Agenda for Sustainable Development* (2015), which affirms that no one should be left behind and that those who are furthest behind should be supported first. The *Sendai Framework for Disaster Risk Reduction* (2015) and the *One Humanity Shared Responsibility: Report of the Secretary-General for the World Humanitarian Summit* (2016) affirm the same principles, as do many commitments that derive from the World Humanitarian Summit, including the *Charter on Inclusion of Persons with Disabilities in Humanitarian Action*.

The United Nations (UN) is currently revising its system-wide policies to become more inclusive of persons with disabilities. In March 2019 it adopted the *UN Disability Inclusion Strategy*, under which UN entities, country teams and humanitarian country teams will measure and track their performance with respect to disability inclusion.

The World Humanitarian Summit in 2016 made a commitment to develop globally endorsed system-wide guidelines on how to include persons with disabilities in humanitarian action (the *Charter on Inclusion of Persons with Disabilities in Humanitarian Action*, mentioned above). These guidelines have been designed to provide practical information for humanitarian actors and other relevant stakeholders. They place persons with disabilities, and their human rights, at the centre of humanitarian action.

Disclaimer

These guidelines provide guiding principles for better inclusion of persons with disabilities in humanitarian action. In the next step towards operationalizing them, the IASC will develop practical implementation tools and resources. IASC cluster lead agencies are encouraged to steward the development of practical and prioritized implementation tools and resources in the sectors they lead.

The tools and resources listed as examples throughout these guidelines may not have been updated since the entry into force of the CRPD in 2008, and some do not properly reflect CRPD standards. Relevant standards address free and informed consent, (de)institutionalization, deprivation of liberty, and (non) coercive treatment, among others. Failure to respect these standards usually leads to human rights violations that disproportionately affect persons with psychosocial and intellectual disabilities. The resources listed have nevertheless been included because they are valuable tools that can promote the inclusion and participation of persons with disabilities in humanitarian action.

1 Introduction

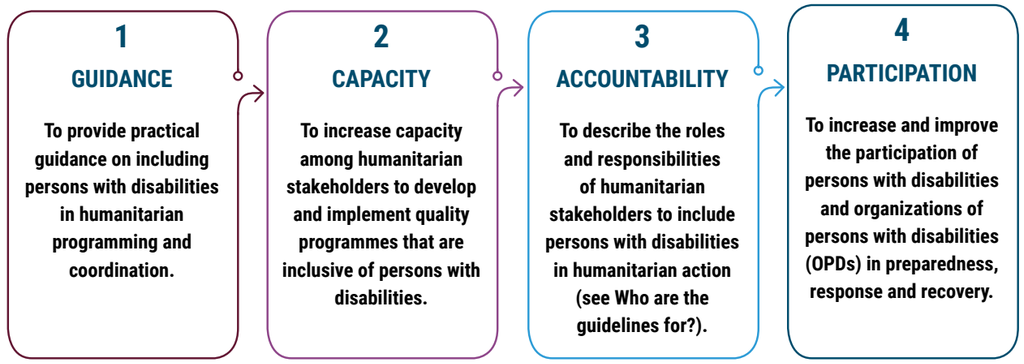
What are the guidelines about?

The guidelines set out essential actions that humanitarian actors must take in order to effectively identify and respond to the needs and rights of persons with disabilities who are most at risk of being left behind in humanitarian settings.

The recommended actions in each chapter place persons with disabilities at the centre of humanitarian action, both as actors and as members of affected populations. They are specific to persons with disabilities and to the context of humanitarian action and build on existing and more general standards and guidelines, including the *Core Humanitarian Standard*, *Sphere Handbook* and *Humanitarian inclusion standards for older people and people with disabilities*.

These are the first humanitarian guidelines to be developed with and by persons with disabilities and their representative organizations in association with traditional humanitarian stakeholders. Based on the outcomes of a comprehensive global and regional multi-stakeholder consultation process, they are designed to promote the implementation of quality humanitarian programmes in all contexts and across all regions, and to establish and increase both the inclusion of persons with disabilities and their meaningful participation in all decisions that concern them.

Diagram 1 | The four objectives of the guidelines

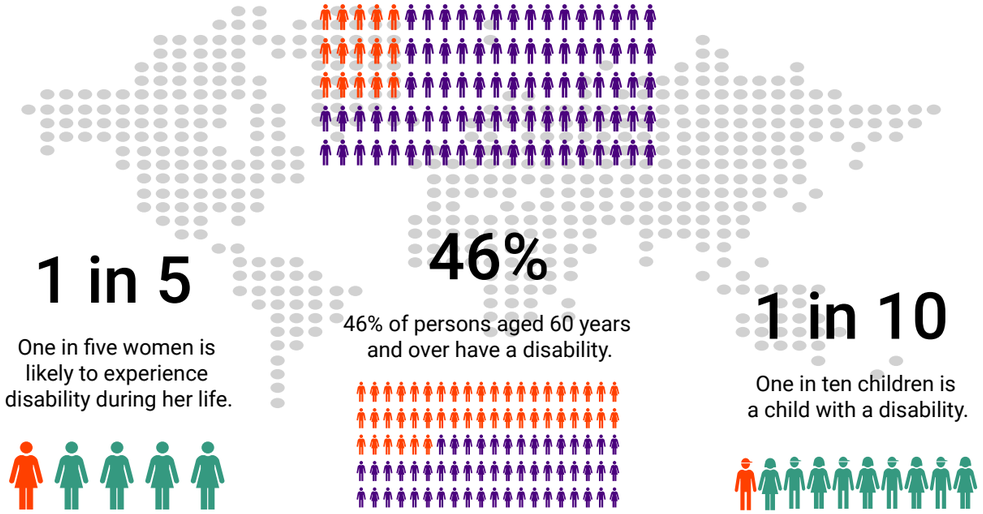


Why are the guidelines important?

Persons with disabilities are estimated to represent 15 per cent of the world's population.[1] In humanitarian contexts, they may form a much higher percentage. They are among the most marginalized people in crisis-affected communities[2] and are disproportionately affected by conflict and emergency situations. In disasters, their mortality rate is two to four times higher than that of persons without disabilities.[3]

Persons with disabilities are not a homogeneous group. They are diverse in their experience, in the ways that attitudinal, physical and communication barriers impede their participation and inclusion in humanitarian action, and in their identity, including their age, gender, ethnicity, location and race. Due to the intersectionality of these factors, persons with disabilities face greater marginalization and discrimination. During humanitarian crises, for example, children with disabilities are at higher risk of abuse and neglect, and women with disabilities are at higher risk of sexual violence.[4]

Diagram 2 | Global population of persons with disabilities[5]



[1] WHO and World Bank, *World Report on Disability* (2011).

[2] Report of the United Nations Secretary-General for the World Humanitarian Summit, *One Humanity, Shared Responsibility*.

[3] Katsunori Fujii, '*The Great East Japan Earthquake and Disabled Persons*', in *Disability Information Resources*, Japan.

[4] UNICEF, *Including children with disabilities in humanitarian action – General Guidance* (2017).

[5] Sources: WHO and World Bank, *World Report on Disability* (2011); UN DESA, *Ageing and Disability*; UNICEF, *Children and Young People with Disabilities* (2013).

Who are the guidelines for?

The guidelines are designed primarily for use by national, regional and international humanitarian actors who are involved in policymaking, coordination, programming and funding. Notably:

- Governments;
- Humanitarian leadership (Emergency, Refugee and Resident Coordinators, humanitarian country teams);
- Cluster/sector leads;
- Programmers (in humanitarian and development organizations);
- Donors;
- Local, national, regional and international organizations of persons with disabilities (OPDs).[6]

The guidelines will also be useful to field practitioners and other humanitarian actors because they describe processes for including persons with disabilities and make recommendations to sectors.

Where can these guidelines be used?

Humanitarian settings vary widely due to the nature of a crisis (natural hazard, conflict, displacement, political crisis, etc.), its location (urban, rural, remote islands), and whether it is a rapid, slow onset or protracted crisis. The recommendations in these guidelines are relevant to all settings but need to be adapted and localized to take account of context.

Contextual factors that should be considered when implementing the guidelines include:

- The degree to which disability is recognized and understood in the affected country;
- The degree to which expertise on disability is available in the affected country;
- The quality of political and legal frameworks on disability in the affected country;
- The degree to which services for persons with disabilities are available, accessible and effective;
- The presence of operational OPDs and whether they are experienced and adequately resourced;
- The availability and quality of data on persons with disabilities and the degree to which available data accurately reflect the diversity of the population of persons with disabilities in the affected country.

To illustrate, OPDs in an affected area may be under-resourced or inexperienced or may not represent the population of persons with disabilities. Where this is the case, it may be necessary to build their capacity on humanitarian action or create and empower community peer-support groups of persons with disabilities. The aim should be to enable OPDs to participate in consultations on assistance and protection during all phases of a humanitarian response (including preparedness, the response itself, and recovery).

In all circumstances, humanitarian actors, together with OPDs, must identify and address factors that make it difficult for persons with disabilities to access assistance and protection (see the section barriers), as well as factors that promote their inclusion and protection. This is necessary both to ensure that every member of an affected population receives the services to which he or she is entitled and to strengthen the accountability of the intervention.

[6] The guidelines seek to meet the needs of mainstream humanitarian stakeholders, including OPDs as humanitarian stakeholders and development actors involved in humanitarian action, rather than organizations specializing in disability. See the minutes of a multi-stakeholder IASC workshop held in October 2017.

2 What you need to know

Legal and policy framework

The Inter-Agency Standing Committee (IASC)[7] is the primary mechanism for inter-agency coordination of humanitarian assistance at the international level. The IASC has emphasized the relevance of international law in humanitarian crises, in particular international humanitarian law (IHL), international human rights law (IHRL), and international refugee law.[8] These bodies of law provide a legal framework that grounds humanitarian action in internationally agreed principles and standards and affirms the rights of all individuals affected by crises. International human rights law, which is applicable at all times, also provides a bridge between humanitarian and development action. It can be used to address the causes and consequences of crises, define and meet humanitarian needs, and establish the conditions that must be met before individuals can enjoy internationally agreed rights.

State actors are the primary duty bearers under international human rights law.[9] They have the first and main responsibility to protect, respect and fulfil the rights of persons on their territory or under their jurisdiction. Persons affected by crises and humanitarian emergencies have civil, political, economic, social and cultural rights, which they may claim from relevant duty bearers.

The Convention on the Rights of Persons with Disabilities (CRPD) is an international human rights treaty that is binding on States that ratify it (States Parties).[10] The CRPD affirms that States Parties must protect and promote the rights of persons with disabilities in their laws, policies and practices; and must also comply with the treaty's standards when they engage in international cooperation.

Article 11 of the CRPD specifically requires States Parties, in accordance with their obligations under international law, to take all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including armed conflicts, humanitarian emergencies and natural hazards.[11]

Other CRPD articles are relevant to humanitarian action and development, and support inclusion of persons with disabilities. The CRPD should be incorporated in all humanitarian interventions. To do so, humanitarian actors should examine and evalu-

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[7] The IASC was established in 1992 in response to UN General Assembly Resolution 46/182. Its membership includes both UN and non-UN humanitarian organizations. For more information, see IASC website.

[8] See IASC, *IASC Policy on Protection in Humanitarian Action* (2016); and IASC, the *IASC Principals' statement: The Centrality of Protection in Humanitarian Action* (2013). Annex I of the IASC Policy on Protection provides useful information on relevant international law.

[9] Under IHL, non-State armed groups (NSAGs) who are involved in an armed conflict are bound to respect IHL. In addition, *de facto* authorities or NSAGs that exercise government-like functions or control territory are increasingly expected to respect international human rights law when their conduct affects the human rights of individuals under their control.

[10] 179 States and the European Union are parties to the CRPD as of June 2019.

[11] See *Convention on the Rights of Persons with Disabilities and Optional Protocol*.

ate current practices, processes and outcomes to ensure that the human rights of persons with disabilities are protected and promoted as required by international law.

International human rights law (IHRL)

IHRL affirms that all individuals have civil, political, economic, social and cultural rights and defines these rights. In applying these universal rights to persons with disabilities, the CRPD significantly shifted the way in which persons with disabilities are perceived. Disability is understood to arise when individuals with impairments interact with the barriers they face. This has important implications for understanding not only what disability is but also how it should be addressed, including in the context of humanitarian action. In order to ensure that people with disabilities can fully exercise their rights, it becomes necessary to identify and remove social, legal, political and environmental barriers that prevent them from enjoying their rights, including attitudes and behaviours that stigmatize and marginalize persons with disabilities. It is also necessary to include persons with disabilities in decision-making, in line with their motto, 'Nothing about us without us'.

International humanitarian law (IHL)

In armed conflict, IHL provides general protection to civilians and persons *hors de combat*, including persons with disabilities, 'without adverse distinction' (discrimination).[12] The prohibition of adverse distinction permits humanitarian actors to prioritize persons with disabilities and may even require them to take specific measures to do so. Humanitarian relief efforts must make sure, for example, that food, water, health care, rehabilitation and shelter are available and accessible to persons with disabilities. Provisions of IHL may also be used to prevent or minimize harm to persons with disabilities during hostilities. Recognizing that persons with disabilities are at risk of being left in areas prone to attack, for instance, IHL specifically prioritizes their evacuation from such areas. Both IHL and IHRL affirm the obligations to protect and ensure the safety of persons with disabilities during armed conflicts; this obligation is set out in Article 11 of the CRPD.

Disarmament treaties include specific protections for survivors of weapons and remnants of war after conflicts end.

Other instruments and policy frameworks

Sustainable Development Goals

The 2030 Agenda emphasizes that all States have a responsibility to respect, protect and promote human rights without discrimination of any kind, including in relation to persons with disabilities. Its 17 Goals provide an internationally agreed framework for national and global development action in the period to 2030. The Agenda includes a global commitment 'to leave no one behind'.

Goal 96 is especially relevant to the inclusion of persons with disabilities in humanitarian action. It affirms the need to promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable and inclusive institutions at all levels. Goal 9 calls on societies to build sound infrastructures, particularly in areas affected by disasters. Goals 11 and 13 serve to remind that no issues, including disaster prevention and relief, can be understood or addressed effectively in isolation.

Sendai Framework for Disaster Risk Reduction 2015-2030[13]

The Sendai Framework aims to reduce disaster risks and loss of lives and assets. It promotes an 'all of society' approach that includes persons with disabilities. The framework promotes inclusion,[14] accessibility,[15] and the application of universal design standards,[16] and recognizes that persons with disabilities and their organizations have a critical role to play at all stages of disaster risk reduction planning.[17]

World Humanitarian Summit (2016) and Agenda for Humanity commitments

The situation of persons with disabilities was discussed during the World Humanitarian Summit and a number of organizations undertook to include persons with disabilities in humanitarian action.[18] Member States, UN organizations, non-governmental organizations (NGOs) and others recognized that humanitarian policies, procedures and programmes that seek to include persons with disabilities must be strengthened and systematized.

The *Charter on Inclusion of Persons with Disabilities in Humanitarian Action*, launched during the Summit, is grounded in both IHL and IHRL. It established five actionable commitments: non-discrimination; participation; inclusive policies; inclusive responses and services; and cooperation and coordination.

In addition to the above, both the *Global Compact on Refugees* and the *Global Compact for Safe, Orderly and Regular Migration* include specific provisions on persons with disabilities that advocate their inclusion in responses to movements of refugees and migrants.

Guiding principles of the IASC guidelines

The *IASC Guidelines on Inclusion of Persons with Disabilities in Humanitarian Action* are underpinned by principles that guarantee that the rights of persons with disabilities will be respected, protected and promoted throughout humanitarian preparedness, response and recovery.

The CRPD includes several principles that are applicable to humanitarian action.[19] They include: respect for inherent dignity; participation and inclusion; non-discrimination and equality of opportunity; and equality between men and women. More specific but equally important principles include: accessibility; respect for difference; acceptance of persons with disabilities as part of human diversity; respect for the evolving capacities of children with disabilities; individual autonomy including freedom to make one's own choices; and independence of persons.

These principles are closely linked to each right affirmed by the Convention. If implemented alongside humanitarian principles and standards, including the *Humanitarian Charter* and the *Code of Conduct*, they guarantee that persons with disabilities will be included in all phases of humanitarian preparedness and response.

Humanitarian action is also informed by the principles of humanity, neutrality, impartiality and independence set out in General Assembly resolutions.[20] These principles are central to the work of humanitarian organizations, many of which make additional commitments to protect human rights, respect the inherent dignity of affected populations, and strengthen accountability, by endorsing a code of conduct or endorsing and implementing the nine commitments of the *Core Humanitarian Standard*. The humanitarian principles underline that it is essential to maintain and improve the accountability, quality and performance of humanitarian action. They are critical to efforts to ensure the inclusion of persons with disabilities in humanitarian settings.

Who are persons with disabilities?

For the purpose of these guidelines, persons with disabilities include persons who have long-term

[12] See ICRC, Discrimination (or adverse distinction).
[13] *Sendai Framework for Disaster Risk Reduction 2015–2030*, adopted at the Third UN World Conference in Sendai, Japan, 18 March 2015.
[14] *Ibid*, para. 7.
[15] *Ibid*, para. 19(d).
[16] *Ibid*, para. 30(c).
[17] *Ibid*, para. 36(a)(iii).
[18] See Agenda for Humanity, Explore Commitments and Reports.
[19] CRPD, Article 3.
[20] On humanity, neutrality and impartiality, see *General Assembly resolution 46/182* (1991). On independence, see *General Assembly resolution 58/114* (2004).

sensory, physical, psychosocial, intellectual or other impairments that, in interaction with various barriers, prevent them from participating in, or having access to, humanitarian programmes, services or protection.[21]

A human rights-based approach to disability places persons with disabilities at the centre and reduces barriers and risks that they face. It requires humanitarian actors to recognize the capacity of persons with disabilities to contribute to the humanitarian response.

Persons with disabilities are a diverse group. They have different impairments and diverse identities (as women, indigenous persons, children, etc.). Due to the intersectionality of these factors, persons with disabilities may face multiple forms of discrimination. To avoid leaving persons with disabilities behind, an understanding of these differences must inform the approach adopted in humanitarian action from the outset.

Key concepts and definitions

Accessibility is one of the eight principles that enable the rights affirmed in the CRPD to be interpreted. It affirms the right of persons with disabilities to enjoy "access, on an equal basis with others, to the physical environment, to transportation, to information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas".[22] Accessibility is a precondition of inclusion: in its absence, persons with disabilities cannot be included.

> *Universal design* is an approach that advocates that "the design of products, environments, programmes and services [should] be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design".[23] The principles of universal design facilitate accessibility, including for persons with disabilities.[24]

Assistive technology, devices and mobility aids are external products (devices, equipment, instruments, software), specially produced or generally available, that maintain or improve an individual's functioning and independence, participation, or overall well-being.[25] They can also help prevent secondary impairments and health conditions. Examples of assistive devices and technologies include wheelchairs, prostheses, hearing aids, visual aids, and specialized computer software and hardware that improve mobility, hearing, vision, or the capacity to communicate.

Barriers are factors in a person's environment that hamper participation and create disability. For persons with disabilities, they limit access to and inclusion in society. Barriers may be attitudinal, environmental or institutional.

> *Attitudinal barriers* are negative attitudes that may be rooted in cultural or religious beliefs, hatred, unequal distribution of power, discrimination, prejudice, ignorance, stigma and bias, among other reasons. Family members or people in the close network of persons with disabilities may also face 'discrimination by association'. Attitudinal barriers are at the root of discrimination and exclusion.
>
> *Environmental barriers* include physical obstacles in the natural or built environment that "prevent access and affect opportunities for participation",[26] and inaccessible communication systems. The latter do not allow persons with disabilities to access information or knowledge and thereby restrict their opportunities to participate.[27] Lack of services or problems with service delivery are also environmental barriers.[28,29]
>
> *Institutional barriers* include laws, policies, strategies or institutionalized practices that discriminate against persons with disabilities or prevent them from participating in society.[30]

Barriers may be classified as a threat if they are put in place intentionally. They are described as a vulnerability if their occurrence is inadvertent. In both cases, barriers lead to exclusion, making it likely that persons with disabilities will face more or worse threats and vulnerabilities than others affected by a crisis.

Disability inclusion is achieved when persons with disabilities meaningfully participate in all their diversity, when their rights are promoted, and when disability-related concerns are addressed in compliance with the CRPD.[31] It is related to the concept of 'social inclusion', which has been defined as "the process by which efforts are made to ensure equal opportunities – that everyone, regardless of their background, can achieve their full potential in life. Such efforts include policies and actions that promote equal access to (public) services as well as enable citizen's participation in the decision-making processes that affect their lives."[32]

Discrimination on the basis of disability refers to any distinction, exclusion or restriction on the basis of disability that has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including failure to respond flexibly to reasonable demands (denial of reasonable accommodation).[33]

> *Reasonable accommodation* requires individuals and institutions to modify their procedures or services (accommodate), where this is necessary and appropriate, either to avoid imposing a disproportionate or undue burden on persons with disabilities or to enable them to exercise their human rights and fundamental freedoms on an equal basis with others.[34]
>
> *Multiple and intersecting forms of discrimination* occur when a person experiences discrimination on two or more grounds at once. In such circumstances, the effects of discrimination are compounded or aggravated. For example, a woman with a disability may simultaneously experience discrimination because of her sex and because of her disability. 'Intersectional discrimination' occurs when multiple forms of discrimination interact together in a way that exposes the individual to unique forms of disadvantage and discrimination.
>
> Discrimination on the basis of disability can target persons who currently have an impairment, who had an impairment in the past, who have a predisposition to an impairment in the future, who are presumed to have an impairment, and to associates of a person with a disability. The latter is called *discrimination by association*.

Enablers are measures that remove barriers, or reduce their effects, and improve the resilience or protection of persons with disabilities.

[21] Modified from CRPD, article 1.
[22] CRPD, Article 9.
[23] CRPD, Article 2.
[24] National Disability Authority, *What is Universal Design?*
[25] WHO, *Guidelines on health-related rehabilitation*, p. 35.
[26] WHO and World Bank, *World Report on Disability* (2011), pp. 4 and 263.
[27] Wapling & Downie, *Beyond Charity: a Donor's Guide to Inclusion* (2012), p. 21; PPUA Penca (Center for Election Access of Citizens with Disabilities), Accessible elections for persons with disabilities in five Southeast Asian countries. USAID & AGENDA (2013), pp. 5, 11; WHO and World Bank, *World Report on Disability* (2011), p. 4.
[28] WHO and World Bank, *World Report on Disability* (2011), p. 262.
[29] GSDRC, Barriers to disability inclusion.
[30] Wapling & Downie, *Beyond Charity: a Donor's Guide to Inclusion* (2012), p. 21; DFID: *Disability, Poverty and Development* (2000), p. 8; WHO and World Bank, *World Report on Disability* (2011), pp. 6, 262; *Bruijn et al.* (2012), *Count Me In: Include people with disabilities in development projects* (2012), p. 23
[31] United Nations Disability Inclusion Strategy website and UNDIS, Annex I. Key concepts and definitions
[32] UN Department of Economic and Social Affairs, Social Inclusion.
[33] See CRPD, Article 4.
[34] See CRPD, Article 2.

Inclusive budgeting occurs when an organization, during its planning process, allocates funds to remove barriers and promote participation for persons with disabilities, and to provide targeted activities for persons with disabilities. Inclusive budgets should include costs for improving physical accessibility, providing reasonable accommodations, and providing specialized non-food items (NFIs), assistive devices, mobility equipment and accessible communications.[35]

Informed consent occurs when a person willingly agrees to do something or allow something (for example, a medical intervention, relocation, the communication of personal information, the transfer of case documents, etc.) based on full disclosure of the risks, benefits, alternatives and consequences of refusal. Persons with disabilities, particularly those with intellectual and psychosocial impairments, are very often denied the right to express their consent. This is a violation of their rights under the CRPD.[36]

Children are entitled to be consulted and to give their informed consent to the degree that their evolving capacities enable them to do so.

Intersectionality is an analytic framework that demonstrates how forms of oppression (such as racism, sexism, ableism) overlap, defining unique social groups. An intersectional approach assumes that harms and violations associated with disability, race and ethnicity, gender, or other identities cannot be understood sufficiently by studying them separately. To see clearly how they affect access to resources or create risks for persons with disabilities, it is necessary to see how disability, age, gender and other factors interrelate and to evaluate their overall effect.[37]

Mainstreaming is the process of incorporating CRPD in protection principles, promoting the safety and dignity of persons with disabilities, and ensuring they have meaningful access to humanitarian support and can participate fully in humanitarian interventions. Mainstreaming does not focus on what is done, but on how it is done. Disability should be mainstreamed in all sectors and all phases of the humanitarian programme cycle.

Organizations of persons with disabilities (OPDs) should be rooted in and committed to the CRPD and should fully respect the principles and rights that it affirms. OPDs must be led, directed and governed by persons with disabilities. A clear majority of their memberships should be persons who have disabilities.[38]

Persons with disabilities "include those who have long-term physical, mental,[39] 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".[40]

Resilience describes the ability of a system, a person, a community or a society to resist, absorb, accommodate, adapt to, transform and recover from the effects of a hazard in a timely and efficient way, including by preserving and restoring essential structures and functions through risk management.

[35] To meet the physical accessibility requirements of persons with disabilities (for example, when constructing buildings or WASH facilities), it is estimated that between 0.5 per cent and 1 per cent should be added to budgets. To provide specialized non-food items (NFIs) and mobility equipment to persons with disabilities, estimates suggest a further 3-4 per cent, and up to 7 per cent, should be added. See Help Age, CBM, Handicap International, *Humanitarian inclusion standards for older people and people with disabilities*, and Light for the World, *Resource Book on Disability Inclusion* (2017), p. 36.

[36] Committee on the Rights of Persons with Disabilities, General comment No. 1 (2014) on Article 12: Equal recognition before the law CRPD/C/GC/1, 19 May 2014. See also Committee on the Rights of Persons with Disabilities, General comment No. 6 (2018) on equality and non-discrimination, CRPD/C/GC/6, 26 April 2018, para. 66. The IASC Policy on Protection in Humanitarian Action states that information and data should not be disclosed in the absence of free and informed consent. See the section on definitions.

[37] See European Parliament Directorate-General for Internal Policies, *Discrimination Generated by the Intersection of Gender and Disability* (2013). See also: Committee on the Rights of Persons with Disabilities, General Comment number 6 on equality and non-discrimination, CRPD/C/GC/6, 26 April 2018, para. 19.

[38] Committee on the Rights of Persons with Disabilities, *Guidelines on the Participation of Disabled Persons Organizations (DPOs) and Civil Society Organizations in the work of the Committee*, Annexe II of CRPD/C/11/2, para. 3. See also: CRPD Committee, General comment No. 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention, CRPD/C/GC/7, 9 November 2018.

[39] The CRPD referred to 'mental' impairment. The CRPD Committee subsequently preferred the term 'psychosocial' impairment.

[40] CRPD, Article 1.

Analysing risks and barriers to the inclusion of persons with disabilities in humanitarian action

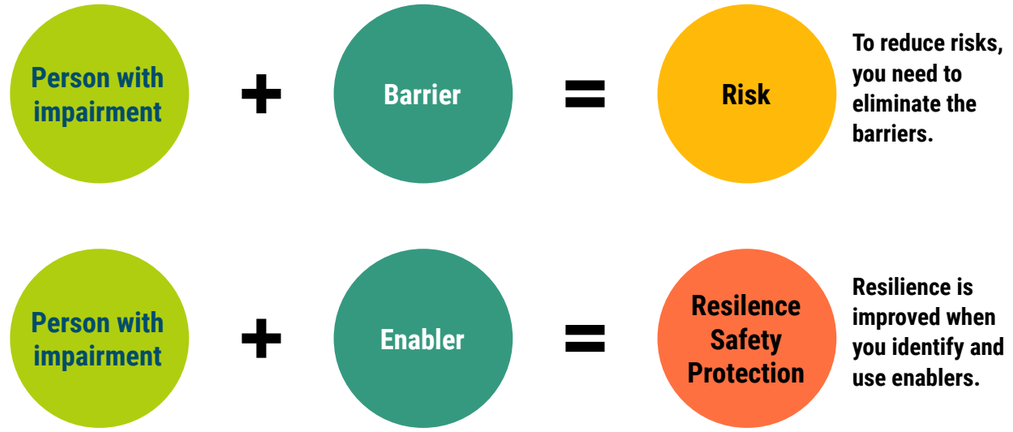
Reducing risk, improving resilience and increasing protection

Persons with disabilities face barriers that increase risk in humanitarian contexts. "Barriers can be either classified as a *threat* if put in place purposefully by an actor or as a *vulnerability* if happening as an inadvertent act. In both cases, these barriers lead to exclusion, which increases the likelihood of persons with disabilities to face threats and vulnerabilities at a higher level than the rest of the crisis-affected population."[41] By making use of enablers (such as support services in camps, facilitated access to food distribution points, or acquisition of assistive devices), persons with disabilities can improve their individual resilience. Falling risk and rising resilience imply improved protection.

What you should know in order to address barriers

This section describes general barriers faced by persons with disabilities during humanitarian crises. Chapters 11 to 18 outline sector-specific barriers. To identify key actions and measures effectively, and plan and implement accessible and inclusive humanitarian programmes, it is vital to understand disability, accessibility and the concept of barriers.

Diagram 3 | Barriers and enablers to inclusion of persons with disabilities in humanitarian action



[41] DG ECHO, *The Inclusion of Persons with Disabilities in EU-funded Humanitarian Aid Operations* (2019, DG ECHO Operational Guidance).

Persons with disabilities frequently face attitudinal, environmental and institutional barriers in their daily lives. Humanitarian crises exacerbate these and may create new ones, further reducing their access to assistance and protection and hindering their participation in humanitarian action. It is also important to recognize that persons with the same impairment may experience barriers differently, for many reasons including their sex, age, culture or socioeconomic status. The complex forms and character of multiple and intersecting discrimination and disability require a multi-criteria risk assessment.

The role of families and social networks

Families and social networks can operate as enablers to remove or reduce barriers that prevent the participation of persons with disabilities. Supportive families can significantly reduce costs and promote inclusion, particularly for persons with disabilities who are stigmatized or excluded. However, families may act as barriers as well as enablers. Humanitarian actors must ensure that the person with disabilities remains at the centre of their intervention.

The left-hand column of the table below lists barriers that occur in humanitarian contexts. The right-hand column describes a disability-inclusive response. The list is not exhaustive; more information on barriers can be found in chapters 11 to 18.

A. **Attitudinal barriers in humanitarian contexts.** Social misconceptions or prejudices against persons with disabilities may generate incorrect assumptions.

Examples of barriers and misconceptions	Examples of enablers and appropriate assumptions
All persons with disabilities died because they were unable to flee.	While some persons with disabilities died, many were able to flee. They are disproportionately represented among survivors.
Persons with disabilities are victims who need to be fully assisted.	Persons with disabilities need assistance just like any other group in the affected population, but they have capacities, resources and a voice, and many can contribute to humanitarian action.
Persons with disabilities have medical conditions and all need medical care.	Persons with disabilities have the same needs as others, and some may require specific medical attention. However, not all persons with disabilities will require medical care.
Health and medical services exclusively meet disability-specific requirements, such as provision of wheelchairs and assistive devices.	Humanitarian actors can deliver assistive devices through a range of channels. They must nevertheless understand what types of devices persons with disabilities require to increase their ability to function in the context and increase their capacities and resilience.
Persons with disabilities are unlikely to be able to make decisions; others are likely to need to take decisions for them in their best interest.	Persons with disabilities have the right to take decisions on issues that affect them, and most can do so. Some, including those with psychosocial or intellectual disabilities, may require support to understand and make decisions.
Persons with disabilities cannot work and therefore humanitarian organizations do not hire them.	Persons with disabilities can work and can make valuable contributions. It is important to discuss with them directly to identify their skills and interests.
Persons with disabilities make people around them uncomfortable.	This may be the case, where high levels of stigma and misunderstanding exist. It is important to conduct awareness-raising and sensitization to challenge negative beliefs.
Providing reasonable accommodation for persons with disabilities is too hard, too expensive. It is someone else's responsibility.	Accommodating the requirements of persons with disabilities can be easy if you know what they need and how to provide it. Ask them. In most cases, simple low-cost solutions can be found. All humanitarian actors have a responsibility to ensure that their programmes are accessible and to provide accommodations where necessary.

Local culture is often one source of prejudice and stigma against persons with disabilities. Identify cultural and social barriers and address them in a culturally acceptable way.

B. **Environmental barriers in humanitarian contexts.** Some environmental barriers are likely to be present already. Humanitarian actors and local populations may unintentionally create others.

Examples of barriers	Examples of enablers
Registration and distribution points are located far away, uphill, across difficult terrain; transport is inaccessible.	Place registration and distribution points in locations everyone can access. If this is not possible, provide transport or deliver services to individuals who cannot reach distribution points.
Food packages are too heavy to be carried by persons with disabilities.	Identify support people to collect and carry the food packages of persons with disabilities.
The latrine blocks are too narrow to accommodate a wheelchair and support person.	Design and procurement documents foresee latrines that are wheelchair accessible.
Tents and temporary shelters have steps and narrow entrances.	Design and procurement documents foresee temporary shelters that are wheelchair accessible.

Examples of barriers	Examples of enablers
Water points have elevated pumps that are difficult to operate.	Design and procurement documents foresee accessible water pumps. (Note that support may be required even for accessible designs.)
Coordination meetings take place in inaccessible buildings that fail the 'Reach, Enter, Circulate and Use' principle.[42]	The response makes sure that coordination meetings are convened in buildings and at sites that are accessible.
Information about humanitarian assistance is provided using only one medium of communication (for example, oral or written messages or posters).	Information about humanitarian assistance is provided in multiple accessible formats (oral, print, sign language, easy-to-read/plain language, etc.). Human assistance is provided to those who need it to access information.
Humanitarian frameworks, codes of conduct and other key documents are not available in multiple accessible formats, including easy-to-read/plain language formats.	Key documents are made available in multiple accessible formats, including easy-to-read/plain language formats.
Consultations with the community (through focus group discussions, feedback and complaint mechanisms, etc.) are not conducted in multiple formats, and persons with hearing, psychosocial or intellectual disabilities are not supported to understand or participate in them.	Consultations are conducted in a range of formats, and persons with hearing, psychosocial or intellectual disabilities are supported to participate in community consultations, focus group discussions, feedback and complaint mechanisms.

C. **Institutional barriers and enablers in humanitarian contexts.** In many countries, few or no policies promote or ensure the inclusion of persons with disabilities.

Examples of barriers	Examples of enablers
Government policies and legal frameworks relevant to humanitarian action and the policies of humanitarian organizations do not promote or ensure the inclusion of persons with disabilities.	Government policies support inclusive approaches aligned with the CRPD. Where appropriate, UN entities, UN country teams and UN humanitarian country teams comply with the *UN Disability Inclusion Strategy* (UNDIS).
Cash-for-work programmes and other employment programmes do not consider the abilities of persons with disabilities and do not employ them.	Cash-for-work and other employment programmes consider the abilities of persons with disabilities and support services are respectful of their autonomy (and provide personal assistance or interpretation).

[42] A location or building is accessible when a person with disabilities can reach it, enter it, circulate from one room or floor to another, and use the services it offers.

Examples of barriers	Examples of enablers
Trained and qualified service providers and skilled staff (such as teachers and physicians) are not available.	Recruitment documents consider inclusion and encourage disability-specific experience. Programmes train staff in principles of inclusion and practical ways to promote it.
Inclusion is not a donor requirement.	OECD-DAC and a growing number of other donors include disability markers and want to focus more on persons with disabilities.[43] UN entities will be obliged to report on their disability performance under the *UN Disability Inclusion Strategy*.
Recruitment documents for humanitarian posts require applicants to be in 'good health' and may exclude persons with disabilities on the grounds that disability is a health issue.	Recruitment policies comply with CRPD standards and evaluate candidates based on their capacity to deliver the core functions of the advertised job, with support if required.[44]
National laws prevent persons with disabilities from opening bank accounts (which can prevent them from accessing cash-based assistance), obtaining loans or credit, or owning land.	The response works with the government to develop inclusive policies aligned with the CRPD. It works with financial entities to make it easier for persons with disabilities to obtain cash safely and legally until new laws or the courts allow them to open bank accounts.
The legal capacity of persons with disabilities is restricted,[45] reducing their access to legal protection, as well as their authority to take decisions and give free and informed consent.	Government supports inclusive policies aligned with the CRPD. Support persons and services are available to support persons with disabilities to make informed decisions, with safeguards to ensure they do not take decisions under duress. The policies of humanitarian organizations do not impose barriers based on legal capacity.
Humanitarian organizations have no disability-inclusive policies and lack accountability mechanisms to measure their performance on disability inclusion. This inhibits the development of an organizational culture that properly supports persons with disabilities.	Policies ensure the inclusion of persons with disabilities. Accountability mechanisms measure improvements in performance. The UNDIS guides humanitarian organizations as they develop inclusion frameworks.[46]
The humanitarian structure has no Area of Responsibility (AoR) for disability.	Disability is a standing agenda item in protection and inter-agency meetings. A person is appointed with responsibility for disability.
Needs assessments are not disaggregated by disability. This hinders understanding of the extent to which persons with disabilities experience particular risks.	Persons with disabilities are targeted in needs assessments. Data are disaggregated and risks are evaluated in detail.

[43] Organisation for Economic Co-operation and Development, Handbook for the marker for the inclusion and empowerment of persons with disabilities (2019).

[44] International Labour Organization, Promoting diversity and inclusion through workplace adjustments: a practical guide.

[45] 'Legal capacity' refers to a person's entitlement to perform valid legal actions, to marry, enter into an employment contract, administer his or her money, accept or reject medical treatment, etc. Most countries deny this right to persons with intellectual and psychosocial impairments, although doing so breaches the CRPD.

[46] United Nations, Disability Inclusion Strategy. See also the ILO *Model Self-Assessment Tool* developed for businesses as proxy.

An inclusive response requires several levels of intervention. Given that persons with disabilities have specific requirements, the CRPD advocates planning on two axes: (i) to progressively develop accessible and inclusive environments and interventions; and (ii) to deliver customized solutions that enable persons with disabilities to participate immediately.

When no mainstream solutions are available, actors should be ready to provide reasonable accommodations to meet the requirements of persons with disabilities.

Take steps to ensure the provision of reasonable accommodation/adjustments

'Reasonable accommodation' means necessary and appropriate modification and adjustments, not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms. (CRPD, Article 2.)

To explain how humanitarian actors can balance mainstream or structural solutions and individual accommodations, consider accessibility. A humanitarian actor that wants to improve accessibility usually does so in steps. It (i) initiates an assessment; (ii) evaluates alternative actions; (iii) prepares a procurement process and documents; (iv) buys or acquires goods, facilities, materials, technologies, etc; and (v) distributes and delivers the chosen goods or services against a planned timetable or schedule. Because denying reasonable accommodation is discrimination, the humanitarian actor also must offer individual solutions on demand.

Bridging the gap between accessibility and individual adjustments

A programme or service is accessible if…	Reasonable accommodation is achieved if…
It can be implemented promptly.	It can be provided immediately (avoiding discrimination).
It offers a general solution.	It is an individual solution.
It is available and accessible regardless of whether it is required.	It is delivered when a person with disabilities requires it, and when they cannot otherwise obtain access to it.
It is guided by general principles of universal design.	It is tailored to meet the person's requirements and designed together with the person.
It meets accessibility standards.	It meets a proportionality test.

A reasonable accommodation is an individual measure that benefits a specific person – but may also bring wider benefits. For instance, a path that is made accessible for one person can subsequently be used by many. The same may be true of changing the procedure for obtaining cash transfers, reorganizing food distribution methods, or reorganizing work to meet the needs of a colleague with a disability. (See Annex 1: Providing reasonable accommodations.)

Accessibility provides just one example of reasonable accommodation. Accountability procedures may be adjusted for certain persons who cannot maintain their attention for long periods; cash for money programmes might extend the time slots they offer to accommodate the requirements of a person for whom travel is a significant barrier, etc.[47]

Rights-based terminology

The terms used to address or refer to persons with disabilities can diminish or empower them. Below are some key terms to be aware of:

Vulnerable/vulnerability. Persons with disabilities are not inherently vulnerable. Rather, vulnerability is imposed on them, including by barriers and lack of support. Rights-based language usually uses vulnerability with a qualifier. For example, 'girls with disabilities are more vulnerable to sexual violence when they are separated from family members and caregivers' or 'boys with disabilities are more vulnerable to bullying than boys without disabilities'.

Carer/caregiver. A carer or caregiver is commonly defined as a person (a family member or paid helper) who regularly looks after a child, a sick person, an older person, or a person with a disability. Rights-based actors tend to prefer the term 'support', rather than 'care', when speaking of adults with disabilities (for example, personal assistance, peer support, support person).

Specific needs. Human needs (for food, shelter, health services, etc.) are universal. Persons with disabilities share those needs with all other human beings. Persons with disabilities may require action to meet needs that are specific to them (accessibility, communication, personal assistance, etc.). Rights-based actors usually replace the term 'specific needs' with the term 'specific requirements', because this places the emphasis on realizing their rights.

Additional considerations on terminology:

- Use person-first terminology. (For example, choose 'person with a disability' rather than 'disabled person'; and 'girl who is blind' or 'girl with a vision impairment' rather than 'blind girl'.)
- Avoid terms that have negative connotations, such as 'suffer', 'suffering', 'victim' or 'handicapped'. Speak of a 'wheelchair user' rather than a person who is 'wheelchair-bound' or 'confined to a wheelchair'.
- Speak of persons 'without impairments' rather than 'normal' or 'regular' persons.
- Do not use acronyms to refer to children with disabilities (e.g. CWD) or persons with disabilities (e.g. PWD).[48]
- Use appropriate terms to refer to different types of impairment, including physical, visual/vision, hearing, intellectual and psychosocial impairments.

[47] See ILO, *Promoting diversity and inclusion through workplace adjustments: a practical guide* (2016).

[48] The CRPD uses the terms 'children with disabilities' and 'persons with disabilities'. Because children and adults with disabilities are often stigmatized and face discrimination, they prefer to be called a 'child' and a 'person' rather than referred to as an acronym.

3 What to do: key approaches to programming

Persons with disabilities must be able to access humanitarian assistance and interventions on the same terms as other members of the population. This requires a **twin-track approach** that combines inclusive mainstream programmes with targeted interventions for persons with disabilities.

First, mainstream humanitarian programmes and interventions, designed for the whole population, need to include persons with disabilities. Their planning, design, implementation and evaluation should reflect this objective. For example:

- Information should be disseminated in multiple accessible formats (oral, print, sign language, easy-to-read/plain language, etc.).
- Distribution sites should be placed in locations that are accessible to everyone, including persons with disabilities.
- Communal latrine blocks should be accessible to persons with disabilities – they should be physically accessible and provide clear signage.

Second, humanitarian programmes need to address the specific requirements of persons with disabilities by providing targeted interventions. For example:

- They should make assistive devices available.
- They should provide transport allowances to persons with disabilities, to enable them to access services.
- They should deliver food and non-food items to persons with disabilities who are unable to reach distribution sites.

The twin-track approach is critical to the inclusion of persons with disabilities in humanitarian action. It should be adopted by all stakeholders in all sectors.

Must do actions

'Must do' actions are required if persons with disabilities are to be included successfully in all phases of humanitarian action and need to be taken by every stakeholder in every sector and all contexts.

The four 'must do' actions described below should be kept in mind when reading or applying each sector chapter and the section on stakeholder roles and responsibilities.

Promote meaningful participation

The Convention on the Rights of Persons with Disabilities (CRPD)[49] affirms the right to participate in decision-making processes. Persons with disabilities are therefore entitled to participate in humanitarian decisions that affect them.

[49] *The Sendai Framework for Disaster Risk Reduction*, the *Global Compact for Refugees*, the *Global Compact for Migration*, among many others, also require humanitarian and other actors to consult and involve persons with disabilities in their programmes and decisions.

Both on the basis of this right, and because they have knowledge and skills to offer, persons with disabilities can be important actors and resource persons in a humanitarian response.

Key actions

- Enable persons with disabilities to participate in all processes that assess, plan, design, implement, monitor or evaluate humanitarian programmes, in all phases and at all levels.
- Recruit persons with disabilities as staff at all levels of humanitarian organizations, including as front-line workers and community mobilizers.
- Seek advice and collaborate with organizations of persons with disabilities (OPDs) when you devise strategies for engaging with persons with disabilities in an affected community.

Remove barriers

Neither inclusion nor participation can be achieved while barriers remain. Removing attitudinal, environmental and institutional barriers is critical to addressing risks.[50]

Key actions

- Identify all attitudinal, environmental and institutional barriers that prevent persons with disabilities from accessing humanitarian programmes and services. Identify enablers that facilitate the participation of persons with disabilities.
- Take appropriate measures to remove barriers and to promote enablers, to ensure that persons with disabilities have access to assistance and can participate meaningfully.

Empower persons with disabilities; support them to develop their capacities

Humanitarian stakeholders, including organizations of persons with disabilities (OPDs), need first to develop their own awareness of the rights and capacities of persons with disabilities. Then they need to work with persons with disabilities to strengthen and extend their capacities. These steps together empower both groups of stakeholders to cooperate in ensuring that persons with disabilities are fully included in all aspects of humanitarian assistance and protection.

Capacity development may take many forms. Consider, for instance: introducing sensitization, training and learning sessions, and sessions to coach and mentor staff; revising training tools, including induction and training courses; creating communities of practice; collecting experiences (lessons learned) and identifying good practices; providing technical support, including disability inclusion experts; communicating skills through advice and help desks, etc.

Key actions

- As a priority, develop the capacities of persons with disabilities and OPDs in the field of humanitarian action. Equip them with the knowledge, skills and leadership skills they need to contribute to and benefit from humanitarian assistance and protection.[51]
- Build the capacity of humanitarian workers. Assist them to design and implement inclusive humanitarian programmes that are accessible to persons with disabilities by strengthening their understanding of the rights of persons with disabilities as well as principles and practical approaches that promote inclusion and reduce barriers to inclusion.

[50] See the section on Barriers.

[51] Include key humanitarian action concepts and tools in training that is offered.

Disaggregate data for monitoring inclusion

To monitor inclusion, data on barriers and on the requirements of persons with disabilities are essential. Humanitarian data should include disaggregated data on disability to ensure that humanitarian action planning, implementation and monitoring are accessible to and include persons with disabilities. Data and information on risks and barriers faced by persons with disabilities should also be collected and analysed. This will strengthen humanitarian stakeholders' understanding of the barriers to inclusion, which in turn will enable them to remove them effectively and adopt measures to promote inclusion.

See also the section on Data and information management.

Key actions

- Where data are unavailable, humanitarian stakeholders, in partnership with OPDs, should collect data on sex, age and disability using a variety of tools tested in humanitarian contexts. These include the Washington Group Short Set of Disability Questions and the UNICEF-Washington Group Child Functioning Module, as well as data related to risks and barriers.
- Use data on disability to monitor equal access, design inclusive programmes, and plan their implementation. Ensure that persons with disabilities can participate at every level.
- Disaggregating data by sex, age and disability makes it possible to develop appropriate indicators and use them to monitor the inclusion of persons with disabilities in all phases of humanitarian action.

4 Data and Information management

Introduction: Why collect data on persons with disabilities?

Quality humanitarian programming is built on an understanding of the requirements and priorities of persons with disabilities during a crisis. This understanding is generated by: (1) identifying the population of persons with disabilities; (2) analysing the risks that persons with disabilities face and the factors that contribute to those risks; (3) identifying barriers that impede persons with disabilities from accessing humanitarian assistance; and (4) understanding the roles and capacities of persons with disabilities in the humanitarian response.

To build this foundation of understanding, it is important to obtain data on persons with disabilities. Specifically, data are required for the following purposes:

1. To identify individuals with disabilities, and households that include persons with disabilities, in order to monitor their situation, target assistance and set response priorities.

2. To identify the total number of persons with disabilities in the affected population. This makes it possible to calculate accurately the general and specific requirements of persons with disabilities in the affected population and mobilize appropriate resources to meet those requirements.

3. To understand how the crisis affects persons with disabilities, including its effects on mortality, nutrition and food security, livelihoods, health, protection, and other essential needs. This information makes it possible to identify factors that reduce the risks that persons with disabilities face and enhance their resilience.

4. To understand the views and priorities of persons with disabilities. Without this information, humanitarian organizations cannot be accountable to affected populations (AAP).

5. To map the capacity and resources of organizations contributing to the response, including organizations of persons with disabilities (OPDs). This information underpins the development of local partnerships and efforts to identify gaps in capacity.

6. To monitor the degree to which persons with disabilities have access to assistance, services and facilities, and identify attitudinal, physical, institutional and communication barriers that impede accessibility. Without this information, humanitarian organizations cannot improve their programmes and mechanisms, remove barriers, or increase the participation of persons with disabilities. This information also informs decisions on training, awareness-raising and capacity gaps.

7. To strengthen the evidence base that informs advocacy initiatives and resource mobilization.

Collecting data on persons with disabilities is also an obligation for States that have ratified the Convention on the Rights of Persons with Disabilities (CRPD). Article 31 of the CRPD, on statistics and

data collection, requires States Parties to "undertake to collect appropriate information, including statistical and research data" and states that data "shall be disaggregated, as appropriate, and used to help assess the implementation of States Parties' obligations under the present Convention and to identify and address the barriers faced by persons with disabilities in exercising their rights."

What types of data are needed?

The decisions or actions that a humanitarian response needs to take will determine what kinds of data it needs to collect.

Quantitative data (information that can be measured and calculated) may be used.	• To identify individuals with disabilities and calculate the number of persons with disabilities in an affected population (via registration data, household surveys, household estimates, etc.). • To determine the number and location of accessible and inaccessible facilities. • To disaggregate data on needs and risks (for example, the number or proportion of food insecure households that are headed by persons with disabilities). • To monitor access to assistance (for example, establish the number or proportion of participants in livelihood programmes who are persons with disabilities). • To monitor protection concerns (for example, establish the number of human rights violations, or types of human rights violation, experienced by persons with disabilities).
Qualitative data (information that is descriptive) may be used.	• To collate the views and priorities of persons with disabilities, for example via feedback and complaint processes. • To understand the risks and barriers that persons with disabilities face, as well as enabling factors, for example via focus group discussions and key informant interviews. • To identify specific risks, barriers and enablers to accessing assistance that persons with disabilities encounter, for example through policy and document reviews. • To monitor protection concerns, for example by privately interviewing persons with disabilities about the human rights violations they have experienced. • To obtain detailed information about the knowledge, attitudes and perceptions of humanitarian actors and local communities with regard to persons with disabilities, for example via surveys or interviews. • To map OPDs and accessible services, for example by gathering 5W data (Who does what, when, where and for whom?).

Tools for disaggregating data by disability

It is important to disaggregate data by disability in order to understand the different ways in which persons with disabilities experience a crisis and to monitor their access to assistance. In principle, data disaggregated by sex and age should also be disaggregated by disability.

The most widely tested tools used to generate comparable data about persons with disabilities are the Washington Group Question Sets and the World Health Organization's Disability Assessment Schedule. There is a growing consensus[52] that the Washington Group Short Set of Disability Questions generates sound, internationally comparable data that can be disaggregated and collected without discrimination and added quickly and inexpensively to censuses and surveys. It is being used increasingly in humanitarian contexts. (See Annex 2 for a short overview of these tools, including commentary on their use in humanitarian contexts.)

It is important to understand that these tools can be used to disaggregate data but are not useful for the identification of particular health conditions or diagnostic categories.[53] They should not be employed for individual assessment or targeting in the absence of complementary data on needs and risk factors, including barriers.

Collecting and using data on persons with disabilities: key steps

Data on persons with disabilities need to be collected at each phase of the humanitarian programme cycle. The following key steps should be taken at each phase:

1. **Identify information needs**

   What is the question that needs to be answered or the decision that needs to be made? Consider why data are being collected on persons with disabilities. Purposes might include: to understand the impact of a crisis; to identify barriers that prevent persons with disabilities from accessing assistance; to map resources and capacities. The purpose of data collection should determine what types of data are collected.

2. **Identify sources of (secondary) data on persons with disabilities**

   What information is needed to answer the key questions? Always start with information that is already available.

   - Make use of official data sources, such as government databases, international monitoring mechanisms (including the reports by UN human rights treaty bodies, Special Procedures of the Human Rights Council and Universal Periodic Reviews, the High Level Political Forum for Sustainable Development, and reports of the UN Secretary-General), and information compiled by humanitarian actors, development projects and OPDs. (See Annex 3 for a more detailed overview of secondary data sources and their use.)
   - However, it is important to recognize that these figures may significantly underestimate the number of persons with disabilities and may not accurately describe their needs, views and priorities. It is therefore necessary to evaluate the quality, robustness and completeness, as well as comparability, of secondary data on persons with disabilities. (See Annex 4 for advice on how to evaluate data on persons with disabilities.)
   - The situation may also have changed since the secondary information was collected. In particular, it may have changed as a result of the humanitarian crisis, especially where large numbers of people have been displaced. The number of persons with disabilities, and their proportion in the population, frequently increase as a result of crises, because these disrupt services, create new barriers, and cause injuries and psychological stress.

[52] Daniel Mont and Nora Groce, *Counting disability: emerging consensus on the Washington Group questionnaire, The Lancet*, July 2017.

[53] Daniel Mont, *How does the WG-SS Differ from Disability Eligibility Determination?* (2017), Washington Group on Disability Statistics.

3. **Fill critical information gaps**

- Include questions relevant to persons with disabilities in needs assessment tools and monitoring and evaluation processes.
- Conduct separate data collection exercises that focus on persons with disabilities where it is relevant and feasible to do so. Separate collection can be particularly valuable when analysis has flagged that persons with disabilities experience specific risks or accessibility gaps.
- Additional data enables the response to understand problems in more detail. It is very important to involve OPDs in such work.
- Put in place appropriate protections when collecting, analysing, storing, sharing, using, destroying or archiving sensitive personal data. Refer to the section on managing data and information in Professional Standards for Protection Work.[54]

See the section on Needs assessment for more detailed guidance

The importance of informed consent in data collection and use

All individuals have a right to make informed decisions on whether their personal data are collected and how their personal data are used. Those who collect personal data need to be able to explain how and for what purpose that data will be used and provide assurances with respect to its confidentiality.

To enable persons with disabilities to give their informed consent, information on the use of their data may need to be provided in multiple formats. It may also be necessary to allocate more time for explanation and arriving at a decision. Some persons with disabilities may wish to ask a trusted person to support them in making an informed decision.

Information and data should be protected. For example, avoid identifying individuals who might subsequently as a result be harassed, persecuted or killed.

Data on persons with disabilities across the humanitarian programme cycle

Preparedness

Gathering of reliable information about persons with disabilities is a key component of preparedness before a crisis. Annex 3 discusses potential sources of secondary data. Sources of secondary data include:

- Government databases, such as Health or Education Management Information Systems (EMIS). Care must be taken when using such sources after a crisis because the situation will have changed and the data may no longer reflect the demography or needs of the affected population.
- Internationally comparable household surveys, such as Multiple Indicator Cluster Surveys (MICS) and Demographic and Health Surveys (DHS).

[54] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

- Other national, provincial and district-level initiatives that compile data on persons with disabilities, and households that include persons with disabilities, such as national censuses or national social protection systems.
- Data collected by OPDs or specialized NGOs, such as project reports.

Additional actions to compile information at the preparedness stage might include:

- Map information on local OPDs and local or national services for persons with disabilities, such as sign language interpreters, companies that offer accessible transport, and providers of assistive devices.
- Map accessible public facilities and other infrastructure that can be used as service delivery points. Link this information to the common operational dataset (COD) maintained by the Office for the Coordination of Humanitarian Affairs (OCHA) at the country level.
- Train staff or partners in the use of tools for collecting data on persons with disabilities. Identify and train local actors, including OPDs, as enumerators.[55]
- Translate tools for collecting data on persons with disabilities into relevant languages, including languages used by host and displaced communities.[56]

Needs assessment and analysis

While sound quantitative data are more often available, not least due to more widespread use of the Washington Group Question Sets, significant data gaps remain and data on persons with disabilities are not consistently robust or comparable. Available secondary data may also be unreliable for a variety of reasons, including different understandings of disability, underreporting due to stigma, different standards for classifying or measuring disability, sampling limitations, inconsistencies in the questions asked, or simply because the sources are out of date. (See Annex 4 for a more detailed overview.)

When Multi-Sector Needs Assessments (MSNA) analyse the severity of a population's needs, they should examine the impact of a situation on persons with disabilities and their families. When household surveys are used as a source of data in the MSNA, disability data should be collected that will enable disaggregation of all data by disability.

When robust quantitative data do not exist, it is recommended to assume that 15 per cent of an affected population has a disability.[57] The 15 per cent estimate informs planning as well as efforts to monitor access to assistance. (For example, it is assumed that 15 per cent of all facilities must be accessible.)

For a needs assessment to be inclusive, persons with disabilities must be key informants and must participate in focus group discussions.

Objectives of an inclusive needs assessment focus group.	• To understand how the concerns of the general population might be experienced differently by women, men, girls and boys with different disabilities. In addition, to understand specific concerns that persons with disabilities may have. • To understand the roles of persons with disabilities in the community. Include their contributions to the community and how other people in the community support them. • To understand how persons with disabilities have experienced past emergencies and identify the barriers they faced and the coping mechanisms they used.

[55] Useful resources, including a training pack for enumerators on using the Washington Group Short Set of Disability Questions, can be found at Humanity and Inclusion, Disability Data in Humanitarian Action.

[56] See Washington Group's translation methodology and training tools online.

[57] WHO and World Bank, *World Report on Disability* (2011).

Select the focus group.	• Seek to identify persons with disabilities who can represent the views and priorities of the group. • Through purposive sampling, select a diverse range of persons with disabilities. Consider differences of risk and barriers, take account of intersectionality and variations in age, gender and diversity. Include persons with different types of disability. • Offer to consult individually those who cannot participate in focus groups.
Make the arrangements.	• Consult OPDs and persons with disabilities to agree on local communication preferences. • Train focus group interviewers in accessible communication methods.[58] • Select accessible and safe interview venues suitable for persons with disabilities.

In addition to disaggregating results by disability, needs assessments should integrate qualitative information that is relevant to persons with disabilities. Questions might include:

- Do persons with disabilities experience any specific forms of discrimination or targeted violence?
- What barriers do persons with disabilities face when they attempt to access assistance?
- What formats and channels of communication are most accessible to persons with disabilities?
- Are specific services that persons with disabilities require (such as assistive technologies) available/not available?
- What are the beliefs and practices of the affected population in relation to persons with disabilities? Are harmful beliefs and practices prevalent?

The above questions (adapted where necessary) can also be asked of humanitarian actors, including first responders.

The answers can help the response not only to understand local knowledge, attitudes and practices but to design protection programmes, advocacy, and appropriate capacity-building activities.

Strategic planning

To plan an inclusive response, it is essential to have information on persons with disabilities. For example:

- Data disaggregated by disability can highlight the degree to which disability is associated with vulnerability to livelihood or food insecurity, violence, exploitation and abuse, or other risks. This information can assist the response to prioritize and target assistance.
- Disaggregated data can reveal where persons with disabilities are unable to access assistance, making it possible to refocus or strengthen services and remove gaps in accessibility. Follow-up assessments may be needed to analyse barriers and design steps to remove them.
- Qualitative information about the views and perceptions of persons with disabilities assist humanitarian organizations to respond more inclusively and appropriately.
- Qualitative data on the coping mechanisms of persons with disabilities can help humanitarian organizations to design interventions that increase resilience.

[58] For more guidance on inclusive communication, see UNICEF, Disabilities, Inclusive Communication Module.

- Data on the number of persons with disabilities in an affected population (including provisional numbers based on the 15 per cent estimate)[59] can inform sector plans and guide planning and monitoring, ensuring that programmes are adequately resourced and appropriately accessible.

Resource mobilization

Data on persons with disabilities can also help to mobilize resources, by highlighting the impact of the crisis on persons with disabilities, specifying the particular risks faced by individual persons with disabilities and their households, and revealing the overall cost of meeting the requirements of all persons with disabilities affected by the crisis.

This said, budgeting for accessibility should not rely on data collection. Estimates suggest that, to meet physical accessibility requirements for persons with disabilities (to construct buildings and WASH facilities), between 0.5 per cent and 1 per cent should be budgeted. To include specialized non-food items and mobility equipment, up to an additional 3–7 per cent budget is recommended.[60]

Donors could further strengthen the inclusion of persons with disabilities by requiring humanitarian actors to disaggregate by disability, deliver results frameworks that include specific outputs or outcome indicators for persons with disabilities, and use resource tracking markers to identify projects that are disability-inclusive.

Outcomes on equal access and inclusion may be identified most clearly by analysing disaggregated data in the course of monitoring. To illustrate, one option is to include a specific indicator on disability, such as 'Number of children with disabilities accessing education'. However, better results may be achieved if general questions ('Number of children accessing education') are disaggregated by disability. Generally, it will be most meaningful to reflect specific disability-related considerations at the output indicator level. These indicators can reflect actions taken to improve accessibility to assistance, measure participation, or provide targeted support to persons with disabilities.

Annex 5 discusses how output indicators can be formulated to identify the extent to which persons with disabilities are included. Indicators are also being developed to monitor the CRPD, including Article 11 on disabilities in humanitarian action. See Bridging the Gap.

Implementation and monitoring

Implementation monitoring should identify both how humanitarian assistance reaches persons with disabilities and how their needs change as a crisis evolves.

Disaggregated data collected via monitoring tools and processes help to identify gaps in accessibility for persons with disabilities. When monitoring identifies such gaps, targeted data collection exercises (including focus group discussions, and interviews with persons with disabilities from the affected population, local OPDs, and humanitarian stakeholders) may be necessary to understand the nature of the barriers that persons with disabilities face and design measures to remove them.

To promote systematic monitoring of access to assistance, a humanitarian response should ensure that contracts and monitoring templates for implementing partners require them to report on the number or proportion of persons with disabilities their programmes have reached. Situation reports, humanitarian dashboards and other reporting mechanisms should record progress in reaching persons with disabilities, including by use of disaggregated data.

Protection monitoring is an important tool for identifying the specific and heightened risks that persons with disabilities face. The information it generates can inform responses that reduce risk and can enhance resilience. Where possible,[61] protection

[59] WHO and World Bank, *World Report on Disability* (2011).

[60] See *Humanitarian inclusion standards for older people and people with disabilities* and Light fsor the World, *Resource Book on Disability Inclusion* (2017), p. 36.

[61] This may not always be feasible. It may not be feasible, for example, when incidents are reported by third party witnesses, or incidents involve communities or groups rather than individuals.

monitoring data should be disaggregated by disability. Protection monitoring processes should also aim to identify protection risks specific to persons with disabilities. These include targeted violence, harmful practices, use of restraint, and institutionalization.

Evaluation

To promote disability inclusion in evaluations of humanitarian action, standard evaluation terms of reference should require data to be disaggregated by disability whenever data are collected on individuals (whether they benefit from or contribute to the response). Further, evaluations should include persons with disabilities among the informants, and ask questions that elicit specific information on persons with disabilities.

Depending on its purpose, an evaluation should consider how persons with disabilities have accessed assistance; how persons with disabilities participated across the humanitarian programme cycle; and how the response reduced the risks that persons with disabilities face and enhanced their resilience. In doing so, it should also capture good practices that promote inclusion. Evaluators might want to develop specific indicators to measure progress in reaching and including persons with disabilities; these might, for example, measure the proportion of persons with disabilities that specific interventions reached.

Annex 6 sets out evaluation criteria in humanitarian action using OECD-DAC criteria definitions. It applies these criteria from a disability-related perspective and, as an example, proposes an issue that could be examined in a humanitarian context.

Summary of key elements: data collection and information management

Preparedness

- Develop guidance on how humanitarian actors can strengthen data collection to enhance the inclusion of persons with disabilities, while safeguarding privacy and data protection.
- Identify reliable sources of data on persons with disabilities, including censuses, administrative databases, and data collected by OPDs or specialized NGOs.
- Map information on OPDs, accessible services and public facilities.
- Build capacity to collect data on persons with disabilities by training local actors and identifying and translating key data collection tools.
- When surveys such as the DHS, MICS and national censuses are conducted in countries at high humanitarian risk, emphasize the value of using and incorporating tools tested in humanitarian contexts, such as the Washington Group Short Set of Disability Questions and the UNICEF-Washington Group Child Functioning Module. Identify other entry points in humanitarian data collection processes where use of these methodologies is appropriate, such as the Displacement Tracking Mechanism managed by IOM.

Needs assessment and analysis

- Organizations with relevant capacity should work with Assessment Working Groups to include disability in needs assessments and associated analyses.
- Collect information on services that include and target persons with disabilities in humanitarian contexts. To do so, modify operational management tools such as the standard 5W process.
- In protracted crises, humanitarian actors have an opportunity to improve data collection techniques. Some situations are stable enough to permit population-level surveys, but often the mobility of affected populations is such that innovative statistical techniques must be used to collect random samples.
- Where reliable data on persons with disabilities are unavailable or outdated, use the 15 per cent estimate[62] as a benchmark for planning purposes.

[62] WHO and World Bank, *World Report on Disability* (2011).

Strategic planning

- Use data on persons with disabilities to inform planning and to prioritize and target assistance.

Resource mobilization

- The demand for data on persons with disabilities in humanitarian action would be strengthened by appropriate donor policies and reporting requirements, results frameworks that include specific output or outcome indicators related to persons with disabilities, and resource tracking using markers to identify projects that are disability-inclusive.
- Targets related to persons with disabilities should be explicitly referenced in funding appeals and projects.

Implementation and monitoring

- Disaggregation of data collected through monitoring tools and processes, including protection monitoring, is key to identifying accessibility and other gaps for persons with disabilities.
- Modify standard data collection tools and databases used in humanitarian action to include qualitative data on how effectively programmes and interventions are reaching persons with disabilities.
- Contracts and reporting templates for implementing partners in a humanitarian response should require them to define and report the number or proportion of persons with disabilities that their interventions reach.

Evaluation

- Effective evaluation depends on regular monitoring and data collection, including registration processes in refugee situations. Standard evaluation terms of reference in humanitarian contexts should require humanitarian actors to disaggregate data by disability where data are collected on individuals (whether they benefit from or contribute to the response). Further, evaluations should include persons with disabilities among their informants, and questions should be asked that elicit specific information on persons with disabilities.
- Evaluators might develop disability-specific indicators to measure progress towards reaching persons with disabilities. Indicators might measure, for example, the percentage of persons with disabilities reached by specific interventions.

Key terms[63]

Quantitative data shed light on the magnitude, the scale and the effects of a humanitarian crisis by providing a statistical description of its impact on affected communities. Quantitative data address questions that generate countable answers, such as 'how many', 'how much', or 'how often'.

Qualitative data shed light on the magnitude, the scale and the effects of a humanitarian crisis by an experiential description of its impact on affected communities. Qualitative data address questions that involve opinions, values, beliefs and conjectures. Why have coping strategies adapted or failed to adapt to changed circumstances? How does a displaced person with disabilities feel about her situation? What does she believe would improve her situation?

Primary data are collected directly from an affected population by an assessment team through field work. Primary data may be quantitative or qualitative.

Secondary data are gathered from previous statistical and analytical research (census data, data from previous surveys, studies). Secondary data may be quantitative or qualitative.

[63] ACAPS, Qualitative and Quantitative Research Techniques for Humanitarian Needs Assessment (2012).

5 Partnerships and empowerment of organizations of persons with disabilities

Introduction: what are organizations of persons with disabilities?

Organizations of persons with disabilities (OPDs) are representative organizations of persons with disabilities, majority-governed and led by persons with disabilities for persons with disabilities. When local OPDs are not present in a location, regional, national and global OPDs can be located through global alliances.

OPDs generally undertake advocacy, guidance, training and technical assistance, and promote rights through a social and human rights model of inclusion and empowerment. OPDs have successfully worked to reform national legislation and raise awareness, and many have trained humanitarian actors, communities, governments and national disaster offices in the rights of persons with disabilities.

OPDs are distinct from organizations that directly provide services to persons with disabilities.

Organizations of persons with disabilities may:

- Work locally, nationally, regionally or globally.
- Focus on one type of disability or cross-disability.
- Represent one specific group (for example, women, or indigenous persons, with disabilities).
- Represent a large or small group; an OPD may not seek to represent all persons with disabilities.
- Be organized in a local or national network, which may belong to one or more regional or global networks.

Partnerships with organizations of persons with disabilities

Partnerships and collaboration improve the effectiveness and accountability of humanitarian operations. They help directly to achieve inclusion and ensure that humanitarian action benefits from and contributes to development. Respectful of the disability community's motto ('Nothing about us, without us'), humanitarian stakeholders must work with persons with disabilities and their representative organizations rather than plan or make decisions on their behalf.

As with any partnership, common interests, added value, expectations and capacity development should be agreed from the beginning.

Partnerships between OPDs and humanitarian stakeholders before, during and after a crisis:

- Give humanitarian actors access to the expertise of persons with disabilities, to their experience and their knowledge of the situations in which they live.

- Generate skills and knowledge that can make humanitarian services and assistance more inclusive, informed and supported by the populations that humanitarian actors assist.
- Foster mutual understanding and knowledge.
- Build capacity and promote cross-learning between OPDs and humanitarian actors.
- Ensure continuity of action, because OPDs remain after a crisis or disaster ends.
- Strengthen and unify the population around shared needs and issues.
- Improve advocacy for protection of displaced persons with disabilities.

Not all OPDs have a mission that aligns with humanitarian action. In many cases, OPDs will not have engaged with the humanitarian sector and the humanitarian programme cycle, or its coordination mechanisms, response and recovery programmes, and funding procedures. Often, they have had few opportunities to partner and collaborate with humanitarian organizations. It is therefore important to manage expectations.

While humanitarian stakeholders may want to develop partnerships with OPDs, their ability to do so is frequently limited by their limited knowledge of the disability movement, prejudices about persons with disabilities, and the perception that disability should be addressed by disability-focused organizations.

The role of OPDs in a partnership or collaboration with humanitarian stakeholders will depend on their pre-crisis capacities, their mandate, and their ability to represent all persons with disabilities or a specific group of persons with disabilities. When OPDs are not present, or existing OPDs do not have adequate capacity, humanitarian actors should establish contact with regional or global OPD networks.

OPDs can fulfil many roles and functions. The list below is not exhaustive but may be a useful starting point when humanitarian actors approach OPDs to discuss cooperation. OPDs may:

- Act as focal points in their communities, applying their expertise on disability.
- Provide valuable information: on where persons with disabilities are located; on their situation; on barriers that prevent them from accessing humanitarian assistance; on threats to them and violations of their rights, etc.
- Provide technical support on disability to humanitarian organizations, for instance by raising awareness, identifying and removing barriers, facilitating access to resources, building capacity for inclusive humanitarian action, protecting and advancing rights, or minimizing the disproportionate impact of crises on persons with disabilities.
- Encourage government officials and humanitarian stakeholders to learn about disability, change and review policies, reform legal frameworks, or adopt tools and processes that strengthen the protection and assistance available to persons with disabilities during crises.
- Provide targeted services to persons with disabilities, often through a peer-support model.

Partnerships when no OPDs adequately represent an affected population

In many humanitarian contexts, no local OPDs may exist; where they do exist, they may have been weakened by the crisis or have limited capacity or may not adequately represent all persons with disabilities in a population. Where a population has been displaced, for example, members of OPDs may be scattered in various locations. They may have difficulty contacting one another or organizing themselves to respond to the crisis or support the humanitarian response.

Whether or not OPDs can be located and engaged, a humanitarian response must include persons with disabilities and must address their priorities and requirements. To do so when no local OPDs exist or when no OPDs can fully represent a displaced population, the following strategies can be adopted:

- Engage with persons with disabilities and their families at community or camp level and encourage them to participate in consultation processes and decision-making bodies, including camp governance. Invite them to use their knowledge of disability to develop specific risk and mitigation strategies for persons with disabilities.
- Identify qualified individuals who have a range of disabilities and are of different ages and gender and recruit them as staff members and volunteers.
- Set up and encourage the formation of formal and informal groups (such as peer-support groups of persons with disabilities and their families) and build the capacity of these groups to represent their constituencies in management and coordination of the response. They can contribute, for example, to identifying barriers, meeting needs and reducing protection risks, and more generally by making sure that persons with disabilities have a voice.
- Where the persons of concern are refugees, coordinate with host country OPDs. If feasible, invite them to mobilize persons with disabilities in camps and in host communities. Encourage and support OPDs to include refugees and other displaced persons in their networks.

Tools and resources

- Accessible Meeting and Event Checklist
- National Network (ADA), A Planning Guide for Making Temporary Events Accessible to People with Disabilities
- National Network (ADA), Accessible Events: Planning and Preparation Are Key

6 Cross-cutting considerations

Age, gender and diversity[64]

Real or perceived differences in personal characteristics significantly influence our experiences, opportunities, capacities, needs and vulnerabilities. Conflict and displacement frequently exacerbate inequality and deepen marginalization or exclusion, because they increase insecurity, damage social support structures, reduce income generating opportunities, and change social and physical environments (among other shocks).

Age, gender, disability and other forms of diversity are universally present in societies. It is vital to consider them, and the way they intersect, during all phases of the humanitarian programme cycle in order to ensure that all affected persons, including those with disabilities, can assert their human rights and participate fully in the humanitarian response. Equally, to meet their duty of accountability to affected populations, humanitarian actors must recognize that the intersection of age, gender, disability and other forms of diversity impacts the resilience, protection and safety of members of affected populations *differently*. To illustrate, older women with disabilities may be at risk of gender-based violence due to age-related discrimination, gender norms *and* barriers related to disability; adolescent girls with disabilities may be excluded from decision-making because of discrimination on the basis of disability *and* gender norms; boys with disabilities may be at risk of recruitment by armed groups, because of their age *and* disability.

To mitigate the impact of humanitarian crises, it is important to understand how crises reduce the capacity of affected persons with disabilities to access and participate in humanitarian assistance and protection. To avoid discrimination and injustice, it is essential to reach all segments of affected populations, not just those who are more visible.

These guidelines consider persons with disabilities in terms of their age, gender, psychosocial status and background.

Age

Age refers to socially and contextually defined stages in a person's life cycle. A person's capacities and requirements change as they age. Age can enhance or diminish a person's capacity to exercise their rights. In order to develop responses that are appropriate for different age groups (children, young adults, mature adults, older persons with disabilities), humanitarian actors must consider the different needs, barriers and threats that persons with disabilities face at different points in their life cycle.

Gender

Gender refers to socially constructed differences between females, males, and others, and the relationships between and among them, throughout the life cycle. These differences are context- and time-specific and change over time within and across cultures. Gender, together with age, sexual orientation and gender identity, determines roles, responsibilities, power and access to resources.

[64] Adapted from UNHCR, *Emergency Handbook*.

Outcomes are also affected by other diversity factors, such as disability, social class, race, caste, ethnic or religious background, economic wealth, marital status, migrant status, displacement, and urban or rural location.[65] To ensure that all affected persons with disabilities have safe and equal access to humanitarian assistance and protection, therefore, humanitarian actors must design programmes that take into account the range of gender identities and sexual orientations of persons with disabilities in the communities they serve.

Diversity

Diversity refers to differences in values, attitudes, cultural perspectives, beliefs, ethnic background, nationality, sexual orientation, gender identity, health, social status, impairments, and other specific personal characteristics. While age and gender dimensions are present in everyone, other characteristics vary from person to person. If they are to protect and assist all affected people, including persons with disabilities, and encourage their participation, humanitarian actors must recognize, understand and value these differences.

Cross-cutting programming

Protection mainstreaming[66]

Given the multifaceted nature of protection threats and the complex contexts in which they arise, the many organizations and authorities that deliver a humanitarian response must coordinate and work in ways that are complementary and collaborative. Putting protection at the centre of humanitarian action requires a system-wide commitment.[67] Humanitarian actors need to mainstream protection in their programmes, taking age, gender, disability and diversity into consideration, following the four key elements of protection mainstreaming:

1. **Prioritize safety and dignity and avoid causing harm**. Prevent and minimize as much as possible any unintended negative effects of your intervention which can increase people's vulnerability to both physical and psychosocial risks.

2. **Meaningful access**. Arrange for people's access to assistance and services in proportion to need and without any barriers (e.g., discrimination). Pay special attention to individuals and groups who may face heightened protection risks or barriers to accessing assistance and services.

3. **Accountability.** Create appropriate mechanisms through which affected populations can measure the adequacy of interventions and address concerns and complaints.

4. **Participation and empowerment**. Support the development of self-protection capacities and assist people to claim their rights, including – but not exclusively – the rights to shelter, food, water and sanitation, health and education.

Prioritize safety and dignity and avoid causing harm

The first principle above (to prioritize safety and dignity and avoid causing harm[68]) must be inclusive of harm to persons with disabilities. It should not be used to deny aid, promote discriminatory actions, or create barriers to aid for persons with disabilities. Organizations that act without consulting persons with disabilities may set priorities incorrectly and plan badly, putting persons with disabilities at greater risk of harm. Failure or refusal to act, to avoid causing harm, can inadvertently cause harm.

[65] Adapted from IASC, *Gender Handbook for Humanitarian Action* (2017), p. 385.
[66] See Global Protection Cluster, Protection Mainstreaming.
[67] IASC, *IASC Policy on Protection in Humanitarian Action* (2016).
[68] See Global Protection Cluster, Protection Mainstreaming Training Package (2014).

Key actions

- Consult persons with disabilities to ensure that decisions take account of their preferences and do not negatively impact their lives. (See Informed consent.)
- Avoid strategies and actions that perpetuate stigma related to disability. For instance, rehabilitation is important in a response but does not address the whole experience of the person and must be supplementary to actions that persons with disabilities prioritize.

Prioritize safety and dignity and avoid causing harm

Doing nothing inadvertently causes harm	Doing wrong causes harm
Setting up programmes or projects (such as food distributions or water points) without considering whether persons with disabilities are able to access the locations chosen.	Acting without the free and informed consent of the person concerned can have irreparable effects on their health.
Failing to provide information about programme or project entitlements in multiple accessible formats and in a language that everyone can understand.	Acting without consulting beneficiaries, including persons with disabilities, may lead humanitarian actors to set incorrect priorities and plan poorly, putting beneficiaries at greater risk of harm.

Mental health and psychosocial support

Mental health and psychosocial support (MHPSS) refers to any type of support that aims to protect or promote psychosocial well-being or prevent or manage mental health conditions.[69] During humanitarian crises, many factors (violence, uncertainty, loss of family members, loss of home…) can negatively affect the mental health and psychosocial well-being of individuals, families and communities; persons with disabilities are often disproportionately affected. By integrating MHPSS into programming, humanitarian actors can improve the mental health and psychosocial well-being of all affected people, including those with physical, sensory, psychosocial or intellectual disabilities. MHPSS responses in emergency settings include various levels of support, coordinated across different sectors, in a multi-layered and complementary model (illustrated by the intervention pyramid for mental health and psychosocial support in emergencies):[70]

1. Actions that restore a sense of dignity and safety in emergency-affected populations, while promoting equal access to basic services, are of paramount importance for their mental health and psychosocial well-being. (Level 1.)

2. Other important interventions strengthen social cohesion and support the community and families. (Level 2.)

3. Individual, family and group interventions that provide emotional and practical support further contribute to mental health and psychosocial well-being.

[69] IASC, *Guidelines for Mental Health and Psychosocial Support in Emergency Settings* (2007).
[70] *Ibid.*

These interventions can be delivered by non-specialized workers and peer supporters in health, education or community services. (Level 3.)

4. When necessary, specialists provide specific MHPSS interventions (which may be psychological or pharmacological). (Level 4.)

MHPSS interventions are based on a human rights framework and promote and protect the rights of persons with disabilities. Multi-layered MHPSS services and support benefit all affected persons, including persons with disabilities, who face significant psychosocial stressors.

7 Accountability to affected people and protection from sexual exploitation and abuse

Accountability to affected populations (AAP)[71] is understood to be a mutual responsibility of aid providers and other stakeholders (donors, governments) who have committed to use their power and resources ethically and responsibly to 'put people at the centre' of humanitarian actions. Humanitarian actors have a duty to make sure assistance generates the best possible outcomes for all groups who are affected by a crisis, including those who may be less visible, such as persons with disabilities. They have undertaken to achieve this by consistently applying technical and quality standards; coordinating their actions to maximize coverage and minimize risks, gaps and duplication; listening to and engaging with affected people; and acting on their feedback.

AAP focuses on the rights, dignity and protection of an affected community in its entirety. It requires humanitarian actors to identify and address the needs and vulnerabilities of members of affected communities; it equally requires them to recognize and harness the capacities, knowledge and aspirations of those communities.

To effectively ensure that accountability is extended to all affected people, including persons with disabilities, mechanisms for accountability must be accessible to persons with disabilities, and must consider their requirements. This duty includes a duty to focus on disability inclusion throughout the humanitarian programme cycle, ensuring that persons with disabilities participate in decision-making processes, and communicating information to them in multiple accessible formats.

Annex 7 discusses how humanitarian actors, including clusters, can help to achieve the commitments and quality criteria set out in the Core Humanitarian Standards (CHS) by working in practical ways to include persons with disabilities.

IASC Commitments on Accountability to Affected People

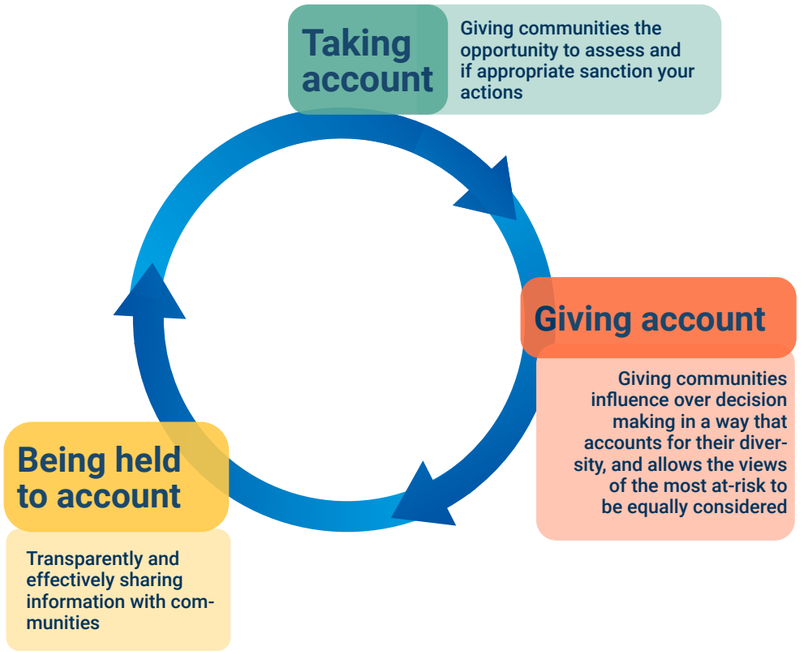
In 2017, the IASC Principals endorsed a revised version of the AAP, titled *Commitments on Accountability to Affected People and Protection from Sexual Exploitation and Abuse* (CAAP and PSEA). The revision took account of new guidance on humanitarian policy, including the Core Humanitarian Standards and the outcomes of the World Humanitarian Summit and the Grand Bargain.[72]

The revised CAAP places a strong emphasis on collective accountability. Humanitarian actors are expected to act singly and together to enhance and integrate AAP in their responses. Their role is central. Annex 7 explains how to ensure inclusion of persons with disabilities with respect to the four commitments.

[71] For the most recent statement of this policy, see IASC, *Commitments on Accountability to Affected People and Protection from Sexual Exploitation and Abuse* (CAAP and PSEA) (2017). For the original policy statement, see IASC, *The IASC Task Team on Accountability to Affected Populations and Protection from Sexual Exploitation and Abuse (AAP/PSEA)*.

[72] See IASC's website on the Grand Bargain.

Diagram 4 | Accountability to affected populations (AAP)[73]



Summary of key elements: accountability to affected people and protection from sexual exploitation and abuse

Needs assessment and analysis

Needs assessment and analysis underpin the ability of a humanitarian response to scale up while retaining excellence and ensuring that AAP remains fully integrated. Minimum recommended actions are to:

- Ensure that persons with disabilities are involved in needs assessments.
- Systematically include at least five qualitative questions in all assessment tools.
- Disaggregate data by sex, age and disability when analysing protection risks or barriers to access.
- Highlight the views, priorities and preferences of affected people and ensure that persons with disabilities are an integral subgroup in all needs analysis.

At the same time, use needs assessments to determine:

- The assistance delivery arrangements that persons with disabilities prefer (locations, times, etc.).
- The communication channels that persons with disabilities prefer (face-to-face, radio, SMS, other).
- Other contextual factors that could influence intervention strategies (including gender, access, protection, cultural and economic factors, etc.).

[73] Adapted from IASC, Accountability to Affected Populations (AAP): A brief overview.

Implementation and monitoring

- Contact, employ and train persons with disabilities who can participate in implementation.
- Develop relevant technical, quality and accountability indicators for monitoring purposes.
- Develop feedback and complaint mechanisms that include persons with disabilities and are accessible to them.
- Regularly monitor the degree to which persons with disabilities, as a subgroup of the affected population, are satisfied by the quality and effectiveness of the humanitarian response.

Monitoring and reporting

- Identify the most appropriate technical standards and good practices, adapting them to the crisis context. Choose approaches that ensure the inclusion of all persons and groups with disabilities.
- Monitor and promote consistent use of agreed quality and technical standards.
- Collect, analyse and respond to monitoring data, including feedback from persons with disabilities.
- Ensure that persons with disabilities participate in monitoring the response.
- Based on feedback, make course corrections and adjustments to intervention strategies and plans.

Protection from sexual exploitation and abuse

Engagement of the local population is core to AAP; it is also where most of the work on protection from sexual exploitation and abuse is done. Work to suppress sexual exploitation[74] and abuse[75] in humanitarian contexts focuses on acts by humanitarian workers that harm affected people.

Sexual exploitation and abuse are among the most serious breaches of accountability. In 2015, the IASC Principals made a formal statement of commitment to prevent and respond to sexual exploitation and abuse by humanitarian workers. Persons with disabilities, especially women and girls, are in greater need of protection due to power imbalances.

It is essential to raise the awareness of persons with disabilities and their communities. They should know their rights and entitlements, and should have access to effective, confidential mechanisms through which they can report complaints and share information regarding their assistance and protection. When responses implement PSEA policies, they should adopt a comprehensive approach that includes prevention, response, coordination and management.

Tools and resources

- IASC, *Commitments on Accountability to Affected People and Protection from Sexual Exploitation and Abuse* (2015)
- The Task Force on Protection from Sexual Exploitation and Abuse by our own staff
- USAID, Social and Behaviour Change Interventions

[74] Sexual exploitation refers to "abuse of a position of vulnerability, differential power or trust for sexual purposes". See UN Secretary-General's Bulletin Special measures for protection from sexual exploitation and sexual abuse (PSEA) (ST/SGB/2003/13).

[75] Sexual abuse refers to "actual or threatened physical intrusion of a sexual nature". *Ibid.*

8 Humanitarian response options[76]

Humanitarian assistance usually involves the analysis and adoption of several response options, including but not limited to:

- In-kind provision of goods.
- Cash and voucher assistance.
- Direct service provision.
- Technical assistance.
- Capacity-building.
- Logistics and supply chain management.

The specific combination of response options chosen usually evolves over time. To determine how humanitarian assistance can best be delivered to persons with disabilities, it is essential to consult persons with disabilities and those who represent them.

This chapter focuses on cash and voucher assistance, recognizing that this option is being used increasingly. Readers should note, however, that it is not a stand-alone section. Its guidance applies to all sectors and should be read alongside other chapters.

Cash-based interventions/cash and voucher assistance

Research shows that, where markets operate, cash-based interventions have the potential to efficiently reach people in need faster and at lower cost than other forms of emergency assistance. This empowers people to make choices about assistance or services, in accordance with principles affirmed in the Convention on the Rights of Persons with Disabilities (CRPD), and simultaneously sustains the local economy. Humanitarian actors now invest in cash-based interventions on a larger scale and more consistently, reflecting a commitment set out in the Grand Bargain, an agreement involving more than 30 of the biggest donors and aid providers.

Cash-based intervention is one modality of assistance and has been used for many years in disability-inclusive social protection and safety net programming in development settings. Humanitarian actors can draw on this experience when they pilot and scale up cash-based support in emergencies.[77]

However, cash is only one modality. It can complement or be complemented by in-kind delivery of assistance at distribution points or at household level.[78] There is still a large evidence gap and an incomplete understanding of the role that cash-based interventions may play in the protection and empowerment

[76] This chapter is adapted from the *Sphere Handbook* (2018).

[77] UNICEF and the Ministry of Federal Affairs and Local Development in Nepal provide an example. They organized an extensive social assistance system in response to the earthquake in 2015. See Cash Learning Partnership (CaLP), *The State of the World's Cash Report – Cash Transfer Programming in Humanitarian Aid* (2018), p. 114.

[78] See the sectoral sections for information on the relevance of in-kind distribution.

of persons with disabilities in humanitarian contexts, or the risks that persons with disabilities may face when they access cash in these settings.[79]

Key legal instruments and other frameworks

- Convention on the Rights of Persons with Disabilities. Articles 11, 12, 27 and 28 specifically mention humanitarian action and raise points of relevance to access to financial assistance.
- Grand Bargain
- Cash Learning Partnership, *Global Framework for Action, a consolidated summary of commitments for cash transfer programming*

Key terms[80]

The terms **cash-based transfer**, **cash-based intervention**, **cash transfer programming**, **cash-based assistance**, **cash relief** and **cash voucher assistance** are used interchangeably to refer to all programmes (for shelter, food, health, etc.) that issue cash or vouchers to beneficiaries to enable them to purchase goods or services directly. In humanitarian contexts, cash or vouchers may be issued to individuals, households or community recipients. Such programmes do not include microfinance activities or financial support during humanitarian interventions to governments or other state actors.

Standards and guidelines

- Cash Learning Partnership
- Cash-Based Assistance Quality Toolbox
- Minimum Standard for Market Analysis
- Help Age, CBM, Handicap International, *Humanitarian inclusion standards for older people and people with disabilities* (2018)

Key elements – must do

'Must do' actions must be undertaken in all phases of humanitarian action when implementing inclusive cash-based programming for persons with disabilities.

Participation

- Ensure that persons with disabilities are fairly represented in both formal and informal mechanisms and processes. Consider a range of disabilities, as well as age, gender and diversity. Seek specifically to promote the participation of groups with disabilities that are underrepresented, including persons with intellectual and psychosocial disabilities, indigenous persons, women and girls.
- Consult persons with different disabilities, and of different ages and genders, about how they access cash, how they prefer to access cash, how they access markets and services, and which needs they usually meet using markets. Ensure that costs associated with enabling participation are included in budgets.
- Ensure that persons with disabilities, their families, and organizations of persons with disabilities (OPDs), are actively involved in identifying barriers, and planning, designing, implementing, monitoring and evaluating cash-based interventions. Consider protection risks, mitigation mechanisms, and benefits at every stage.
- Identify the preferences of beneficiaries with disabilities with regard to the value, frequency and duration of cash transfers.
- Develop partnerships with OPDs and organizations that deliver cash-based interventions; partnerships can both support persons with disabilities to use cash-based programmes and advocate for and promote inclusive services and assistance.

Addressing barriers

- Address staff attitudes that stigmatize persons with disabilities (that suggest, for example, that persons with disabilities do not have the capacity to access and manage cash, or participate in cash-for-work, livelihood activities or skills development programmes).
- Consider the different access requirements of persons with disabilities. Consider those who live in rural and in urban areas; differences in financial and technological access and literacy; and physical and information barriers (for example, the distance to distribution points, the availability and cost of accessible transport).
- Assess how accessible different cash delivery mechanisms are (cash, cash cards, mobile phone credit, etc.).
- Remember that some forms of cash transfer (such as restricted cash) may reduce access to assistive devices, which are often classified as health-related expenses.

Empowerment and capacity development

- Before any intervention, assess cash intervention policies and processes; the capacity of organizations that provide cash-based interventions; and the capacity of staff to design and implement cash interventions that include persons with disabilities.
- Provide support and training to persons with disabilities to enable them to access cash-based assistance and use cash distribution systems (such as banks). Provide basic literacy and financial literacy courses when technology that will be used is unfamiliar.

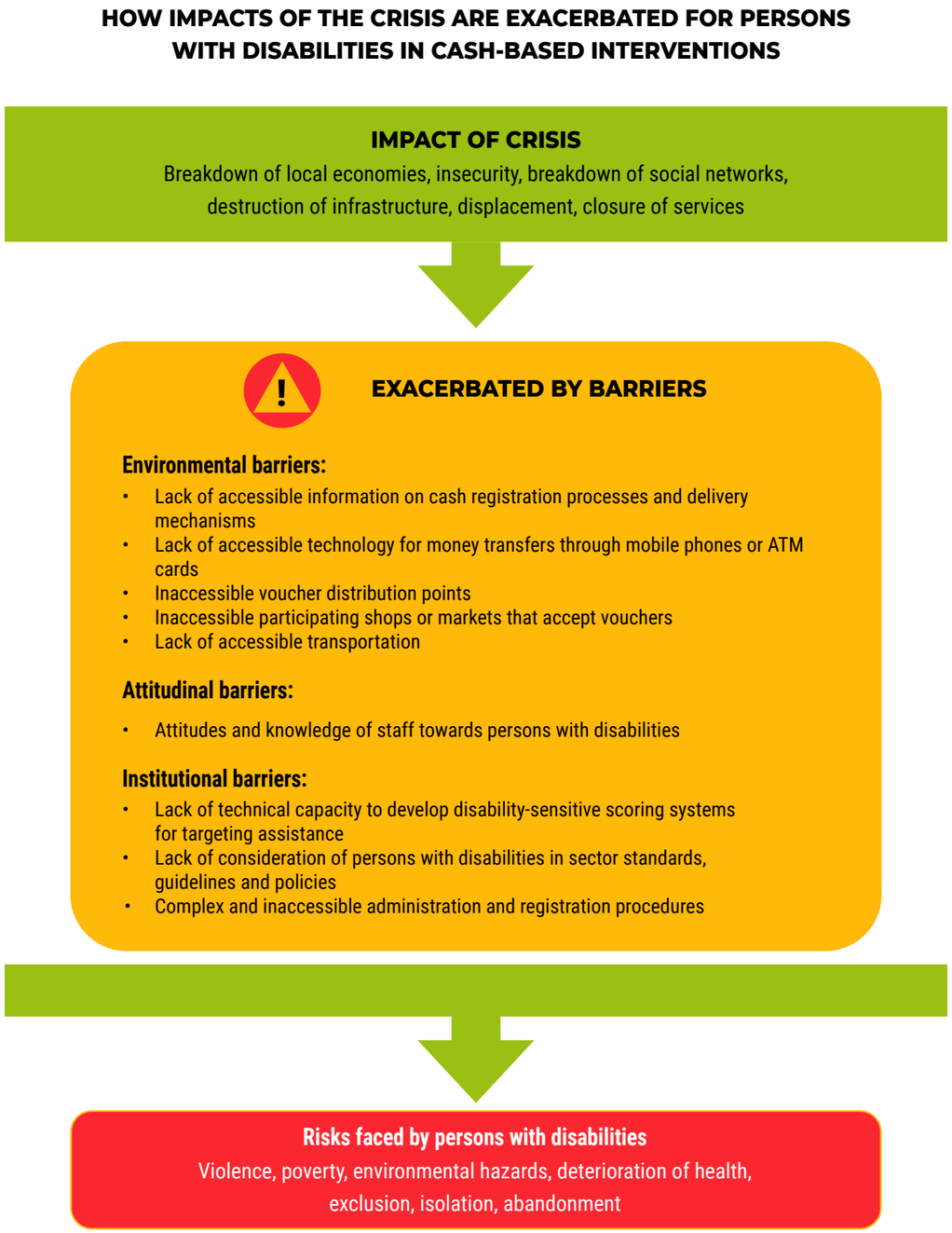
Data collection and monitoring

- Monitor whether persons with disabilities have equal access to cash and vouchers in their households and can spend them.
- Monitor whether persons with disabilities are exposed to exploitation and abuse in the context of cash transfer programmes, or face barriers when they seek to access or spend cash.
- Collect evidence and share lessons learned on what works. What practices increase the inclusion of persons with disabilities in cash-based interventions?

[79] Cash Learning Partnership, *As the movement for cash transfer programming advances, how can we ensure that people with disabilities are not left behind in cash transfer programming for emergencies?* (2015); UNHCR and WFP, *Mitigating risks of abuse of power in cash assistance in the Democratic Republic of Congo* (2018).

[80] For more on terms, see Cash Learning Partnership, Glossary of Terminology for Cash and Voucher Assistance (2017).

Diagram 5 | Barriers to access and inclusion in cash-based interventions



The guidance below will help humanitarian actors to identify and address the barriers that persons with disabilities (and also those who give them support) may face in accessing humanitarian cash-based transfer programmes.

MAINSTREAMED

Design cash-based intervention programmes that are inclusive of everyone, including persons with disabilities, and have accessible infrastructure and communication arrangements.

TARGETED

Provide financial literacy training for persons with disabilities who have been excluded from education.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Train staff to identify barriers and protection risks, related to cash-based interventions, that persons with disabilities face.	X		
Map existing social protection programmes and assess the accessibility of administrative procedures and processes. Assess whether they will cope if humanitarian programming is scaled up. Modify programme objectives accordingly and plan measures to address administrative barriers.	X		
Identify potential barriers to inclusion of persons with disabilities in cash-based interventions (for example, physically inaccessible markets).	X	X	X
Map partners that are already working with persons with disabilities; establish new partnerships and work with OPDs, as well as leaders with disabilities, to identify and remove barriers and risks that persons with disabilities face.	X		
Assess the degree to which markets are physically accessible to persons with disabilities, and the ease with which persons with disabilities can obtain market information.	X	X	X
Analyse market systems and services that might help to protect persons with disabilities. Consider alternative care, health, assistive devices, legal services, accessible transport, and education. Assess how persons with disabilities currently access these services and the barriers they face.	X		X
Consider the costs and risks persons with disabilities may face if they have to rely on intermediaries to pick up and deliver goods.	X		X
Assess how cash can be used to remove barriers and strengthen the resilience of households that include persons with disabilities.	X	X	X

	Preparedness	Response	Recovery
Plan how market actors can be helped to make their markets and services more accessible to persons with disabilities (for instance by improving physical or communications accessibility).[81]	X		
Assess the degree to which financial and technology solutions are accessible to persons with disabilities.	X		X
Consider other disability-related costs, including additional costs that households including persons with disabilities may incur when they access cash (transport costs, assistive devices, etc.).	X		X
Provide clear information, in accessible formats and in plain language, on the delivery of cash-based interventions, their duration, and alternative programmes that are available.	X	X	X
Ensure that financial institutions are prepared to make cash interventions accessible to persons with disabilities. Ensure they are willing to undergo vulnerability assessments.	X		
2. Resource mobilization			
Assess whether social protection programmes for persons with disabilities can be delivery mechanisms.	X	X	
3. Implementation			
Ensure that all affected people have equal opportunities to access cash-for-work programmes and are paid the same for work of equal value. Do not channel persons with disabilities into lower paid or less desirable work on grounds of disability.			X
Ensure that the environments and working conditions of cash-for-work and food-for-work programmes are accessible to persons with disabilities.	X		X
Choose distribution sites that are safe and accessible to persons with disabilities.	X	X	
Consider setting up 'market fairs' or itinerant markets in areas that are remote or difficult to access, so that persons with disabilities who live in those areas can participate.			X
Assess whether naming a person with a disability as the registered beneficiary might place that person at risk.			X
Clearly communicate assistance objectives. In doing so, seek to mitigate stigma, myths or envy that persons with disabilities who receive benefits may be subject to.	X	X	X
Consider alternative delivery mechanisms, such as outreach programmes or home delivery, that allow persons with disabilities to collect assistance themselves.	X	X	X
4. Coordination			
Involve OPDs in protection and cash coordination efforts, for example in the Protection Cluster and Cash Working Group.	X	X	X
Link up with national programmes and systems that offer cash transfers to persons with disabilities.	X		
Coordinate with other sectors to ensure that cash-based interventions facilitate access for persons with disabilities to other humanitarian services (such as child-friendly spaces or education).	X	X	X
5. Monitoring and evaluation			
Regularly collect feedback from persons with a range of disabilities, and of different age and gender, on the barriers and risks they face when they access cash transfers.		X	X
During post-distribution monitoring, consult persons with different disabilities to identify the barriers they face when they access beneficiary registration systems.			X
Conduct accessibility audits of service delivery mechanisms and feedback and complaint mechanisms.			X
Conduct accessibility audits of markets and propose modifications that will make them more accessible.			X
Disaggregate individual data by sex, age and disability at a minimum, using tools tested in humanitarian contexts, such as the Washington Group Short Set of Disability Questions.			X
Adopt accessible methods and procedures for enabling persons with disabilities to consent to use of their data. Make sure they know with whom their data is being shared (for example, other humanitarian organizations, the government, etc.).			X

Tools and resources

- Cash Learning Partnership
- CBM, *CBM Humanitarian Hands-on Tool*[82]
- Cash Learning Partnership, *Cash-Based Assistance: Programme Quality Toolbox*
- Convention on the Elimination of All Forms of Discrimination Against Women, Articles 11 and 14
- Cash Learning Partnership, *Safer Cash Research and Toolkit*
- UNHCR, *Guide for Protection in Cash-Based Interventions*
- Women's Refugee Commission and Mercy Corps, *Mainstreaming GBV Considerations in CBIs and Utilizing Cash in GBV Response: Toolkit for Optimizing Cash-based Interventions for Protection from Gender-based Violence*
- Women's Refugee Commission, *Cohort Livelihoods and Risk Analysis*

[81] See Cash Learning Partnership with Catholic Relief Services, *Market Support Interventions in Humanitarian Contexts – a Tip Sheet* (2018).

[82] A reference and learning app for humanitarian aid workers.

9 Stakeholder roles and responsibilities

The following tables outline the roles and responsibilities of different stakeholder groups throughout the humanitarian programme cycle to support persons with disabilities as well as humanitarian stakeholders, and ensure they are included and can participate in the humanitarian response.

Governments

Preparedness	• Ensure that contingency plans consider the needs of persons with disabilities, and that plans are inclusive and accessible. For example, deliver training in and promote awareness of relevant laws; establish accessible communication, feedback and complaint mechanisms; and encourage the collection and use of data using tools tested in humanitarian contexts, such as the Washington Group Short Set of Disability Questions. • Actively seek the participation of organizations of persons with disabilities (OPDs) that represent the diversity of persons with disabilities. Involve them in developing and reviewing disaster risk reduction policies, other humanitarian policies, laws, national plans, and other programmes and processes. Ensure legal frameworks support inclusion and participation of persons with disabilities in the humanitarian response. • Ensure that national systems that provide services (rehabilitation, education, health, peer support) are able to respond if large population movements occur. Map disability resources at local level (sign language interpreters, inclusion experts, service providers) and establish a roster. • In consultation with OPDs that represent the diversity of persons with disabilities, nominate a disability focal point to liaise with the Humanitarian Country Team and inter-cluster coordination systems on behalf of government agencies.
Needs assessment and analysis	• Give humanitarian actors access to population data on persons with disabilities for all types of assessments (rapid needs assessments, Multi-Cluster Initial Rapid Assessments, Post-Disaster Needs Assessments). Evaluate the quality of population data on persons with disabilities. • Involve OPDs that represent the diversity of persons with disabilities, and disability service providers, in planning and implementing data collection activities; collect, analyse and share information on barriers and enablers; promote use of data collection tools tested in humanitarian contexts, such as the Washington Group Short Set of Disability Questions. (See the section on Data and information management.)

Strategic response planning	• Involve OPDs in strategic response planning. • Take steps to ensure that strategic response planning includes persons with disabilities and adopts a human rights-based approach that complies with national, regional and international legal instruments and frameworks.
Resource mobilization	• Mobilize national and international resources and budgets (OPDs, service providers, funds). Ensure the inclusion of persons with disabilities, including refugees and other displaced persons with disabilities; ensure they receive support and protection during all phases of the humanitarian programme cycle.
Implementation and monitoring	• With OPDs that represent the diversity of persons with disabilities, monitor the degree to which all persons with disabilities have access to assistance and protection. • Ensure that assistance provided by the government and other humanitarian actors is accessible to persons with disabilities. • Enable social protection schemes to act as response mechanisms. Establish and facilitate access[83] to and use of social protection schemes as response mechanisms. • Address abuses and violations of the human rights of persons with disabilities, including gender-based violence (GBV).
Evaluation	• Commission real-time evaluations of the extent to which persons with disabilities can access assistance and protection, with the objective of improving their inclusion. • Ensure that all evaluations include a component that examines the equal access, participation and protection of persons with disabilities. • Ensure that persons with disabilities participate in sectoral and intersectoral evaluations.
Coordination	• Invite local OPDs that represent the diversity of persons with disabilities, and private and government providers of disability services, to coordinate with humanitarian stakeholders and share information. • Systematically require relevant meeting agendas and reporting processes to update and report on disability.
Information management	• Share official information on persons with disabilities, including information on barriers, risks, available services and training. • Develop, implement and enforce legislation to strengthen accessible information management systems during emergencies. The legal data protection framework should address data collection, appropriate dissemination of information, and access to information.[84]

[83] For example, simplify procedures for obtaining disability ID, for accessing the disbursement system, etc.

[84] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

Humanitarian leadership (Emergency/Resident Coordinator, Humanitarian Country Team)[85]

For this section refer to *Guidance on strengthening disability inclusion in Humanitarian Response Plans*.

Preparedness	• Integrate disability inclusion in the Terms of Reference for Humanitarian Country Teams (HCTs). • Encourage the government to nominate a disability focal point for the HCT. • Maintain oversight to ensure that all preparedness and contingency plans are inclusive of persons with disabilities: promote the IASC guidelines on inclusion of persons with disabilities in humanitarian action; ensure that OPDs and persons with disabilities participate in all relevant processes; provide capacity development on disability to the HCT. • Ensure that preparedness and contingency plans are adequately resourced (in terms of funding and human resources) for accessibility and inclusion of persons with disabilities in preparedness and contingency plans.
Needs assessment and analysis	• Ensure that needs assessment processes that estimate the severity of needs consider the impact of the situation on persons with disabilities and their families. • Ensure that multisectoral needs assessments consider the requirements, risks, skills, capacities, and views and perceptions of persons with disabilities. • All data collected in the course of multisectoral needs assessments should be disaggregated by sex, age and disability (using data collection tools tested in humanitarian contexts, such as the Washington Group Short Set of Disability Questions). • Include persons with disabilities and OPDs in needs assessment teams.
Strategic response planning	• Include disability in the strategic and results frameworks of response plans; ensure that reporting reflects the diversity of persons with disabilities. • Ensure that all strategic response plans (humanitarian response plans, rapid response plans, etc.) include all persons with disabilities who are in need. • Describe in the plan how the response will address factors that help to heighten the risks faced by persons with disabilities. • Involve OPDs in developing the humanitarian response plan.
Resource mobilization	• Encourage donors to allocate response funding for persons with disabilities and their inclusion in response actions. • Define criteria on inclusion of persons with disabilities for flash appeals, emergency response funds, country-based pooled funds and other emergency funding mechanisms. • Ensure that budget programmers are trained in disability inclusion. Ensure that sufficient resources are allocated to improving accessibility and providing reasonable accommodations.

[85] See also United Nations, Disability Inclusion Strategy (2019), which sets out specific expectations for leaders of United Nations organizations.

Implementation and monitoring	• Systematically include inclusion and protection of persons with disabilities in the agendas of HCT meetings. • Ensure that monitoring tools address the concerns of persons with disabilities; include accessibility, risks and risk management, specific requirements, views and perceptions. Ensure that persons with disabilities participate in monitoring, needs assessments and the response more generally.
Evaluation	• Encourage all sectors and clusters to include disability inclusion (protection, safety and equal access) in their evaluations. • Ensure that persons with disabilities participate in sectoral and intersectoral evaluations. • Disseminate evaluation findings in multiple accessible formats. Ensure that all sectors use evaluation findings when they plan their programmes or make adjustments to them.
Coordination	• Ensure that disability focal points and/or OPDs are included in inter-cluster meetings. • Promote disability mainstreaming across humanitarian action (tools, standards), using these guidelines.
Information management[86]	• Obtain agreement, including with government, on system-wide arrangements for collecting and sharing data on persons with disabilities in line with data ethics and protection principles.[87] • Systematically report on persons with disabilities; where no information is available, report 'no information available'. • Require that all collection, analysis and use of data is disaggregated by sex, age and disability.

[86] Information management refers to collection, analysis and management of data and information across the humanitarian programme cycle.

[87] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

Cluster and sector leads[88]

For this section, refer to IASC policy on accountability to affected populations.[89]

Preparedness	• Involve national and local OPDs in clusters and sectors and seek their advice on good practices and challenges. • Appoint a disability focal point in each cluster. • Identify the safety and protection risks, and the disability-inclusive services that are available, in each sector. Assess the capacities of persons with disabilities and ensure they are included in sector-specific contingency plans. Ensure contingency plans include prepositioning of assistive devices (such as wheelchairs, crutches, white canes, hearing aids, peer-support systems) to replace those that are likely to be lost or damaged. • Ensure contingency plans put clear communications systems in place, including early warning systems, and inclusive feedback and response mechanisms. Communication arrangements should take account of the communications requirements of persons with disabilities and should be accessible to them.
Needs assessment and analysis	• Ensure that needs assessment processes that estimate the severity of needs consider the impact of the situation on persons with disabilities and their families. • Ensure that multisectoral needs assessments consider the requirements, risks, skills, capacities, and views and perceptions of persons with disabilities. • Ensure that needs assessments identify persons with disabilities and their requirements. When primary data are collected, consider using tools tested in humanitarian contexts, such as the Washington Group Short Set of Disability Questions. • Consult affected populations, including persons with disabilities. Allocate 15–20 per cent of consultation time and resources to persons with disabilities. • Ensure that joint needs assessments include OPDs representing the diversity of persons with disabilities in their teams.
Strategic response planning	• Involve OPDs representing the diversity of persons with disabilities in strategic response planning processes, including analysis of information relating to persons with disabilities. • Develop and use appropriate indicators to measure the inclusion of persons with disabilities, applying the recommendations of these guidelines. • Design a twin-track approach and response strategy, including standard operating procedures (SOP), based on sector-specific guidelines and standards on inclusion of persons with disabilities. The approach and the strategy should take account of the intersectionality of gender, age, disability and other diversity factors.

[88] See also United Nations, Disability Inclusion Strategy (2019), which sets out specific expectations for leaders of United Nations organizations.

[89] IASC Task Team on AAP, Global protection cluster and OCHA, *Suggested Actions for cluster coordination groups to strengthen Accountability to Affected Populations and Protection in the Humanitarian Programme Cycle* (2016).

Resource mobilization	• Ensure that sectoral budgets and the funding needs overview allocate adequate sums to disability-inclusive programming. Include universal design of new or temporary structures, modification of existing structures, providing reasonable accommodations, outreach mechanisms, sign language interpreters, etc.). Seek advice from OPDs and disability focal points when budgets are planned and prepared. • Involve OPDs representing the diversity of persons with disabilities in the review committee of selected projects (for example, emergency response funds and pooled funds) to ensure that proposals adequately and appropriately include and address the requirements of persons with disabilities.
Implementation and monitoring	• Monitor and report on the degree to which persons with disabilities are able to access assistance and protection; disaggregate information by sex, age and disability. • Ensure that persons with disabilities are included in cluster reporting. • In partnership with OPDs, develop and disseminate advocacy messages on the rights and protection of persons with disabilities who are affected by the crisis.
Evaluation	• Organize sector evaluations, and participate in intersectoral evaluations, that examine inclusion of persons with disabilities. • Systematically include disability focal points, disability task teams, and OPDs that represent the diversity of persons with disabilities, in evaluation processes.
Coordination	• Ensure that sectors and clusters harmonize the work they do on disability-inclusive programming, in and across clusters and sectors. • Encourage OPDs, disability-related organizations and service providers to participate in cluster meetings. Make sure that meetings are in accessible locations; provide reasonable accommodations when needed. • Coordinate the development of an inclusive inter-cluster system, for referrals and to monitor accessibility for persons with disabilities.
Information management[90]	• Ensure information management systems include information on the degree to which persons with disabilities can access assistance and protection and participate in activities that are relevant to them. • Make certain that information collected on persons with disabilities is reliable, updated, and identifies good practices with respect to protection of, assistance to, and participation by persons with disabilities. Share information in cluster reports that use accessible formats. Adhere to data ethics and protection principles.[91]

[90] Information management refers to collection, analysis and management of data and information across the humanitarian programme cycle.

[91] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

Programmers (in humanitarian and development organizations)[92,93]

Preparedness	• Consult, include and partner with disability focal points, persons with disabilities, and OPDs that represent the diversity of persons with disabilities, during all stages of disaster risk reduction and emergency preparedness programmes. • Organize awareness-raising and capacity development on inclusion of persons with disabilities for staff and partners, in partnership with OPDs. • Support OPDs to build and strengthen their capacity to work in humanitarian action at all levels: administrative, human resources, accountability, financial management, proposal writing.
Needs assessment and analysis	• Analyse the factors that contribute to risks that persons with disabilities in affected populations face. With respect to needs assessment, identify barriers that prevent persons with disabilities from accessing assistance and protection, and enablers that facilitate access to assistance and protection. • Make needs assessment processes accessible to persons with disabilities. Offer reasonable accommodations where needed to simplify and facilitate collection of information from and by persons with disabilities. • Ensure that persons with a range of disabilities participate as key informants in focus groups and needs assessment teams.
Strategic response planning	• Make sure that meeting the requirements of persons with disabilities is among the objectives of the humanitarian response plan. Design and include indicators that measure the inclusion of persons with disabilities. • Adopt a twin-track plan to implement projects and strategies that ensure that persons with disabilities enjoy equitable access to assistance and protection. For this purpose, consider outreach, home-based services, accessible infrastructures, reasonable accommodations, etc. • Liaise and develop partnerships with disability-focused organizations, service providers, and OPDs that represent the diversity of persons with disabilities.
Resource mobilization	• Build an inclusive budget that recognizes the importance of accessibility and reasonable accommodations. Involve OPDs and disability focal points in setting priorities and determining the resources that will be needed to remove barriers that persons with disabilities face when they try to obtain assistance and protection. • Hire persons with disabilities and persons skilled in disability issues as staff or consultants.

[92] Some actions in this section will also be relevant for analysis and information management officers.

[93] See also United Nations, Disability Inclusion Strategy (2019), which sets out specific expectations for leaders of United Nations organizations.

Implementation and monitoring	• Ensure that activity monitoring uses disability-inclusive indicators, disaggregated by sex, age and disability. • Systematically review and analyse the degree to which persons of concern can access programmes and take corrective measures when required. • Report on the barriers and risks that persons with disabilities face when they try to access humanitarian assistance and protection. Share good practices; disseminate and apply standards[94] and tools.
Evaluation	• Seek advice from OPDs that represent the diversity of persons with disabilities when designing, planning and implementing evaluations that include questions related to disability (protection, safety and equal access). • Ensure that persons with disabilities have access to evaluation processes and can actively participate in them. • Disseminate evaluation reports in a range of accessible formats. Use their findings to adjust programming as needed.
Coordination	• Involve OPDs that represent the diversity of persons with disabilities in coordination mechanisms. • Promote inter-cluster collaboration on disability inclusion. Establish referral pathways; promote cross-learning activities; offer training by sectoral experts and OPDs.
Information management[95]	• Ensure that data related to disability measure and report on outcomes, outputs and indicators defined in humanitarian response plans. • Train staff to collect and analyse disability-related data, including on barriers to inclusion and factors that enable inclusion. • Create or adapt tools to capture information that report the degree to which persons with disabilities can access assistance and protection programmes and participate in response activities that are relevant to them. • Ensure that the collection, storage and processing of sensitive personal data is carried out in line with appropriate data ethics and protection principles.[96]

[94] Such as the Sphere Standards, the Humanitarian Inclusion Standards, and the Humanitarian Hands-on Tool App.

[95] Information management refers to collection, analysis and management of data and information across the humanitarian programme cycle.

[96] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

Donors

Preparedness	• Include criteria and policies related to disability inclusion in calls, proposals and contract agreements. • Ensure that staff are trained in inclusion of persons with disabilities and that a dedicated disability focal point is appointed. Prepare disability guidance for implementing partners using these guidelines. • Invest in preparedness and provide funding to support capacity development designed to ensure that all humanitarian stakeholders, including OPDs, are equipped and prepared to include persons with disabilities in humanitarian action. • Stipulate that reporting must include data collection on persons with disabilities, including on accessibility, the removal of barriers, and quality of services. Insist that data must be disaggregated by sex, age and disability.
Needs assessment and analysis	• Support implementing partners to facilitate needs assessments and analyses that include persons with disabilities. These should address risks faced, access to protection and assistance, quality of services, and barriers.
Strategic response planning	• Require implementing partners to design and include strategies on disability inclusion as part of funding requirements. • Promote and assist partners to develop approaches that identify, analyse and address the risks that persons with disabilities face.
Resource mobilization	• Make inclusion of persons with disabilities a funding priority and allocate funding targets to promote their access and participation. • Use a disability marker along with other relevant markers, such as the gender and age marker, to assist selection and monitoring of proposals. • Create incentives for disability-inclusive programming in line with global participation commitments. • Ensure funding appeals are accessible to OPDs that represent the diversity of persons with disabilities. Adapt funding criteria, where required, to make local OPDs eligible.
Implementation and monitoring	• Consult persons with disabilities when evaluating partners' programmes; discuss their access to assistance and protection. • Assess reports, or monitor implementing partners' performance, using criteria drawn from the Convention on the Rights of Persons with Disabilities (CRPD). Provide feedback and recommendations to partners. • Monitor partners' efforts to include persons with disabilities.

Evaluation	• Require partners to make the inclusion and participation of persons with disabilities a systematic component of evaluations. • Disseminate the results of evaluations in multiple accessible formats. • Follow up evaluation recommendations on inclusion and participation of persons with disabilities. • Ensure that persons with disabilities participate in sectoral and intersectoral evaluation.
Coordination	• Support the appointment of staff with relevant expertise in disability inclusion (as disability focal points, members of the humanitarian country teams, sector and cluster coordination mechanisms). • Encourage and support OPDs that represent the diversity of persons with disabilities to become involved in humanitarian interventions and coordination mechanisms.
Information management[97]	• Require partners to disaggregate information, including information on barriers and their removal, by sex, age and disability. • Report on progress that is made to include persons with disabilities; share lessons learned and good practices. • Where information is not available on a crisis or on the exposure to risks of affected persons with disabilities, assist partners to collect data on disability. • Require that the collection, storage or processing of sensitive personal data is carried out in line with appropriate data ethics and protection principles.[98]

[97] Information management refers to collection, analysis and management of data and information across the humanitarian programme cycle.

[98] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2)

Organizations of Persons with Disabilities (OPDs)

Humanitarian actors should include OPDs representing the diversity of persons with disabilities in all phases of the humanitarian programme cycle. They can share their knowledge and expertise about disability, provide leadership, and ensure that persons with disabilities are fully included and fully participate in humanitarian action. When no OPDs are locally present, humanitarian actors should involve peer-support groups or individuals with disabilities.

Preparedness	• Promote the use of tools tested in humanitarian contexts, such as the Washington Group Short Set of Disability Questions for data collection, which make it possible to disaggregate data by sex, age and disability. • Advocate for the rights of persons with disabilities in situations of risk and emergencies and for all disaster risk reduction programmes and emergency preparedness programmes to be fully accessible to persons with disabilities. • Raise awareness and provide training to community members, persons with disabilities, humanitarian stakeholders, and first responders on the needs, rights and capacities of persons with disabilities. Explain their communications requirements. • Advocate for refugees with disabilities to have access to national services and systems.
Needs assessment and analysis	• Participate in needs assessments and the collection of quantitative and qualitative information. Participate in identifying both barriers that impede the inclusion of persons with disabilities and enablers that facilitate their inclusion. • Help to develop tools and design accessible needs assessments. These should permit reasonable accommodations, and should include persons with disabilities in assessment teams and focus group discussions, etc.
Strategic response planning	• Apply a rights-based approach to disability in order to make humanitarian stakeholders and governments accountable when they design humanitarian response plans and other humanitarian planning tools. • Represent disability constituencies in meetings and advocate for the rights of persons with disabilities. • Reach out to persons with disabilities from affected populations, including refugees and other displaced persons, and include them in local OPD networks.
Resource mobilization	• Support the development of budgets that fund activities promoting the inclusion of persons with disabilities. Budgets should make provision for reasonable accommodations, appropriate housing, OPD participation, etc. • Support general advocacy to increase funding to respond to crises. • Contribute to and facilitate mobilization of resources at all levels.

Implementation and monitoring	• Participate in data collection for monitoring and reporting on access to services and assistance, protection risks, human rights violations, use of funding, etc. • Support interventions that benefit at-risk groups, including persons with disabilities. • Advise on the development of accessible infrastructures, facilities and communication materials.
Evaluation	• Assist evaluation teams to assess accessibility and the degree to which persons with disabilities can fully exercise their human rights, taking gender, age and disability diversity into account. • Identify appropriate questions for inclusion in evaluations. With respect to persons with disabilities, evaluations should address accessibility, availability, affordability, accountability, and quality of services, as well as the effectiveness, efficiency, impact and the relevance of the response. • In cooperation with government and humanitarian stakeholders, collect and document good practices and lessons learned, with respect to inclusion and the accessibility of assistance and protection. • Advocate that evaluation findings must be integrated in programme planning and implementation.
Coordination	• Identify focal points in OPDs who can participate in cluster and sub-cluster meetings at all levels, including as members of the humanitarian response team. • Coordinate OPDs (both national and local) and contribute their inputs, using the 5W tool, to humanitarian coordination mechanisms.[99] • Participate in collecting information on risks and barriers that persons with disabilities face, and their access to services. Provide feedback to humanitarian actors and disability focal points.
Information management[100]	• Encourage information managers to collect and analyse information on the degree to which persons with disabilities have access to assistance and protection services. • Support the interpretation and analysis of information on disability trends and disability programmes. • Ensure that information is disseminated in multiple accessible formats to OPD members, persons with disabilities, and other audiences. • Communicate data and assessments on persons with disabilities to disability focal points and coordination mechanisms. • Require that the collection, storage or processing of sensitive personal data is carried out in line with appropriate data ethics and protection principles.[101]

[99] The Who does What, Where, When and for Whom (5W) tool is used to capture data from the field and generate information products, such as maps and tables of achievement. The 5Ws tool can help avoid unintentional duplication by different agencies, and assists stakeholders, including affected communities and local governments, to identify response gaps.

[100] Information management refers to collection, analysis and management of data and information across the humanitarian programme cycle.

[101] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

10 What sectors need to do

Sector and intersectoral coordination

Humanitarian coordination seeks to improve the effectiveness of a humanitarian response by strengthening predictability, accountability and partnership.

Sectoral and intersectoral coordination provide leadership and guidance in implementing humanitarian action by agreeing commitments and actions that improve inclusion and participation. Coordination mechanisms can take different forms, and several may be implemented simultaneously in the same country.

Cluster and sector coordination mechanisms are activated (when required) by the Emergency or Humanitarian Coordinator, or Resident Coordinator with the humanitarian country team (HCT) and the government concerned. Activation triggers the humanitarian programme cycle.

While coordination mechanisms increasingly address disability through working groups, coordination remains ad hoc and inconsistent. Disability is not yet systematically included in inter-agency coordination mechanisms.

Where cluster/sector coordination mechanisms have not been established, or are only partly activated, concerned governments may set up their own coordination system. Whatever form coordination mechanisms adopt, it is imperative to include organizations of persons with disabilities (OPDs) in government-led coordination processes and other response strategies.

Addressing disability in coordination mechanisms

Disability inclusion is an opportunity to strengthen intersectoral coordination. Intersectoral coordination mechanisms should ensure that persons with disabilities have access to assistance and protection on an equal basis with other people affected by a crisis and should consider OPDs to be humanitarian stakeholders. Achieving these goals at inter-agency, sectoral and intersectoral levels will promote the centrality of protection, support a rights-based approach, and increase accountability to affected populations (AAP).

Actions that humanitarian coordination mechanisms should take to promote inclusion of persons with disabilities are listed in the table on stakeholder roles and responsibilities.

Key elements – must do

'Must do' actions must be undertaken throughout intersectoral and sectoral coordination in all phases of humanitarian action for inclusion of persons with disabilities.

Participation

- Ensure that persons with disabilities, their families and OPDs are actively involved in coordination mechanisms, intersectoral needs assessments, and the development of

Humanitarian Needs Overviews and Humanitarian Response Plans (HRPs).

- Ensure that the diversity of the population of persons with disabilities is fairly represented. Consider the various forms of disability, and gender and age. Make concerted efforts to promote underrepresented groups, including persons with intellectual and psychosocial disabilities, indigenous persons, women and girls.

Addressing barriers

- When conducting needs assessments, identify barriers and risks that persons with disabilities face.
- When developing humanitarian response plans, draw on qualitative as well as quantitative information on persons with disabilities in order to identify persons with disabilities, the risks and barriers they face, and means to mitigate or remove these barriers.

Empowerment and capacity development

- Ensure that coordination mechanisms include OPDs in their capacity-building initiatives.
- Build the capacity of coordination personnel on disability inclusion. Incorporate components on disability inclusion in coordination trainings.
- Establish intersectoral referral pathways that increase the inclusion of persons with disabilities.

Data collection and monitoring

- Share available data on sector-related requirements of persons with disabilities and engage in joint intersectoral analysis to achieve a holistic understanding of their situation and requirements.
- Where reliable data are unavailable or cannot be collected, apply the 15 per cent estimate of global disability prevalence.[102]
- Ensure that humanitarian response plans explicitly reference disability across sectors, and clearly recommend that targets and indicators should disaggregate data by disability.
- Ensure that the HCT's periodic monitoring reports routinely cover the situation of persons with disabilities (including their access to humanitarian assistance, the challenges they face, achievements, and lessons learned).
- Share information on persons with disabilities (disaggregated by sex, age and disability) in intersectoral dashboards and reporting, using multiple accessible formats.

[102] WHO and World Bank, *World Report on Disability* (2011).

11 Camp coordination and camp management

See Chapter 10, Shelter and settlements and WASH.

Introduction

Camp coordination and camp management (CCCM) is a technical sector. The term refers to standardized coordination mechanisms that may be applied in refugee operations (through the Refugee Coordination Model), and also in operations to protect internally displaced persons (IDPs) (through the CCCM Cluster).[103] The CCCM sector's primary objective is to protect the rights of populations affected by forced displacement (but also host families and communities).

In practice, the sector works to ensure that those living in collective or communal displacement settings have equitable access to assistance and protection. This is achieved by coordinating and monitoring the delivery of services and establishing representative and accountable governance and participation structures at site level (camp management); providing strategic and operational coordination at inter-site level (camp coordination); and overall supervision of the response (camp administration). Governance and participation structures can take the form of committees, interest or influence groups, or feedback and complaint mechanisms, etc.; together, these structures ensure that all individuals are able to have their voices heard and participate in decisions that affect them.

In sites that host displaced populations, the CCCM sector also plays a key role in coordination and monitoring of assistance and protection services. It ensures that needs are identified and covered, that responsible sectors or actors fill gaps, and that services are not duplicated. Site-level coordination meetings are often attended by all sectors, from WASH and shelter to protection, education and distribution, as well as representatives from the displaced population, camp security and the host community.

Key legal instruments and other frameworks

- Convention on the Rights of Persons with Disabilities
- Global Compact on Refugees
- Global Compact for Safe, Orderly and Regular Migration

[103] UNHCR, *Emergency Handbook: Camp Coordination, Camp Management*.

Key terms

Camps/sites. The terms 'camp' or 'site' refer to a variety of temporary settlement options that include planned camps, self-settled camps, collective centres, reception centres, transit centres and evacuation centres.[104] Because the word 'camp' is sensitive in many contexts, CCCM actors use a range of terms when referring to displacement settings. It is recognized that camps are not the solution to population displacement, but sometimes they offer the only available way to protect and assist a displaced population. The CCCM sector does not advocate the establishment of camps.

Camp administration. Camp administrations fulfil the functions of government or national authorities in camps and camp activities.[105]

Camp management. Camp management coordinates and monitors services, protection and assistance on one camp or site, in compliance with the relevant national and international legal protection frameworks and minimum humanitarian standards.[106] It encourages active and meaningful participation by the displaced population. Camp management is both technical and social in that it strives to provide appropriate living conditions (through inter-agency coordination at camp level) and sustain social inclusiveness and dignity (through participation, feedback and governance structures). Camp management may be undertaken by humanitarian actors (UNHCR, IOM, INGOs, national NGOs), civil society organizations, private sector institutions, or the government or national authorities.[107]

Camp coordination. Camp coordination is responsible for coordinating the response between sites, and provides access to, and delivers, humanitarian services and protection at sites that host displaced populations. It coordinates roles and responsibilities in the overall humanitarian displacement response, and is led by UNHCR and/or IOM, often in tandem with national authorities. The CCCM Cluster (in IDP situations) or Sector Lead Agency (in refugee situations) strives to deliver an effective and efficiently coordinated humanitarian response in situations where displaced populations are forced to seek refuge in temporary settlements. It improves living conditions during displacement, provides assistance and protection, seeks durable solutions to end temporary displacement, and finally manages the organized closure and phase-out of sites that have hosted displaced populations. The lead agency or cluster seeks to end displacement of persons by promoting durable solutions. IOM and UNHCR co-lead the Global CCCM Clusters for natural disaster and conflict-induced IDP situations respectively, as well as other clusters in the field, often in tandem with national authorities.[108]

Evacuation centres are buildings used to provide temporary shelter for persons fleeing a specific and immediate threat, such as fighting, or a natural hazard, such as a cyclone or an earthquake. Schools, sports arenas and religious or civic buildings are often used for this purpose. Wherever possible, emergency evacuation centres should be identified and prepared before disasters occur.[109]

Local preparedness committees are community-based or government response structures that oversee disaster preparedness measures.[110]

Barriers

Displacement is often sudden, and limited time is usually available to prepare for it. It is a disruptive event that can exacerbate or create barriers for persons with disabilities. In temporary sites hosting displaced populations, persons with disabilities are often unable to take care of their most basic needs or obtain adequate assistance and protection.

Persons with disabilities who are hosted in temporary settlements are entitled to receive humanitarian assistance. In practice, this means that humanitarian actors must act to identify and remove environmental, attitudinal and institutional barriers that impede their access to assistance and protection. Persons with disabilities in camps are also entitled to exercise their right to participate in camp life and in decisions that concern them. This implies that humanitarian actors must ensure they can meaningfully participate in site governance and representative structures, give them effective access to information and feedback and complaint mechanisms, and ensure they can participate in social events and economic activities. The responsibility to remove barriers and promote meaningful inclusion and participation persists in all phases of the life of a site, from planning and set-up, through care and maintenance, to closure and durable solutions.

Standards and guidelines

- UNHCR, *Working with Persons with Disabilities in Forced Displacement* (2019).
- Sphere, *Sphere Standards Handbook* (2018).
- Help Age, CBM, Handicap International, *Humanitarian inclusion standards for older people and people with disabilities* (2018).
- IOM, Norwegian Refugee Council, UNHCR, *Camp Management Toolkit* (2015).
- CCCM Cluster, *Collective Centre Guidelines* (2010).
- *Guiding Principles on Internal Displacement* (2004).
- CCCM, *Urban Displacement and Out of Camps Review* (2013).
- CCCM Cluster, *MHPSS in Emergency Settings: What should Camp Coordination and Camp Management Actors Know?* (2014).

Key elements – 'must do'

'Must do' actions must be undertaken in all phases of humanitarian action when implementing inclusive CCCM programming for persons with disabilities.

Participation

- Actively involve persons with disabilities, their families, and organizations of persons with disabilities (OPDs) in identifying barriers. Ensure they participate in planning, designing, implementing, monitoring and evaluating site infrastructures, and protection and assistance services at displacement sites.
- Ensure that persons with disabilities are fairly represented in site governance mechanisms, such as site management committees, technical committees for shelter, WASH, food distribution, safety and security, and other formal and informal participation structures, such as community groups, women's groups, youth groups, etc. When planning representation, take into account the range of forms of disability as well as age, gender and diversity. Make concerted efforts to promote underrepresented groups of persons with disabilities, such as persons with intellectual and psychosocial disabilities, indigenous persons, women and girls.
- Involve persons with disabilities in community activities and feedback and complaint mechanisms. Promote effective and barrier-free access that is respectful of all types of disability.

[104] IOM, Norwegian Refugee Council, UNHCR, *Camp Management Toolkit* (2015), p. 9.

[105] In practice, where the government or national authorities oversee camp management or camp coordination, camp management, camp coordination and camp administration share the responsibilities in a variety of ways.

[106] See, for instance, the Sphere Standards, *Core humanitarian standard*; and Help Age, CBM, Handicap International, *Humanitarian inclusion standards for older people and people with disabilities*, among others.

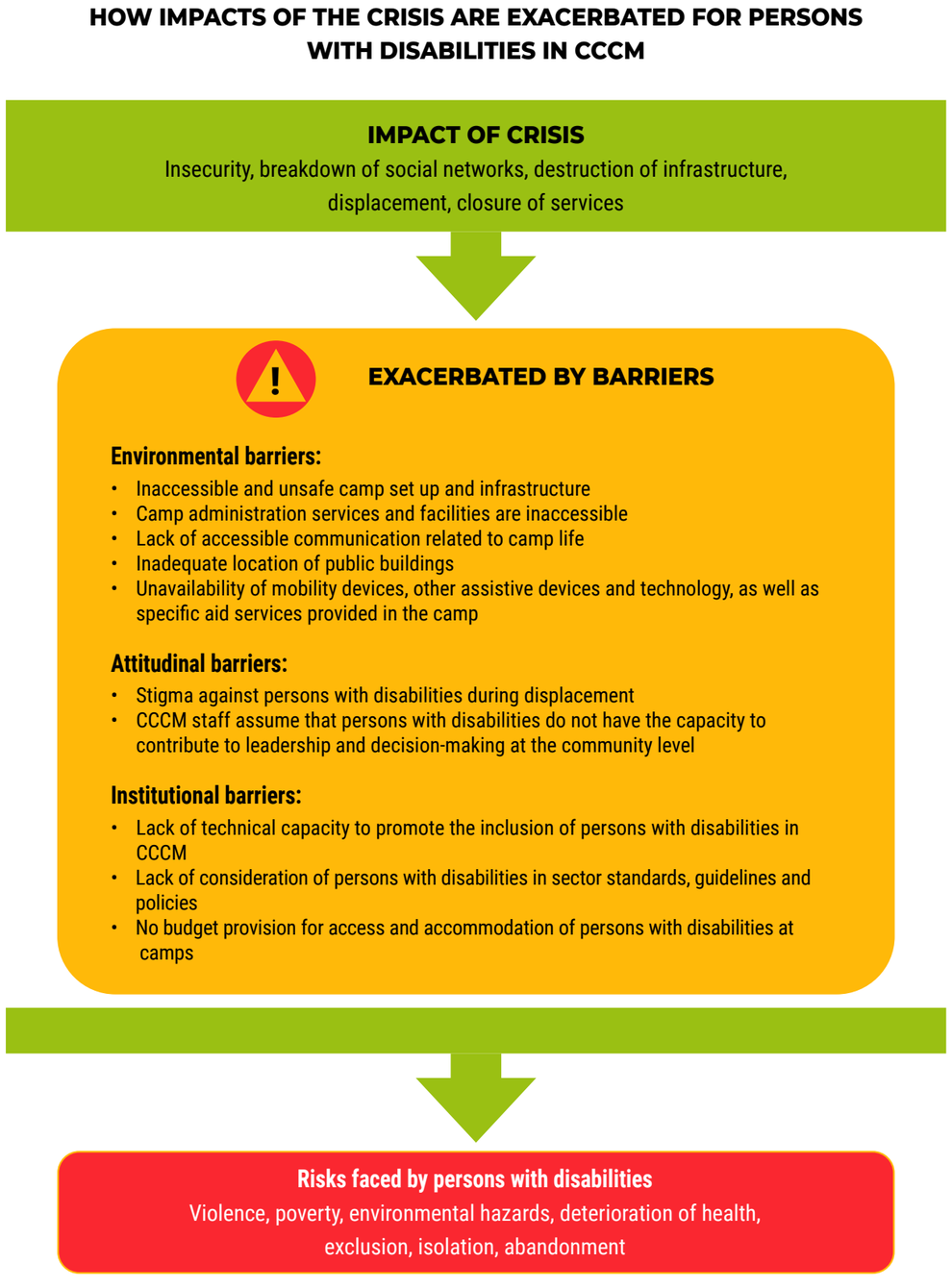
[107] See IOM, Norwegian Refugee Council, UNHCR, *Camp Management Toolkit* (2015) and CCCM Cluster's training material.

[108] See IOM, Norwegian Refugee Council, UNHCR, *Camp Management Toolkit* (2015), p. 14.

[109] *Ibid*, p. 18.

[110] Global Camp Coordination and Camp Management (CCCM) Cluster, *The MEND Guide – Comprehensive Guide for Planning Mass Evacuations in Natural Disasters* (2014), p. 23.

Diagram 6 | Barriers to access and inclusion in CCCM



Addressing barriers

- Identify and monitor barriers that prevent persons with disabilities from accessing services in temporary settlements. Seek solutions that will remove barriers and take steps to provide reasonable accommodations.
- Encourage all contractors to adopt universal design principles when they plan and build sites.
- Make sure that all information and communications (regarding assistance and protection services, durable solutions, site closure procedures, etc.) are made available in multiple accessible formats. Consider the needs of persons with hearing, visual, intellectual and psychosocial disabilities.
- Implement strategies to reduce stigmatization of disability. Raise community awareness of the rights of persons with disabilities. Establish support groups. Encourage persons with psychosocial and intellectual disabilities to become advocates themselves.
- Review sectoral policies, guidelines and tools to ensure that they clearly affirm the right of persons with disabilities to access and inclusion.

Empowerment and capacity development

- Build the capacity of CCCM actors and partners working in temporary settlements (responders, staff, service providers, contractors). Offer awareness training on the rights of persons with disabilities, including the intersection of disability with age, gender, migration status, religion and sexuality.
- Train OPDs in CCCM to support an inclusive response and to facilitate the meaningful participation of persons with disabilities.
- Recruit persons with disabilities and OPDs to contribute to capacity-building activities that camps provide.

Data collection and monitoring

- Across the humanitarian programme cycle, systematically collect and analyse data on persons with disabilities, disaggregated by sex, age and disability. Use the data to measure the degree to which persons with disabilities have effective access to essential documentation and available services (such as registration processes, disability certificates, birth registration). Where reliable data are unavailable or cannot be collected, use the 15 per cent estimate of global disability prevalence.[111]
- Map service routes and their accessibility; map access to facilities and resources. Set up referral systems.
- Share information on barriers to access that are associated with specific sectors and partners (WASH, protection, education) and ensure cross-sectoral coordination when required.
- Ensure that data ethics and protection principles (including confidentiality, provision of information, informed consent, security) are respected whenever data on persons with disabilities are collected and used.[112]

[111] WHO and World Bank, World Report on Disability (2011).

[112] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

MAINSTREAMED

CCCM programmes and coordination structures are designed and adapted to ensure that the assistance and protection services provided in temporary settlements, as well as governance structures and other activities, are inclusive of and accessible to everyone, including persons with disabilities.

TARGETED

CCCM agencies take specific actions to accommodate the needs of persons with disabilities and ensure they have access to site infrastructure, services, information, and two-way communication systems. They seek to empower persons with disabilities through participation and governance mechanisms.

The following guidance will support CCCM actors to identify and remove the barriers faced by persons with disabilities, as well as their families, support persons and caregivers, when they try to access infrastructures, information and services in camps.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Review policies, guidelines, tools and standard operating procedures using the IASC guidelines on inclusion of persons with disabilities.	X		
Form partnerships with OPDs. Invite them to explore areas of collaboration and train CCCM staff and stakeholders on disability.	X		
Build the skills and knowledge of CCCM actors and stakeholders on inclusion of persons with disabilities.	X		
Conduct identification and accessibility audits of collective/evacuation centres, including site set-up.	X	X	
Identify and analyse risks and barriers. During planning, design mitigation measures to address these.	X		

	Preparedness	Response	Recovery
Map stakeholders. Include national interest organizations and government agencies with a disability portfolio (such as Ministries of Health, Education, Social Services, Housing, Public Works…). Reinforce existing networks.	X		
Involve, consult and seek feedback from persons with disabilities and OPDs on access to services, assistance and protection. Identify barriers and actions to remove them, as well as measures that will facilitate access.		X	X
Using trained staff, organize and implement inclusive registration systems and processes that identify persons with disabilities by means of differentiated data matrices for gender, age and disability. Take steps to include the full range of disabilities.[113]		X	X
Include persons with disabilities in assessments, operational planning, strategic design, programme implementation, and monitoring activities.		X	X
Ensure that plans incorporate exit and solution strategies, and that these are accessible to persons with disabilities and can accommodate their requirements.		X	X
Ensure that the collection, storage and processing of sensitive personal data is carried out with appropriate data protection.		X	X
2. Resource mobilization			
Consider the needs of persons with disabilities from the outset, and mainstream inclusion into all aspects of the displacement response, including emergency evacuation, access to sites, access to services, identification of durable solutions, etc.	X	X	X
Identify the skills and experience needed in the team. Consider recruitment to secure sufficient technical expertise. Recruit staff with disabilities or staff who know how to include persons with disabilities. Involve OPDs, if feasible.		X	
Ensure funding is flexible. Carry out site improvements to remove obstacles. Make necessary accommodations to ensure that persons with disabilities have direct access to services and can participate in governance structures and other activities. (Consider provision of transport, interpreters, etc.)		X	

[113] See UNHCR, *Working with Persons with Disabilities in Forced Displacement* (2011); see also the registration tools and specific requirement codes in IOM, Norwegian Refugee Council, UNHCR, *Camp Management Toolkit* (2015), p. 141.

	Preparedness	Response	Recovery
3. Implementation			
Involve persons with disabilities and OPDs in site planning and improvement meetings. Seek their advice on how to remove barriers and reduce protection risks.		X	X
Support or establish governance mechanisms that ensure persons with disabilities can participate in formal and informal processes of consultation and decision-making.		X	X
Ensure information campaigns and complaint and feedback mechanisms are accessible to all, independent of disability, and are disseminated in multiple accessible formats (oral, print, sign language, easy-to-read/plain language, etc.), and in languages spoken by the affected community.		X	X
Monitor the degree to which persons with disabilities successfully obtain access to general services and to services targeting persons with disabilities.		X	X
Set up or support committees, interest groups, or peer-support groups of persons with disabilities in the camps. Take steps to ensure that camp groups and OPDs inside and outside the camp adequately represent the diversity of persons with disabilities.	X	X	X
Ensure that camp infrastructures (latrines, water, shelter) are maintained. Make changes and identify resources to improve accessibility.		X	X
Involve persons with disabilities in all activities and decision-making processes related to durable solutions. Arrange 'go and see' and 'come and tell' visits.			X
4. Coordination			
Coordinate and promote the implementation of international standards in camps (including these guidelines). Agree standards and monitor and evaluate their application.[114]	X	X	X
Ensure that meeting spaces are accessible. Take steps to provide reasonable accommodation for persons with disabilities (provide sign language interpreters, easy-to-read materials, additional lighting, etc.).	X	X	X

[114] See The Sphere Project (2018); and Help Age, CBM, Handicap International, *Humanitarian inclusion standards for older people and people with disabilities* (2018).

	Preparedness	Response	Recovery
Support efforts by national authorities to address barriers to access and inclusion that persons with disabilities face. Discuss solutions and offer appropriate support (for example, training and capacity-building).	X		
Advocate for the rights of persons with disabilities; for the removal of barriers that impede their inclusion and their access to services and protection; and for the integration of targeted services for persons with disabilities in sectoral responses and programmes.	X	X	X
5. Monitoring and evaluation			
Make complaint and feedback mechanisms accessible to persons with all types of disability, including those who stay in their shelters or homes.		X	X
Involve women, men, girls and boys with a representative range of disabilities in monitoring activities and teams.		X	X
Monitor site and services accessibility, as well as protection risks (including GBV) that might affect persons with disabilities. Do so by regular audits. Consult persons with disabilities as well as protection teams, OPDs, etc.		X	X
Conduct evaluations and use their findings to adjust programming and ensure better inclusion. Share lessons learned and integrate good practices in preparedness plans.	X	X	X

Tools and resources

- CCCM Cluster website
- CCCM Cluster, *The Collective Centre Guidelines* (2010)
- CCCM Cluster, *Urban Displacement and Out of Camps Review* (2013)
- *Guiding Principles on Internal Displacement* (2004)
- IASC, *Mental Health and Psychosocial Support in Emergency Settings: What should Humanitarian Health Actors know?* (2011)
- IOM, NRC, UNHCR, *The Camp Management Toolkit* (2015)
- UNHCR, Conclusion on refugees with disabilities and other persons with disabilities protected and assisted by UNHCR (2010)
- UN Refugee Agency et al., *Working with people with disabilities in forced displacement* (2019)

12 Education

Introduction

Education in emergencies provides lifesaving and life-sustaining psychosocial, physical and cognitive support. It can sustain the progress of children who were in education and create opportunities for those who missed out, via accelerated education programmes, vocational training, and other non-formal and formal learning programmes. Through education, people living through crises learn key survival skills and risk reduction strategies, including how to protect themselves from sexual abuse, infections and explosive devices, and acquire essential information about their rights, and about health and nutrition. Education can be a transforming, peace-building force that strengthens resilience to future shocks and offers a vital space of normality and routine to children, young people and adults who have been profoundly affected by emergencies.

Inclusive, equitable education in emergencies can enhance learning opportunities for all, improve outcomes, generate innovation, assist governments to 'build back better', and normalize or embed inclusion in systems emerging from crises.

During emergencies, humanitarian organizations play a fundamental role in restoring education systems by supporting the efforts of national governments. This can be a transformative opportunity, if governments are willing to prioritize the inclusion of learners with disabilities and ensure that national and local frameworks comply with recognized global standards and guidelines on inclusion of persons with disabilities.

See also the sections on WASH, CCCM, Health, Nutrition and Protection.

Key legal instruments and other frameworks

- Sustainable Development Goal 4
- UN Convention on the Rights of Persons with Disabilities
- The Dakar Framework for Action
- The Salamanca Statement and Framework for Action
- UN Convention on the Rights of the Child
- UN Convention on the Elimination of All Forms of Discrimination against Women
- International Covenant on Economic, Social and Cultural Rights
- Universal Declaration of Human Rights

Key terms

Education in emergencies refers to programmes that provide learning opportunities in situations of crisis to people of all ages. Programmes offered include early childhood development, primary, secondary, non-formal, technical, vocational, higher and adult education. Education in emergencies provides physical, psychosocial and cognitive protection that can sustain and save lives. It is essential in situations of conflict, violence, forced displacement, disasters and public health emergencies. Conceptually, 'education in emergencies' is broader than, but also an essential element of, an 'emergency education response'.[115]

Inclusive education systems include *all* students and welcome and support them, regardless of background, capacities or requirements. To meet this aim, teaching, curricula, school buildings, classrooms, play areas, transport and toilets must be appropriate for all children at all levels. Inclusive education means that all children learn together in the same schools.[116]

Special education provides education to children with disabilities in a segregated learning environment, such as a special school or centre, which is often isolated from the community, other children and mainstream schools.[117] Special schools are usually organized by impairment (for example, schools for the blind or deaf).[118]

Learners refers to those who are enrolled or engaged in educational activities, and also potential learners who may currently be excluded. Learners with disabilities include women, men, girls and boys. They may be in any type of formal or non-formal education: from early childhood care and development programmes, in primary, secondary or tertiary education, or on vocational or lifelong learning courses.

Teachers include trained educators directly involved in teaching students. They can be classroom teachers, special education teachers, or other types of teachers. They may work with students in a whole class in a classroom, in small groups in a resource room, or one-to-one inside or outside a regular classroom.[119]

Accessibility applies to buildings, information, communication, curricula, educational materials (including textbooks), teaching methods, assessment, language, support services, school transport, water and sanitation, school cafeterias and recreational spaces.

Barriers

Learners with disabilities are routinely the most marginalized and excluded group in education systems, including in emergencies.

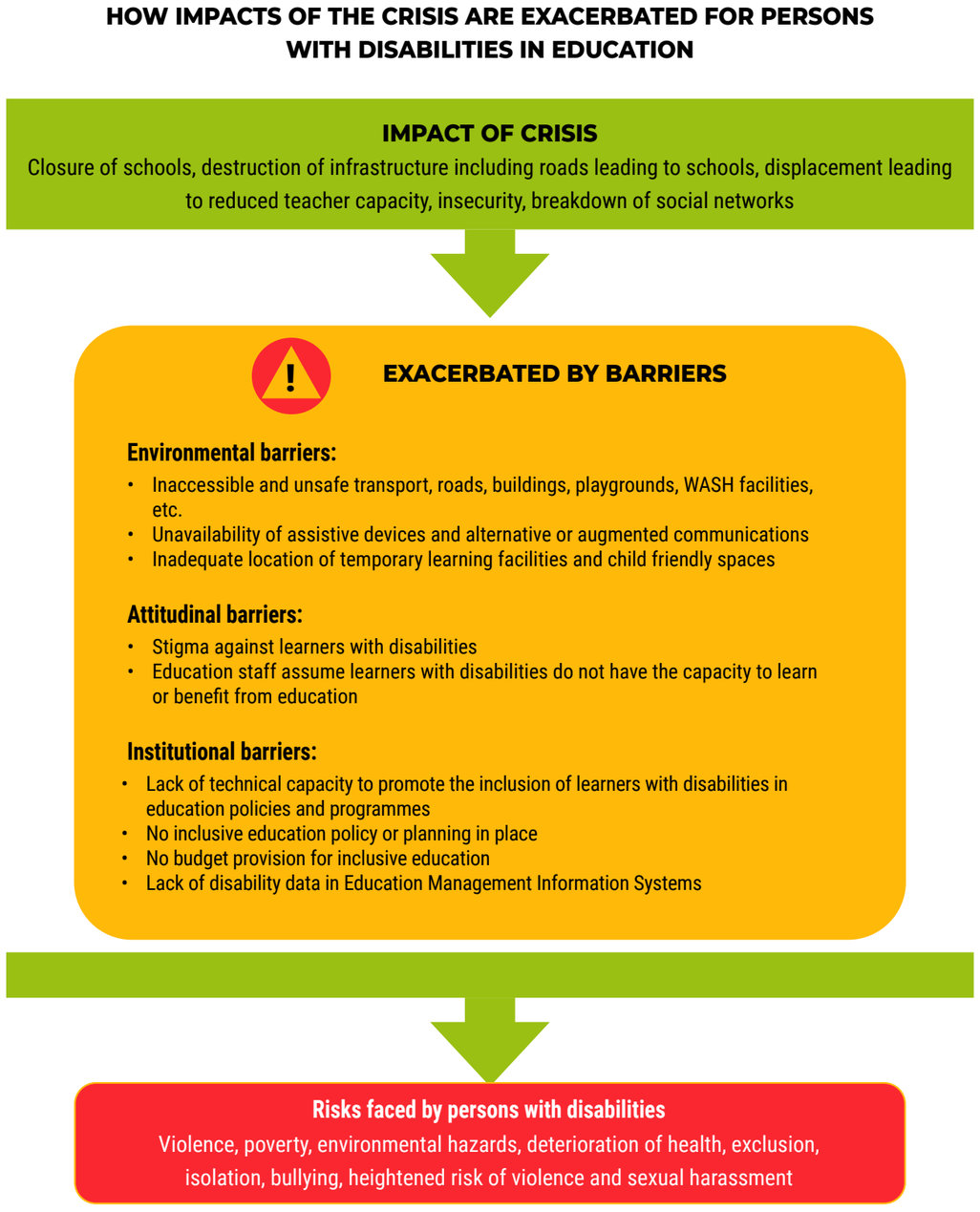
Barriers that keep learners with disabilities out of early childhood care and development, schools, colleges and universities are amplified during conflicts. Barriers may be environmental, attitudinal or institutional.

The term **intersectionality** recognizes the many elements of individual identity, such as gender, ethnicity, age, economic status and disability, and that these interact in ways that often compound advantage or disadvantage. Intersectionality can influence the degree to which a learner is marginalized or not included in emergency preparedness, response and recovery. It is also important to recognize that there is diversity within disability. Learners with disabilities or with difficulties in learning are not a homogeneous group. A boy with an intellectual disability or a physical disability will face different barriers and may possess different strengths to a boy who is deaf or blind. Persons with intellectual or psychosocial disabilities, particularly women and girls, can be the most marginalized during a humanitarian response.[120]

These and other factors, including location and remoteness, must be systematically identified and mitigated by applying strategies to ensure that education and lifelong learning in an emergency are inclusive.

[115] Inter-Agency Network for Education in Emergencies/INEE.
[116] UNICEF, *Inclusive Education - Including children with disabilities in quality learning: what needs to be done?* (2017).
[117] Handicap International, *Policy Paper on Inclusive Education* (2012) pp. 10–12.
[118] Save the Children, *Schools for all. Including disabled children in education* (2002), p. 10.
[119] INEE, *Minimum Standards for Education: Preparedness, Response, Recovery* (2010), p. 94.
[120] EENET, *The implications of ensuring equal access and inclusion of persons with intellectual disabilities and mental health issues in disaster risk reduction and humanitarian action, A rapid literature review* (2017).

Diagram 7 | Barriers to access and inclusion in education



Standards and guidelines

- Inter-Agency Network for Education in Emergencies, *Minimum Standards for Education: Preparedness, Response, Recovery* (2010)
- Help Age, CBM, Handicap International, *Humanitarian inclusion standards for older people and people with disabilities* – Education section (2018)
- UNHCR, Education Emergency Standard (Version 1.5)
- INEE, *Pocket Guide to Supporting Learners with Disabilities* (2010)
- INEE, *Education in Emergencies: Including Everyone* (2009, INEE pocket guide to inclusive education)
- UNHCR, Education in Emergencies

Key elements – must do

'Must do' actions must be undertaken in all phases of humanitarian action when implementing inclusive education programming for persons with disabilities.

Participation

- Ensure that persons with disabilities, children, their families, and organizations of persons with disabilities (OPDs) are involved and actively participate in decision-making, identifying barriers, planning, designing, implementing, monitoring and evaluating all policies and programmes that support access to education for learners with disabilities.
- Ensure that persons with disabilities are fairly represented, taking into account the various forms of disability as well as age, gender and diversity. Make concerted efforts to promote underrepresented groups, such as persons with intellectual and psychosocial disabilities, indigenous persons, women and girls in formal and informal mechanisms and processes.
- Develop partnerships with OPDs and other organizations working in education. Involve them in supporting teachers and learners with disabilities, providing personal assistance, and advocating for and supporting inclusive education.

Addressing barriers

- Identify and monitor barriers and solutions to education and learning, and support learners with disabilities to meet their requirements and psychosocial needs.
- To ensure that education is accessible to learners with disabilities, enable all students to enrol in mainstream courses and provide reasonable accommodation to meet their requirements by removing barriers to participation in physical and digital[121] environments. Include learning spaces and areas where children play, eat and congregate.[122]
- Encourage all service providers to apply universal design principles when they plan and build education and learning facilities.
- Ensure that all education assessment and reporting tools, as well as information and communications, are issued in multiple accessible formats, meeting the requirements of persons with hearing, visual, intellectual and psychosocial disabilities.
- Run public awareness campaigns to address stigma and discrimination and promote the rights of persons with disabilities.
- Review sectoral policies, guidelines and tools to ensure that they clearly affirm the right of persons with disabilities to access and inclusion.

[121] For more information on digital accessibility, see CBM, Digital Accessibility Toolkit (2018).

[122] See Annex 7 for a checklist on learning space accessibility. Article 9 of the CRPD, on accessibility, outlines the steps that States Parties should take to enable persons with disabilities to live independently and participate in all aspects of life.

Empowerment and capacity development

- Mainstream protection and safeguarding measures across education and learning activities. Inform learners with disabilities of protection and safeguarding measures and how to access them. Recognize the gendered dimension of some protection and safeguarding risks.
- Build the capacity of teachers and school personnel (including staff involved in transport, canteens, and other school-related services). Provide training on, and make them aware of, the principles of inclusive pedagogy and the rights of persons with disabilities.
- Build the capacity of OPDs to enable them to contribute to the design, delivery and monitoring of education programmes.
- Engage persons with disabilities and OPDs in all community mobilization and outreach activities.
- Ensure that inclusive education systems (including through international cooperation) are able to include and meet the requirements of persons with disabilities.

Data collection and monitoring

- Collect and analyse data on learners with disabilities, disaggregated by sex, age and disability. Do so systematically, across the humanitarian programme cycle, in education management information systems, national reporting databases and other systems. Where reliable data are not available or cannot be collected, use the 15 per cent estimate of global disability prevalence.[123]
- Map existing services, accessible education facilities, OPDs and key stakeholders, and where learners with disabilities reside.
- Together with OPDs and the community, identify groups or individuals with disabilities who may be out of school as well as those who require immediate support. Connect them to protection, health and other relevant services.
- Share information on the cross-sectoral needs of learners with disabilities in inter-agency coordination mechanisms (such as WASH, protection, health), and ensure cross-sectoral coordination.
- Ensure that data ethics and protection principles (including confidentiality, provision of information, informed consent, security) are respected whenever data on persons with disabilities are collected and used.[124]
- Review education standards and tools and make sure they recommend the collection of data on learners with disabilities, and their disaggregation by sex, age and disability.

These guidelines conform to the INEE Minimum Standards. These standards apply to emergencies, including natural and human-made disasters, to situations of conflict, and to slow and rapid onset crises, in both rural and urban environments. They affirm the rights, needs and dignity of people affected by disasters.

Education authorities and humanitarian organizations should adopt a twin-track approach to promote inclusive education in emergencies. Disability-specific interventions **targeted** to meet the requirements of learners with disabilities should complement **mainstream** interventions that benefit all learners.

[123] WHO and World Bank, *World Report on Disability* (2011).

[124] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

MAINSTREAMED

Education facilities and programmes are designed and adapted to ensure that they include and are accessible to everyone, including learners with disabilities. (For example, teachers are trained in inclusive pedagogy, the curriculum is learner-centred, etc.)

TARGETED

Education programmes are designed to accommodate the individual requirements of learners with disabilities. (For example, learning materials are accessible, assistive devices are provided, etc.)

The following guidance will support education actors to identify and address barriers faced by persons with disabilities, as well as their families, support persons and caregivers, when they access education programmes in humanitarian settings.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Together with OPDs, carry out assessments to identify and analyse the barriers that keep children, youths and adult learners with disabilities out of education opportunities. Do this in coordination with other sectors (such as child protection, MHPSS and WASH) in order to promote coordinated programming and avoid assessment fatigue.		X	
Adapt the Global Education Cluster's Joint Education Needs Assessment Toolkit to: (1) prevent the exclusion of students with disabilities from mainstream settings; (2) ensure that reasonable accommodations are made when needed; (3) clarify the impacts of a crisis both on learners with disabilities and the education system. Identify capacity gaps and gaps in the provision of disability-inclusive education.	X		
Plan actions to strengthen inclusive education systems. (For practical ideas and resources refer to INEE, *Pocket Guide to Learners with Disabilities*.)	X	X	
Consult a wide range of data sources to analyse capacities and gaps in inclusive education.	X		
Establish a referral mechanism for providing students with disabilities, and their families, with specific forms of assistance. Include cash support, prosthetic devices, protection services, etc.	X	X	X
2. Resource mobilization			
Identify and mobilize local resources (accessible transport, community-based programmes, other forms of assistance) to increase access to inclusive education.	X	X	
Secure financing and prepare an inclusive budget that allocates resources for accessibility and inclusion.		X	X
Ensure inclusive education is included in all funding appeals. Ensure funding appeals allocate resources for accessible infrastructures and assistive devices, and for making reasonable accommodations.		X	X
3. Implementation			
With OPDs, develop response strategies that remove specific barriers to inclusive education faced by learners with disabilities.		X	
Build the capacity and awareness of education staff (including teachers, school drivers and canteen staff) on inclusive education and use (and monitoring use) of assistive devices. Set up maintenance schedules.	X	X	
Make communities aware of the importance of inclusive education and the need to fight stigma and discrimination.	X	X	X
Develop learning materials that are comprehensive, culturally appropriate and include all learners.	X	X	X
Make sure that engineers and architects adopt a universal design approach when they build schools and other amenities.	X	X	X
4. Coordination			
Include OPDs in cluster and inter-agency coordination mechanisms.	X	X	X
Create referral pathways that connect persons with disabilities with specialized services (such as screening, identification and speech therapy), in order to promote inclusive education and identify students who need specific support.	X		
Work with cash transfer programmes to remove financial barriers (such as the cost of transport or assistive devices) that prevent households which include children with disabilities from accessing educational opportunities. Work with livelihoods programmes to make sure that households which include children with disabilities can cover such costs in the long term.		X	X
Coordinate with nutrition actors to provide accessible information on nutrition. Intervene together to support good feeding practices for children with disabilities. Help to establish mechanisms that can provide such support to children with disabilities who are out of school or receive home-based education.		X	X

	Preparedness	Response	Recovery
5. Monitoring and evaluation			
Collect baseline data on school enrolment for children with disabilities to facilitate monitoring at programme and national level. Advocate through good practice for the integration of the UNICEF-Washington Group Child Functioning Module in the national Education Management Information System.	X	X	
Monitor the performance of protection and safeguarding measures for learners with disabilities.		X	X
Include learners with disabilities, their parents, and OPDs in monitoring and evaluating educational activities. Ensure that the findings of such exercises are shared and discussed.		X	X
Develop a knowledge management system to share learning and good practices on inclusive education. Establish inter-school support systems to strengthen their capacity.	X	X	X

Tools and resources

- Committee on the CRPD, General Comment 4 on Article 24, the right to education (2016)
- INEE, *Pocket Guide to Supporting Learners with Disabilities* (2010)
- INEE, *Pocket Guide to Inclusive Education* (2009)
- INEE, *Guidance Note on Psycho-social Support and Social Emotional Learning* (2018)
- INEE, Inclusive Education
- INEE, Teachers in Crisis Contexts – Training for Primary School Teachers
- Inter-Agency Working Group on Accelerated Education
- Kett, M., Risk, resilience and inclusive humanitarian action, in UNICEF, *State of the World's Children* (2013)
- Saebones, A. M., et al., *Towards a Disability Inclusive Education: Background paper for the Oslo Summit* (2015)
- UNICEF, *Including children with disabilities in humanitarian action: Education guidance* (2018)
- UNHCR, Education in Emergencies Guidance
- UNICEF, *Early Childhood Development in Emergencies: Integrated Programme Guide* (2014)
- UNICEF, Early Childhood Development in Humanitarian Action
- UNICEF and The Washington Group on Disability Statistics, Module on Inclusive Education (forthcoming)

13 Food security and nutrition

See also WASH, Health and Education.

Introduction

Every human being has the right to adequate food and to be free from hunger. This right is recognized in various international legal instruments, including international humanitarian law (IHL), which governs situations of armed conflict.

Disability is linked to food security and nutrition in many ways. In particular, disability can adversely affect household food security and nutrition. Research has shown that households that include persons with disabilities are more likely to experience food insecurity, because they possess fewer economic resources and fewer work opportunities, require more health services, and spend extra time on care work. When the person with disabilities heads the household and is its primary income earner, the chances of falling into food insecurity are generally higher. Malnutrition rates may also be higher among persons with disabilities when they have difficulty eating and swallowing, are frequently ill, or are neglected.[125] It is important to remember that slow and rapid onset emergencies can have significantly different effects, not least on the food insecurity of persons with disabilities.

Key legal instruments and other frameworks

- Convention on the Rights of Persons with Disabilities
- Sustainable Development Goal 2
- Convention on the Rights of the Child
- Convention on the Rights of Women

Key terms

Cash-based transfer and **cash-based intervention** are used interchangeably to refer to all programmes that provide cash or vouchers to beneficiaries to enable them to purchase goods or services directly. In humanitarian contexts, the terms refer to cash or vouchers allocated to individuals, households or community recipients; they do not include financial allocations to governments and other State actors.[126]

Food access means that individuals of different ages and gender, from diverse backgrounds, are able regularly to acquire sufficient quantities of appropriate foods to provide a nutritious diet, through purchase, home production, barter, gifts, borrowing, or food aid

[125] Children with disabilities may require more time and help to eat if they find it hard to suckle, hold spoons, sit upright, etc. Nora Groce, Eleanor Challenger, Marko Kerac, *Stronger Together: Nutrition-Disability Links and Synergies*, Briefing Note, UNICEF; and UNICEF (2017), *Including children with disabilities in humanitarian action. Nutrition* (2011), p. 13.

[126] Adapted from Cash Learning Partnership, *Cash Transfers Glossary*.

(SDG Target 2.1). Persons with disabilities may not have access to a reliable food supply or a well-balanced diet.

Food availability refers to the presence, consistently, of sufficient quantities of food to meet the needs of a given area. It may be achieved through domestic production or imported food aid.

Food consistency refers to the density, firmness or viscosity of food that is provided to children and adults, including older persons who find eating difficult. The consistency of a food determines how easy or difficult that food is to chew and swallow. The main categories of food consistency are unmodified regular foods, soft foods (such as banana), minced and moist foods, and blended foods.[127]

Food security is achieved when a population has physical, social and economic access to sufficient, safe and nutritious food to meets its food preferences and dietary needs for an active and healthy life (SDG Targets 2.3, 2.4).[128]

Food stability refers to both the availability and access dimensions of food security; it highlights the need of a population to be food secure over time.

Food utilization refers to the nutritional effects of processing, cooking and consuming foods. It covers cooking, storage and hygiene practices, individuals' health, water and sanitation, and the feeding and sharing practices of households.[129]

Food assistance for training/assets describes initiatives that aim to meet the immediate food needs of an affected population through cash, voucher or food transfers, while building or rehabilitating assets that improve long-term food security and resilience.[130]

In-kind assistance refers to the direct provision of goods (food) or services to beneficiaries. In-kind assistance remains an important solution in crisis situations.

Livelihood refers to the means by which an individual secures the necessities of life. It covers a wide range of different forms of work, which may be remunerated in kind (for example, food-for-work), in cash or as a salary.

Malnutrition is a physiological condition caused by inadequate, unbalanced or excessive consumption of macro- and/or micro-nutrients. Expressions of malnutrition include undernutrition, overnutrition and micro-nutrient deficiency.[131]

Nutritional status[132] is the physiological state of an individual that results from the relationship between nutrient intake and requirements and the body's ability to digest, absorb and use those nutrients.

Standards and guidelines

- Handicap International, CBM, HelpAge International, *Humanitarian inclusion standards for older people and people with disabilities* (2018). See the section on food, nutrition and livelihoods
- *Sphere Handbook* (2018). See the section on food security and nutrition
- Livestock Emergency Guidelines and Standards
- The Minimum Economic Recovery Standards (2017)
- Cash Learning Partnership, Minimum Standard for Market Analysis MISMA (2018)

[127] UNICEF, *Including children with disabilities in humanitarian action. Nutrition* (2017), p. 108.

[128] Adapted from IFAD, WFP, FAO, *The State of Food Insecurity in the World: The multiple dimensions of food security* (2013), p. 50.

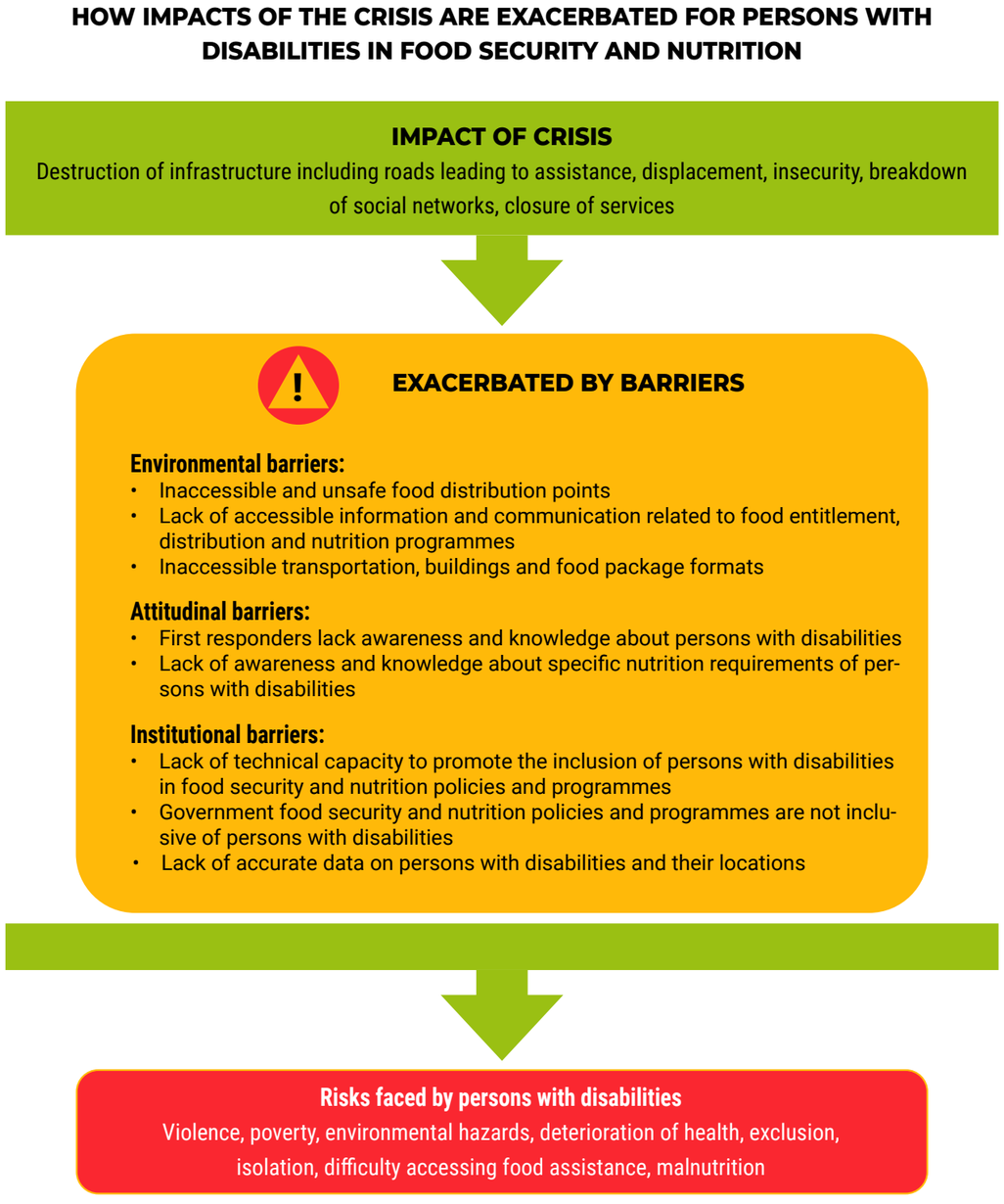
[129] For the WFP definition of food access, availability and utilization, see *Emergency Food Security Assessment Handbook (EFSA) – 2nd edition* (2009).

[130] WFP, *Food Assistance for Assets*.

[131] IFAD, WFP, FAO, *The State of Food Insecurity in the World: The multiple dimensions of food security* (2013), p. 50.

[132] No guidelines currently exist for measuring the nutritional status of persons with disabilities. Traditional methods, such as MUAC (mid-upper arm circumference), can be used, but these methods may be misleading, for example if people with disabilities have built up their upper-arm muscles to aid mobility. Source: *Humanitarian inclusion standards for older people and people with disabilities*.

Diagram 8 | Barriers to access and inclusion in food security and nutrition



Key elements – must do

'Must do' actions must be undertaken in all phases of humanitarian action when implementing inclusive food and nutrition programming for persons with disabilities.

Participation

- Ensure that persons with disabilities, their families, and OPDs are actively involved in identifying barriers, and in planning, designing, implementing, monitoring and evaluating food security and nutrition policies and programmes. Consider a wide range of issues, including appropriate locations, time, frequency, distribution and assistance arrangements.
- Ensure that persons with disabilities are fairly represented, taking into account the full range of disabilities as well as age, gender and diversity. Make concerted efforts to encourage the participation of underrepresented groups, including persons with intellectual and psychosocial disabilities, indigenous persons, women and girls in formal and informal mechanisms and processes that address food security and nutrition.
- Recognize that, with adequate nutrition, persons with disabilities have the capacity to participate in activities and in society on an equal basis with others.

Addressing barriers

- Identify and monitor barriers and solutions that impede the ability of persons with disabilities to access food security and nutrition programming and services. Provide reasonable accommodations to promote full inclusion.
- Make available all assessment and reporting tools, and information related to food security and nutrition, in multiple accessible formats. Consider the requirements of persons with hearing, visual, intellectual and psychosocial disabilities.
- Implement strategies to reduce disability-related stigma. Raise awareness in the community about the rights of persons with disabilities. Establish peer-support groups that include persons with psychosocial and intellectual disabilities.
- Review sectoral policies, guidelines and tools to ensure that they clearly affirm the right of persons with disabilities to access and inclusion.

Empowerment and capacity development

- Mainstream protection and safeguarding measures in all food security and nutrition programming. Inform persons with disabilities of these measures and how to access them. Recognize the gendered dimension of some protection and safeguarding risks.
- Build the capacity of OPDs to enable them to participate actively in all phases of food security and nutrition programming, including design, implementation and monitoring. Enable them to represent the interests of persons with disabilities in coordination structures and mechanisms.
- Strengthen the capacity of food security actors to understand the risks and obstacles faced by persons with disabilities and how to remove them in compliance with humanitarian principles.
- Make food security actors aware of the rights of persons with disabilities, and the interactions between disability and age, gender, migration status, religion and sexuality.

Data collection and monitoring

- Collect and analyse food security and nutrition data on persons with disabilities, disaggregated by sex, age and disability. Do so systematically in all phases of the humanitarian programme cycle. Where reliable data are not available or cannot be collected, use the 15 per cent estimate of global disability prevalence.[133]
- Share information on the cross-sectoral needs of persons with disabilities in inter-agency coordination mechanisms (WASH, protection, health) and ensure cross-sectoral coordination.
- Ensure that data ethics and protection principles (including confidentiality, provision of information, informed consent, security) are respected whenever data on persons with disabilities are collected and used.[134]

MAINSTREAMED

Food and nutrition distributions and programmes are designed and adapted to ensure they include and are accessible to everyone, including persons with disabilities.

TARGETED

Food and nutrition programmes accommodate the individual requirements of persons with disabilities, with respect to outreach, infrastructure, communications, food rations, packaging, and assistive devices relevant to food and nutrition.

The following guidance will support food and nutrition actors to identify and remove barriers faced by persons with disabilities, as well as their families, support persons and caregivers, when they try to access food and nutrition programmes in humanitarian settings.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Identify key information on the situations of persons with disabilities, including whether government food security and nutrition policies and programmes are inclusive. Analyse risks and barriers that impede persons with disabilities from accessing food security and nutrition.	X		

[133] WHO and World Bank, *World Report on Disability* (2011).

[134] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

	Preparedness	Response	Recovery
Map information and resources on food and nutrition that are relevant to persons with disabilities (expertise, markets, accessibility of services) at community, district and national level. Use this information when planning.	X		
When conducting food security and nutrition assessments, involve persons with disabilities in affected communities.		X	
Conduct targeted assessments of the food security and nutrition requirements of persons with disabilities. Focus on children, pregnant and lactating women, and older persons with disabilities. Consider assisted eating and dietary requirements, and the nutritional quality of foods, including processed foods (proteins and other nutrients). Identify the types of food required (such as liquid foods) and adapt the size and format of food packages accordingly.	X	X	
Include questions on the capacities and requirements of persons with disabilities in mainstream assessment processes and tools. Consider nutritional status, barriers to and enablers of food security, nutrition, livelihood activities, facilities, and related information.[135]	X	X	
2. Resource mobilization			
Encourage humanitarian actors to mobilize adequate resources for food security and nutrition. Resources should be reliably available during emergency preparedness and throughout the response and should be accessible to persons with disabilities.	X		
Allocate and mobilize resources for inclusive food security and nutrition interventions that are accessible to and target persons with disabilities. Set up coordination arrangements. Allocate sufficient resources in the budget to cover accessibility and inclusion costs.		X	X
3. Implementation			
Make community members aware of how important it is to adopt a disability-inclusive approach to food security and nutrition, during emergency preparedness, contingency planning, response and recovery.	X	X	
Prepare a contingency plan that sets out the initial response strategy and the operational plan to meet urgent food and nutrition needs during the first three to four weeks of an emergency; ensure it includes persons with disabilities and covers transport and food rations.	X		
Involve OPDs and other actors who work with persons with disabilities in designing and delivering an inclusive food security and nutrition assessment. Identify barriers to delivering the assessment and to implementing interventions.		X	
Assess the capacity of staff with respect to disability inclusion. Provide training to staff and partners, including emergency managers and first responders. Trainings should explain the rights and requirements of persons with disabilities and make clear that disability needs to be integrated in food security and nutrition-related preparedness plans.[136]	X		
Find ways to reach marginalized and isolated affected populations, including persons who have psychosocial disabilities, who are not mobile, or who face other barriers. Consider outreach and community-based distribution processes both to prepare and deliver food.		X	X
Partner with relevant actors to design an inclusive food security and nutrition programme and to advocate for an inclusive approach to sectoral and cross-sectoral activities.	X	X	
Develop a community approach. Identify staff who will support persons with disabilities to access food rations (on site and via outreach). Provide reasonable accommodations; include assistance with transport, and childcare for parents of children with disabilities and for parents with disabilities.	X	X	
Ensure that vendors, other distribution points and markets, and nutrition services and other facilities, meet the 'Reach, Enter, Circulate and Use' criteria of accessibility.		X	
Train relevant local and national staff on good nutrition practices for persons with disabilities.			X
Work with national systems that have responsibility for food security and nutrition, including social protection systems, to put in place arrangements for supporting persons with disabilities after the emergency ends. Establish clear referral mechanisms for persons with disabilities who require food security and nutrition-related support.			X

[135] Having a disability does not automatically imply food insecurity or malnutrition, or additional needs. How persons with disabilities experience emergencies can differ greatly; assessment and targeting must be sensitive to this.

[136] When organizing trainings, make use of the resources available. For example, specialists can provide expertise on data collection, information, support services, etc. The International Disability and Development Consortium lists NGOs and organizations in a number of countries who can provide support.

	Preparedness	Response	Recovery
Advise government counterparts and other national stakeholders on how to integrate disability-inclusive practices in relevant national food security and nutrition programmes and trainings.			X
Advise on accessibility compliance during the construction, reconstruction and repair of nutrition-related infrastructure. Include sites that deliver nutrition and food security-related services.			X
4. Coordination			
Promote knowledge and skills on disability. Include disability in the terms of reference of food security and nutrition-related emergency rosters and other surge capacity mechanisms. Do so at all levels.	X		
Work with communication colleagues, disability experts and OPDs to develop inclusive community-based approaches and accessible information on food security and nutrition.		X	
In consultation with OPDs and relevant health and nutrition actors, adapt the food basket to meet the nutritional and eating needs of persons with disabilities who find it difficult to eat, chew or swallow, or have specific dietary requirements.		X	
At sectoral level, work with relevant sectors to create referral pathways to meet the food security and nutrition needs of persons with disabilities.		X	
Work with national actors, including ministries and service providers, to make persons with disabilities more resilient with respect to food security and nutrition. Strengthen food security and nutrition policies and laws; ensure they include persons with disabilities.			X
5. Monitoring and evaluation			
Ensure feedback and complaint mechanisms are accessible and include persons with disabilities.		X	
Include persons with disabilities in monitoring and evaluation teams.		X	
Identify or develop disability-specific indicators to monitor the food security and nutritional status of persons with disabilities.		X	
Assess the degree to which food security and nutrition interventions and facilities are accessible to persons with disabilities. Include temporary ones. Take steps to make all interventions and facilities accessible.		X	

	Preparedness	Response	Recovery
Document and report progress towards meeting the food security and nutrition needs of persons with disabilities. Describe progress in cross-sectoral monitoring and reporting (situation reports and dashboards).		X	
List 'inclusion of persons with disabilities' among the criteria for evaluations of food security and nutrition programmes and activities.		X	
Systematically ensure that food security and nutrition interventions are accountable to persons with disabilities by making information accessible, establishing complaint and feedback mechanisms, and involving persons with disabilities in decision-making and planning processes.		X	
Document lessons learned with respect to the inclusion of persons with disabilities in food security and nutrition interventions.			X

Tools and resources

- Cash Learning Partnership and Handicap International, *As the movement for cash transfer programming advances, how can we ensure that people with disabilities are not left behind in cash transfer programming for emergencies?* (2016)
- Cash Learning Partnership, *Minimum Standard for Market Analysis* (2017)
- Handicap International, *Disability in humanitarian context. Views from affected people and field organisations* (2015)
- Help Age, CBM, Handicap International, *Humanitarian inclusion standards for older people and people with disabilities* (2018) (part of the ADCAP programme)
- Sphere Project, 'Minimum Standards in Food Security and Nutrition' in *Sphere Handbook* (2018)
- UNICEF, *Including children with disabilities in humanitarian action: Nutrition* (2017)
- United Nations, *Charter on the Inclusion of Persons with Disabilities in Humanitarian Action* (2016)
- United Nations, Convention on the Rights of Persons with Disabilities and Optional Protocol (2008)
- WFP, *Guide to Inclusion of Persons with Disabilities in Food Assistance* (forthcoming)
- WHO, *Guidance Note on Disability and Emergency Risk Management for Health* (2013)

14 Livelihoods

Introduction

In a disaster or conflict, loss of livelihood is one of the biggest impacts that a household can experience. It affects people's ability to survive. In addition, assets and resources may be destroyed or become inaccessible, and household support networks are often disrupted. Livelihood programming assists people to meet their basic needs and achieve self-reliance by helping them to recover and acquire (or reacquire) access to resources and assets that will enable them to safely and sustainably secure a living.

International human rights law affirms that every person has the right to work, to freely choose their employment and to be protected from unemployment. However, persons of working age with disabilities have very high unemployment rates in both developing and industrialized countries. In developing economies, unemployment is as high as 80–90 per cent.[137] A number of factors explain this, including employer bias, the absence of accessible workplaces, and poor access to information and finance. The fact that the abilities of persons with disabilities are widely unrecognized, often by their families as well, is also a contributing factor.

Key legal instruments and other frameworks

- Convention on the Rights of Persons with Disabilities
- Sustainable Development Goal 1
- Sustainable Livelihoods Framework
- Global Compact on Refugees

Key terms

Livelihood refers to all activities, entitlements and assets by which people make a living. Livelihoods are the means by which human beings make a living and satisfy their daily needs.

The term **sustainable livelihoods** refers to the capacity of persons to generate and maintain a living and enhance their own well-being and that of future generations. A livelihood is **sustainable** when it is market-based, can cope with and recover from shocks and economic stress, and can maintain its capabilities and assets without undermining the natural environment.

The terms **cash-based transfer** and **cash-based intervention** are used interchangeably to refer to programmes that provide cash or vouchers to beneficiaries to enable them to purchase goods or services directly. In humanitarian contexts, they refer to cash or vouchers given to individuals, households or community recipients; they do not include allocations to governments or other State actors.[138]

[137] UN, Disability and Employment Fact sheet 1.

[138] Adapted from Cash Learning Partnership, *Cash Transfers Glossary*.

In-kind assistance is the direct provision of goods (food) or services to beneficiaries of assistance. In-kind assistance remains an important solution in crisis situations.

Coping strategies are actions to which people resort when times are hard. They enable people to continue to meet their basic needs during a crisis. They may be reversible (for example, short-term reductions in food consumed, use of savings), or negative and harder to reverse (for example, sale of productive assets, resort to degrading or criminal activities).

Standards and guidelines

- Help Age, CBM, Handicap International, *Humanitarian inclusion standards for older people and people with disabilities* (2018). See the section on food, nutrition and livelihoods.
- *Sphere Handbook* (2018). See the section on food security and nutrition.
- *Livestock Emergency Guidelines and Standards*.
- *Minimum Economic Recovery Standards* (2017).
- Cash Learning Partnership, *Minimum Standard for Market Analysis (MISMA)* (2018).

Key elements – must do

'Must do' actions must be undertaken in all phases of humanitarian action when implementing livelihood programming for persons with disabilities.

Participation

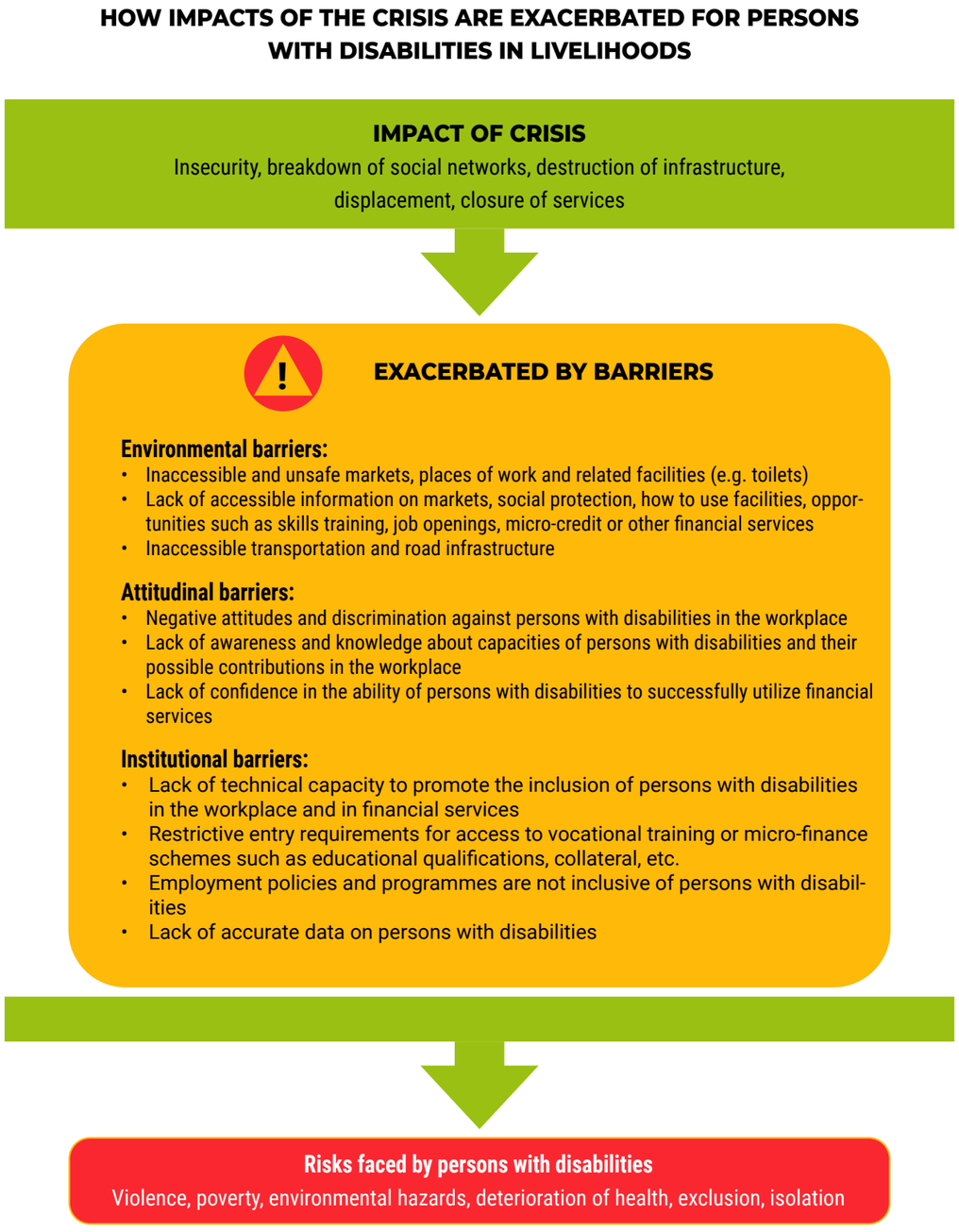
- Ensure that persons with disabilities, their families, and organizations of persons with disabilities (OPDs), are actively involved in identifying barriers, and in planning, designing, implementing, monitoring and evaluating livelihood and economic inclusion policies and programmes. Include access to markets and services, the length of trainings and their arrangements, the frequency and arrangements for assistance, and decision-making.
- Ensure that persons with disabilities are fairly represented, taking account of the range of disabilities, as well as sex, age and diversity. Make concerted efforts to promote the involvement of underrepresented groups, including persons with intellectual and psychosocial disabilities, indigenous persons, women and girls in formal and informal mechanisms and processes.

Develop partnerships with OPDs and other organizations working on livelihoods. Involve them in supporting persons with disabilities and advocating for and promoting inclusive forms of assistance and services.

Addressing barriers

- Identify and monitor barriers and take steps to remove them, to ensure that livelihood and economic inclusion programmes are accessible to persons with disabilities. Provide reasonable accommodations and reach out to persons with disabilities to facilitate their full inclusion.
- Work with training and apprenticeship service providers, business development and financial service providers, potential employers, and apprenticeship providers to include persons with disabilities and ensure that all premises are accessible.
- Ensure that information on assessment and reporting tools, and programmes (including targeting criteria, duration, assistance arrangements, etc.), is made available in multiple accessible formats that take into account the requirements of persons with hearing, visual, intellectual and psychosocial disabilities.
- Implement strategies to reduce stigma about disability. Take steps to make the community aware of the rights of persons with disabilities.

Diagram 9 | Barriers to access and inclusion in livelihoods



Establish peer-support groups and encourage persons with psychosocial and intellectual disabilities to become advocates themselves.

- Review sectoral policies, guidelines and tools to ensure that they clearly affirm the right of persons with disabilities to access and inclusion.

Empowerment and capacity development

- Mainstream protection and safeguarding measures across livelihood and economic inclusion programming. Inform persons with disabilities about these measures and how they can access them. Recognize the gendered dimension of some protection and safeguarding risks.
- Build the capacity of livelihood stakeholders. Provide training on the rights of persons with disabilities, including the interactions between disability and gender, age, migration status, religion and sexuality.
- Strengthen the capacity of livelihood stakeholders to understand the risks and obstacles faced by persons with disabilities and how to remove them in compliance with humanitarian principles.
- Build the capacity of OPDs to enable them to contribute to the design, delivery and monitoring of livelihood programmes, and represent disability constituencies in coordination structures and mechanisms.

Data collection and monitoring

- Ensure that all persons with disabilities in target communities are identified.
- Collect and analyse livelihood data on persons with disabilities, disaggregated by sex, age and disability. Do so systematically across the humanitarian programme cycle. Where reliable data are not available or cannot be collected, use the 15 per cent estimate of global disability prevalence.[139]
- Share information on the cross-sectoral requirements of persons with disabilities in inter-agency coordination mechanisms (WASH, protection, health) and ensure cross-sectoral coordination.
- Ensure that data ethics and protection principles (including confidentiality, provision of information, informed consent, security) are respected whenever data on persons with disabilities are collected and used.[140]

MAINSTREAMED

Livelihood-related facilities and programmes are designed and adapted to ensure they are inclusive of and accessible to everyone, including persons with disabilities.

TARGETED

Livelihood programmes accommodate the individual requirements of persons with disabilities, with respect to infrastructures, communications, tools, assets and training (e.g. providing assistive technology, modified workspaces based on individual requirements, etc.)

[139] WHO and World Bank, *World Report on Disability* (2011).

[140] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

The following guidance will support livelihood actors to identify and remove barriers faced by persons with disabilities, as well as their families, support persons and caregivers, when they try to access livelihood programmes in humanitarian settings.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Assess the accessibility of skills training, apprenticeships and financial service providers, and markets and market-related information, for persons with different types of disability.		X	X
Identify OPDs who might help identify, access and support persons with disabilities.	X	X	X
Identify and analyse risks related to livelihoods for persons with different types of disability and plan risk mitigation measures.	X	X	X
Assess the psychosocial requirements and literacy and numeracy of persons with disabilities, in order to support those who have not had a livelihood or access to education.		X	X
Identify referral services that are available in the target area. Include psychosocial support, physical rehabilitation, prosthetics, orthotics, etc.		X	X
Ensure that livelihood targeting criteria adequately address differences in the character and severity of disabilities.		X	X
Provide training on inclusive livelihoods for INGO staff and other stakeholders. Include vocational trainers, farmers' associations, women's groups, business persons, local councils, private companies, third-party monitors, etc.	X		X
2. Resource mobilization			
Hire persons with disabilities to join the project team. As role models, they may encourage others with a disability to participate in the programme.	X	X	X
Mobilize resources; apply them to prepare adaptive tools, make infrastructure accessible, organize additional trainings (for example on literacy and numeracy), and provide transport and other technical support (physical rehabilitation, assistive devices).	X	X	X

	Preparedness	Response	Recovery
3. Implementation			
To address negative perceptions, make the community more aware of the capacities of persons with disabilities and the contributions that they make to the community.		X	X
Inform the families of persons with disabilities of the rights and capacities of persons with disabilities, including their right and capacity to work.	X	X	X
Persuade and encourage employers, local leaders and government bodies to respect the rights of persons with disabilities, including their right to have full access to livelihoods.	X	X	X
Make sure that humanitarian actors understand that persons with disabilities are individuals with a variety of experience, knowledge and capacities. Make sure they are not stereotyped or placed in stereotypical roles. For instance, a woman with a hearing impairment may be able to do physically demanding work.	X	X	X
Work with financial service providers; assist them to adapt their products to the requirements of persons with disabilities.		X	X
Assist vocational or business skills training centres to make the curricula and courses they offer accessible to persons with different types of disability.		X	X
In workplaces, provide tools that have been adapted for use by persons with disabilities.	X		X
Consider adapting community infrastructures (such as markets and training institutes) to make them more accessible.		X	X
Teach project staff how to interact with and support persons with various types of disability.		X	X
Develop outreach and community-based processes that can identify and connect with persons with disabilities who are not 'visible'.	X		
Cooperate with OPDs and other actors that support persons with disabilities to design and deliver inclusive livelihood and economic security assessments. These should identify barriers to the delivery of assessments as well as barriers to the implementation of programmes.	X	X	

	Preparedness	Response	Recovery
4. Coordination			
Assign an inclusion expert to the Food Security and Livelihoods Cluster. He or she should assist sector partners to mainstream inclusion and support referrals across relevant sectors.	X	X	
5. Monitoring and evaluation			
Involve OPDs and persons with disabilities in monitoring humanitarian and protection indicators. Indicators should be disaggregated by sex, age and disability.		X	
Ensure that beneficiary feedback mechanisms are accessible and include persons with various types of disability.		X	
Systematically ensure that livelihood programmes are accountable to persons with disabilities. Information, dissemination modalities, and complaint and feedback mechanisms should be accessible. Persons with disabilities should be able to participate in decision-making and planning processes.		X	X
Identify good practices and initiatives that have successfully promoted the inclusion of persons with disabilities. Document and disseminate these.			X

Tools and resources

- Cash Learning Partnership, *Minimum Standard for Market Analysis*
- EMMA, *Emergency Market Mapping and Analysis (EMMA) Toolkit*
- Livelihood Centre
- SEEP, *Minimum Economic Recovery Standards*
- *Sphere Handbook* (2018)
- USAID, *Cohort livelihoods and risk analysis guidance*
- FAO Regional Office for Asia and the Pacific, *A handbook for training of disabled on rural enterprise development* (2003)
- ILO and FAO, *Guidance on how to address decent rural employment in FAO country activities: Second Edition* (2010)

15 Health

See also WASH, Food security and nutrition, Education and Protection.

Introduction

By their nature, humanitarian disasters and conflicts harm health systems and the health of people whom they affect. Apart from the direct effects of injuries and trauma, they exacerbate public health concerns (including the incidence of malaria, cholera, malnutrition, non-communicable diseases, and problems of sexual and reproductive health) because they disrupt social protection systems as well as essential health services. For persons with disabilities, many of whom access education and shelter and other services on referral from health services, crises and disasters disrupt their access to care, worsening the position of those who are already excluded or marginalized.

Persons with disabilities have the right to access all mainstream health services and to receive information about their health conditions and treatment. They also have the right to make decisions about treatment (informed consent). Many medical staff hold misperceptions about the capacity and requirements of persons with disabilities. They often assume they need disability-related services alone; or they permit family members, medical staff or other proxies to give consent on their behalf.

The absence of health services or their disruption can have grave consequences for persons with disabilities. For example, if it is perceived that women with disabilities are asexual, they may be excluded from sexual and reproductive health services, putting them at higher risk of unwanted pregnancy or sexually transmitted infections. If children with disabilities are not appropriately identified, they may not receive child development interventions and may fail to reach their potential.

Key legal instruments and other frameworks

- Convention on the Rights of Persons with Disabilities
- Convention on the Rights of the Child
- WHO, Emergency Response Framework
- Reproductive Health Sub-working Group of the ISDR/WHO Thematic Platform for Disaster Risk Management for Health, Policy Brief: Integrating Sexual and Reproductive Health into Health Emergency and Disaster Risk Management
- Sendai Framework for Disaster Risk Reduction 2015-2030

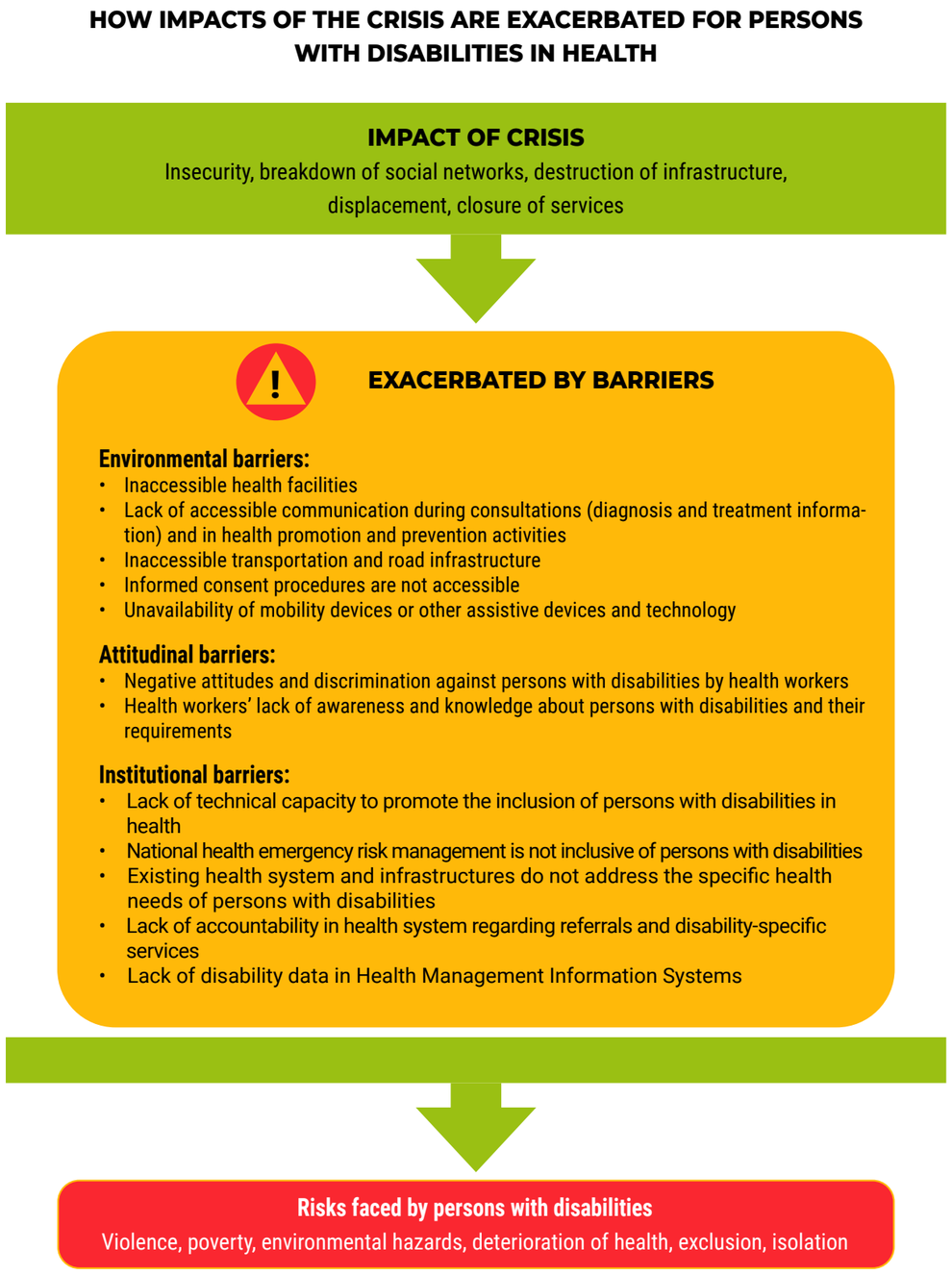
Key terms

A **health system** is composed of all organizations, people and actions whose primary interest is to promote, restore or maintain health.[141] It focuses on ways to influence the factors that determine health and promotes activities that directly improve health. To this end, it delivers preventive, promotive, curative and rehabilitative interventions through State and non-State actors and services.[142]

[141] WHO – Western Pacific Region, The WHO health system framework (2018).

[142] WHO, *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies* (2010).

Diagram 10 | Barriers to access and inclusion in health[143]



[143] For a list of barriers specific to health care, see WHO, Factsheet on disability and health.

Standards and guidelines

- Inter-Agency Standing Committee, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007)
- WHO, *Emergency medical teams: minimum technical standards and recommendations for rehabilitation* (2016)
- WHO, *Guidance Note on Disability and Emergency Risk Management for Health* (2018)
- *Sphere Handbook* (2018)[144]
- WHO, *Community-Based Rehabilitation Guidelines*
- HelpAge International, CBM, and Handicap International, *Humanitarian inclusion standards for older people and people with disabilities* (2018)

Key elements – must do

'Must do' actions must be undertaken in all phases of humanitarian action when implementing health programming for persons with disabilities.

Participation

- Ensure that persons with disabilities, family members, and organizations of persons with disabilities (OPDs) actively participate in decision-making and in designing, implementing, monitoring and evaluating health programmes.
- In cooperation with persons with disabilities and OPDs, make health workers aware of the rights of persons with disabilities, including the intersection of disability with gender, age, migration status, religion and sexuality.

Addressing barriers

- Implement strategies to reduce stigma about disability. Make the community aware of disability. Establish peer-support groups that include persons with psychosocial and intellectual disabilities.
- To increase mutual understanding, counter misconceptions and myths, and foster cooperation, encourage persons with disabilities and health staff to dialogue, exchange ideas and share their knowledge.
- Make health facilities accessible to persons with disabilities. Promote initiatives to transport persons with disabilities to health facilities, widen entrances, improve signage, and generally facilitate movement.
- Communicate information on health in multiple accessible formats, taking into account the requirements of persons with hearing, visual, intellectual or psychosocial disabilities.
- Address socioeconomic barriers to health, such as lack of education and low income.

Empowerment and capacity development

- Strengthen OPDs' health programming capacity. Enable them to participate in designing, implementing and monitoring health services.
- Involve OPD staff, self-advocates with intellectual and psychosocial disabilities, mental health service users, family members, and caregivers in trainings for health professionals on disability.
- Adopt informed consent procedures for medical and surgical decisions and data sharing (including referrals) to enable persons with disabilities to make decisions for themselves.

[144] The Sphere Project, *Humanitarian Charter and Minimum Standards in Humanitarian Response* (2011).

Data collection and monitoring

- Determine what data are available on the number of persons with disabilities. Assess the data's accuracy and identify gaps. Where data are not available, use the 15 per cent global estimate.[145]
- Run health assessments, surveys and surveillance tools to collect data on the health of persons with disabilities. Do so consistently, through all phases of the crisis. Disaggregate the data by sex, age and disability.
- Create clear referral systems across different services. Document and monitor their performance.
- Run an intersectional analysis to understand power imbalances based on gender, age and disability and how intersectionality affects access to financial resources, mobility and decision-making.

Delivery of quality health services

To be excellent, health services must provide equitable access to essential medical products and technologies of assured quality; must be safe, efficient and cost-effective; and must be scientifically sound. In humanitarian settings, all persons should have access to excellent health services, regardless of disability.

MAINSTREAMED

Health facilities and programmes adopt universal design and are inclusive of and accessible to everyone, including persons with disabilities. For example, health workers are trained in disability and health care is people-centred.

TARGETED

Health programmes accommodate the individual requirements of persons with disabilities. For example, assistive devices are provided, and medical products meet individual requirements.

The following guidance will support health actors to identify and remove barriers faced by persons with disabilities, as well as their families, support persons and caregivers, when they access health programmes in humanitarian settings.

[145] WHO and World Bank, *World Report on Disability* (2011).

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Document pre-disaster prevention and health needs. Consider sexual and reproductive health, mental health, psychosocial support, communicable and non-communicable diseases and injury care. Focus on providing access to excellent, affordable primary health services, universal health care, essential medicines, and assistive devices for persons with disabilities, regardless of age and gender.	X		
Map mainstream health and disability-targeted services. Consider primary health care centres, acute and rehabilitation hospitals, early intervention services, community-based rehabilitation programmes, mental health and psychosocial support (MHPSS) services at community and hospital level, and suppliers and manufacturers of assistive devices.	X	X	
Map local OPDs, health-related peer-support groups, mental health service users, self-advocates with disabilities, caregivers and parents, and organizations that work on disability. Involve them in all preparedness activities.	X		
Develop the capacity of humanitarian health actors to include persons with disabilities in programming.	X	X	
Conduct accessibility audits of organizations, health facilities and services, and health products. Prepare action plans to inform monitoring and evaluation.	X	X	X
With OPDs, review national emergency health policies and ensure they allocate funds to meet the health and well-being needs of persons with disabilities.	X		X
Assign a disability-inclusive health focal point or expert to the health sector to provide technical guidance on programming disability-inclusive health services and supporting cross-sectoral referrals.	X	X	X
2. Resource mobilization			
Allocate money and raise funds to ensure the continuity of health services used by persons with disabilities, including specific services that are critical.	X	X	X

	Preparedness	Response	Recovery
Mobilize professionals who understand and can address the health needs of persons with disabilities. Recruit experts in mainstreaming disabilities in health services.		X	
Establish a database of disability-specific and mainstream health actors and service providers who are in a position to facilitate an effective referral system.	X	X	
3. Implementation			
Raise awareness among health staff and communities to reduce stigma with respect to disability. Implement strategies to meet this objective, for example through communications and outreach.	X	X	X
Make sure that persons with disabilities can access all health facilities, including temporary ones. When health facilities are rebuilt or rehabilitated, make sure that engineers and architects adopt universal design principles.		X	X
Make health facilities fully accessible to persons with disabilities. Consider entrances, restrooms, ease of movement within buildings, signage.	X	X	X
Ensure that all information on health services, and information issued by user-satisfaction and feedback mechanisms, is available in multiple accessible formats.		X	X
Ensure, after the emergency starts, that patient information remains available and accessible for purposes of referral, movement and transfer, and follow-up.			X
4. Coordination			
Include information on disability in health management information systems. Consider health facility registers, the accessibility status of the facility, health-related surveillance.	X	X	
Establish coordination groups. Involve health stakeholders and representatives of OPDs, including persons with intellectual and psychosocial disabilities.	X	X	X
Ensure that referral systems connect health care providers and health actors with expertise in disability.		X	

	Preparedness	Response	Recovery
5. Monitoring and evaluation			
Ensure that feedback and complaints mechanisms are accessible and include persons with disabilities.		X	
Collect data on health; ensure data are disaggregated by sex, age and disability.		X	X
Monitor and evaluate the accessibility and inclusiveness of health facilities, programmes and services, to ensure that they address the needs and concerns of women, men, girls and boys with disabilities, at all ages.		X	X
When measuring the quality of health service delivery, include criteria that measure inclusion and accessibility and compliance with health standards. (See *Resources* below.)		X	X

Tools and resources

- mhGAP Training Manuals (2017)
- WHO, OECD, World Bank, *Delivering quality health services: A global imperative for universal health coverage* (2018)

Health workforce

A well-performing health workforce is responsive, respectful, fair and efficient. It works to achieve the best health outcomes possible, given available resources and circumstances. This implies a workforce that is fairly distributed, diverse, competent and productive, and sufficiently large to fulfil the functions required.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Conduct a needs assessment of the health workforce to determine its understanding both of disability and the importance of including persons with disabilities in health programming and service delivery.	X	X	X
Identify shortcomings in the capacity and awareness of health staff, and in policy and guidance, with respect to inclusion and disability.	X	X	
Map and regularly update the number and location of staff who work with persons with disabilities (health and rehabilitation professionals, community workers, etc.).	X	X	
2. Resource mobilization			
Map resources. Include in the health workforce persons with disabilities who have health skills and training.	X	X	X
Recruit professional staff who have expertise in responding to the health needs of persons with disabilities.		X	
Mobilize funds to strengthen the disability expertise of health staff. Include communication skills and health examinations.	X	X	X
Include rehabilitation staff in emergency medical teams.		X	
Mobilize a range of health providers (including occupational and speech therapists) to enable persons with disabilities to obtain the services they require.		X	X
3. Implementation			
Ensure all health programming and core trainings for health professionals address disability awareness and the rights of persons with disabilities.	X		X

	Preparedness	Response	Recovery
Train health staff on the effects humanitarian disasters have on the health of persons with disabilities. (For example: persons with psychosocial disabilities have more serious symptoms; lack of medication makes it impossible to manage epilepsy, diabetes, etc.; persons with spinal injuries cannot manage their pressure sores if they are separated from support persons, etc.).	X	X	
Develop outreach and community-based care strategies, and home-based care, to enable health workers to reach persons with disabilities who cannot travel or who live at a distance.		X	X
Ensure that all feedback and complaint mechanisms are accessible to persons with disabilities.	X	X	X
4. Coordination			
Develop and field test referral pathways between the community and hospitals and between health services and other sectors and services.	X	X	
Create a database of health workers at all levels who have disability training.	X		
5. Monitoring and evaluation			
Regularly monitor the knowledge and skills of health workers with respect to persons with disabilities and their inclusion. Propose follow-up training.	X	X	X
Evaluate the training on disability that is available to the health workforce.	X		X

Tools and resources

- Global Health Workforce Alliance and others, *Scaling up the community-based health workforce for emergencies – a joint statement* (2011)
- Health Cluster, Knowledge Bank
- WHO, *Building a global health workforce for a better response* (2016)

Health information management

A well-functioning health information management system should ensure that information on health determinants, health system performance and health status is produced, analysed, disseminated and used reliably and promptly.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Disaggregate national surveys and health surveillance by sex, age and disability.	X		
Include disability-related data, disaggregated by sex and age, in demographic and health surveys.	X		
Map the availability of relevant health services, including physical rehabilitation, occupational therapy and orthopaedic workshops.	X		
2. Resource mobilization			
Develop, communicate and deliver trainings on disability-related data collection methodologies that have been tested in humanitarian contexts, such as the Washington Group Short Set of Disability Questions and the UNICEF-Washington Group Child Functioning Module.	X		X
Train staff that collect data on health infrastructure to document its accessibility to persons with disabilities.	X		X
3. Implementation			
Design a health information management system that disaggregates data by sex, age and disability.	X	X	
Design health registers for use in health facilities, and in outreach and home-based care, that collect data on sex, age and disability.	X	X	
Train health workers to collect data on sex, age and disability and to audit the accessibility of health facilities.	X	X	X
4. Coordination			
Require reporting to include disability-specific indicators.		X	X
5. Monitoring and evaluation			
Require monitoring and evaluation tools to include disability-specific indicators.		X	X

Tools and resources

- Health Cluster, Knowledge Bank (See information and planning)
- Humanity & Inclusion, Using the Washington Group Questions in humanitarian action (learning toolkit on disability data collection) (2019)
- Humanity & Inclusion, Disability Data in Humanitarian Action

Essential health services

Essential health services include lifesaving health services. Some persons with disabilities require rehabilitation or respiratory support or other specialized health services to ensure their survival and well-being.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Assess health workers' skills and knowledge with respect to rehabilitation of: (1) persons with disabilities; (2) persons with disabilities who have acquired new injuries;[146] and (3) persons with new injuries.[147] Develop an action plan (training materials, resources) to address the issues identified.	X	X	
Identify and assess the health needs of affected persons with disabilities. Consider health maintenance, mental health and psychosocial support, and rehabilitation.	X	X	
Map essential health needs of persons with disabilities. Include respiratory support, electrical power, medication and treatment.	X	X	
Identify barriers and risks that persons with disabilities face when they access essential health services.	X	X	
2. Resource mobilization			
Encourage donors to fund the restoration or supply of essential health services for persons with disabilities.	X	X	

[146] WHO, *Minimum Standards and Recommendations for Rehabilitation* (2016).

[147] *Ibid.*

	Preparedness	Response	Recovery
3. Implementation			
Establish community-based health services to provide rehabilitation and outreach.		X	X
Restore essential health services and supplies that persons with disabilities require to maintain their health and survive.		X	
Set up a sound referral system and refer persons with disabilities to health services that were identified during the preparedness stage. These services should be appropriate and culturally sensitive.		X	X
Re-stock products and medicines in rehabilitation centres, health points and hospitals. Include assistive devices and essential medicines, and mental as well as physical health facilities.	X	X	
Integrate agreed essential health needs of persons with disabilities in health services.		X	X
4. Coordination			
Coordinate with the Ministry of Health, Ministry of Social Development, OPDs and other relevant stakeholders. With them, agree what health services for persons with disabilities are essential.	X	X	
Work with OPDs, caregivers and local health service providers to determine the pre-disaster/pre-crisis health needs of persons with disabilities in the affected area. Include rehabilitation.	X		
5. Monitoring and evaluation			
Monitor the extent to which persons with disabilities have access to all essential services. Include access to medication, assistive devices and allied service providers.		X	X

Tools and resources

- Health Cluster, Knowledge Bank

Communicable diseases

Regardless of their age or sex, persons with disabilities are likely to be more susceptible to communicable diseases during humanitarian crises, because they are likely to lack access to safe water, adequate sanitation and health prevention programmes, and may live in inaccessible shelters that endanger their health and lives.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Together with OPDs and other stakeholders, identify persons with disabilities in the affected population.	X	X	
Identify barriers and risks that persons with disabilities face when they access health prevention activities and communicable disease programmes. Include vaccination and access to safe water programmes.	X	X	
2. Resource mobilization			
Mobilize funds and human resources to organize outreach, community-based and home-based services, and health promotion and disease prevention campaigns.	X	X	
3. Implementation			
Collect disease surveillance and household survey data disaggregated by sex, age and disability.		X	
Involve persons with disabilities and OPDs in developing information, education and communication materials.	X	X	
Communicate health promotion and disease prevention measures in multiple accessible formats. Do the same with information and education resources.	X	X	
When designing cross-sectoral communicable disease prevention measures for at-risk populations, address the specific requirements and concerns of persons with disabilities.	X	X	
4. Coordination			
Coordinate with other sectors to ensure that persons with disabilities have access to water, sanitation, and clean and safe shelter, and can meet other emergency requirements.		X	

	Preparedness	Response	Recovery
5. Monitoring and evaluation			
Monitor the degree to which persons with disabilities have access to promotion and prevention campaigns and activities.		X	

Tools and resources

- Health Cluster, Knowledge Bank

Child health

Failure to coordinate interventions for children across health, education, protection and nutrition is a major threat to child health. It hinders fulfilment of children's rights, limits their development potential, and makes it impossible to reduce socioeconomic inequalities that affect health.

Children with disabilities have the right to access all child- and adolescent-related health services.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Obtain available data on the number of children with disabilities.	X		
Map assessment tools commonly used with children, including in early childhood. Adapt them to meet the requirements of children with disabilities and train staff to use them.	X	X	
Map health service providers and their accessibility. Include professionals with expertise in paediatrics, nutrition, early intervention, early childhood development and rehabilitation.	X	X	
Document the health and psychosocial and nutritional needs of children with disabilities. (For example, a child with a disability who has lost parents or caregivers may also be malnourished or depressed.)	X	X	
Assess what training health workers need with respect to children with disabilities and their inclusion.	X	X	

	Preparedness	Response	Recovery
When screening children with disabilities in needs assessments and health surveys, consider using the UNICEF-Washington Group Child Functioning Module, or other standardized assessment tools that have been tested by humanitarian actors and stakeholders.	X	X	
Identify barriers and risks that children with disabilities face when they access child health services.	X	X	
2. Resource mobilization			
Plan, budget and implement training for health staff on the rights of children with disabilities. Include child development, and early detection of disability.	X	X	X
3. Implementation			
Make health services and programmes accessible to children and adolescents with disabilities, and their caregivers, by removing barriers to their full inclusion.		X	X
Involve girls and boys with disabilities, and their caregivers, in designing, implementing, monitoring and evaluating health programmes.		X	X
Integrate early detection of disability in relevant programmes. Include school health, nutrition, maternal health and newborn health.	X	X	X
Integrate health information and disability management in maternal and child health programmes and services. Include immunization, antenatal and postnatal care, nutrition, and sexual and reproductive health.		X	X
Integrate early identification and detection of disability in the work of community-based workers and community health practitioners. Assist them to identify children with disabilities, including intellectual and psychosocial disabilities, and refer them for early intervention.	X	X	X
Where child health programmes are delivered through schools, run outreach programmes for out-of-school children with disabilities.		X	X
Encourage parents and caregivers of children with disabilities to join parent support groups. Disseminate child health information and education through community health centres.	X	X	X

	Preparedness	Response	Recovery
4. Coordination			
Coordinate with other sectors to ensure that children with disabilities have access to assistance and protection.		X	X
Develop and implement referral systems for children with disabilities. Include targeted services, such as occupational and speech therapy.	X	X	X
5. Monitoring and evaluation			
Include indicators about girls and boys with disabilities in monitoring tools. Report on the health outcomes for girls and boys with disabilities.		X	X

Tools and resources

- Health Cluster, Knowledge Bank
- WHO, *Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential*

Sexual and reproductive health and rights

Persons with disabilities are entitled to sexual and reproductive health, which is a component of the right to health. Women, men, girls and boys with disabilities must have access to accessible sexual and reproductive services and information that meets their specific requirements. Generally, the sexual and reproductive health of persons with disabilities is a low priority for health stakeholders, due to the misconception that persons with disabilities are not able to make free choices about their sexual lives.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Map sexual and reproductive health services, and supplies, for persons with disabilities, and their accessibility. Include maternal and newborn care, contraception and emergency contraception, adolescent sexual and reproductive health, prevention and response to gender-based violence (GBV), sexually transmitted infections, and HIV/AIDS services.	X	X	
Determine the degree to which persons with disabilities have access to health facilities, services and supplies. Plan how to address gaps. (For example, use large print or Braille to make information more accessible.) Reduce wait times.	X	X	
To address the sexual and reproductive health requirements of persons with disabilities, including persons with intellectual disabilities, organize outreach services and delivery of supplies to persons with disabilities who are isolated in their homes. Make sure outreach programmes include accurate information on sexual and reproductive health.		X	
Assess the protection concerns of women, men, girls and boys with disabilities. Consider how easily they can access sexual and reproductive health information and services. Address safety risks that persons with disabilities identify.	X	X	X
Identify barriers and risks that persons with disabilities face when they access sexual and reproductive health services and programmes.	X	X	
2. Resource mobilization			
Allocate funds to train health staff on the cumulative effect on sexuality of the intersectionality of age, gender and disability.	X	X	
Recruit persons with disabilities who have expertise in and experience of sexual and reproductive health.		X	X

	Preparedness	Response	Recovery
Include disability modules in all sexual and reproductive health trainings for staff. Make training available to service providers, support staff, community outreach workers, mobilizers, and staff who work on gender-based violence (GBV) and HIV.	X	X	X
3. Implementation			
Integrate disability inclusion in all sexual and reproductive health prevention and response services (information, services and supplies). Do so for adolescent sexual and reproductive health; maternal and newborn health; contraceptive services; services to prevent and respond to GBV; and services to prevent and address sexually transmitted infections, including HIV/AIDS.		X	X
In collaboration with OPDs and disability-focused organizations, develop public information materials on sexual and reproductive health and disseminate them in a range of accessible formats.	X	X	X
Ensure that informed consent procedures are respected, including when persons with disabilities are asked to take decisions. Procedures should comply with the Convention on the Rights of Persons with Disabilities (CRPD). Train staff and providers in how to communicate with people who have a range of disabilities.[148]		X	X
Ensure all health facilities are physically accessible, and that sexual and reproductive health personnel are sensitized to disability inclusion and equipped to provide information in multiple accessible formats. Include adolescents with disabilities.	X	X	X
Encourage and mobilize persons with disabilities and OPDs to undertake evidence-based advocacy on sexual and reproductive health issues, including HIV, gender and rights.	X		X
Create a steering committee to advocate for the adoption of a sexual and reproductive health model that is disability-inclusive. Members should include persons with disabilities, OPD members and representatives of INGOs, the protection and health sectors, and national authorities.	X		
Reach out to women, girls and youth with disabilities during community information sessions on sexual and reproductive health.		X	
Include sexual and reproductive health information, services and supplies for persons with disabilities in school health programmes, nutrition programmes and other relevant programmes.		X	X

[148] Women's Refugee Commission, *"I see that it is possible": Building Capacity for Disability Inclusion for GBV Practitioners Toolkit*, Tool 9: Informed Consent Process with Adult Survivors with Disabilities.

	Preparedness	Response	Recovery
4. Coordination			
Coordinate with other sectors (such as protection, and food and nutrition) to ensure a quality sexual and reproductive health system and an efficient referral system to support it.		X	X
Coordinate with the health and protection sectors, the sexual and reproductive health working group, and gender-based violence Areas of Responsibility to ensure that persons with disabilities are protected and have access to all sexual and reproductive health information, services and supplies.		X	
Encourage national and community-based OPDs to participate actively in sexual and reproductive health working groups.	X	X	X
5. Monitoring and evaluation			
Collect and analyse data on sexual and reproductive health services and their delivery. Disaggregate information by sex, age and disability.		X	X
Monitor the accessibility of sexual and reproductive health services.	X	X	X
Use monitoring and reporting processes to promote reflection and accountability. Review the extent to which persons with disabilities have access to and use sexual and reproductive health services.		X	X

Tools and resources

- Health Cluster, Knowledge Bank
- Inter-Agency Working Group on Reproductive Health in Crises (IAWG), Reproductive health is an essential component of humanitarian response, pp. 1–2
- Inter-Agency Working Group on Reproductive Health in Crises, On Reproductive Health in Crises
- Inter-Agency Working Group on Reproductive Health in Crises, Training Partnership Initiative
- Inter-Agency Working Group on Reproductive Health in Crises, *Inter-Agency Field Manual on Reproductive Health in Emergencies* (2018)
- Sphere Project, Minimum Initial Service Package for Reproductive Health (in *Sphere Handbook*)
- UNFPA, *A Deeper Silence: The Unheard Experiences of Women with Disabilities – Sexual and Reproductive Health and Violence against Women in Kiribati, Solomon Islands and Tonga* (2013)
- Women's Refugee Commission, Reports on disabilities and sexual reproductive health

Injury care

Individuals with and without disabilities are at risk of sustaining injuries and trauma during humanitarian situations. Standard procedures are implemented to treat each type of injury; however, pre-existing disabilities are seldom considered. (See WHO, *Minimum Technical Standards and Recommendations for Rehabilitation*.)

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Map trauma centres and rehabilitation services in affected areas. Include assistive devices, prostheses and orthotics, and mental health and psychosocial support (MHPSS) services.	X		
Map local OPDs and other related services and programmes in affected areas. Assess their availability and accessibility.	X	X	
Map suppliers of assistive devices, and the availability of specific items and materials that persons with disabilities require.	X		
Examine available data on new injuries and the likely need for long-term specific health care services.		X	
Understand patterns of injury among persons with disabilities, their trajectory, response and recovery, and access to services.		X	X
Identify barriers and risks persons with disabilities face when they access services and programmes that provide injury care.	X	X	
2. Resource mobilization			
Mobilize rehabilitation professionals who understand inclusion and are trained to work with persons with disabilities.		X	
Raise funds to improve rehabilitation services in the short and long term.		X	X
Ensure that rehabilitation programme budgets include the cost of removing barriers that impede access by persons with disabilities.		X	
3. Implementation			
Train rehabilitation professionals who work in areas vulnerable to hazards. Include acute trauma care, MHPSS and disaster management.	X		

	Preparedness	Response	Recovery
Integrate rehabilitation services in all mass casualty and disaster management plans, including in treatment protocols and care pathways for common life-changing injuries (loss of vision, hearing or speech, spinal cord injuries, amputation).	X		
Conduct accessibility audits of trauma centres and rehabilitation services. Consider physical accessibility, and the accessibility of communications and information, and service. Design and implement action plans to address barriers; follow up.	X	X	
Train trauma and rehabilitation staff in needs assessment. Include the wider protection of people with injuries, and their referral to other services and sectors (such as shelter, protection and WASH).		X	
Regularly monitor and evaluate the action plan to ensure that trauma centres and rehabilitation services remain accessible.		X	
Provide affordable, locally appropriate, sustainable or free assistive devices, prostheses and orthotics that comply with international standards (for example, WHO wheelchair standards).		X	
Provide medical and surgical treatment and rehabilitation, including MHPSS services, for people who sustain injuries during the disaster or crisis.		X	
Ensure that persons with disabilities who are not injured can access services they require. Restore pre-emergency services.		X	
To reach more isolated individuals with disabilities, develop community-based services, and provide outreach and follow-up. Include persons with disabilities living in refugee or internally displaced persons camps, besieged areas and rural areas.		X	X
Establish one-stop shops in primary health care clinics so that persons with disabilities do not have to go to multiple locations to receive services they require.		X	
4. Coordination			
Coordinate with other sectors to develop and implement a referral pathway to other services and to protection.		X	X
5. Monitoring and evaluation			
Ensure rehabilitation and trauma centres disaggregate data by sex, age and disability.	X	X	X
Report on the number of persons with disabilities injured during the crisis.		X	X

Tools and resources

- CBM, Handicap International, ICRC, WHO, *Minimum Technical Standards and Recommendations for Rehabilitation in Emergency* (2016)
- Health Cluster, Knowledge Bank
- WHO, ISPO, USAID, *Guidelines on the provision of manual wheelchairs in less resourced settings* (2008)
- WHO, Global cooperation on assistive technology (GATE)

Mental health and psychosocial support

Activities that protect and promote mental health and psychosocial well-being need to be realized and implemented across all sectors, including in health, education, protection and nutrition.

In humanitarian emergencies, violence, fear and uncertainty can create chaos and deplete community resources. As a result, people experience stress reactions that may impair daily functioning and social interaction.[149] In many instances, these reactions are transient or people are able to adapt to the sudden changes. With appropriate social and emotional support, many people will overcome these difficult experiences. To achieve this outcome, however, it is necessary to draw on and strengthen the resources in families and communities that foster resilience and mutual support. In protracted humanitarian crises, lack of hope and prolonged and accumulated stress can lead to persistent distress, increasing the incidence or severity of mental health conditions, including severe depression and suicide. Some people, particularly individuals who have been particularly severely affected, or who have pre-existing mental health and psychosocial needs, or who face discrimination and exclusion, may need focused additional support delivered by trained non-specialists or mental health and psychosocial health (MHPSS) specialists.

People with psychosocial and intellectual disabilities frequently experience discrimination and exclusion. Their human rights may be violated by segregation, confinement, restraints on their autonomy, or threats to their physical and mental integrity. Emergency responses should include action to redress rights abuses and inequities that were present before the crisis occurred, as well as to create opportunities for people with psychosocial disabilities to enjoy their rights fully, including their rights to health and to live in dignity.

Psychosocial disability in these guidelines results from barriers to social participation and access to rights linked to mental health or cognitive conditions or disturbance in behaviour that is perceived as socially unacceptable. The term is usually reserved for people with more persistent or recurrent functional impairment, who are confronted with systematic exclusion and participation barriers. The term is less often used for those with temporary mental health conditions who recover quickly, sometimes in response to MHPSS interventions. During humanitarian emergencies, distress leading to functional impairment is often transient, and it is important not to label such response as a medical condition or disability.

MHPSS should not focus only on persons with psychosocial and intellectual disabilities. It should focus on all community members, including persons with disabilities who experience different levels of distress in humanitarian contexts. However, these guidelines recognize that persons with psychosocial and intellectual disabilities face specific forms of structural discrimination, are particularly at risk of human rights violations, and are in addition markedly underrepresented in decision-making fora. The protection sector should look closely at this subgroup in the population and take steps to make sure that its members can participate socially and in all matters that are of concern to them.

The health and protection sectors should work closely to protect, support and care for people living in prisons, social welfare institutions and other residential institutions, or who are homeless. They should act to develop and strengthen community-based services and structures, to both prevent institutionalization and end coercive treatment, violence, abuse and other violations of human rights in such places. These forms of mistreatment disproportionately affect people with mental health conditions and psychosocial and intellectual disabilities with higher support requirements. In the course of providing community care, support and living arrangements for this population, the protection sector should also promote independent and effective monitoring of all institutions, including prisons, in which persons are detained, and secure appropriate housing for those who are homeless.

When an emergency occurs, the mental health and psychosocial support system of the region affected is likely to be disrupted. In many instances, it may not be equipped to provide community-based and human rights-oriented mental health care and support. Humanitarian crises are an opportunity to invest effort and resources to construct an equipped, comprehensive community-based system that is aligned with international human rights standards.

In practice, it is frequently difficult during an emergency to respond adequately to the needs of people with psychosocial and intellectual disabilities. This is particularly true in countries that have not ratified the Convention on the Rights of Persons with Disabilities. Where mental health systems are not community-based or human rights-oriented, additional guidance should be provided on core aspects of care and support, at all levels, including in the community and in families. For instance, capacity-building programmes should focus attention on establishing procedures that secure and effectively safeguard informed consent (to treatment, for example), supported decision-making and non-coercive interventions.

Recommended actions

All actions should be concerted with persons with disabilities (including persons with psychosocial and intellectual disabilities), their families, and OPDs, in close collaboration with MHPSS experts and providers in MHPSS technical working groups.

	Preparedness	Response	Recovery
1. Assessment, analysis, and planning			
Conduct a needs assessment, using adapted tools for rapid participatory approaches. Include persons with psychosocial and intellectual disabilities. Integrate MHPSS components in other assessments.	X	X	
Map and assess available MHPSS resources and staff. Include services and staff competencies (of specialists and non-specialists) across sectors. Consider experts and providers from MHPSS technical working groups, OPDs, and persons with psychosocial and intellectual disabilities.	X	X	X
Using the WHO Quality Rights toolkit, map and assess all health facilities and residential care institutions in the affected area, as well as traditional or informal service providers for people with disabilities.	X	X	X

[149] IFRC, *Guidelines on mental health and psychosocial support* (2018).

	Preparedness	Response	Recovery
Based on assessment findings, plan a MHPSS response and MHPSS programmes. Ensure these address the requirements of persons with disabilities.	X	X	X
Develop or update national mental health policies, strategies, plans and legislation. Ensure the national MHPSS system is community-based and aligned with human rights.		X	X
Develop institutional emergency preparedness and response plans, including evacuation plans. Evacuation plans should safeguard family and community links.	X		
2. Resource mobilization			
Mobilize dedicated budgets for community-based and human rights-oriented MHPSS responses and services that are inclusive of persons with disabilities.		X	X
Allocate budgets and resources to deploy peer supporters (including from other regions) to assist people with psychosocial disabilities in affected areas.	X	X	X
Ensure that cross-sectoral appeals, proposals and concept notes integrate MHPSS considerations.		X	X
Establish, empower or mobilize peer-support groups, advocacy groups led by persons with disabilities, and social support.	X	X	X
Mobilize resources to support outreach activities for individuals with disabilities who are institutionalized, live in confinement or receive traditional religious healing at home. These budgets should cover the costs of: essential services; monitoring; interventions to prevent human rights violations; and integration in the community.		X	X
Mobilize influential community members to challenge norms and attitudes that perpetuate or legitimize violations of the rights of persons with disabilities.	X	X	X
3. Implementation			
Raise awareness in the community of disability and the rights of persons with disabilities, including persons with psychosocial and intellectual disabilities.	X	X	X
Build the capacity of specialists and non-specialists, including OPD representatives, volunteers and peer supporters. Training should include the human rights framework; multidisciplinary approaches in MHPSS; community-based care; task sharing; and psychological first aid.	X	X	X
Build the capacities of humanitarian staff. Train them in how to interact in emergency settings with people who have psychosocial disabilities.	X	X	X
Integrate evidence-based MHPSS interventions in the primary health care system.	X	X	X
Make community-based and human rights-oriented MHPSS services available and accessible to persons with disabilities at all levels of care. Make use of task sharing.	X	X	X
Make evidence-based psychological interventions available and accessible to persons with disabilities at all levels of care.[150]	X	X	X
Implement the WHO Quality Rights tools to protect the lives and dignity of persons who are institutionalized; to strengthen human rights surveillance; to put institutional evacuation plans in place; and to safeguard family and community links in the course of evacuations.	X	X	X
Develop protocols to prevent coercive treatment, including forced institutionalization, forced medication, forced electroconvulsive treatment, and physical and chemical restraints.	X	X	X
Take steps to ensure that destroyed or inactive care centres that formerly institutionalized persons with disabilities are not reopened or restored in the recovery phase. Advocate for a comprehensive community-based and human rights-oriented MHPSS system.			X
4. Coordination			
Coordinate with active MHPSS Technical Working Groups in the field to ensure that persons with disabilities are included in the MHPSS response.		X	X
Foster intersectoral collaboration to ensure that MHPSS programmes involve (at minimum) OPDs and actors from health, community-based protection, child protection and education.		X	X
Establish a sound community-based MHPSS system, based on a human rights approach, that delivers excellent services, supported by a strong and effective cross-sectoral referral system that includes community resources, traditional healers and religious centres.		X	X
Where persons with disabilities have been institutionalized, identify an agency to take responsibility for promoting de-institutionalization. Seek to transfer people from institutions to community-based accommodation that provides appropriate support, while ensuring their continued care and protection.		X	X

[150] For example, Problem Management Plus, Interpersonal Therapy for Depression.

	Preparedness	Response	Recovery
5. Monitoring and evaluation			
Establish a monitoring mechanism for MHPSS programmes and services, based on the IASC MHPSS common framework for Monitoring and Evaluation.	X	X	X
Include persons with disabilities, including persons with intellectual and psychosocial disabilities, in monitoring MHPSS programmes and services. Involve also their families, support persons and caregivers, and OPDs.	X	X	X
Systematically monitor the human rights of persons with disabilities, using the WHO Quality Rights tools.	X	X	X
Design or adapt information management systems and facility registers. Ensure that information collected is disaggregated by sex, age and disability.	X		

Tools and resources

- IASC, *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007)
- IASC, *Guidelines on Mental Health and Psychosocial Support in Emergency Settings: What should Humanitarian Health Actors know?* (2011)
- IASC, *Guidelines on Mental Health and Psychosocial Support in Emergency Settings: What should Camp Coordinators and Camp Manager Actors Know?* (2014)
- IASC, *Inter-Agency Referral Guidance Note for Mental Health and Psychosocial Support in Emergency Settings* (2017)
- IASC, *MHPSS common framework for Monitoring and Evaluation* (2017)
- IASC, *Who is Where, When, doing What in Mental Health and Psychosocial Support?* (2014, a 4W Tool)
- IASC Reference Group on Mental Health and Psychosocial Support, *Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Protection Programme Managers Know?* (2010)
- Sphere, *Sphere Handbook* (2018)
- UNHCR, *Community-based Protection and Mental Health and Psychosocial Support* (2017)
- UNHCR, Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations (2013)
- UN Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/HRC/35/21, 28 March 2017
- UNICEF, *Operational guidelines on community-based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families* (2018, field test version)
- WHO and UNHCR, Assessing mental health and psychosocial need and resources (2012)
- WHO, *QualityRights Toolkit* (2012)
- WHO, QualityRights Training Materials (2019)

Non-communicable diseases

Non-communicable diseases (NCDs), or chronic diseases, tend to be of long duration and result from a combination of genetic, physiological, environmental and behavioural factors. The main types are cardiovascular diseases (such as heart attacks and strokes), cancers, chronic respiratory diseases (such as obstructive pulmonary disease and asthma), diabetes, and mental and neurological conditions (such as dementia).[151] Persons with disabilities are sometimes at higher risk of NCDs because, for example, they may be less mobile, live in overprotective environments, or eat unbalanced diets.

According to WHO, to manage NCDs during emergencies, it is necessary to:

1. Treat acute complications that require special attention in emergency settings, and introduce additional arrangements including a referral mechanism.
2. Continue ongoing treatment (by means of medicines, technologies or appliances).
3. Make adjustments to accommodate declines in ability to cope.
4. Coordinate care provision and follow-up across a range of providers and settings.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Include data disaggregated by sex, age and disability in the rapid risk assessment tool. Document the pre-crisis burden of disease and available care.	X		
Work with the community to identify persons with disabilities who have NCDs and who are isolated due to distance or stigma and discrimination.	X	X	
Involve OPDs in identifying barriers that persons with disabilities face when they access essential medicines they require. Use the provisions for acute treatment of chronic conditions in the Interagency Emergency Health Kit.	X	X	
Map and review protocols, guidelines and tools for managing NCDs and ensure they take account of and include persons with disabilities.	X	X	
Map OPDs and related service providers for referral and support.	X	X	
Ensure that intervention principles fully include persons with disabilities. Train health staff who work on integrated NCD management in emergencies to understand and implement the principles.	X	X	X

[151] Recognizing the importance of mental health and psychosocial support services, a separate section looks at barriers that persons with mental health conditions and those in psychosocial distress face. See Mental health and psychosocial support.

	Preparedness	Response	Recovery
2. Resource mobilization			
Support the development of NCD-inclusive budgeting. Advocate for funds to cover the cost of making NCD services in emergencies available and accessible to persons with disabilities.	X	X	
3. Implementation			
Disseminate widely the Interagency Emergency Health Kit provision for the acute treatment of chronic conditions. *Make sure it is available to persons with disabilities.*	X		
Design and disseminate health promotion and patient education materials in multiple accessible formats (including oral, print, sign language, easy-to-read/plain language, large print, etc.).	X	X	
Ensure that medicines, protocols and referrals for NCDs take account of the specific requirements of persons with disabilities (for example, treatments for epilepsy).		X	
Work with OPDs and disability-focused organizations to remove barriers that impede the effective and prompt delivery of NCD interventions to persons with disabilities.	X	X	
4. Coordination			
Ensure meaningful participation of persons with disabilities in NCD coordination mechanisms.	X	X	
Ensure that health services coordinate intersectoral referrals for persons with disabilities who have NCD-related impairments.		X	
5. Monitoring and evaluation			
Include disability-specific indicators in NCD monitoring tools and report on them.		X	
Monitor the inclusion of persons with disabilities in NCD programming and service delivery.	X	X	X
Include NCD-specific indicators in rapid assessment tools, including Multi-Cluster/Sector Initial Rapid Assessment and other routine monitoring and evaluation tools.	X	X	

Tools and resources

- Health Cluster, Knowledge Bank
- UN Interagency Task Force on NCDs and WHO, *Noncommunicable Diseases in Emergencies* (2016)
- WHO, *Emergency medical team guidelines*
- WHO, *Integration of NCD care in emergency response and preparedness* (2018)
- WHO, *Package of Essential Noncommunicable (PEN) Disease Intervention for Primary Health Care in Low-Resource Settings* (2010)
- Americares, *Non-Communicable Diseases in Humanitarian Emergencies* (2018)

16 Protection

See Data and information management, Camp coordination and camp management, Education, Food security and nutrition, Livelihoods, Health, Shelter and settlements, and WASH.

Introduction

The IASC defines protection as "all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of relevant bodies of law (i.e., international human rights law, international humanitarian law and international refugee law)".[152] Protection is at the centre of humanitarian action.[153] In addition, a protection perspective recognizes that affected populations have capacities. They are rights holders who can claim their rights; they are not passive recipients of aid.

The *Sphere Handbook* sets out four protection principles that represent the basic elements of protection in a humanitarian response:[154]

- Enhance the safety, dignity and rights of people, and avoid exposing them to harm.
- Ensure people have access to assistance according to their requirements, without discrimination.
- Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation.
- Help people claim their rights.

Protection activities can be:

- Responsive (aiming to prevent or stop ongoing rights violations).
- Remedial (aiming to provide redress for past violations).
- Environmental (building the legal and institutional frameworks, capacity and awareness required to promote respect for human rights).[155]

Adopt a cross-cutting approach to protection and community-based protection

A protection intervention is stronger if it involves affected communities in responses to the threats they face. Community-based protection focuses on putting affected populations at the centre of a response and strengthening local resources and capacity. It works with affected populations as partners, rather than relying solely on external actors. This approach should be adopted by all protection sub-sectors because it helps them to identify protection risks and develop solutions to them that can be implemented successfully at local level.

[152] IASC, *Human Rights and Natural Disasters: Operational Guidelines and Field Manual on Human Rights Protection in Situations of Natural Disasters* (2008). See also IASC Protection Policy.

[153] IASC Principals' Statement, *The Centrality of Protection in Humanitarian Action* (2013).

[154] *Sphere Handbook* (2018).

[155] IASC, *Human Rights and Natural Disasters: Operational Guidelines and Field Manual on Human Rights Protection in Situations of Natural Disasters* (2008).

These activities are implemented through protection mainstreaming, protection integration or specific or specialized protection programmes. In humanitarian contexts, persons with disabilities often face heightened protection risks as well as multiple barriers to reporting rights violations and accessing protection services. It is therefore essential to put them at the centre when designing, implementing and monitoring protection activities. In addition, family members, caregivers and support persons play a vital role in the lives of many persons with disabilities. It is important to consider them when analysing protection and protection risks, because they are often part of the solution and sometimes part of the risk.

The Global Protection Cluster includes several areas of responsibility (AOR): child protection; protection related to sexual and gender-based violence; housing, land and property; and mine action. This section reflects the Global Protection Cluster structure.

Key terms

Protection mainstreaming, sometimes called 'safe programming', is the "process of incorporating protection principles and promoting meaningful access, participation, accountability, safety and dignity in humanitarian aid".[156]

Protection integration involves "incorporating protection objectives into the programming of other sector-specific responses (i.e., beyond the protection sector response) to achieve protection outcomes".[157]

Specific protection activities or **specialized protection activities**, sometimes called 'stand-alone interventions', are specific activities that help people stay safe, recover from harm, and secure access to their rights.[158] Humanitarian actors with specific protection expertise undertake these activities.[159]

'Do no harm' is an injunction to humanitarian organizations to act in ways that do not generate unintended negative consequences. They should avoid causing harm and minimize any harms that they may inadvertently cause because they are present and provide assistance. Humanitarian actors need to be aware of and take steps to minimize harms associated with their presence and activity.[160]

Key legal instruments and other frameworks[161]

- Convention on the Rights of Persons with Disabilities
- Convention on the Rights of the Child
- Anti-Personnel Mine Ban Convention
- Convention on Cluster Munitions
- Convention on Certain Conventional Weapons, Protocols II and V[162]
- Convention on Eliminating All Forms of Discrimination Against Women
- Convention on the Elimination of All Forms of Racial Discrimination
- International Covenant on Economic, Social and Cultural Rights
- International Covenant on Civil and Political Rights
- IASC Policy on Protection in Humanitarian Action (2016)

[156] Global Protection Cluster, *Protection Mainstreaming Training Package* (2014).
[157] IASC, *Policy on Protection in Humanitarian Action* (2016).
[158] Oxfam and Global Protection Cluster, *Protection: What is it anyway?* (2016).
[159] IASC, *Policy on Protection in Humanitarian Action* (2016).
[160] UNICEF, Humanitarian Principles (2004). See also CDA, *The Do No Harm Handbook*.
[161] See also IASC, *Policy on Protection in Humanitarian Action*, Annex I: Normative Framework.
[162] IASC, *Policy on Protection in Humanitarian Action* (2016).

Diagram 11 | Barriers to access and inclusion in protection

Standards and guidelines

- *Sphere Handbook* (2018). See the section on protection
- Global Protection Cluster. See tools and guidelines
- Help Age, CBM, Handicap International, *Humanitarian inclusion standards for older people and people with disabilities* (2018). See the section on protection
- *Minimum Standards for Child Protection in Humanitarian Action*
- IASC, *Guidelines on Integrating Gender-Based Violence Interventions in Humanitarian Actions* (2015)
- IASC, *Gender-based Violence - Standard Operating Procedures* (2008)
- Inter-Agency Gender-Based Violence Case Management Guidelines (2017)
- IASC and Global Protection Cluster, *Caring for Survivors of Sexual Violence* (2010)

Key elements – must do

'Must do' actions must be undertaken in all phases of humanitarian action when implementing protection programming for persons with disabilities.

Participation

- Ensure that persons with disabilities and organizations of persons with disabilities (OPDs) actively participate in identifying protection risks and barriers to accessing protection.
- Ensure that persons with disabilities are fairly represented in formal and informal protection mechanisms including community-based protection mechanisms (camp leadership mechanisms as well as women's groups and youth groups), taking into account all forms of disability as well as age, gender and diversity. Make concerted efforts to promote underrepresented groups, such as persons with intellectual and psychosocial disabilities, indigenous persons, women and girls.

Addressing barriers

- Identify and monitor barriers that impede persons with disabilities from accessing protection and take steps to make protection systems and services accessible to them. Provide outreach and make other reasonable accommodations to reach persons with disabilities who are unable to leave their homes.
- Communicate all protection-related information in multiple accessible formats, taking into account persons with hearing, visual, intellectual and psychosocial disabilities.
- Review sectoral policies, guidelines and tools to ensure that they clearly affirm the right of persons with disabilities to access and inclusion.

Empowerment and capacity development

- Ensure that, when persons with disabilities need to take personal decisions, including persons with intellectual and psychosocial disabilities, procedures always require their informed consent.[163]
- Through training and building awareness, make protection actors more conscious of the rights of persons with disabilities, and the specific protection risks they face. Equip them with practical tools and approaches that strengthen their protection and resilience.

[163] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018).

- Map local and national OPDs, assess their capacity to work in protection mainstreaming, and provide training and support where required. Involve them in the work of protection coordination mechanisms.
- Involve persons with disabilities and their representative organizations in all community mobilization and outreach activities. Build their capacity to identify and refer persons at risk of violence or abuse and take appropriate steps to protect rights and address violations.[164]

Data collection and monitoring

- Collect and analyse protection data on persons with disabilities, disaggregated by sex, age and disability. Do so systematically across the humanitarian programme cycle in all protection information management systems, including the Gender-Based Violence Information Management System, Child Protection Information Management System and national reporting databases.
- Collect data and information on barriers to claiming rights and barriers that impede access to protection services.
- Ensure that data ethics and protection principles (including confidentiality, provision of information, informed consent, security) are respected whenever data on persons with disabilities are collected and used.[165]
- Share information on the cross-sectoral needs of persons with disabilities in inter-agency coordination mechanisms (WASH, health, education) and ensure cross-sectoral coordination.
- Monitor violations of the rights of persons with disabilities.

Protection

Protection-related risks and impacts

- Persons with disabilities may experience targeted violence and abuse because of their disability.[166] In a recent survey of persons with disabilities in humanitarian contexts, 27 per cent of respondents reported that they had experienced physical, psychological or other forms of abuse, including forms of sexual abuse.[167] Targeted violence against persons with disabilities may include physical attacks, killings,[168] denial of food and medicine, harassment, emotional abuse, profound neglect, shackling, and confinement. These abuses are often perpetrated by persons known to them.[169] Frequently, targeted violence against persons with disabilities is not reported or monitored, and few programmes identify or respond to such violations.
- Persons with disabilities are more likely to experience violations if they are in institutions. Numerous reports have documented severe violations in institutions of the rights of adults and children with disabilities, particularly persons with psychosocial disabilities.[170] The violations in question include inhuman and degrading treatment, unsanitary conditions, neglect, verbal, sexual and physical abuse, involuntary medication, and restraint.[171]

[164] See IASC, *Policy on Protection in humanitarian action* (2016), p. 2.

[165] See ICRC, *Professional Standards for Protection Work Carried Out by Humanitarian and Human Rights Actors in Armed Conflict and Other Situations of Violence* (2018), Chapter 6, Managing data and information for protection outcomes, pp. 106–148; and CRPD, Article 22(2).

[166] See WHO, *Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies* (2012); and WHO and World Bank, *World Report on Disability* (2011).

[167] Handicap International, *Disability in Humanitarian Context – Views from affected people and field organisations* (2015).

[168] See UNICEF, *Violence Against Disabled Children: Summary Report* (2005), p. 6.

[169] *Ibid.*

[170] WHO, *Promoting Rights and Community Living for Children with Psychosocial Disabilities* (2015).

[171] Human Rights Watch, *They Stay There Until They Die* (2018); Human Rights Watch, *Chained Like Prisoners* (2015).

- Persons with disabilities are more likely than others to lack personal documents (birth certificate, marriage certificate, travel documents). This may happen for a number of reasons, including failure to register their birth, or denial of their legal capacity (a form of discrimination).
- Persons with disabilities who are unable to tell their story may also be at higher risk. This problem arises particularly for persons with intellectual or psychosocial disabilities and persons who have difficulty communicating. During security screening processes, for example, persons with disabilities may not be able to respond accurately to security-related questions.

MAINSTREAMED

Protection programmes are designed and adapted to ensure that they are inclusive of and accessible to everyone, including persons with disabilities. For example, they ensure access to protection programmes, and train protection staff on disability.

TARGETED

Protection programmes accommodate the individual needs of persons with disabilities by providing reasonable accommodations. For example, extension programmes reach out to persons with disabilities who are isolated or distant and support their participation in decisions that are relevant to them.

The following guidance will support protection actors to identify and remove barriers faced by persons with disabilities, as well as their families, support persons and caregivers, when they access protection programmes in humanitarian settings.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Ensure that protection assessments consult persons with disabilities. Include them in focus group discussions and key informant interviews. Assessments should identify groups at heightened risk of protection violations and disability-related discrimination, and persons who may face barriers to accessing protection services. Include persons with disabilities who are isolated or confined to their homes or communities.	X	X	X
Ensure that planning considers the risks that persons with disabilities face, the barriers that impede them from accessing protection services, and specific actions that may be required to remove those barriers. Ask persons with disabilities to help define protection sector priorities.	X	X	X
2. Resource mobilization			
Ensure that all proposals or concept notes identify and analyse the protection risks and the capacities of women, men, girls and boys with disabilities. Ensure that interventions promote their protection and participation.	X	X	
Establish inclusive budgeting processes. Allocate resources to improve accessibility and inclusion.		X	X
3. Implementation			
Develop outreach activities, including community-based outreach, to reach individuals who are isolated in their homes or institutions.	X	X	X
Include case studies and discussions of disability in core trainings for protection staff, community outreach staff, protection focal points and protection committees.	X	X	
Communicate information on protection, and about complaint and feedback mechanisms, in multiple and accessible formats. Take steps to include individuals who are isolated in their homes or in institutions or who rely on support persons for communication.	X	X	X
Take steps to assist persons with disabilities to obtain personal documentation. Publicize the importance of marriage and birth registration; organize mobile registration for refugees and other displaced populations, including persons with disabilities; make legal case management available to persons with disabilities who lack access to civil documentation.	X	X	X
Ensure that family tracing and reunification services identify and respect the wishes of persons with disabilities who have become separated.		X	X
Include residents of institutions in protection-related activities and ensure they have access to all the information that is provided to other members of the affected population.	X	X	X
Monitor and report on violations of the rights of persons with disabilities. Include targeted violence, forced medical treatment, disability-related discrimination and barriers to accessing protection services. Follow cases up and remove barriers that impede or deter persons with disabilities from accessing protection services or reporting violations.	X	X	X
Design and implement protection interventions for persons with disabilities that assessments have found to be at risk. (Assessments need to be gender and age sensitive.)	X	X	X

	Preparedness	Response	Recovery
Work with OPDs and influential community members (traditional and religious leaders, educators, local media) to challenge norms and attitudes towards persons with disabilities that perpetuate discrimination and other violations of human rights.	X	X	X
Provide technical assistance to the Ministry of Justice and other relevant ministries to strengthen the national legal and policy framework. Make sure persons with disabilities, especially women and children, are protected from violence.	X	X	X
4. Coordination			
Include disability and persons with disabilities as a standing agenda item in protection coordination meetings.		X	X
Engage persons with disabilities and OPDs in protection coordination meetings and provide reasonable accommodations to enable them to do so meaningfully.		X	X
5. Monitoring and evaluation			
Document and report progress on the achievement of protection outcomes that reduce risks to affected persons.[172]		X	X

Tools and resources

- Global Protection Cluster website
- *Humanitarian inclusion standards for older people and people with disabilities* (2018)
- IASC, *Operational Guidelines on the Protection of Persons in Situations of Natural Disasters* (2011)
- International Committee of the Red Cross, *Professional Standards for Protection Work* (2018)
- OHCHR, *Monitoring the Convention on the Rights of Persons with Disabilities. Guidance for Human Rights Monitors* (2010)
- Oxfam and Global Protection Cluster, *Protection: What is it anyway?* (2016)
- UNHCR, *Understanding Community-Based Protection* (2013)
- UNHCR, *Age, Gender and Diversity Policy* (2018, revised)

[172] IASC, *Policy on Protection in Humanitarian Action* (2016).

Gender-based violence

Gender-based violence (GBV) is "any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e., gender) differences between males and females. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty. These acts can occur in public or in private."[173] Women, girls and transwomen are disproportionately affected by GBV due to the systemic inequality between males and females that exists in all societies. According to estimates of the World Health Organization, approximately one in every three women experiences sexual or physical violence, very often at the hands of her intimate partner.[174] The term 'gender-based violence' is also increasingly used by some actors to highlight the gendered dimensions of certain forms of violence against men and boys, particularly some forms of sexual violence committed with the explicit purpose of reinforcing inequitable gender norms of masculinity and femininity. Examples include sexual violence committed in armed conflicts with the aim of emasculating or feminizing the enemy. This violence against males is based on socially constructed ideas of what it means to be a man and to exercise male power. It is used by men (and in rare cases by women) to cause harm to other males.[175] Finally, lesbian, gay, bisexual, transgender and intersex persons may also experience GBV, because they are perceived by others to be "defying gender norms".[176]

In any emergency, certain groups of individuals in affected populations are more vulnerable to GBV. These individuals often hold less power in society, are more dependent on others for survival, and are less visible in the community or otherwise marginalized. When other factors, such as age, disability, sexual orientation, gender identity, religion or ethnicity intersect with gender-based discrimination, the risk of GBV is likely to rise.[177] In humanitarian contexts, women, men, girls and boys with disabilities experience multiple, intersecting, and sometimes mutually reinforcing forms of discrimination and oppression, adding to the risk of violence, including GBV, that they may face. Women and girls with disabilities disproportionately experience GBV; they are victims of domestic violence twice as frequently as other women. Because of the discrimination and stigma associated with both gender and disability, this violence also takes unique forms. For example, women and girls with disabilities are more likely to be subjected to forced medical treatment, including forced sterilization and other reproductive health procedures, without their consent.

Risks associated with GBV during crises and displacement

- Women and girls with disabilities, and particularly women and girls with psychosocial, hearing and intellectual disabilities, are at higher risk of sexual violence and other forms of GBV. Repeated and regular rape by multiple perpetrators is the most common form of GBV reported.
- Women with disabilities who have been in exploitative relationships or have engaged in transactional sex frequently experience sexual exploitation. Associated risk factors include extreme poverty and unmet needs for assistance.[178]
- Sexual violence against men and boys with intellectual disabilities has been reported in several contexts. Risk factors include race, ethnicity and gender, underlining the intersection of disability with other dimensions of identity.[179]
- Girls with disabilities are at risk of child marriage, especially in protracted refugee

[173] Human Rights Watch, *Chained Like Prisoners* (2015).

[174] IASC, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, promoting resilience and aiding recovery* (2015).

[175] *Ibid*, p. 5.

[176] *Ibid.*

[177] *Ibid.*

[178] Reported in Burundi and Ethiopia.

[179] Reported in Burundi, Jordan and Lebanon.

contexts. This risk arises from the intersection of several risk factors, including socio-economic stress, gender inequality, age and disability.[180]

Female caregivers may experience harassment when they try to access services or assistance for their husband or for a male head-of-household with a disability. Adolescent girls may be removed from school to assist with caregiving needs in the household.[181] Members of the community, the authorities or humanitarian actors may not listen to or believe women and girls with disabilities who report violence or want to negotiate safe sexual relationships. These forms of harassment or discrimination reduce their access to services and exacerbate stigma, discrimination, and harmful attitudes and norms; often, in addition, they increase the impunity of perpetrators.

The following guidance will assist humanitarian actors who work on GBV to identify and address barriers faced by persons with disabilities, as well as their families, support persons and caregivers, when they try to access GBV prevention mechanisms or respond to GBV in humanitarian settings.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Ensure that persons with disabilities are included in community consultations on GBV. Consultations should be age- and gender-appropriate. Employ participatory methods to identify barriers to access and take steps to make GBV activities and services accessible to persons with disabilities.[182]	X	X	
Assess the attitudes and assumptions to disability inclusion of GBV programme staff and service providers.[183]	X	X	
Map local OPDs. Identify who they represent and the degree to which they have the capacity to work on safe identification and referral of GBV survivors to appropriate services.[184] Take steps to fill gaps in capacity.	X	X	

[180] Women's Refugee Commission and UNICEF, *Disability Inclusion in Child Protection and Gender-Based Violence Programs in Lebanon* (2018).

[181] Reported in Jordan.

[182] Women's Refugee Commission and International Rescue Committee, *Building capacity for disability inclusion in gender-based violence programming in humanitarian settings. A toolkit for GBV practitioners* (2005). Guidance Note 1 states that humanitarian and other actors who work on GBV should hold community consultations on GBV risks. 15–20 per cent of community members involved in designing, monitoring and evaluating GBV programmes should be persons with disabilities, in line with international standards for safe data collection on sexual violence in humanitarian contexts. This implies that 1–2 persons with disabilities from each age- and gender-appropriate group, and in addition persons with a range of disabilities, should participate. Concurrently, it may be appropriate to interview some individuals. Interviews can be held at a location of the interviewee's choice. Steps should be taken to identify and mitigate risks.

[183] *Ibid.* Guidance Note 2 states that humanitarian and other actors who work on GBV may believe that GBV prevention and response services are not relevant to or appropriate for persons with disabilities, or fear 'doing harm' if they include them in activities. GBV case workers may incorrectly assume that survivors with intellectual disabilities do not have the capacity to make their own decisions, may defer to caregivers on what support and referral is appropriate, or may not adopt a survivor-centred approach. All GBV staff should be trained to consider their attitudes and assumptions about persons with disabilities and hold open conversation about working with persons with disabilities. See Other Tools and Resources.

[184] *Ibid.* Guidance Note 3 notes that local organizations of persons with disabilities (OPDs) are familiar with disability-friendly service providers, and this knowledge can be used to inform and improve standard operating procedures and referral systems. As the first contact point for survivors with disabilities, OPDs may need training in the principles of safe identification and referral. Seek out OPDs that are in contact with marginalized groups of persons with disabilities, including persons with intellectual disabilities and adolescent girls with disabilities, who may be at highest risk of GBV.

	Preparedness	Response	Recovery
Ensure that planning addresses the gender and disability-specific requirements of persons with disabilities, as well as the risks and violations of human rights that they experience. Invite persons with disabilities to help define GBV sector priorities.	X	X	X
2. Resource mobilization			
Develop proposals that address the GBV risks of women, men, girls and boys with disabilities.	X	X	X
Secure financing and prepare inclusive budgets that allocate resources to improve accessibility and inclusion.		X	X
3. Implementation			
Recruit persons with disabilities as staff, volunteers and community mobilizers. Take steps to achieve gender balance in GBV activities.[185]	X	X	X
Integrate and mainstream content about persons with disabilities in core GBV training packages. Add case studies and discussions of disability to practitioner training and community awareness-raising materials.[186]	X	X	
Train local OPDs, in particular women-led OPDs, in how to safely identify and refer GBV survivors.	X	X	X
Strengthen national policies and protocols, including standard operating procedures, case management systems and referral systems. Ensure they adopt a survivor-centred approach and provide responsible, compassionate and confidential care to GBV survivors with disabilities.	X	X	X
Establish safe, accessible and confidential complaint mechanisms. These should comply with protection from sexual exploitation and abuse (PSEA) standards.[187]	X	X	X

[185] *Ibid.* Guidance Note 4 notes that research has shown that women with disabilities in humanitarian settings are often underrepresented in community leadership structures. Recruiting women with disabilities as community mobilizers and social workers draws attention to the concerns of this group and simultaneously increases respect for the skills and capacities of persons with disabilities among both humanitarian staff and in the community (WRC/IRC 2015).

[186] Women's Refugee Commission and International Rescue Committee, *Building capacity for disability inclusion in gender-based violence programming in humanitarian settings. A toolkit for GBV practitioners*. (2005). Guidance Note 5 argues that persons with disabilities and their caregivers should be included in core GBV training packages, which should include case studies and examples centred on women, children and youth with disabilities. Over time, GBV staff should increasingly recognize that responding to the needs of persons with disabilities is a core part of their work and acquire relevant skills to do this work. (See the section on other tools and resources.)

[187] *Ibid.* Guidance Note 8 makes the point that NGOs, international organizations and the UN system have a shared responsibility to eradicate sexual exploitation and abuse by their personnel. All actors operating in a humanitarian response, including those who work on GBV, must ensure that affected populations can report violations by personnel in a safe, accessible, and confidential manner. See UN Doc. 3ST/SGB/2003/13, 9 Oct 2003; for more information, see PSEA website.

	Preparedness	Response	Recovery
Ensure that engineers and architects adopt universal design principles when women's centres, health clinics, safe houses and transportation systems are constructed.[188]	X	X	X
Facilitate the participation of women and girls with disabilities in peace negotiations and peace-building, in line with international commitments.[189]			X
4. Coordination			
Include disability and persons with disabilities as a standing agenda item in GBV coordination meetings.	X	X	
5. Monitoring and evaluation			
Monitor how many persons with disabilities (disaggregated by sex and age) attend GBV activities.[190]		X	
Data information management systems, such as the Gender-Based Violence Information Management System, should be disaggregated by sex, age and disability, in line with safe and ethical practices for the collection and dissemination of GBV data. This will make it possible to determine whether particular gender and age groups of persons with disabilities are excluded.	X	X	

Tools and resources

- GBV Area of Responsibility Working Group, *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings* (2010)
- GBV Area of Responsibility (AoR), *Handbook for Coordinating GBV in Emergencies* (2019)
- GBV Area of Responsibility (AoR), *GBV Minimum Standards on Prevention and Response to GBV in Emergencies* (2019, in publication)
- IASC, *Gender Handbook for Humanitarian Action* (2018)
- IASC, *Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action* (2015)
- *Inter-agency Gender-based Violence Case Management Guidelines* (2017)

[188] *Ibid.* Guidance Note 6. 'Universal design' refers to "the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design". Ensuring that buildings and facilities are accessible consumes approximately 1 per cent of construction costs. It is more cost-effective than retrofitting buildings and facilities at a later stage.

[189] This aligns with UN Security Council Resolution 1325 on women, peace and security, which notes the inordinate impact of war and violent conflict on women and girls and the crucial role that women play in conflict prevention, conflict resolution, peace-making and peace-building. The resolution urges all actors to increase the participation of women and incorporate gender perspectives in all United Nations peace and security efforts. See United States Institute of Peace, 'What is UNSCR 1325?'

[190] Women's Refugee Commission and International Rescue Committee, *Building capacity for disability inclusion in gender-based violence programming in humanitarian settings. A toolkit for GBV practitioners* (2005). Guidance Note 7 argues that it is critical to monitor the number of persons with disabilities who use GBV services and programmes in order to understand whether programmes are reaching those who need them most. At least 15 per cent of participants in any GBV activity should be persons with disabilities; this ratio is not always met. (WRC/IRC 2015)

- UNFPA, *Minimum Standards for Prevention and Response to Gender-based Violence in Emergencies* (2015)
- WHO, UNHCR and UNFPA, *Clinical Management of Rape Survivors* (2004)
- WRC and ChildFund, *GBV Against Children and Youth with Disabilities* (2016)
- WRC and IRC, *Building capacity for disability inclusion in gender-based violence programming in humanitarian settings* (2015)
- WRC and UNICEF, *Guidance on Disability Inclusion for GBV Partners in Lebanon: Case management of survivors and at-risk women, children and youth with disabilities* (2018)

Child protection

During humanitarian crises, children are more exposed to violence, abuse, neglect and exploitation. Their protection may be weakened as families are put under additional strain[191] and community networks break down. The impact on children with disabilities can be especially marked, because they are subject to stigma and discrimination and may have less access to coping mechanisms. As a result, they are at higher risk of rights violations. According to the former Child Protection Working Group, "exclusion fundamentally affects the development of a child's full potential… Excluded children are more vulnerable to violence, abuse, exploitation and neglect. Humanitarian crises and responses can make cycles of exclusion worse or can offer opportunities for change."[192]

Studies indicate that children with disabilities are three to four times more likely to be survivors of violence than children without disabilities.[193] Further, some forms of violence are specific to children with disabilities. Examples include violence administered under the guise of treatment to modify behaviour, forced sterilization of girls with disabilities, or enforced abortion.[194]

In line with the definition in Article 1 of the Convention on the Rights of the Child (CRC), a child is defined as a person under 18 years of age.

The CRC sets out four principles on the rights of the child, which also apply in humanitarian action:

- **Survival and development**. Humanitarian workers must consider how an emergency and the response to it affect the development of children.
- **Non-discrimination**. Humanitarian workers must address patterns of discrimination and power in the response.
- **Child participation**. Humanitarian workers must enable children to meaningfully participate in all stages of humanitarian preparedness and response.
- **Best interests of the child**. The best interests of the child must be a primary consideration in all actions concerning children.[195]

Child protection-related risks and impacts

- In many countries, children with disabilities are frequently placed in institutions,[196] where they are at risk of abuse, exploitation and neglect. Such facilities often have low standards of care and lack monitoring. Perpetrators of violence and abuse are rarely held to account.[197]
- Placement in residential facilities also increases the risk of trafficking of children with disabilities. Studies have found that girls with disabilities are at risk of being trafficked

[191] Child Protection Working Group, Minimum Standards for Child Protection in Humanitarian Action (2019).

[192] *Ibid.*

[193] Hughes K. et al., *Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies*, in The Lancet, 2012, doi:10.1016/S0410-6736(11)61851-5.

[194] UNICEF, *State of the World's Children: Children with disabilities* (2013).

[195] Child Protection Working Group, Minimum Standards for Child Protection in Humanitarian Action (2019).

[196] See Lumos, *Children in Institutions: the Global Picture* (2017).

[197] African Child Policy Forum, *The African Report on Violence against Children* (2014).

because their impairments are presumed to limit their chances of escape.[198]

- In sub-Saharan societies, myths that body parts of persons with albinism have magical powers have led to attacks and mutilation, primarily of children with albinism.[199]
- Children with disabilities are particularly likely not to be registered at birth. This increases their exposure to risks, including child marriage and statelessness, and can block their access to education, health care and other basic services.[200]
- Children with disabilities who have become separated from caregivers are especially endangered. Family members may have been the only persons to know how to care for a child's specific physical requirements or how to communicate with a child.[201] Children with disabilities may be unable to communicate information that is essential for family tracing and reunification. Unaccompanied children with disabilities may be excluded from traditional systems of care if local families do not accept them.
- Girls with disabilities are at risk of gender-based violence,[202] including rape, sexual exploitation and abuse.[203] This in turn may expose them to HIV and severe neglect.[204] Although research on this issue is limited, girls with disabilities are also at higher risk of child and forced marriage.
- Children with disabilities may be engaged in hazardous child labour including the worst forms of child labour, such as prostitution and begging.
- Children with disabilities, especially those with intellectual disabilities, may be more likely to be recruited into armed groups.

The following guidance will support humanitarian actors working in child protection to identify and remove barriers faced by persons with disabilities, as well as their families, support persons and caregivers, when they try to access child protection programmes in humanitarian settings.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Include girls and boys with disabilities in age-appropriate assessments and consultations, including Child Protection Rapid Assessments.	X	X	
Make sure that children with disabilities participate in child protection decisions that concern them; ensure the procedures are confidential.	X	X	

[198] Leonard Cheshire Disability, *Still left behind: pathways to inclusive education for girls with disabilities* (2017).

[199] *Report of the Independent Expert on the enjoyment of human rights by persons with albinism*, A/HRC/34/59, 10 January 2017, para. 29.

[200] UNHCR, *Need to Know: Guidance on Working with Persons with Disabilities in Forced Displacement* (2019). See also Violence Against Women with Disabilities Working Group, *Forgotten Sisters - A Report on Violence against Women with Disabilities: An Overview of Its Nature, Scope, Causes and Consequences* (2012).

[201] UNICEF, *State of the World's Children: Children with disabilities* (2013).

[202] *Ibid.*

[203] Women's Refugee Commission, *Gender-based Violence among Displaced Women and Girls with Disabilities* (2012).

[204] UNICEF, *Violence against Disabled Children: Summary report* (2005).

	Preparedness	Response	Recovery
Involve children with disabilities and their families in identifying barriers that impede access to child protection interventions and child-friendly spaces. Invite them to suggest how barriers can be removed and access improved.	X	X	X
Make sure that teams appointed to run child protection assessments and plan programmes are gender-balanced; ensure that the representation of persons with disabilities on those teams is also gender-balanced.	X	X	
Ensure that planning addresses disability-specific requirements and risks. Involve persons with disabilities in setting child protection priorities.	X	X	X
2. Resource mobilization			
Ensure that all proposals or concept notes consider and analyse child protection risks and the capacities of girls and boys with disabilities. Ensure that interventions address the protection and promote the participation of girls and boys with disabilities.	X	X	
Secure financing. Establish an inclusive budgeting system that allocates resources to promote accessibility and inclusion.		X	X
3. Implementation			
Disaggregate data by disability in the Child Protection Information Management System and all data collection tools. (Use the UNICEF-Washington Group Child Functioning Module.)	X	X	
Increase the capacity of staff and volunteers to understand and apply a rights-based approach to disability.	X	X	
Give training and support to foster carers and interim caregivers on the needs of children with disabilities.	X	X	X
Train all child protection staff in disability. Integrate case studies and discussions of violence, exploitation and abuse of children with disabilities in core trainings. Include social workers, community outreach workers, education staff, health workers, protection focal points, and committees.	X	X	
Choose locations for child protection activities that are physically accessible; where this is not possible, make necessary adjustments and provide reasonable accommodations.	X	X	X
Raise awareness of the rights of children with disabilities. Discuss these rights with children (with and without disabilities), with their families, and with community leaders, religious leaders, traditional healers, education and health staff, and the wider community.	X	X	X

	Preparedness	Response	Recovery
Identify the safety concerns of children with disabilities, such as bullying or risk of injury, and physical or sexual abuse. Take steps to remove or mitigate these risks.		X	X
Include adolescents and youth with disabilities in activities that help build their resilience. Foster leadership and strengthen peer networks. Consider recreational activities, sports, cultural activities, education, and life skills.[205]	X	X	X
Identify mentors with disabilities. Encourage mentors to use their leadership, skills and capacities to counter negative attitudes to disability. Consider introducing a buddy system for adolescents and youth with and without disabilities.	X	X	
Promote access to birth registration for all children, including children with disabilities.		X	X
Identify children living in residential facilities, including children who have been separated and abandoned when communities flee. Where it is in their best interest, include them in family tracing and reunification.		X	X
Consider the requirements of unaccompanied and separated children with disabilities who are in respite or alternative care.		X	
Ensure that any actions to prevent and respond to the worst forms of child labour include children with disabilities.		X	X
Ensure case management systems are inclusive. Map their accessibility. Train case workers in how to work with children with disabilities. (For example, give them practical skills in accessible communication; make them aware of the rights of children with disabilities and the risks they face.)		X	X
Use mobile outreach teams to reach children with disabilities who cannot travel to registration sites or child-friendly spaces. Ensure they visit children in residential facilities, including detention centres.		X	X
Work with communities to include children with disabilities and their parents in community-based child protection mechanisms.	X	X	X
Provide support to enable families and caregivers of children with disabilities to access assistance.	X	X	X
Ensure that monitoring and reporting mechanisms, including the Monitoring and Reporting Mechanism on Grave Violations, report violations of the human rights of children with disabilities.		X	X

[205] Child Protection Working Group, Minimum Standards for Child Protection in Humanitarian Action (2019).

	Preparedness	Response	Recovery
4. Coordination			
Include children with disabilities as a standing agenda item in the Child Protection Coordination Group.		X	X
5. Monitoring and evaluation			
Integrate child protection data in household-level monitoring tools; disaggregate the data by sex, age and disability status. Encourage monitoring teams to adopt data collection tools tested in humanitarian contexts, such as the UNICEF/Washington Group Child Functioning Module.		X	

Tools and resources

- Alliance for Child Protection in Humanitarian Action, *Field Handbook on Unaccompanied and Separated Children* (2017)
- Better Care Network
- Child Protection in Crisis Learning Network
- Child Protection Working Group, *Minimum Standards for Child Protection in Humanitarian Action* (2019)
- Child Protection Working Group, *Inter Agency Guidelines for Case Management and Child Protection* (2014)
- GBV Responders' Network, Caring for Child Survivors
- Global Protection Cluster, Child Protection Working Group
- International Committee of the Red Cross, *Inter-Agency Guiding Principles on Unaccompanied and Separated Children* (2004)
- UNICEF, *Including children with disabilities in humanitarian action*
- UNICEF, *Children With Disabilities In Situations of Armed Conflict* (2018)
- Women's Refugee Commission and Childfund, *Gender-Based Violence Against Children and Youth with Disabilities: A Toolkit for Child Protection Actors* (2016)

Housing, land and property

Individuals affected by humanitarian emergencies increasingly live in urban areas, informal settlements and collective centres, rather than in camps or planned settlements. Humanitarian actors need to consider the challenges and opportunities that this evolution presents for displaced persons with disabilities.[206]

The Universal Declaration of Human Rights recognized in 1948 that adequate housing is part of the right to an adequate standard of living. Article 25(1) states that "everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights (1966) also recognized the right to adequate housing, which is understood to include legal security of tenure; the availability of services, materials, facilities and infrastructure; affordability; habitability; accessibility; location; and cultural adequacy.[207]

The right to property is understood as the right to enjoy one's house, land and other property possessions without interference or discrimination. In a humanitarian context, realization of this right may involve safeguarding property and possessions that have been left behind by people fleeing conflict or natural hazard from looting, destruction, or arbitrary or illegal appropriation, occupation or use.[208]

Disputes over housing, land and property (HLP) are common in humanitarian contexts due to secondary occupation, loss of ownership documents, illegal or forced sales, insecurity of tenure, unequal distribution of land, and ongoing grievances over land and property.[209]

HLP-related risks and impacts

- Some persons with disabilities face multiple forms of discrimination with regard to housing. Displaced persons with disabilities may face discrimination due to their disability as well as racism and xenophobia; and may simultaneously lose vital coping mechanisms and support structures during flight. Others are unable to claim access to housing because they have lost essential documentation,[210] or cannot challenge discriminatory rental practices because they lack legal status.[211] As a result, displaced persons with disabilities may lack accommodation, may be unable to rent adequate accommodation, may be forced to live in insecure and unsafe conditions, and may be vulnerable to eviction.[212]

- Multiple and intersecting discrimination is experienced by women with disabilities, who face additional gender-related barriers that impede them from exercising HLP rights. In particular, widowed, abandoned or divorced women may only be able to own property or acquire access to property through male relatives.[213] Women with disabilities who are forced to live in insecure housing are also at higher risk of violence, including sexual violence.[214]

- Persons with disabilities are often denied the right to choose where and with whom they live, either by direct discrimination or *de facto* removal of choice. Women are deprived of effective choice, for instance, if they lack access to transport and other services, lack information, or live in extreme poverty.[215]

- Some persons with disabilities are placed involuntarily in institutions or are unable to leave the institutions in which they have been placed. Both situations deprive them of their right to choose independently where they live. This risk is particularly common for persons with intellectual and psychosocial disabilities.[216]

- Forced institutionalization often occurs as an indirect result of other failures to respect the right to adequate housing. In some societies, for example, the State does not provide persons with disabilities necessary forms of support to enable them to live in the community; in others, housing is simply unaffordable.[217]

- The cost of housing can disproportionately affect persons with disabilities, because they often face additional expenses (for healthcare, for example) as well as barriers that prevent them from accessing employment.[218]

- Higher rates of poverty and discrimination may force persons with disabilities into slums and informal settlements.[219]

- Homelessness disproportionately affects persons with disabilities. In some cases, this occurs when persons with disabilities are de-institutionalized but not supported adequately to live in the community. Poverty and discrimination are other causes.[220]

- If their legal capacity is not recognized, persons with disabilities may not be allowed to enter into agreements to lease or own property. In addition, they are particularly likely to experience discrimination when property is inherited.

The following guidance will assist humanitarian actors working in HLP to identify and remove barriers faced by persons with disabilities, as well as their families, support persons and caregivers, when they try to access HLP programmes in humanitarian settings.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Through participatory analysis, identify barriers that prevent persons with disabilities from realizing their HLP rights. Disaggregate the data by sex and age. Include persons living in institutions.		X	X
Work with OPDs and legal experts to clarify the forms of discrimination that persons with disabilities face. Identify legal avenues of recourse.	X	X	X

206 See for example, Norwegian Refugee Council, *Guidance Note on HLP Issues in Informal Settlements and Collective Centres in Northern Syria* (2017). The NRC recognizes that limited guidance is available on housing, land and property issues in informal settlements and collective centres, which are common in Syria.

207 UN Committee on Economic, Social and Cultural Rights, General Comment No. 4: The Right to Adequate Housing (Art. 11(1) of the Covenant), 13 December 1991.

208 IASC, *Protection in Natural Disasters*.

209 Norwegian Refugee Council and IFRC, *The Importance of Addressing Housing, Land and Property (HLP) Challenges in Humanitarian Response* (2016).

210 *Ibid.*

211 UN Habitat and OHCHR, *The Right to Adequate Housing. Human rights factsheet no. 21 (rev. 1)* (2009).

212 Norwegian Refugee Council and IFRC, *The Importance of Addressing Housing, Land and Property (HLP) Challenges in Humanitarian Response* (2016).

213 See, for example, Norwegian Refugee Council, *Displaced Women's Rights to Housing, Land and Property* (2018).

214 See, for example Norwegian Refugee Council and IFRC, *The Importance of Addressing Housing, Land and Property (HLP) Challenges in Humanitarian Response* (2016).

215 UN Habitat, *The Right to Adequate Housing for Persons with Disabilities Living in Cities: Towards Inclusive Cities* (2015).

216 *Ibid.*

217 UN Special Rapporteur on Adequate Housing as a Component of the Right to an Adequate Standard of Living, *Adequate Housing as a Component of the Right to an Adequate Standard of Living, and the Right to Non-Discrimination in this Context*, A/72/251 72b, 12 July 2017.

218 UN Habitat, *The Right to Adequate Housing for Persons with Disabilities Living in Cities: Towards Inclusive Cities* (2015).

219 UN Habitat and OHCHR, *The Right to Adequate Housing. Human rights factsheet n. 21 (rev. 1)* (2009).

220 UN Habitat, *The Right to Adequate Housing for Persons with Disabilities Living in Cities: Towards Inclusive Cities* (2015).

	Preparedness	Response	Recovery
With OPDs, map local services (such as in-home and community support services) that enable and assist persons with disabilities to live independently.	X	X	X
Ensure that planning covers the requirements of persons with disabilities, and the risks they encounter. Involve persons with disabilities in setting priorities for housing, land and property.	X	X	X
2. Resource mobilization			
Ensure that proposals and concept notes that examine legal capacity and literacy include persons with disabilities.	X	X	
3. Implementation			
Support networks that call for persons with disabilities to have equal access to HLP rights in humanitarian situations. Encourage campaigns that affirm HLP rights and campaigns that affirm the principles of the Convention on the Rights of Persons with Disabilities (CRPD).		X	X
Integrate case studies and discussions of disability in core trainings for staff involved in HLP programmes. Include community outreach staff, protection focal points, and committees.	X	X	X
When allocating safe emergency shelter, consider giving priority to groups that are particularly at risk, including persons with disabilities.		X	
Improve accessibility to housing, housing services and infrastructure, including transport. (See the section on Shelter and settlements for more guidance.)		X	X
Work with OPDs to advocate for restitution of property without discrimination. The right of persons with disabilities to own property should be recognized; they should also enjoy access to information and legal aid.		X	X
Ensure that persons with disabilities can make restitution claims and that procedures for restitution are accessible. Provide information and training to improve legal literacy; assist people with disabilities who need support to complete claims procedures.[221]		X	X
Ensure that, when refugees and internally displaced persons are asked to report on their use, ownership, residence in, and possession of land and property in their country of origin, persons with disabilities are asked the same questions. (Disaggregate the data by sex and age.)		X	X
Include persons with disabilities in any processes that assist refugees and internally displaced persons to obtain access to HLP documentation.		X	X
Connect displaced persons, OPDs and civil society organizations, including tenants' associations, that advocate for HLP rights.		X	X
Ensure that monitoring and reporting mechanisms report violations of the HLP rights of persons with disabilities.	X	X	X
4. Coordination			
Include persons with disabilities as a standing agenda item in HLP coordination meetings.		X	X
Engage persons with disabilities and OPDs in HLP coordination meetings. Provide reasonable accommodations to facilitate their meaningful participation.		X	X
5. Monitoring and evaluation			
Integrate data on persons with disabilities in household-level monitoring tools.		X	

[221] The Pinheiro Principles set out international standards on housing, land and property restitution for refugees and internally displaced persons. See Centre on Housing Rights and Evictions, *The Pinheiro Principles*.

Tools and resources

- FAO and others, Housing and Property Restitution for Refugees and Displaced Persons in *Pinheiro Principles* (2007)
- IASC, *Framework for Durable Solutions for Internally Displaced Persons* (2010)
- Norwegian Refugee Council and IFRC, *The Importance of Addressing Housing, Land and Property (HLP) Challenges in Humanitarian Response* (2016)
- Norwegian Refugee Council, *Technical Guidelines for Addressing HLP Issues in Informal Settlements/Camps and Collective Centres in Northern Syria* (2017)

Mine action

Mine action activities aim to reduce the risks and harms to civilians and humanitarian workers of explosive hazards.[222]

The five pillars of mine action are:

- **Clearance of mines and explosive remnants of war (ERW)**. This is the process of using technical and non-technical surveys to gather information on explosive hazards and ordnance, and then removing them. The aim is also to remove the contaminating effects of mines and ERW, so that civilians can return to their homes and their daily activities safely.

- **Risk education** includes activities (such as information campaigns, training, and liaison with communities) that reduce the risk of injury due to explosive hazards by raising awareness and promoting behaviour change.

- **Victim assistance** has the end goal of ensuring that persons with disabilities, including mine survivors, participate fully and effectively in society on an equal basis with others. This implies taking steps to achieve the highest attainable standards of health, rehabilitation, psychosocial support, inclusive education, social protection, work and employment, as well as full participation and inclusion in society and an adequate standard of living. It includes action to meet the needs of casualties, survivors, other persons with disabilities, the families of people injured and killed, and affected communities. Fields of action include medical care, rehabilitation, psychosocial support, social inclusion, inclusive education and economic inclusion, including social protection. Data collection on the needs of victims is also required, and laws and policies protecting and promoting the rights of victims need to be passed and applied.

  Non-discrimination, the recognition of human rights, the role of gender, and recognition of development contexts are key principles. Article 5(2a) of the Convention on Cluster Munitions states that victim assistance programmes must not discriminate against or between cluster munition victims, persons with disabilities, and persons who have been injured or have acquired impairments through other causes.[223]

- **Stockpile destruction** refers to a broad range of activities by States to destroy their stockpiles of anti-personnel landmines and cluster munitions.

- **Advocacy** refers to activities to mobilize support for mine action and to convince Member States to accede, ratify and implement the Anti-Personnel Mine Ban Convention, the Convention on Cluster Munitions, the Convention on Certain Conventional Weapons and other relevant international agreements such as the CRPD.

Mine action-related risks and impacts

- Persons with disabilities may lack access to risk education programmes. As a result, they may remain unaware of the dangers that munitions pose or safe behaviours that mitigate those dangers.

- Persons with disabilities may be forced to adopt unsafe behaviour. For example, if latrines are not accessible, they may be forced to use uncleared areas at the outskirts of settlements where ERW are still present.

- Persons with disabilities may also have less influence than others over land release and land clearance decisions. They may not participate in land release processes or decisions about which land is prioritized for clearance, may not be given access to released land, and may be unable to secure title to land. For these and other reasons, persons with disabilities may be excluded from development and livelihood opportunities associated with mine clearance.

[222] Global Protection Cluster, *Mine Action* (2018).

[223] Convention on Cluster Munitions (2008). See also UN Human Rights Council, *Thematic study on the rights of persons with disabilities under article 11 of the Convention on the Rights of Persons with Disabilities, on situations of risk and humanitarian emergencies*, A/HRC/31/30, 30 November 2015, para. 19.

The following guidance will support humanitarian actors working in mine action to identify and remove barriers faced by persons with disabilities, as well as their families, support persons and caregivers, when they try to access mine action programmes in humanitarian settings.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Invite survivors, persons with disabilities, and organizations that represent persons with disabilities (OPDs) to participate in efforts to understand how mines and ERWs affect communities. Involve them in setting priority areas for clearance and marking.		X	X
Ensure that planning addresses the specific requirements of persons with disabilities, and the risks they face. Involve persons with disabilities in setting priorities for the mine action sector.	X	X	X
2. Resource mobilization			
Make sure that proposals on mine action systematically consider persons with disabilities regardless of the cause of their impairment.		X	X
3. Implementation			
Take steps to make sure that community liaison activities take into account, and involve, persons with disabilities, OPDs, and survivor organizations. Consider capacity-building at community level to enable persons with disabilities and OPDs to assess risk, manage information, develop local risk reduction strategies and advocate for mine action and other assistance interventions.[224]		X	X
Integrate case studies and discussions of disability and disability inclusion in core trainings for staff involved in mine action. Include community outreach staff, protection focal points and committees.	X	X	
Ensure that persons with disabilities are involved in decisions on the handover of cleared land to communities, and decisions on the use of cleared land.			X

[224] UNICEF and GICHD, *International Mine Action Standards (IMAS) Mine Risk Education Best Practice Guidebook 1* (2005), and IMAS 04.10, 2nd edition, 1 January 2003 (as amended on 1 December 2004), 3.157.

	Preparedness	Response	Recovery
Ensure that reparations are not replaced by social protection schemes.[225]			X
Involve persons with disabilities and their representative organizations in designing, implementing and evaluating risk education activities, including through peer-to-peer education activities.		X	
Ensure that risk education information is presented in multiple accessible formats; adapt education materials.		X	
Consult persons with disabilities and OPDs to identify their preferred communication channels.	X	X	
Involve persons with disabilities and OPDs in designing and delivering peer-to-peer education activities.		X	
4. Coordination			
Systematically include persons with disabilities in mine action coordination forums.		X	
Coordinate with all relevant sectors to ensure that referrals of persons with disabilities are made regardless of the cause of their impairments.		X	X
Engage persons with disabilities and OPDs in mine action coordination meetings and provide reasonable accommodations to facilitate their meaningful participation.		X	X
5. Monitoring and evaluation			
Monitor and provide information on measures that are taken to improve access to risk education and analyse the various impacts of mines and ERW on the lives of persons with disabilities.		X	X

Tools and resources

- Geneva International Centre for Humanitarian Demining (GICHD), *Guide to Mine Action and Explosive Remnants of War* (2007)
- Handicap International Factsheets, *How to Implement Victim Assistance Obligations?*
- IMAS, *International Mine Action Standards*
- Mine Action Area of Responsibility website
- UNICEF and GICHD, *IMAS Mine Risk Education Best Practice Guidebook 1: An Introduction to Mine Risk Education* (2005)
- UNICEF, *Assistance to Victims of Landmines and Explosive Remnants of War: Guidance on Child-focused Victim Assistance* (2014)
- United Nations, *United Nations Policy on Victim Assistance in Mine Action* (2016)
- United Nations, *Gender Guidelines for Mine Action Programmes* (2010)
- United Nations, *The UN Mine Action Strategy (2019–2023)* (2018)
- Victim Assistance Resources Portal of the Landmine and Cluster Munitions Monitor

[225] Office of the UN High Commissioner on Human Rights, *Thematic study on the rights of persons with disabilities under article 11 of the Convention on the Rights of Persons with Disabilities, on situations of risk and humanitarian emergencies*, A/HRC/31/30, 30 November 2015, para. 12.

17 Shelter and settlements

Introduction

In the early stages of an emergency, shelter is a critical determinant of survival, along with water supply, sanitation, food and health care. Shelter plays an essential role in reducing vulnerability and building resilience in communities.[226]

The shelter and settlement sector aims to ensure the dignity, privacy, safety and security of the affected population while providing them with protection from the climate.

During humanitarian action, the shelter and settlement sector also plays a key role in the inclusion of persons with disabilities, because of its impact on the built environment and environmental barriers and its important roles in personal protection and livelihoods.

The cost of investing in barrier-free shelters that respect universal design principles when shelter kits are being prepared is significantly lower than the cost of adapting shelters after construction. The benefits of barrier-free shelters are felt by persons with disabilities but also children, older persons and people who are sick or injured.

Shelters should find solutions that meet the requirements of persons with all kinds of disability. In addition, they should allow adequate space for caregivers, support personnel and family members.

See the section on Protection, especially SGBV and HLP.
Ensure coordination with WASH.

Key legal instruments and other frameworks

- Convention on the Rights of Persons with Disabilities (Articles 9 and 19 in particular)
- Sustainable Development Goal 11
- Habitat III: The New Urban Agenda
- Office of the UN High Commissioner for Human Rights and UN Habitat, The Right to Adequate Housing (Fact Sheet No 21, Rev. 1)

Key terms

Shelter is defined as a "habitable covered space providing a secure and healthy environment with privacy and dignity for those residing within it". Over time, this habitable space may evolve from an emergency to a durable shelter.[227] Shelter assistance includes (and often combines) many modalities and solutions: shelter kits and tents and their distribution; cash-based assistance; rental support; provision of construction materials; labour; repairs; training and technical support; shelter and house construction, etc.

[226] IFRC, *Shelter and Settlements*.

[227] For UN, DFID and Shelter Centre documents on shelter, see *Shelter, Settlement and Recovery – (GBV) Guidelines*.

Shelter assistance includes three distinct response phases: emergency, recovery and durable solutions. In reality these phases usually overlap, and shelter responses are planned and implemented as a continuous, uninterrupted effort. In conflict settings, the phases are less clearly defined, because people may experience numerous or prolonged displacements.

Settlements are socially, economically, geographically and often politically and administratively defined entities in which human beings live and interact. In a humanitarian context, settlements can be classified according to their size, duration (temporality), condition, and legitimacy.[228]

Transitional shelters include rapid, post-disaster household shelters made from materials that can be upgraded or re-used in more permanent structures or relocated from temporary to permanent locations. They aim to facilitate the transition of affected populations to more durable forms of shelter.[229]

Emergency shelter refers to the provision of basic and immediate shelter support that is necessary to ensure the survival of crisis-affected persons. It includes rapid response solutions such as the distribution of shelter items (tarpaulins, ropes, kits and toolkits, tents, insulation materials), construction of temporary shelters, and distribution of household items.

Host families may be friends or family, or local families, who offer temporary shelter in their own homes to persons displaced by a natural hazard or conflict. This is usually a short-term arrangement but may persist if the displacement becomes protracted.[230]

Non-Food Items (NFIs) are items other than food used in humanitarian contexts when providing assistance to those affected by natural hazard or crisis. They may include mattresses, blankets, plastic sheets, hygiene kits, fans or heaters, etc.[231]

(See also the definitions of universal design and accessibility in the section on key concepts.)

Barriers

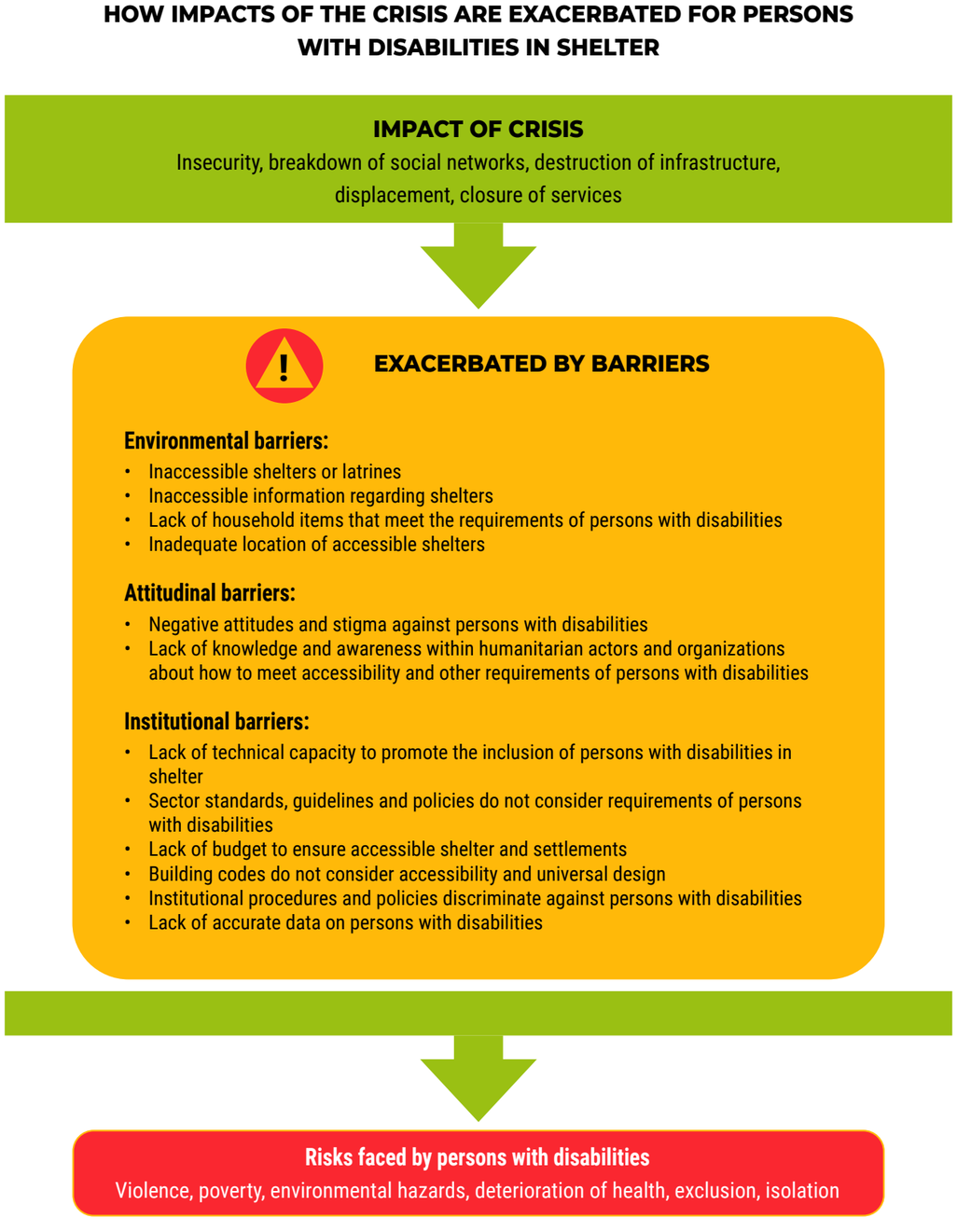
Shelter and settlement play an important role in supporting inclusion and participation. Humanitarian emergencies often affect the built environment and create new barriers that the design and construction of shelters and settlements can help to remove. Inclusive shelter and settlement programming enables persons with disabilities to contribute more to their communities, participate more in consultations and decision-making, and facilitate their own protection.

Standards and guidelines

- *Sphere Handbook* (2018)
- Help Age, CBM, Handicap International, *Humanitarian inclusion standards for older people and people with disabilities* (2018)
- IFRC, *All Under One Roof: Disability-inclusive shelter and settlements in emergencies* (2015)
- AusAid, *Accessibility Design Guide: Universal design principles for Australia's aid programme* (2009)
- Handicap International Nepal, *Guidelines for Creating Barrier-free Emergency Shelters* (2009)

[228] Handout for USAID/OFDA shelter and settlement presentation at Harvard University, 19 April 2018.
[229] IFRC, *Transitional shelters: Eight designs* (2011).
[230] IOM, Norwegian Refugee Council, UNHCR, *Camp Management Toolkit* (2015), p. 18.
[231] Adapted from UNHCR Syria, Non-food items.

Diagram 12 | Barriers to access and inclusion in shelter and settlements



Key elements – must do

'Must do' actions must be undertaken in all phases of humanitarian action when implementing shelter and settlement programming for persons with disabilities.

Participation

- Make sure that persons with disabilities, their families, and organizations of persons with disabilities (OPDs) participate in identifying barriers that impede access for persons with disabilities, and in planning, designing, implementing, monitoring and evaluating shelter and settlements.
- Ensure that persons with disabilities are fairly represented, taking into account the various forms of disability as well as age, gender and diversity. Make concerted efforts to promote underrepresented groups, including persons with intellectual and psychosocial disabilities, indigenous persons, women and girls in formal and informal activities, decision-making and governance.
- Involve persons with disabilities in the development of community participation mechanisms, and feedback and complaint mechanisms, to ensure effective and barrier-free access.

Addressing barriers

- Identify and monitor barriers that prevent persons with disabilities from accessing emergency relief, and measures that improve access. Provide reasonable accommodations and organize outreach to facilitate full inclusion of persons with disabilities.
- Use universal design principles to design shelters and plan settlements. Create shaded or sheltered community spaces that are appropriate for the climatic conditions.
- Provide all assessment and reporting tools, and all information and communications on shelter and settlement in multiple accessible formats, taking into account persons with hearing, visual, intellectual and psychosocial disabilities.
- Implement strategies to reduce disability-related stigma. Take steps to make the community more aware of the rights of persons with disabilities. Establish peer-support groups that include self-advocates with psychosocial and intellectual disabilities.
- Review sectoral policies, guidelines and tools to ensure that they clearly affirm the right of persons with disabilities to access and inclusion.

Empowerment and capacity development

- Build the capacity of shelter and settlement staff. Provide training on the rights of persons with disabilities and the interactions between disability and gender, age, migration status, religion and sexuality.
- Build the capacity of OPDs to engage with shelter and settlement agencies, identify tools and resources, map challenges, capacities and priorities, build knowledge of humanitarian aid and strengthen coordination.
- Partner with OPDs and persons with disabilities to develop and deliver training.

Data collection and monitoring

- Collect and analyse shelter and settlement data on persons with disabilities; disaggregate the data by sex, age and disability. Do this systematically across the humanitarian programme cycle. Where reliable data are not available or cannot be collected, use the 15 per cent estimate of global disability prevalence.[232]
- Ensure that persons with disabilities and OPDs are included as key informants about barriers and enablers. Informants should also be sensitive to wider issues, such as age and gender.

The recommended actions below follow a twin-track approach. They ensure that persons with disabilities have equal rights and opportunities to shelter and settlements and can contribute to efforts to remove barriers and promote comprehensive inclusion and effective and meaningful participation.

MAINSTREAMED

Shelter and settlement programmes and interventions are designed and adapted to ensure they are inclusive of and accessible to everyone, including persons with disabilities.

TARGETED

Shelter, settlement and NFI distribution programmes accommodate the individual requirements of persons with disabilities, including in the emergency and recovery response.

Recommended actions

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Map stakeholders. Include national interest organizations and government agencies with a disability and shelter-related portfolio (social services, housing, public works, etc.).	X		
Analyse gaps in technical expertise with regard to universal design and accessibility. Recruit stakeholders who can fill these gaps. Be sure to extend recruitment to include persons with disabilities and organizations that represent persons with disabilities (OPDs).	X	X	
Evaluate recent shelter and settlement responses and design a response that meets the requirements of persons with different types of disability. Build a library of good practice, including technical documentation and tools, to promote knowledge and learning in the sector.	X		
Involve OPDs in joint Vulnerability and Capacity Assessments (VCA) and joint site visits to designated emergency shelters.	X		

[232] WHO and World Bank, *World Report on Disability* (2011).

	Preparedness	Response	Recovery
With OPDs, conduct accessibility audits of emergency shelters and plan accessible design adaptations to remove barriers.	X	X	
Consider the needs of persons with disabilities from the outset and mainstream inclusion into all aspects of the shelter and settlement response.	X	X	X
Review shelter and settlement assessment tools and adapt questionnaires to be inclusive of persons with disabilities and reflect a gender and age perspective. (See the section on identifying Barriers.)	X		
Working with local preparedness committees (where they exist), bring together disability experience and technical expertise.	X		
2. Resource mobilization			
Identify members of your team, or recruit staff, who have knowledge and experience of disability and disability inclusion.	X	X	X
Establish inclusive budgets that allocate resources to promote accessibility and inclusion and cover the costs of adapting shelter and NFI kits to meet the requirements of persons with disabilities.	X	X	
3. Implementation			
Involve OPDs and persons with disabilities in consultations on suitable emergency shelter solutions for persons with different types of disability.	X	X	
Identify and set up safe shelter spaces to mitigate the protection risks that persons with disabilities face. Consider women, youth and those with psychosocial disabilities particularly.		X	X
With OPDs, identify the best distribution modalities for shelter kits and NFI kits. Options include accessible distribution sites, door-to-door delivery, a buddy system with other beneficiaries, sponsored transport, priority lines, etc.	X	X	X
Use temporary mobile ramps to increase accessibility. Focus on important public buildings and service points, including distribution sites.		X	X
Locate households that include persons with disabilities on plots closer to support networks, water points, sanitary facilities, and services.		X	
Consult persons with disabilities to understand their individual accessibility requirements for tents.		X	
When allocating durable shelter solutions, prioritize households that include persons with disabilities; bypass the transitional stage.		X	
Consult persons with disabilities to assess the accessibility of shelters. Base the analysis on the requirements of persons with disabilities who live in them. Adapt temporary shelters accordingly.	X	X	
Ensure that 'build back better' strategies and plans consider accessibility, adopt universal design principles and prioritize the safety of persons with disabilities.			X
4. Coordination			
If possible, coordinate joint distributions with other sectors to minimize the burden on persons with disabilities and their support networks. (For example, prefer small separate distributions.)		X	X
With other sectors, identify the best locations for households with persons with disabilities; or bring essential services (water, sanitation, food) closer to them.		X	
Use coordination mechanisms to identify host families that can accommodate persons with disabilities.		X	
With OPDs, design and build transitional shelters using universal design principles.		X	X
Locate transitional shelters for persons with disabilities near to accessible sanitary facilities, water points and services; make them accessible in other ways.			X
When repairs and retrofitting are required, do an accessibility audit alongside a damage assessment.			X
Identify suitable units for rent, that are accessible and need little or no adaptation.			X
Recruit persons with disabilities to work in building and construction. (See the section on cash-based intervention.)		X	X
5. Monitoring and evaluation			
Involve persons with disabilities and OPDs in monitoring processes. Prioritize persons with disabilities who live in a shelter.		X	X
Make complaint and feedback mechanisms accessible to persons with disabilities.	X	X	

	Preparedness	Response	Recovery
Monitor the accessibility of shelters and settlements (by audits, or by consulting OPDs or persons with disabilities).		X	
Appoint women, men, girls and boys with disabilities to monitoring teams. Make sure they represent a range of disabilities.		X	
Closely monitor the protection risks that persons with disabilities experience in different locations and types of shelter. Monitor regularly.		X	

Tools and resources

- CBM, *Practical Ways of Building Inclusive Project Cycle Management: Project planning and design*
- GPDD, Toolkit for inclusive reconstruction in Haiti (2010)
- Handicap International, *Haïti: Abri transitionnel* (2011)
- Handicap International, *Disability and Vulnerability Focal Points (DVFP)* (2014)
- HelpAge International and Handicap International, *A study of humanitarian financing for older people and people with disabilities* (2012)
- HelpAge International and IFRC, *Guidance on including older people in emergency shelter programmes* (2012)
- IFRC, *Transitional shelters: Eight designs* (2011)
- IFRC, *Shelter Safety Handbook: Some important information on how to build safer* (2011)
- IFRC, *Post-disaster shelter: Ten designs* (2013)
- IFRC, CBM, Handicap International, *All Under One Roof: Disability-inclusive shelter and settlements in emergencies* (2015)
- HelpAge International, *Ensuring inclusion of older people in initial emergency needs assessments* (2012)
- IFRC, *Guidelines for assessment in emergencies* (2008)
- UNHCR and Handicap International, *Need to know guidance 1: Working with persons with disabilities in forced displacement* (2011)
- Handicap International Nepal, *Guidelines for Creating Barrier-free Emergency Shelters* (2009)
- IASC Emergency Shelter Cluster, *Selecting NFIs for Shelter* (2008)
- ICRC and IFRC, *Emergency Items Catalogue* (2009, third edition)
- IFRC, *The IFRC shelter kit* (2009)
- IFRC, *Shelter Safety Handbook: Some important information on how to build safer* (2011)
- IFRC and Oxfam International, *Plastic Sheeting: a guide to the specification and use of plastic sheeting in humanitarian relief* (2007)
- Handicap International, *Accessibility Assessment of Zaatari Refugee Camp* (2012)
- IOM and UNHCR, *Collective Centre Guidelines* (2010
- Jones, H. and Wilbur, J., *Compendium of accessible WASH technologies* (2014)
- IOM, Norwegian Refugee Council, UNHCR, *Camp Management Toolkit* (2015)
- UNHCR, *Handbook for Emergencies* (2007, third edition). See Chapter 13: Commodities distribution
- IFRC, *Vulnerability and Capacity Assessment*
- US Department of Justice, *Checklist for emergency shelters* (2007)
- AusAid, *Accessibility Design Guide: Universal design principles for Australia's aid programme* (2009)
- IDDC, *Make Development Inclusive: Mainstreaming disability in development coordination* (2008)
- Global Shelter Cluster, *Inclusion of Persons with Disabilities in Shelter and Settlements Programming Working Group*
- Global Shelter Cluster, *Distributions: Shelter Materials, NFI and Cash – Guidance to reduce the risk of Gender-Based Violence*
- *Americans with Disabilities Act Checklist for Polling Places*

18 Water, sanitation and hygiene

Introduction

The right to water and sanitation is a human right. Adequate drinking water, sanitation and hygiene all make contributions to health. The water, sanitation and hygiene (WASH) sector seeks to guarantee this right for all, even in times of crisis. WASH is more than 'just' water. It addresses hygiene, water supply, sanitation (excreta management and solid waste management) and vector control. It also relies on expertise from a range of fields, including engineering, public health, communications and behaviour change. In this section, vector control will not be addressed because there is little information on the relevance of this sub-sector to persons with disabilities.

The need for water varies based on the living environment. With respect to persons with disabilities, the sector must consider various factors, such as whether the context is urban or rural, the crisis is due to conflict or natural hazard, and whether social and religious practices influence the uses of water.

In addition, water use affects protection. Armed conflict and inequity affect water security for individuals and groups. Competing demands for water, for consumption and domestic and livelihood purposes, can cause protection concerns. Personal protection and safety also play a central role in WASH responses, recognizing the risks that are associated with water collection, water pollution, defecation, and menstrual hygiene management.[233]

See the section on Protection. The Health and Education sectors should ensure that WASH stakeholders draw on this section when they deal with WASH concerns in schools and health centres.

WASH plays a key role in ensuring the well-being of people, including persons with disabilities and their families, who may need to access extra quantities of water as well as extra or specific hygiene-related items, and have reliable access to water and sanitation infrastructures. Persons with disabilities who live in isolation or in institutions, or who are not included in mainstream services, such as education, may be excluded from WASH-related information and therefore be at higher health and water-related risks, which can be life-threatening for them and their families.

Key legal instruments and other frameworks

- The right to water is defined as the right of everyone "to sufficient, safe, acceptable, physically accessible and affordable water for personal and domestic uses".[234]
- Convention on the Rights of Persons with Disabilities
- Sustainable Development Goal 6

[233] *Sphere Standard* (2018). See the chapter on WASH.

[234] UN Committee on Economic, Social and Cultural Rights, *General comment No. 15* on the Right to Water (Articles 11 and 12 of the Covenant), E/C.12/2002/11, 20 January 2003.

Key terms

Hygiene is the practice of keeping persons and public facilities, and their environments, clean, especially in order to prevent illness or the spread of disease.

Hygiene promotion supports behaviour and community engagement and action to reduce the risk of disease. A well-integrated hygiene promotion component, adapted to local culture and contextual needs, is vital to the success of any WASH package.

Water supply is the provision of water for personal and household needs. It is to be distinguished from irrigation and water for industrial use. In certain specific situations and for limited periods of time, it may include water for livestock. The minimum quantity of safe water to be provided in an emergency varies according to context. It ranges from 5 to 50 litres (or more) per capita per day. Water may be supplied by public utilities, formal or informal commercial organizations, community-based organizations or individuals. Management arrangements also vary widely according to the context.

Sanitation definitions may differ. A narrow definition refers to the provision of facilities and services for the safe disposal of human faeces and urine and their processing. A wider definition refers also to the maintenance of hygienic conditions, through services such as garbage collection, wastewater disposal and drainage.

Excreta management refers to the safe disposal of excreta, in a manner that does not contaminate the environment, water, food or hands. The safe disposal of human faeces is one of the principal ways of breaking the faecal-oral disease transmission cycle. Defecation practices are highly culture-dependant.

Solid waste management refers to the process of collecting and treating solid waste. Normally managed by public authorities, solid waste collection and disposal systems may be disrupted in an emergency, requiring the intervention of humanitarian actors.

Vector control refers to any action taken to limit or eradicate animals and insects (collectively called vectors) that transmit disease pathogens. Where no effective cure for a disease has been found (true of the Zika virus, West Nile virus and Dengue fever), vector control is the only way to protect human populations. It is achieved through a range of interventions. Environmental controls remove or reduce physical spaces where vectors can easily breed (such as stagnant water, solid waste, food waste and rubble) or reduce contact with vectors (for example, by distributing mosquito nets). Chemical controls disperse chemical agents (by spraying or fumigation) that kill, repel or disrupt the reproduction cycle of vectors. In humanitarian action, environmental control is a joint effort of the WASH and shelter sectors, while chemical control (and occasionally the distribution of mosquito nets) is often coordinated by the health sector.

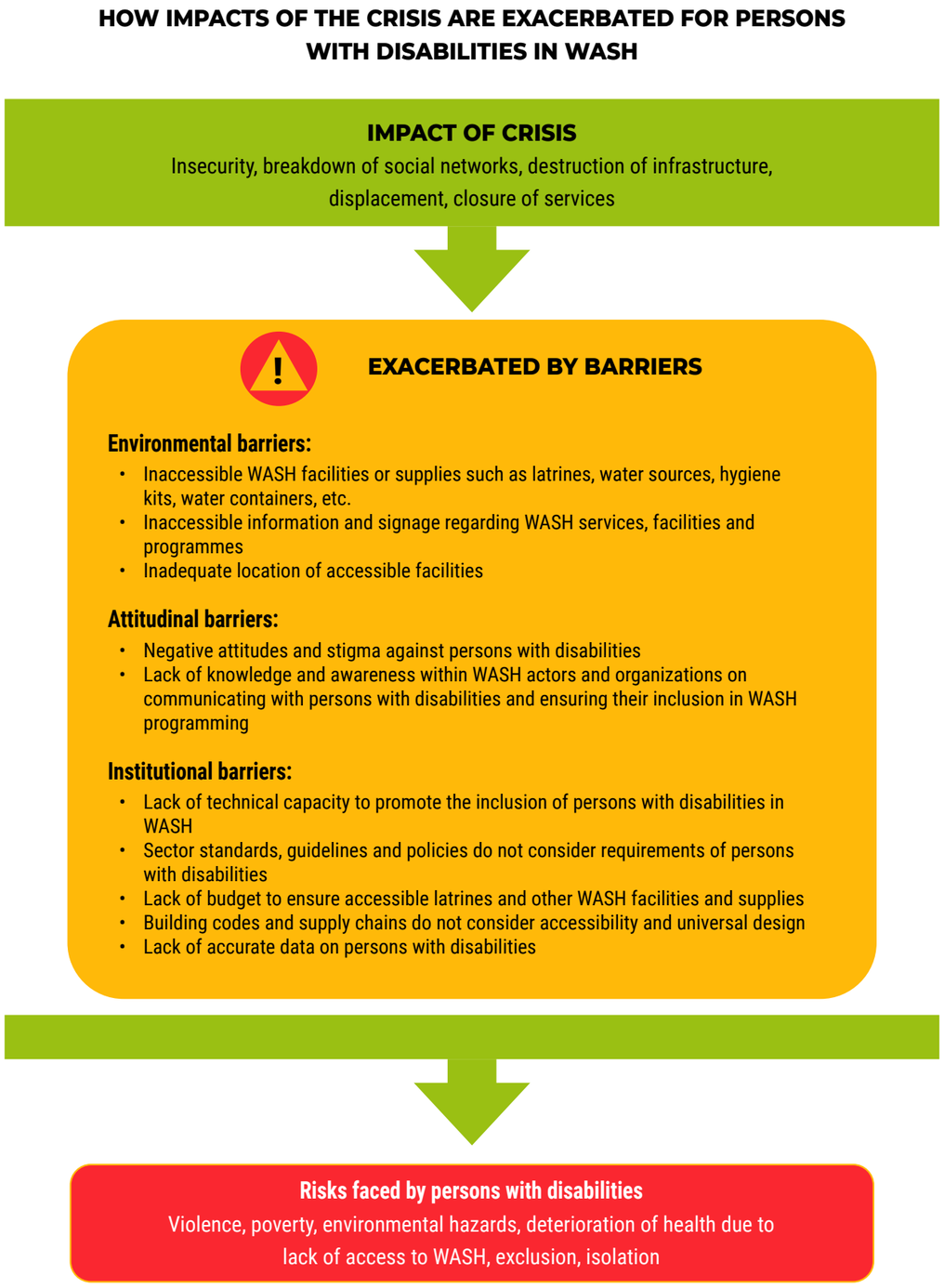
Incontinence occurs when a person cannot control the flow of their urine or faeces. It is a complex health and social concern that can lead to stigma, social isolation, stress, and an inability to access services, education and work opportunities. It is often not reported but a wide range of people live with degrees of incontinence.

WASH interacts with most other humanitarian sectors. Its activities can directly improve the protection and health of persons with disabilities as well as affected populations. Failures of sanitation and hygiene, equally, pose significant risks to both protection and health.

Standards and guidelines

- *Sphere Handbook* (2018)
- Handicap International, CMB, HelpAge International, *Humanitarian inclusion standards for older people and people with disabilities* (2018). See the section on WASH
- *Accessibility for All in an Emergency Context: A guideline to ensure accessibility for temporary infrastructure, WASH facilities, distribution and communication activities for persons with disabilities and other vulnerable persons* (2009)

Diagram 13 | Barriers to access and inclusion in WASH



Key elements – must do

'Must do' actions must be undertaken in all phases of humanitarian action when implementing WASH programming for persons with disabilities.

Participation

- Ensure that persons with disabilities, their families, and organizations of persons with disabilities (OPDs) are actively involved in identifying barriers that impede their access, and planning, designing, implementing, monitoring and evaluating WASH and related policies and programmes. Involve them in decision-making.
- Ensure that persons with disabilities are fairly represented, taking into account the various forms of disability as well as age, gender and diversity. Make concerted efforts to promote underrepresented groups, including persons with intellectual and psychosocial disabilities, indigenous persons, women and girls in formal and informal mechanisms and processes.
- Develop partnerships with OPDs and other organizations working in WASH. Work with them to support persons with disabilities and advocate for and promote inclusive WASH services.

Addressing barriers

- Identify and monitor barriers that limit the accessibility of WASH facilities, as well as enablers that make them more accessible. At minimum, strive to ensure that at least 15 per cent of facilities are fully accessible. Include water sources, toilets and distribution points. Provide reasonable accommodations, for example by provision of assistive devices, and organize outreach to facilitate full inclusion of persons with disabilities in all WASH services and facilities.
- Encourage or require all WASH service providers to implement universal design principles when they plan or build WASH facilities.
- Provide all assessment and reporting tools, and all information and communications on WASH programming and monitoring (hygiene promotion, place and times of distribution, management of water sources) in multiple accessible formats, taking into account the needs of persons with hearing, visual, intellectual and psychosocial disabilities.[235]
- Implement strategies to reduce disability-related stigma. Take steps to make the community aware of the rights of persons with disabilities. Establish peer-support groups that include self-advocates with psychosocial and intellectual disabilities.
- Review sectoral policies, guidelines and tools to ensure that they clearly affirm the right of persons with disabilities to access and inclusion.

Empowerment and capacity development

- Mainstream protection and safeguarding measures across all WASH interventions. Inform persons with disabilities about these measures and the procedures for accessing them. Recognize the gendered dimension of some protection and safeguarding risks.
- Build the capacity of WASH workers. Provide training on the rights of persons with disabilities, including the interactions between disability and age, gender, migration status, religion and sexuality.
- Make WASH actors more aware of the risks and obstacles that persons with disabilities face and how to remove them in compliance with humanitarian principles.

[235] Handicap International, CBM, HelpAge International, *Humanitarian inclusion standards for older people and people with disabilities*. See the section on WASH.

- Build the capacity of OPDs to work on WASH programming. Facilitate their meaningful participation in designing, implementing and monitoring services.
- Engage persons with disabilities and OPDs in all community mobilization and outreach activities.

Data collection and monitoring

- Review WASH standards and tools to ensure they require collection of data on persons with disabilities, including qualitative information and information on barriers and enablers.

The recommended actions that follow apply a twin-track approach. They ensure persons with disabilities have equal rights and opportunities to access WASH programmes and services, remove barriers, and promote comprehensive inclusion and effective participation.

MAINSTREAMED

WASH programmes and interventions are designed and adapted to ensure that they are inclusive of and accessible to everyone, including persons with disabilities.

TARGETED

WASH programmes accommodate the individual requirements of persons with disabilities, for additional water, incontinence kits, toilet chairs, skin care lotion, etc.

Recommended actions

WASH general and water supply

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Map OPDs and service providers; gather WASH data relevant to persons with disabilities.	X		
Identify and analyse the risks and barriers that persons with disabilities face when they access WASH services, facilities and information. Plan measures to mitigate and remove them.	X		
Collect and make available national and international standards on WASH, WASH practices and WASH accessibility.	X		
Design or adapt WASH infrastructures in accordance with universal design principles to ensure they are accessible.	X		X

	Preparedness	Response	Recovery
Review WASH rapid assessment tools; ensure they include questions and indicators on disability.	X		
Ensure that educational materials (for example, on hygiene promotion) are disseminated in multiple accessible formats and with different delivery options.	X		
Train WASH staff in disability inclusion. Consider practices, standards, tools and programme designs.	X		
Map the location of persons with disabilities before WASH facilities are constructed, especially if some locations are inaccessible.	X	X	X
Ensure that intersectoral assessments take account of WASH data disaggregated by sex, age and disability.		X	
Ensure that WASH technical assessments assess the accessibility of infrastructures.		X	
Consult persons with disabilities before siting water facilities, to take account of their specific requirements. Do so alongside household surveys.	X	X	
2. Resource mobilization			
Include persons with disabilities when preparing and budgeting WASH-related humanitarian response plans or flash appeal projects.		X	
Budget for the costs of making services and programmes accessible.		X	
3. Implementation			
When standardizing hygiene and dignity kits, consider the specific requirements of persons with disabilities.	X		
Disseminate WASH guidance and tools. If necessary, organize specific training for implementing staff.	X	X	
Develop WASH cluster/organization guidance in consultation with persons with disabilities.		X	
Establish partnerships with OPDs and NGOs that work on issues related to disability and WASH.	X		X
Work with local government and OPDs to develop WASH standards in schools, hospitals and public buildings. In designing these, take into account the specific requirements of persons with disabilities.			X
Build WASH facilities that are accessible to persons with disabilities; take into account their specific requirements.		X	X
Consult and involve persons with disabilities when water and sanitation facilities are sited, designed, constructed and maintained. When promoting hygiene, consult similarly.	X	X	X
Adapt the shape and weight of water containers to the capacities of persons with disabilities; make the containers available.	X	X	
4. Coordination			
Invite OPDs to participate in WASH coordination and technical working groups.	X	X	X
Plan accessible WASH facilities in consultation with the CCCM and shelter clusters. Follow a similar procedure to place families that have particular accessibility requirements close to communal facilities.		X	
5. Monitoring and evaluation			
Ensure that the standard monitoring tools promoted by the sector report on the accessibility of WASH infrastructures.		X	
Include disability indicators in routine quantitative and qualitative monitoring; design them to allow disaggregation by disability.		X	
Invite persons with disabilities to participate in 'lessons learned' reviews, efforts to identify good practice, and the adoption of recommendations for WASH programmes.			X
Include persons with disabilities in WASH committees. Encourage them to highlight their needs. Ensure they have access to sufficient water and to water points.		X	
Include OPDs in monitoring teams.	X	X	

Hygiene

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
When developing communication materials, include initiatives to reduce stigma. Take steps to remove social, physical and communication barriers that impede persons with disabilities from accessing WASH facilities and services.	X	X	
Messaging should be accessible. Include practical tips on how to maintain personal hygiene.	X	X	
Add items that persons with disabilities require to their hygiene kits. Include provision for incontinence (adult diapers, absorbent cotton material, disposable or reusable pads, washable leak-proof mattress protector, second bucket, additional soap, etc.).	X	X	X
2. Resource mobilization			
Include in the budget the cost of publishing and disseminating WASH messages in multiple accessible formats.	X	X	X
3. Implementation			
Develop hygiene promotion messages in multiple accessible formats (oral, print, sign language, easy-to-read/plain language, etc.).	X	X	
Instruct hygiene promotion field workers to provide WASH information at household level. Make sure all members of households have access to the information distributed.		X	
Raise the awareness of field workers about the use and disposal of additional hygiene kit supplies.	X	X	
Women with disabilities may need access to flexible and diverse menstrual hygiene management materials. Adapt menstrual hygiene materials to meet their requirement. Consider supplying absorbent cotton pads, disposable or reusable sanitary pads, underwear, soap, a dedicated storage container with lid, and rope and pegs for drying.	X	X	
Make sure that persons with mobility difficulties have proper access to hygiene-related items and facilities, such as soap, water and taps.		X	

	Preparedness	Response	Recovery
Ensure that hygiene items are distributed safely and are accessible to persons with disabilities. Choose a distribution site that is not too far from the affected population. Make it accessible to older persons and persons with disabilities. (For example, install ramps, rails and guide ropes at water points.) Deliver items to persons with disabilities who are unable to travel to distribution points.		X	
Whenever possible, prioritize older persons and persons with disabilities in queues for distribution. Organize dedicated queues or distribution times for them if they prefer.		X	X
Provide seating, food, shade, safe drinking water and toilets at distribution points. Distribute supplies in a gender-sensitive way that protects personal dignity.		X	X
4. Coordination			
Disseminate hygiene-related messages in multiple accessible formats.	X	X	
Ensure that hygiene messages consider the specific requirements of persons with disabilities.	X	X	
5. Monitoring and evaluation			
Ensure that monitoring and evaluation processes involve persons with disabilities and take their opinions into account.		X	X

Sanitation (excreta management and solid waste management)

	Preparedness	Response	Recovery
1. Assessment, analysis and planning			
Identify and analyse the risks and barriers faced by persons with disabilities in accessing WASH facilities. Take measures to remove or mitigate them.	X		
Locate WASH facilities at an appropriate distance from each other and from people's homes. Locate handwashing facilities close to latrines; position communal waste disposal areas at some distance from residences.	X	X	

	Preparedness	Response	Recovery
Design obstacle-free access routes to sanitation facilities.	X		
Take steps to make community infrastructures accessible (markets, health centres, schools…). Make individual dwellings accessible as well. In communal latrines, install specific facilities for persons with disabilities.	X	X	X
In the absence of detailed assessments, assume that 15 per cent of new or rehabilitated facilities must be accessible to everyone, including persons with disabilities.	X		
Ensure that persons with disabilities and their families are consulted about the disposal of waste. Consider excreta and menstrual hygiene and incontinence materials. Make sure that waste disposal arrangements are safe, respect personal dignity, and counter stigmatization.	X	X	
2. Resource mobilization			
Involve persons with disabilities when preparing the budgets for WASH-related humanitarian response plans or flash appeal projects.		X	
Ensure that proposals and budgets include the costs of making facilities and services accessible.		X	
3. Implementation			
Conduct awareness-raising sessions with families on the significance of toilet accessibility for the independence and dignity of persons with disabilities.		X	
Make latrine blocks accessible by installing ramps and handrails. Make doorways wide enough for wheelchairs to pass.		X	X
Ensure cubicles are large enough to accommodate a wheelchair when the door is closed.		X	X
Provide low-level, easy-to-use taps for handwashing.		X	X
Install drainage systems to prevent surfaces from becoming slippery.		X	X
Always hold a community consultation about arrangements for safe excreta disposal and hygiene practices. Consult the community about the location, design and appropriateness of sanitation facilities. Consider the specific access requirements of persons with disabilities: they need to travel to reach the toilet; to have access to the toilet; and to be able to squat or sit on the toilet.	X	X	X
Advise and support caregivers and support persons on managing faeces at home. Inform them how to dispose of faeces safely and hygienically.		X	
Install waste storage containers adapted to the different accessibility requirements of persons with different disabilities. Ensure that they are positioned where persons with disabilities can access them.		X	X
Train humanitarian workers and programmers in the WASH needs of persons with disabilities. Ensure that facilities are designed with access in mind. Facilities should respect personal dignity, be appropriate, and straightforward to maintain.	X		
Develop instructions and signage in multiple accessible formats that explain how to dispose of waste safely and hygienically.	X		
4. Coordination			
Ensure that public building facilities (e.g., schools, hospitals…) have sufficient accessible latrines.	X	X	
Consult persons with disabilities when communal solid waste disposal points are designed and sited.	X		
5. Monitoring and evaluation			
Monitor how persons with disabilities use latrines. Record the percentage who report that the toilets meet their requirements and the percentage who are dissatisfied. Use this information to improve hygiene and the quality of facilities and services.		X	X

19 Annexes

Annex 1 | Providing reasonable accommodations

Two actions are required to provide reasonable accommodations.

1. Identify what the person with disabilities requires to participate (interactive dialogue)

2. Justify the denial of reasonable accommodation objectively (without discrimination).

Consider every resource that is available to hand. Consider an express purchase from external providers. Check that the offered solution does not meet the requirement of the person concerned.

If none of the available options meet the requirements of the person, failure to meet his or her requirement is not discriminatory.

ASK	True	False
Is it impossible to provide this adjustment because it is not available?		
Is it impossible to procure this adjustment in time to meet its purpose?		
Is it illegal to provide this adjustment?		

Guiding questions to objectively justify denial of an accommodation

Any justification of the denial of reasonable accommodation must be based on objective criteria and communicated in a timely fashion to the person concerned.[236]

The following questions should guide reasoning when assessing a request for reasonable accommodation and justify its denial without discrimination on the basis of disability. Please note that the assessment ends at the first negative response; if the response is positive, continue to the next question.

1. **Is it legal to provide the adjustment required?**

(In this context, 'legal' should be understood to mean that no legal barrier prohibits the adjustment. The absence of an explicit regulation establishing the duty to provide reasonable accommodation does not justify inaction; inaction might imply discrimination on grounds of disability. 'Illegal' should be interpreted strictly to mean that a law or regulation prohibits the accommodation proposed. Even where this is true, the parties should seek to obtain waivers when this is appropriate and feasible.)

- **If the adjustment is illegal, refusal of accommodation is not discriminatory.** *("This adjustment cannot be provided because it is prohibited by law.")*

- **If the adjustment is legal, move to the next question.**

2. **Is it possible or feasible to provide the adjustment? (Is the requirement obtainable?)**

(This question seeks to establish whether the requirement is objectively achievable whenever and wherever it is required. It does not assess whether it is actually necessary or appropriate to meet its purpose; or whether available resources, including external resources that can be easily obtained, are available to cover the cost.)

- **If it is not possible to provide the adjustment, refusal of accommodation is not discriminatory.** *("This adjustment cannot be made because it is not possible or is not feasible to obtain the required product or service in the local market or any accessible market.")*

- **If the adjustment can be made, move to the next question.**

3. **Is the adjustment required necessary and appropriate? Will it remove the barrier in question and effectively ensure realization of the right on an equal basis with others?**

(This question determines whether the required adjustment meets its purpose. Does it contribute to the removal of a particular barrier and therefore enable the concerned person with disabilities to exercise his or her right on an equal basis with others?)

- **If the adjustment does not meet the purpose or would not enable exercise of the right, refusal of accommodation is not discriminatory.** *("This adjustment cannot be provided because it will not meet the intended purpose and will not contribute to the removal of a barrier.")*

- **If the adjustment meets the purpose, move to the next question.**

4. **Does the adjustment required impose a disproportionate or undue burden?**

(This question assesses whether it is disproportionately burdensome to provide the required adjustment. Answering this question requires a judgement of proportionality. Is it reasonable to expend the resources that will be required to make the adjustment (in time, cost, impact, etc.) in order to achieve the aim, which is the enjoyment of the right concerned?)

- **If the adjustment required is judged unduly burdensome, refusal of accommodation is not discriminatory.**

It could be unduly burdensome because, for example:

- The adjustment is expensive, and no financial means or options are available to cover the cost.
- The adjustment is expensive and covering its cost would jeopardize the functioning of the programme.
- Making the adjustment would undermine core functions of the programme.
- Other considerations relating to the means or aims of the requirement would clearly undermine core functions of the programme.

- **If the adjustment required is not judged unduly burdensome, a decision to refuse reasonable accommodation would discriminate on grounds of disability.**

[236] CRPD Committee, General Comment 6 on Equality and Non-discrimination, CRPD/C/GC/6, para. 27.

Annex 2 | Tools for disaggregating data

Tool	Use	Application in humanitarian settings
Washington Group Short Set of Disability Questions (WG-SS).[237]	This tool contains six questions which can be inserted in censuses and surveys. The questions generate internationally comparable prevalence data on persons with disabilities.	The tool is increasingly being used by humanitarian organizations and has recently been tested in various humanitarian contexts.[238] Note. The WG-SS does not directly address mental health or identify barriers that persons with disabilities face.
Washington Group Enhanced Set of Disability Questions.	Includes additional questions on upper body functioning, anxiety and depression.	
Washington Group Extended Set of Disability Questions.	This tool contains additional questions (37 in total) that capture anxiety and depression, pain, fatigue, use of assistive devices, age onset of disability, and environmental factors.	Some humanitarian responses have added the questions on anxiety and depression in this set to WG-SS questionnaires.
UNICEF-Washington Group Child Functioning Module.	Slightly longer than WG-SS, this tool gathers data on children and youth aged 2–17 years; the respondent is the primary caregiver.	This questionnaire has been used in resource-poor settings (for example, embedded in the MICS 6 survey that covers many high-risk humanitarian settings).
WHO Model Disability Survey.	This general population survey identifies environmental barriers that prevent full participation by persons with disabilities. The brief version contains 40 questions; the full version contains more.	So far this tool has not been tested in humanitarian contexts.
Manual for WHO Disability Assessment Schedule Version 2.0.	This tool provides a standardized summary measure of functioning in six life domains: cognition, mobility, self-care, getting along, life activities, and participation. Different versions of the tool have been developed to meet different needs. They include 12–36 items, each with multiple questions.	The tool has been tested in one humanitarian context (Pakistan) and over 100 other settings.

[237] Further versions of the Washington Group Short Set of Disability Questions have been developed. Leonard Cheshire and Humanity & Inclusion have produced one called the Washington Group Enhanced Set of Disability Questions. It has 12 questions: the six included in the short set, plus additional questions covering anxiety, depression and upper body mobility.

[238] Leonard Cheshire and Humanity & Inclusion, *Disability Data Collection: A summary review of the use of the Washington Group Questions by development and humanitarian actors* (2018).

Annex 3 | Potential sources of secondary data

Information needed	Data sources	Considerations
How many persons with disabilities are there?	Government statistical departments, for example: • Education. • Health. • School enrolment data.	National disability statistics should be treated with caution because they vary widely and use a variety of methodologies. Note that many administrative data systems may exclude persons with disabilities because they lack access. Data on exclusion can be particularly impactful (for example, on out-of-school children), but can be difficult to extract from these databases. Health data often focus narrowly on impairments but may permit certain assumptions to be made (for example, on functioning).
	Registration or profiling of refugees, internally displaced persons and migrants.	Registration or profiling data may under-identify persons with disabilities due to the methodology used (for example, visual cues or medical reports).
	UN Statistics Division.[239]	Database for disability statistics at national level.
	Humanitarian Data Exchange (HDX).	HDX is a platform that enables organizations to make their data available to other users. In November 2018, less than 1 per cent of the data sets in HDX were specifically about disability, but wider surveys may include disability as an indicator.

[239] Besides curating national census and survey estimates of disability prevalence for many countries, the UN Statistics Division database includes metadata on the types of disability included in national surveys, and in many cases an example of the survey instrument itself.

Annex 3 *(cont.)*

Information needed	Data sources	Considerations
	Surveys and assessments, such as: • Household surveys (e.g., MICS and DHS) conducted by humanitarian or development actors. • Site assessment surveys conducted by humanitarian actors. • Data kept by OPDs or specialized NGOs.	Recent MICS round 6 (since 2017)[240] and DHS (since 2016) have used the Washington Group short set questions[241] for adults. The MICS has used the UNICEF-Washington Group Child Functioning Module for children to assess disability prevalence. Consider the sample size and methodology of data collection exercises you consult, and their purpose. These influence the kind of information provided in reports.
	Mine action data.	This information is designed to track incidents related to landmines and explosive remnants of war (ERW). It does not capture disabilities unrelated to landmine and ERW incidents.
What barriers impede access to assistance?	Accessibility audits.	These take a checklist-based approach[242] to evaluate the level of accessibility and safety of facilities, premises and service delivery. They may have been done by local OPDs or NGOs.
	Post-distribution monitoring systems.	If these disaggregate by disability, it may be possible to analyse the barriers that persons with disabilities face, as well as instances of exploitation and other protection risks.

[240] In view of its methodology, MICS data should be interpreted cautiously to obtain disability prevalence. Among adults, only those of reproductive age (15–49 years) are surveyed, which excludes older persons – who have a much higher disability prevalence. For adults, MICS targets individual respondents who are excused from participating if they are 'incapacitated', which could be interpreted by enumerators to include many persons with disabilities. DHS surveys overcome these limitations to some degree by interviewing at household level, where the head of the household can respond on behalf of others. DHS also includes a broader age group and so captures older persons with disabilities more completely.

[241] The Washington Group question sets were developed for use in censuses and surveys. The questions reflect advances in the conceptualization of disability and use the World Health Organization's International Classification of Functioning, Disability, and Health (ICF) as a conceptual model. The questions ask whether people have difficulty performing basic activities (walking, seeing, hearing, cognition, self-care and communication) and were originally designed for use with the general population. However, the focus on functioning and the brevity of the tool mean that it can be deployed rapidly and easily in a variety of settings, including humanitarian needs assessments.

[242] For guidelines on conducting accessibility audits, see Handicap International, Conduct an accessibility audit in low- and middle-income countries (2014).

Annex 3 *(cont.)*

Information needed	Data sources	Considerations
	Feedback or complaint mechanisms.	These can provide important insights into the barriers that persons with disabilities face and their satisfaction with the quality of assistance. However, feedback mechanisms are often inaccessible to persons with disabilities. This is especially true if they address sensitive issues; in many cases, they are also anonymous or confidential. As a result, they may not disaggregate by disability.
	Humanitarian Data Exchange.	In addition to data on numbers of persons with disabilities, HDX also includes reports on barriers and facilitators.
	Special Procedures of the Human Rights Council, and Universal Periodic Reviews.	National and international human rights mechanisms can provide valuable information on barriers and risks, violations of rights, and the requirements of persons with disabilities. Relevant mechanisms include National Human Rights Institutions, the Committee on the Rights of Persons with Disabilities and the Special Rapporteur on the Rights of Persons with Disabilities.
What are the requirements and specific risks faced by persons with disabilities?	Information management systems, such as: • Gender-Based Violence Information System • Child Protection Information System • Protection Case Management Systems.	Incident tracking can suggest gaps in access to reporting, for example if persons with disabilities are particularly underrepresented. Physical, institutional and communication barriers, as well as public perceptions and stigma, may inhibit persons with disabilities from using case management services.
	Assessments, such as: • Needs assessments. • Participatory assessments.	Persons with disabilities may not have been systematically included in assessments, which as a result may generate limited or unreliable data. For example, persons with disabilities may have been hidden, or been unable to access the process; or assessments may not have sought information about their specific risk factors (e.g., barriers to accessing assistance).

Annex 4 | Considerations when assessing secondary data

How is the concept of disability understood?	Survey and databases define disability in a range of ways. Some focus narrowly on impairment, while others are also interested in issues of participation, access and support needs. The range of disability domains that a data collection tool considers (mobility, sight, hearing, intellectual, etc.) will also influence who is recorded as having a disability. In different cultural contexts, the concept of disability varies. This influences who is identified, and who self-identifies, as a person with a disability. For example, age-related impairments or impairments acquired during conflicts are not everywhere identified as disabilities.
Is stigma a factor?	In many situations, disabilities are hidden or misunderstood because disability is stigmatized. This can affect the quality of data collection, both because persons with disabilities may be reluctant to identify themselves, may be concealed or may not be acknowledged by their families, and because enumerators and humanitarian staff may also have biases. Direct questions (such as 'Do you have a disability?') that require binary responses ('Yes' or 'No') often result in underreporting, because of stigma or because respondents differ in their idea of what disability is. In addition, disability data may be sensitive for political reasons.
What 'counts' as a disability?	Disability exists on a spectrum; a person has a lesser or greater degree of disability. Data collections may set different thresholds for who is and who is not considered as having a disability.
For what purpose was data collected?	The purpose for which data are collected influences who is surveyed and who is identified as having a disability. For example, a health survey, a general population census and a household livelihood survey may adopt different criteria to identify persons with disabilities.
Does the sample have a limited reach?	Some persons with disabilities, notably those who are isolated in the home or live in institutions, may not be included in data collection processes. This issue particularly affects children with disabilities.
Are data up to date?	Data collected pre-crisis may no longer reflect the demography of an area post-crisis. Large-scale population outflows and inflows change population profiles, while both conflicts and disasters increase the number and proportion of persons with disabilities.

Annex 5 | Examples of output-level indicators

See also: Human Rights indicators for the Convention on the Rights of Persons with Disabilities in support of a disability inclusive 2030 Agenda for Sustainable Development

Thematic area	Examples of activity/output-level indicators
Health	Number of health facilities constructed or adapted in accordance with universal design standards.
Health	Number of persons with disabilities who access health-related rehabilitation services, including assistive technologies.
Education	Number of classrooms retrofitted or constructed in accordance with universal design standards.
WASH	Number of toilet facilities retrofitted or constructed in accordance with universal design standards.
WASH	Number of hygiene messages provided in a minimum of two formats (written and oral).
Food security and nutrition	Number of distribution points or markets retrofitted or constructed in accordance with universal design standards.
Protection	Number of staff, partners and communities trained to work inclusively with persons with disabilities.
Protection	Complaints alleging violence against persons with disabilities, discrimination on the basis of disability, and other violations of rights.
Gender-based violence prevention and response	Percentage or number of GBV staff trained in disability inclusion.
Gender-based violence prevention and response	Number of women with disabilities who participate in community-based mechanisms for GBV prevention and response.
Child protection	Number of children and youths with disabilities participating in child rights committees and other community-based structures for child protection.
Child protection	Number of child protection staff trained to provide inclusive mental health and psychosocial support and recreational activities for children, including children with disabilities.
Housing, land and property	Number of OPDs trained to participate in housing, land and property issues.
Mine action	Number of OPDs and individuals with disabilities trained to participate in risk reduction and education activities.
Mine action	Number of persons with disabilities who participate in community liaison activities to identify and assess risk.
Shelter	Number of houses and shelters adapted to improve accessibility.
Camp coordination and management	Number of persons with disabilities represented in community leadership structures.
Camp coordination and management	Number of participatory assessments conducted that include persons with disabilities.

Annex 6 | Evaluation criteria through a disability-inclusive lens

Evaluation criteria[243]	Definition	Example of disability-related considerations
Appropriateness, relevance	The extent to which humanitarian activities are tailored to local needs, thereby increasing ownership, accountability and cost-effectiveness.	Adaptations made to improve accessibility; persons with disabilities participate in design and implementation.
Effectiveness, timeliness	The degree to which an activity achieves its purpose; whether it does so within an appropriate time frame.	Persons with disabilities have access; they perceive positive benefits.
Efficiency, cost-effectiveness	Expected qualitative and quantitative outputs are achieved from inputs; alternative outputs would not achieve the same result at lower cost.	Accessibility is addressed from the start, improving cost-effectiveness.
Impact	Measures the wider social, economic, technical and environmental effects of an intervention. Includes results that are intended, unintended, positive, negative, macro (sector) and micro (household).	Whether persons with disabilities benefit equally; whether persons with disabilities experienced unintended impacts.
Connectedness	The extent to which activities of a short-term emergency nature take into account the local context and longer-term concerns.	Impacts on the inclusiveness of national/local services. Whether local/national systems providing assistive technology, inclusive education, etc., are strengthened; whether OPDs build capacity.
Coverage	The extent to which major population groups facing life-threatening events were reached.	Levels of access for persons with disabilities.
Coherence	The extent to which policies are consistent and consider humanitarian and human rights.	The extent to which humanitarian action complies with the Convention on the Rights of Persons with Disabilities (CRPD).
Coordination	The extent to which the interventions of different actors are harmonized to promote synergy and avoid gaps, duplications and resource conflicts.	Level of engagement by OPDs and other disability actors in the humanitarian response; quality of coordination.
Protection	The extent to which affected populations are protected from violence, abuse, exploitation and other harms, taking into account their rights and capacities.	The extent to which risks faced by persons with disabilities are identified, removed or mitigated.

[243] OECD-DAC, *Guidance for evaluating Humanitarian Assistance in Complex Emergencies* (1998).

Annex 7 | Accountability to affected people and protection from sexual exploitation and abuse

The table below illustrates how humanitarian actors, including clusters, can meet the commitments and quality criteria of the Core Humanitarian Standards (CHS) by including persons with disabilities.

CHS commitments and Quality criteria:	How can humanitarian actors support this?
1. Communities and people affected by crisis receive appropriate assistance that is relevant to their needs. **Quality criteria:** • The humanitarian response is appropriate and relevant.	• Define a common approach to needs assessment. Consult and involve persons with disabilities when defining and prioritizing response activities. • Regularly consult persons with disabilities, as members of affected communities, to verify whether response plans and activities are appropriate and relevant.
2. Communities and people affected by crisis have access to the humanitarian assistance they need at the right time. **Quality criteria:** • The humanitarian response is effective and timely.	• Define benchmarks and targets for timely delivery of assistance, based on the priorities and preferences of affected people. Persons with disabilities are a highly important subgroup that must access all types of information shared about assistance. • Regularly consult persons with disabilities when monitoring communities' satisfaction with the quality, timeliness and effectiveness of the response.
3. Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at risk as a result of humanitarian action. **Quality criteria:** • The humanitarian response strengthens local capacities and avoids negative effects.	• Define common strategies to strengthen local capacities. Take steps to involve local actors and communities in managing response activities. Develop the capacities of persons with disabilities to become resilient, to be able to obtain information they need, and to find out when and how they can access services. • Regularly consult persons with disabilities when monitoring negative effects that the response might have on affected communities or risks it might create.
4. Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them. **Quality criteria:** • The humanitarian response is based on communication, participation and feedback.	• Prepare a communication strategy for persons with disabilities. Adopt two-way communication channels based on their information needs and communication preferences. Make the strategy an integral part of the wider effort to engage and communicate with affected communities. • Prepare a strategy for engagement and participation of communities in management and decision-making processes. Make sure it describes how persons with disabilities will be engaged. Make their participation and inclusion a fundamental part of the community engagement strategy.

Annex 7 *(cont.)*

CHS commitments and Quality criteria:	How can humanitarian actors support this?
	• Regularly consult affected people to obtain feedback on the quality of the response and their relationship with aid providers. Persons with disabilities should always provide feedback on project designs. • Share information on the situation of persons with disabilities (barriers, risks, capacities…) in partner and cluster meetings and in inter-agency and cross-sectoral coordination mechanisms. Use the information to improve projects. • Include organizations of persons with disabilities (OPDs) in projects, the design of feedback and complaint mechanisms, and when mapping existing and new mechanisms. • Disseminate information and raise awareness about the Convention on the Rights of Persons with Disabilities (CRPD) and other legal protection instruments.
5. Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints. **Quality criteria:** • Complaints are welcomed and addressed.	• Identify the most appropriate channels and approaches for feedback and complaint mechanisms. Consider using common platforms. • Define clear protocols and the responsibilities of all humanitarian partners and stakeholders when dealing with complaints on sensitive issues such as protection against sexual exploitation and abuse (PSEA), gender-based violence (GBV), discrimination on the basis of disability, or other protection risks. • Regularly consult affected people to obtain feedback on the accessibility and appropriateness of complaint mechanisms. • Use a range of communication channels that are accessible to all persons with disabilities (including sign language, braille, accessible information and communication technology, easy-to-read/plain language materials, etc.). • Ensure feedback and complaint mechanisms are tailored to the context and to the communication requirements of all. • Ensure that feedback mechanisms that report on the quality of assistance and protection are accessible to all and are confidential.

Annex 7 *(cont.)*

CHS commitments and Quality criteria:	How can humanitarian actors support this?
6. Communities and people affected by crisis receive coordinated and complementary assistance. **Quality criteria:** • The humanitarian response is coordinated and complementary.	• Ensure that humanitarian coordination (including clusters) is accessible to and inclusive of local actors. Ensure it focuses on communities' needs holistically, and particularly on the requirements of people who work with and for persons with disabilities. • Regularly share information with other partners and clusters, and at inter-cluster level, to jointly identify and implement measures that address gaps in needs. • Regularly consult persons with disabilities, and other subgroups of the affected population, of different ages and gender, to determine whether assistance is coordinated and complementary.
7. Communities and people affected by crisis can expect delivery of improved assistance as organizations learn from experience and reflection. **Quality criteria:** • Humanitarian actors continuously learn and improve.	• Define a common approach to monitoring the quality and the effectiveness of responses. • Encourage joint monitoring and regular learning and knowledge sharing among humanitarian partners. • Regularly consult persons with disabilities and other subgroups of the affected population, of different ages and gender, to obtain information on how aid providers have addressed feedback, complaints and other issues.
8. Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers. **Quality criteria:** • Staff are supported to do their job effectively and are treated fairly and equitably.	• Identify any gaps in humanitarian actors' capacities and develop a common capacity-building strategy if required. • Advocate for adequate support, human resources and funding to support local partners' capacity to deliver quality assistance. • Regularly consult with persons with disabilities and other subgroups in the affected population, of different ages and gender, to obtain feedback on the relationship between aid providers and persons with disabilities.

Annex 7 *(cont.)*

CHS commitments and Quality criteria:	How can humanitarian actors support this?
9. Communities and people affected by crisis can expect the organizations that assist them to manage resources effectively, efficiently and ethically. **Quality criteria:** • Resources are managed and used responsibly for their intended purpose.	• Define common technical and quality criteria for projects and funding allocations, including criteria for community engagement and participation. • Set out clear procedures for monitoring and reporting resource use, including on issues of corruption or nepotism. • Regularly consult persons with disabilities, as an integral subgroup of affected people, to obtain information on how efficiently aid resources are used. • Train staff in disability and disability inclusion before departure. • Explicitly mention disability, gender and life cycle perspectives in job descriptions, evaluations, terms of reference, and monitoring frameworks. • Develop partnerships with OPDs. Allocate funding to them and provide support. Ensure that all partnership agreements are in line with the CRPD and guarantee that persons with disabilities shall enjoy protection and access to assistance and are entitled to participate fully in decisions and activities that are relevant to them.

The table below explains how to ensure inclusion of persons with disabilities in the four commitments for humanitarian actors.

IASC CAAP and PSEA commitments	
The IASC principles affirm that humanitarian actors will undertake to:	**What does this mean?**
1. **Leadership**	
Demonstrate their commitment to AAP and PSEA by enforcing, institutionalizing and integrating AAP approaches in the humanitarian programme cycle and strategic planning processes at country level, and by establishing appropriate management systems to solicit, hear and act upon the voices and priorities of affected people in a coordinated manner, including about sexual exploitation and abuse, before, during and after an emergency.	Humanitarian actors are acccountable to affected populations (AAP). They will focus on disability inclusion in all phases of the humanitarian programme cycle, including its processes and outputs. They will integrate the voices of persons with disabilities in decision-making processes. This requires leadership and the support of managers in humanitarian agencies, including managers of clusters and cluster lead agencies.

IASC CAAP and PSEA commitments	
The IASC principles affirm that humanitarian actors will undertake to:	**What does this mean?**
2. **Participation**	
Adopt agency mechanisms that feed into and support coordinated person-centred approaches that enable women, men, girls and boys, including the most marginalized and at-risk persons among affected communities, to participate in and play an active role in decisions that will impact their lives, well-being, dignity and protection. Adopt and sustain equitable partnerships with local actors to build upon their long-term relationships and trust with communities.	Humanitarian actors will define, implement and coordinate the most appropriate and relevant measures in order to enable persons with disabilities, and other subgroups of affected populations, of different ages and gender, to participate in project decision-making processes, including the work of clusters. They will encourage and support partners to implement person-centred and participatory approaches in their work. They will strengthen and prioritize local capacities and promote equitable, respectful relations with local actors, in line with CHS and the *Principles of Partnership*.
3. **Information, feedback and action**	
Adopt agency mechanisms that feed into and support collective and participatory approaches that inform and listen to communities, address feedback and lead to corrective action. Establish and support the implementation of appropriate mechanisms for reporting and handling of SEA-related complaints. Plan, design and manage protection and assistance programmes that are responsive to diversity and expressed views of affected communities.	Humanitarian actors will define and apply the most appropriate and relevant methods for disseminating information to persons with disabilities and other subgroups of different ages and genders in the affected people. They will collect and analyse feedback and draw on that feedback in decision-making processes. They will report back to affected people on what corrective actions have been taken. Humanitarian actors and cluster coordinators, with support from the Cluster Lead Agency, will ensure that partners understand and are supported to implement their PSEA responsibilities. They will define clear protocols on how they will deal with and report on sensitive feedback and complaints.
4. **Results**	
Measure AAP- and PSEA-related results at the agency and community level, including through standards such as the Core Humanitarian Standard and the Minimum Operating Standards on PSEA; the Best Practice Guide to establish Inter-Agency Community-Based Complaint Mechanisms and its accompanying Standard Operating Procedures.	Humanitarian actors will define indicators to measure outputs and outcomes for persons with disabilities and other affected groups, including measures of satisfaction with results. They will ensure that partners have the capacity, and are supported, to apply and measure relevant technical, quality, protection and accountabillity standards.